Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Mr. Mark Haynes
Associate Medical Director
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

8 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.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference.

The Inquiry is of the view that in your roles you will have an in-depth knowledge of matters that fall within our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now, or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

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

If it would assist you, I am happy to meet with you and/or your 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 an 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

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

Issued by the Urology Services Inquiry on 8 June 2022. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 6A 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: **Mr. Mark Haynes**
Associate Medical Director
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

Issued by the Urology Services Inquiry on 8 June 2022. Annotated by the Urology Services Inquiry.

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 11th 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 4th July 2022**.

Issued by the Urology Services Inquiry on 8 June 2022. Annotated by the Urology Services Inquiry.

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: Personal information redacted by USI

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 6A of 2022]

General

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

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

The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders or, if not, please identify who held the posts referred to and name any additional personnel not referenced by the Inquiry but which you are aware of.

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 reported and those departments, services, systems, roles and individuals whom you managed 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 roles and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

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

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

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

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog. The Inquiry notes the period of your tenure post-dates this review, so please just answer the following questions as relevant:

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

II. From your perspective, how was it implemented, reviewed and its effectiveness assessed?

III. What was your role, if any, in ~~that~~ those processes?

IV. Did the Plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

14. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the Plan resolved satisfactorily or did problems persist following the setting up of the urology unit, and during your tenure?

16. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, 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?

17. Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

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

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

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

21. Has your role changed in terms of governance during your tenure? If so, explain how and why it has changed with particular reference to urology services, as relevant? If so, do changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

22. Explain your understanding as to how the urology unit and urology services were and are supported by ~~non-medical~~ 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, so please set out in full all assistance and support you receive from administrative to fulfil your role. ~~to the medical and nursing staff~~. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

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

24. In your role as Associate Medical Director and/or Consultant were concerns of administrative support staff, if any, ever raised 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 did in response.

25. Do all Consultants have access to the same administrative support? If not, why not? Have you ever sought additional administrative assistance? If so, what was the reason, whom did you ask and what was the response?

26. 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?

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

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

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

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

31. ~~26.~~ What, if any role did you have in staff performance reviews?

32. ~~27.~~ Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide 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.

Engagement with unit staff

33. ~~28.~~ Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

34. ~~29.~~ 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.

35. ~~30.~~ Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

36. ~~31.~~ During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Governance – generally

37. ~~32.~~ What was your role in relation to the Directors of Acute Services and Directors of Human Resources and Organisational Development, the Heads of Service for Urology, the Clinical Directors, Medical Directors, consultants and other clinicians in the unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

38. ~~33.~~ Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

39. ~~34.~~ As AMD, how did you oversee 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?

40. ~~35.~~ How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

41. ~~36.~~ As AMD and Consultant, 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?

42. ~~37.~~ How could issues of concern relating to urology services be brought to your attention as both (i) the AMD and (ii) a Consultant? 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?

43. ~~38.~~ Did those systems or processes change over time? If so, how, by whom and why?

44. ~~39.~~ How did you ensure that you were appraised of any concerns generally within the unit?

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

46. ~~41.~~ 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.

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

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

49. ~~44.~~ During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

50. ~~45.~~ How well did you think the cycle of job planning and appraisal worked and explain why you hold that view? Did you have any issues with your appraisals or any you were involved in for others? If yes, please explain.

51. ~~46.~~ 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. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated 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.

52. ~~47.~~ Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

53. ~~48.~~ The Inquiry is keen to understand how, if at all, you liaised with and had both formal and informal meetings with:

    (i) The Chief Executive(s) during your tenure (the inquiry understand these post holders to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin)
    (ii) the Medical Director(s) during your tenure (the inquiry understand these to have been John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane),

(iii) the Director(s) of Acute Services during your tenure (the inquiry understand these may have been Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements),

(iv) the Assistant Directors, namely Heather Trouton and Ronan Carroll,

(v) the Associate Medical Director during your tenure (the inquiry understand this to have been Damian Scullion)

(vi) the Clinical Director(s) during your tenure (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)

(vii) the Head of Service, namely Martina Corrigan, and

(viii) the consultant urologists in post during your tenure.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals 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. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (viii) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

54. ~~49.~~ During your tenure, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

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

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

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

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

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

(f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

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

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

55. ~~50.~~ Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

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

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

57. ~~51.~~ What, if any, support was provided to urology staff (other than Mr O'Brien) by you and 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. (Q71 will ask about any support provided to Mr O'Brien).

58. ~~52.~~ Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

59. ~~53.~~ Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

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

61. ~~55.~~ When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

62. ~~56.~~ 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.

63. ~~57.~~ 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.

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

    (i) what risk assessment did you undertake, and
    (ii) what 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.

65. ~~59.~~ 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.

66. ~~60.~~ What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? <u>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 and/or indicate where the Inquiry may find a record of any oversight.</u>

67. ~~61.~~ 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?

68. ~~62.~~ 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?

69. ~~63.~~ Did Mr O'Brien raise any concerns 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 with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

70. ~~64.~~ 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 it was 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, why did you not?

71. ~~65.~~ 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 option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

72. ~~66.~~ 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. If the concerns raised were not reflected in governance

documents and raised in meetings relevant to governance, please explain why not.

Learning

73. ~~67.~~ 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.

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

75. ~~69.~~ 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?

76. ~~70.~~ 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.

77. ~~71.~~ 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?

78. ~~72.~~ 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?

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

NOTE:

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

Urology Services Inquiry

SCHEDULE

[No 6A 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.**

1.1 A response is provided within this statement to each individual question with regard to the nature of my knowledge of the matters which fall within the scope of the Terms of Reference of the Inquiry, including my role and responsibilities. With regard to timelines, I have provided a commentary of my memory of relevant events, prompted by my review of documentation provided by the Trust to the Inquiry to date. Relevant documents are referenced within the individual responses below. I have not been able to review all emails sent or received by me during the relevant period (2014 onwards) and, as such, it is possible that my responses inadvertently overlook some aspect of my involvement. A table summarising some key aspects of my role in relation to events that are of relevance to the Terms of Reference of the Inquiry is set out below. A more detailed account of my involvement in and/or knowledge of specific matters is, however, provided in my answers from Q4 onwards below.

1.2

Date (month/ year)	**Description**
May 2014	Commenced employment in Southern Trust as Consultant Urologist.

2014-2016	During 2014 there were multiple meetings with urology team and HSCB with a view to creating a vision for Southern Trust Urological services, culminating in the presentation of 'The Vision' to HSCB / Director of Commissioning in September 2014. I continued to engage with HSCB and the Urology Professional Issues Group (PIG) meetings throughout 2014, 2015 and 2016 (and onwards).
May 2015	Sent 'RE Longest waiters' email expressing concern regarding non-chronological management of private patients.
October 2015	Submitted IR1 relating to the absence of outpatient clinic letters and absence of notes for a patient admitted for surgery (Mr Patient 102).
November 2015	Sent 'Queue Jumpers' email expressing concern regarding non-chronological management of private patients.
January 2016-March 2017	On 6 January 2016 submitted IR1 relating to Mrs Patient 10 . This was screened on 15 March 2016. Final SAI report signed off on 15 March 2017. Subsequent SAI identified non-triage of her initial referral and raised concern that other referrals for the same week had also not been triaged. Subsequently, a large number of untriaged referrals were located. Additional work along with the entire consultant urology team to triage and subsequently provide timely review of patients who should have been upgraded to red flag. See further Question 45.2 below.

April 2016	Email responding to Dr Beckett enquiry (cc HoS) about a patient highlighting the absence of correspondence from outpatient consultation and the absence of the patient's perceived outcome action from the clinic consultation (addition to waiting list). See further Question 61.3 below.
August 2016	Email sent regarding non triage of referral which should have been upgraded to Red Flag regarding Mr Patient 93 . See further Question 61.6 below.
June 2016 - September 2017	Appointment as Clinical Director within Surgery and Elective Care (with responsibility for Surgery CAH and T&O).
2017	During early 2017, I engaged with HSCB / Belfast Trust with regard to provision of nephron sparing surgery in Northern Ireland following the departure, on a sabbatical, of a colleague in Belfast Trust. Following this, I commenced in-reach surgery in Belfast Trust in April 2017. I Chaired my first meeting of the NICAN Urology Clinical Reference Group in September 2017 and continue in this role. I continued to engage with HSCB regarding issues affecting Southern Trust Urology and attend the Regional Urology PIG meetings. I also worked with colleagues in HSCB on some work related to Procedure Based Commissioning.
January 2017	Location of 783 Untriaged referrals in Filing cabinet in Mr O'Brien's Office.
January 2017 – March 2017	Remedial workplan formulated and conducted by urology consultant team with Martina Corrigan (HoS) and Ronan Carroll (AD) to address

	triage backlog, undictated clinics / clinic outcomes.
January 2017 – September 2017	SAI conducted into the patients who had delayed cancer diagnosis as a result of the failure to triage referrals; conducted and chaired by Mr Julian Johnston. I provided urological input as part of the SAI review team. SAI Report signed off May 2020.
October 2017 – August 2021	Appointment as Divisional Medical Director Surgery and Elective Care.
2018	During 2018 there were various meetings or contact made with Senior Managers on issues such as capacity, waiting lists and the MHPS Investigation and evidence of this is provided throughout my statement, in particular see Question 53.1 below.
2019	In March 2019 I submitted an IR1 regarding non-action of CT report showing kidney cancer ([redacted]). See further Question 61.7 below. As Chair of the NIcAN Clinical Reference Group (CRG), I sent a letter to the Director of Commissioning re urological capacity. See further Question 54.1 below. I continued to raise concerns regarding the Backlog report. See Question 62.9 below.
2020	Following comments from Mr O'Brien in December 2019 in respect of the RCA Report on the Review of SA[redacted] I was requested by the Head of Governance, Trudy Reid, to input into Mr O'Brien's comments. In January

	2020 I was involved in a meeting to discuss issues in relation to Mr O'Brien's deviation from the Return to Work Action Plan. See further Question 69.5 below. In March 2020, Mr O'Brien indicated his intention to retire in and around June 2020. On 7th June 2020 I was copied into an email from Mr O'Brien, which raised concerns and I highlighted to the Medical Director, Acute Director, Assistant Director of Acute, and Head of Service. As a result of this email and these concerns we instigated an admin lookback. I identified additional clinical concerns regarding prostate cancer care which subsequently led on to the lookback review and subsequently the Public Inquiry. See further Question 62.11 below. Alongside this workload, and as part of the response to the COVID pandemic, I provided clinical leadership with regard to configuration and access to limited capacity for surgical treatments and prioritisation across specialities within Southern Trust, and regionally chaired the NICAN surgical group and sat as a member of the Cancer Reset Cell, Regional Prioritization Group. and Elective Care Cell, in addition to continuing my clinical work.
2021 - present	I continued to attend and input into the clinical and general Urology oversight meetings both internally and externally with HSCB, in addition to providing clinical input where any queries or potential concerns are identified. In addition to my usual clinical workload, I

	conduct outpatients clinics for patients identified as part of the lookback review, including those in respect of whom concerns regarding their previous care have been identified. I continue as NICAN CRG Chair, continue to attend the regional Urology PIG meetings and continue to work clinically across Southern and Belfast Trusts.
August 2021	Appointed as Divisional Medical Director for Surgery and Elective Care.
December 2021	Appointment as Divisional Medical Director Urology Improvement.

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

2.1 I can confirm that, to the best of my knowledge, I have provided all documents in my custody or under my control, either to the trust previously or with this statement. However, and as mentioned at Q1 above, due to the sheer volume of, for example, email correspondence, I have not been able to fully review every email sent or received during the relevant time periods and it is therefore possible that documents in my custody or under my control have been overlooked by me but may be identified by others and/or at a later date.

2.2 All relevant documents referenced in this statement can be located in S21 6a of 2022 Attachments Folder.

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.**

The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders or, if not, please identify who held the posts referred to and name any additional personnel not referenced by the Inquiry but which you are aware of.

Your position(s) within the SHSCT

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

4.1 Please find enclosed a copy of my job application *(see 1. MDH 1 (Job application form) at* the time of appointment to my post as Consultant Urologist in Southern Trust which summarises my qualifications and experience at the time of commencing employment in the Southern Trust.

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 Since commencing employment in the Southern Trust I have held the following trust posts (in addition to my position as Consultant Urologist, which I have held since May 2014, *please see 2. 20131000 - REF15 - MR M HAYNES Job Description).* The job descriptions are attached and are, I believe, an accurate outline of my duties and responsibilities;

a. Clinical Director (Surgery CAH / T&O); 1st June 2016 – 30th September 2017 (please see *3. 20160600 - REF2b - CD SEC CAH Job Description)*

b. Associate Medical Director (Surgery and Elective Care); 1st October 2017 – August 2017 *(please see 4. 20170600 - REF2b - AMD SEC Job Description)*

c. Divisional Medical Director (Surgery and Elective Care) – 1st August 2021 (3-year fixed term) *(please see 5. DIVISIONAL MEDICAL DIRECTOR SURGERY AND ELECTIVE CARE)*

d. Divisional Medical Director (Secondment to Urology Improvement) – (1st December 2021) *(Please see 6. DIVISIONAL MEDICAL DIRECTOR UROLOGY IMPROVEMENT)*

5.2 In addition I undertake the following external role;

a. NICAN Urology Clinical Reference Group Chair – Chaired first meeting September 2017 and continue in this role.

6. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.**

6.1 My line management in each trust post was/is as per the job descriptions. The job descriptions also give an overview of the departments, services, systems, roles and individuals for which / for whom I had responsibility.

6.2 As a Consultant Urologist I did not have any line management responsibilities. I was responsible to the Associate Medical Director (Mr Mackle at the time of my appointment) and the Director for Acute Services (Mrs Burns at the time of my appointment). On a day to day basis, Mr Young, as Clinical lead for Urology, operationally managed the consultant on-call rota and clinical activity schedule, along with Mrs Corrigan, as Head of Service for Urology and ENT.

6.3 As a Consultant Urologist, I attended monthly Patient Safety Meetings (which may have been termed 'Audit meetings', and 'Morbidity and Mortality meetings' at various points), and in this forum would take part in the discussion of patient care where an inpatient death had occurred, and in the discussion of any morbidity cases brought for discussion. I also raised concerns (where I became aware of them) either in email (link emails re private practice, lack of triage etc), or via the trust Incident Reporting System (IR1) (link IR1 from 2015).

6.4 As a Consultant Urologist I also attended departmental meetings which took place on a weekly basis.

6.5 I was Clinical Director within Surgery and Elective Care but my responsibilities in this role were for Trauma and Orthopaedics and General Surgery (Craigavon Area Hospital based team). In this role I had line management responsibilities for the medical staff within the Trauma and Orthopaedic department and Craigavon Area Hospital General Surgery department, including Job planning. Mr Weir was the corresponding Clinical Director with responsibility for the Urology team. As Clinical Director, my clinical line manager was the Associate Medical Director who at this time was Dr McAllister.

6.6 As Clinical Director, therefore, I did not have any additional responsibilities for systems and processes within the Urology service.

6.7 As Associate Medical Director, and subsequently Divisional Medical Director, for Surgery and Elective Care my line managers were the Medical Director (Dr Wright, Dr Khan, Dr O'Kane) and the Director for Acute Services (Mrs Gishkori, Mrs McClements). I was line manager, including job planning, for the Clinical Directors (Mr Weir, Mr Gilpin, Mr McNaboe) and supported the Clinical Directors as line managers to the medical staff within Surgery and Elective Care. With support of the Clinical Directors, I ensured that a Patient Safety Lead was appointed within each speciality who was responsible for the speciality patient safety meetings. I took part in the Incident Reporting / SEA / SAI / complaints process including participation in incident screening, identification of SEA / SAI chairs and review of SEA / SAI reports through the Monthly Acute Clinical Governance meetings.

6.8 The Associate Medical Director job description refers to a 'Divisional Governance Forum' / 'Divisional Speciality Governance Group' which has not been in existence during my time as Clinical Director / AMD / Divisional Medical Director.

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, responsibility and line of management with regards the operation and governance of urology services is as per the attached job descriptions as Consultant Urologist and as Associate Medical Director / Clinical Director, and as outlined in 6.1 – 6.8. As per 6.5, I was Clinical Director for General Surgery / Trauma and Orthopaedics and therefore, as Clinical Director, I had no additional role in the operation and governance of urology services beyond that of a Consultant Urologist.

7.2 As AMD, and as per my job description, I reported operationally to the Director of Acute Services and professionally to the Medical Director. I have outlined the roles I performed with regard to the governance of urology services in Q37/Q38.

7.4 The job description outlines my responsibilities with regard to governance within SEC, with Urology being part of SEC. The outline contained therein is a fair reflection of these responsibilities and lines of management, with the exception of the section referring a 'Divisional Governance Forum' / 'Divisional Speciality Governance Group' which has not been in existence during my time as Clinical Director / AMD / Divisional Medical Director, and the section regarding Appraisal which is coordinated through the medical revalidation team with a separate management team having responsibility for these processes. I am not an appraiser and therefore do not conduct appraisals.

8. **It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.**

8.1 As consultant and Clinical Director (General Surgery / Trauma and Orthopaedics) I had no additional role / responsibility for the operation and governance of urology services beyond those of any consultant member of staff. As Associate Medical Director/Divisional Medical Director, my roles were / are as described in the attached job descriptions.

8.2 The Clinical Director for Urology was the immediate line manager for the medical staff within the urology team and worked operationally with the Head of Service. As AMD I provided support to the CD within the line management structure which also includes the Medical Director.

8.3 Operationally, the Head of Service for urology was responsible for coordinating the day to day delivery of urological services across the utilized

Trust infrastructure (outpatients, inpatients, theatres, day case units, etc). In addition, the CD and HoS worked together with the Urology clinical team in strategic planning and delivery of urological care. As AMD, where operational / strategic challenges were posed I also provided input (e.g., emails re cystoscopies, Bipolar resection and Trans-Perineal Biopsy of prostate). *Please see;*

7. 20181205 E re Transperineal Prostate Biopsy Equipment
8. 20171120 E re Saline TUR
9. 20171120 E re Saline TUR A1
10. 20171120 E re Saline TUR A2
11. 20171120 E re Saline TUR A3
12. 20171120 E re Saline TUR A4
13. 20160611_ minutes Departmental Mtg - TUR

8.4 With regard to job planning, the Clinical Directors acted as 'first sign off'. This role involved them engaging directly with a consultant in establishing an agreed job plan. As Associate Medical Director, I provided guidance with regard to aspects of job planning in line with Trust job planning guidelines, and input / guidance where job planning discussions were meeting challenge. I was also the 'second sign-off'. Where required, I would seek additional input / guidance from the Medical Director / HR team.

8.5 With regard to the governance of urology services, I have further outlined roles and responsibilities in my responses to Q37/38.

Urology services/Urology unit - staffing

9. **The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern**

Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

9.1 I commenced my employment in Northern Ireland on 14th May 2014 (having previously worked as a Consultant Urologist in Sheffield) and was not party to any review or discussions of implementation until after 14th May 2014. During the initial year of my employment in Southern Trust, regular meetings were held, led by the Director of Commissioning, Mr Dean Sullivan, regarding development / provision of urological services in the Southern Trust. I enclose the presentation and summary of the presentation given to the Director of Commissioning *(please seeb14. 20190611-email AOB mins etc att 25 and 15. 20190611-email AOB mins etc att 28)* by me, on behalf of the Southern Trust team, in September 2014. I would have expected minutes / output following this meeting to have been available from HSCB and/or the Trust but I have made attempts to obtain records of notes following this presentation from each which have, to date, been unsuccessful. Within the presentation is a *capacity:demand* analysis and calculation of workforce requirements to deliver and meet demand (based upon the projections) which identified, at that time, that in order to meet demand 7 consultants, working 11.4 PA each, were required. At the time the workforce was 6 consultants. I recall follow-up meetings taking place with HSCB and have enclosed a copy of a presentation given by me on behalf of the Southern Trust Urology team to the regional Urology PIG (I suspect this was approximately September 2016 as this is the date the file was last modified but I cannot be certain of this) in which I outlined progress within Southern Trust against the proposals outlined in the 2014 presentation (please see *16. Urology PIG CAH presentation).*

10. **What, if any, performance indicators were used within the urology unit at its inception?**

10.1 I was not in employment in Northern Ireland at the time of the Southern Trust urology service's inception and am therefore not able to answer this question.

11. **Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?**

11.1 I was not in employment in Northern Ireland at the time of the publication of the 'Integrated Elective Access Protocol'. I became aware of the existence of the 'IEAP' at a later date through reference to such a document by others in meetings, but have no recollection of having been provided with a copy, either on my initial appointment or subsequently. However, as the document principally addresses the 'rules' for monitoring provider (NHS Trust) performance against quality indicators (targets) set by the commissioner (HSCB) I would not consider it to be a document that I require a significant working knowledge of, except where aspects directly impact on how I deliver care. Where aspects of monitoring place expectations on a member of staff or staff group, I would anticipate that this staff member / staff group would be made aware of the expectations relating to their role (e.g., time limits) and who / how to escalate when this is not achievable.

11.2 However, despite not recalling having ever been provided with the IEAP, I have always been aware of the existence of cancer waiting times targets and many of the rules relating to the monitoring of these. I would also be aware that it is my responsibility to return triage promptly, with recognition that Red Flag referral triage should assume a higher priority than urgent and routine referrals. While I was not made directly aware of the precise triage time aspects of the IEAP, having read the document as part of the process of responding to this question, I would consider these to be a reasonable expectation in general, with some recognition of flexibility around bank holidays / weekends and that, on occasion, competing workload pressure may also impact. I would also be aware of my responsibility to act on results and correspondence received by me in a timely manner and a requirement on me to ensure I work within available processes to ensure correspondence / results do not get overlooked. I would

also consider it absolutely expected that, if I am unable to meet an aspect of my workload, it is my responsibility to escalate this within my line management structure. When conducting triage during my Urologist of the week activity I aimed to as much as possible keep up to date on a daily basis, in particular with Red Flag referral triage, and ensured at the end of my week all was up to date for the incoming consultant taking over as Urologist of the Week. On rare occasions emergency activity was such that I subsequently completed the triage over the Thursday / Friday after handing over.

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

12.1 Trust performance is monitored against the targets as outlined in the IEAP and these access targets are reported through the trust performance teams to the Trust Senior Management Team and HSCB, and the directorate management teams. As has regularly been outlined in news articles, cancer access targets have not been met in Northern Ireland for a significant length of time. The primary issue in this is recognised as capacity. Operationally, actions have been taken to prioritise access such that patients referred on suspected cancer pathways are seen as a priority, such as changing the templates of outpatient clinics, increasing the proportion of available appointments for 'Red Flag' referrals, but this 'cancer focus' inevitably means that patients not referred on suspected cancer pathways (urgent or routine) wait many years for initial outpatient assessment and then wait many more years for surgery when indicated. In addition, operationally Waiting List Initiative sessions (additional extra contractual work) are regularly funded to provide both outpatient and inpatient / day case clinical activity to attempt to address waiting times.

12.2 The triage times outline in IEAP were not to my knowledge monitored for any clinicians. I do not have any recollection of being contacted as a consultant with

concerns regarding my triage activity taking too long, nor do I have any recollection of any escalation to me as CD or AMD of concerns regarding any monitoring of clinicians triage performance, or other clinicians (including urologists) not undertaking triage within the timescales noted in the IEAP, outside of the concerns identified regarding Mr O'Brien and detailed later in this statement.

12.3 As an individual consultant, the time limits outlined in the IEAP per se did not impact on how I delivered care on a day to day basis, aside from the impact on the proportion of Red Flag new patients I saw in outpatient clinics. Consultant urologists have a limited ability to impact on the scale of the capacity:demand mismatch and so our primary role is in prioritisation of those awaiting surgical treatment based on clinical priority. The IEAP details a number of principles for management of waiting lists. These principles align with what should be standard for any doctor with patients managed in chronological order, according to their clinical priority. Where the capacity:demand mismatch is such as in NI urology it has meant that effectively patients on routine waiting lists do not get treatment, and urgent non cancer cases may often wait many years.

12.4 Unfortunately, this approach (chronological management of waiting lists based on clinical priority) was not always followed in the department and I identified that Mr O'Brien, in particular, was bringing patients in whom he had seen privately ahead of those who had been on the waiting list for longer, even though, as far as I could see, they had the same indication and urgency as patients who waited years. Examples of emails escalating this concern are attached. *Please see:*

17. 20151126-email queue jumpers
18. 20150527-email urology longest waiters
19. 20150527-email urology longest waiters attachment 1
20. 20150527-email urology longest waiters attachment 2

12.5 As AMD the IEAP and time limits within it did not have any impact on my role in the management, governance and oversight of urology services. However,

in that role I did escalate concern regarding the scale and impact of waiting times experienced by urology patients.

13. **The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog. The Inquiry notes the period of your tenure post-dates this review, so please just answer the following questions as relevant:**

    I. **What is your knowledge of and what was your involvement, if any, with this plan?**
    II. **From your perspective, how was it implemented, reviewed and its effectiveness assessed?**
    III. **What was your role, if any, in ~~that~~ those processes?**
    IV. **Did the Plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?**

13.1 I was not in employment in Northern Ireland at the time of the publication of the '*Regional Review of Urology Services, Team South Implementation Plan*'. As identified in the attached presentation (*please see 16. Urology PIG CAH presentation*), backlogs were an issue at the time that I took up post, and, in order to address these backlogs and meet demand, recommendations for workforce expansion were made to the HSCB (80 consultant PAs required to meet demand at that time = 8 x 10PA consultants, 7 x 11.4PA consultants). Expansion of the funded posts to 7 consultants did not occur until June 2020 *(please see 21.* Personal information redacted by USI *02-Urology Allocation letter Southern Trust, 22. IPT_Urology Team - 7th Consultant_for SIC 10 Feb 2020 and 23. 20220503 email LL Urology Consultant 7th IPT and ESWL IPT)* over the intervening 6 years demand will have continued to increase (due to recognised demand pressure on healthcare services), and therefore it remains the case that current commissioned capacity does not address ongoing population demand.

13.2 I have reviewed the implementation plan as part of my response to these questions. It is important to recognise that commissioning of healthcare in Northern Ireland differs from England (for example), with the providers (Trusts) commissioned to provide a level of service and monitoring is performed against this level of service. The Implementation Plan details what level of service would be provided (commissioned). However, from this review I am of the opinion that the service was not going to meet the demand as identified at that time, was not going to address unmet need, did not have any plan to bring in the Newry and Mourne population demand (despite identifying that the General Surgeon who conducted this activity was anticipated to retire), and did not have any 'front loading' of capacity to address backlogs (e.g., provide for projected demand in 10 years' time now using surplus capacity available over the initial years of delivery to address backlog). The plan identified theatre capacity based on 3 session days delivered 48 weeks a year, a level of delivery that is unrealistic for a small team. Despite these failings, it recognised that the population's inpatient surgical needs would not be met. The service was effectively commissioned at a level where it would fail to meet population need from its inception and this gap would widen given the absence of projections related to increasing demand resultant from population / demographic changes. This is the pattern across Urology in Northern Ireland and remains the case. There are fewer consultant Urologists and fewer Urology Clinical Nurse Specialists per head of population in Northern Ireland compared with elsewhere in the NHS so, unsurprisingly, the needs of the population are not met and waiting times for our services are the worst in the NHS.

13.3 The Document also fails to recognise and attempt to quantify the demand impact of not providing timely appropriate care – i.e., not treating conditions at the time (or soon after) they are identified often results in an increase healthcare cost (e.g., using a hypothetical cancer treatment as an example, an early stage cancer may be treated completely with a single 2-hour operation with no need for additional treatment such as chemotherapy / radiotherapy; however, if treatment is delayed the cancer becomes advanced and requires a 4-hour operation, and a course of chemotherapy, thereby placing a greater demand on the healthcare system) and is not aligned to a manpower strategy covering

medical and Clinical Nurse Specialist workforces. As a result, Northern Ireland is behind all other areas of the NHS in its urology service on all fronts and continues to fall further behind each year.

14. **As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.**

14.1 I was not in employment in Northern Ireland at the time of the publication of the '*Regional Review of Urology Services, Team South Implementation Plan*' and cannot comment regarding the time prior to my commencing employment in May 2014. The capacity:demand gap and resultant waiting times and treatment risks are identified on the Trust's Risk Registers. However, I am of the opinion that the risks posed to patients are inadequately represented, and not explicit enough. The reference is in general and does not quantify the extent of the risk for each and every service / specialty and so understates the importance. As highlighted, I presented 'the vision' for the urology service in Southern trust to HSCB in late 2014 which included comment on this. I was also co-clinical lead on a regional review of day case urology surgery conducted by Ernst and Young *(please see 24. DECC Draft Final Report - Urology).* This external project again identified the significant gap between urology capacity and demand across Northern Ireland for day case surgery and HSCB (now SPPG) investment in the regional DPC project specifically with regards to urology is targeted at this need.

15. **To your knowledge, were the issues noted in the Plan resolved satisfactorily or did problems persist following the setting up of the urology unit, and during your tenure?**

15.1 The primary issues detailed within the Implementation Plan are a historic backlog (from failure to meet demand), ongoing capacity:demand mismatch,

and impending increasing demand upon the retirement of a general surgeon based at Daisy Hill Hospital. These challenges have not been resolved. Indeed, demand was increased temporarily for a period during my time as a consultant in Southern Trust with the Southern Trust taking patients from the BT80 post code (in addition to the agreed geographical area) from Team North West due to personnel challenges in Team North West. This increased demand was perpetuated for a period after the resolution of the Team North West challenges. Changes to the geographical area have since been made (to my understanding, as part of agreed expansion of Team North West aligned to the centralization of Penile cancer services to Altnagelvin) with patients from the Fermanagh area now being part of the Team North West area and this has reduced Southern Trust demand.

16. **Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them? Did you ever complain about inadequate staffing? If so, to whom, what did you say and what, if anything, was done?**

16.1 I have enclosed at question 9 the presentation and summary of the presentation given to the Director of Commissioning, by me, on behalf of the Southern Trust team, in September 2014. Within the presentation is a capacity:demand analysis and calculation of workforce requirements to deliver and meet demand (based upon the projections) which identified, at that time, that in order to meet demand 7 consultants, working 11.4 PA each, were required. At the time the workforce was 6 consultants. This shortfall of clinical staff (and the supporting bed/theatre/OP/support staff capacity to support the workload) undoubtedly led to an inevitable inability of the service to meet demand, long waiting times for all aspects of care, and unsatisfactory workload pressure on all members of the urology team. This shortfall of workforce capacity was also mirrored across NI and outlined in the Urology Workforce Planning Report (*please see 25. Workforce plan*). I recall the Director for Commissioning at the time of these meetings commenting to the consultant urology workforce, '… come on guys you are not far off, it's not that much more

…', implying that the solution to the workforce shortage was us to work harder. I understand this shortfall is also recognised across Northern Ireland at a Clinical Nurse Specialist level, and indeed, when I commenced in Southern Trust, I was struck by the vast difference in numbers of Clinical Nurse Specialists in Northern Ireland compared with the services I worked within in South Yorkshire. This shortfall relates to the staffing required to meet demand, not relating to the service level commissioned.

16.2 I (and others) continued to raise the issue of insufficient capacity to meet demand, and the impact of resultant waiting times, in departmental meetings, email communication, AMD meetings, regional meetings, and discussions with my line managers.

17. **Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.**

17.1 The Trust will be able to provide the precise dates of commencement / departure for members of staff and details of any periods of sick leave *(please see 26. List of Consultants and SAS Medical Grades 2009-2016 and 27. 20160401 Ref15 - Full Staff in Post from 2016 to 2021).* During the time of my employment in Southern Trust one substantive consultant left post (Mr Suresh – October 2016). Attempts to appoint a replacement were unsuccessful until the appointment of Mr Tyson. A locum (Mr Jacob) was employed by the Trust for a significant proportion of the intervening period. Soon after taking up post, Mr Tyson went on sabbatical abroad; this was initially planned to be a one-year period but was extended due to the impact of COVID 19 on global travel. During this time, a number of locums were employed. Mr O'Brien retired in Summer 2020 and, despite adverts (for his replacement plus an additional post), no successful substantive appointment has been made.

17.2 Currently 7 full time consultant Urologist posts are funded. At present there are 4 substantive consultants in post and a recently retired colleague returning to work on a part-time basis but does not partake in the out of hours rota / emergency cover, and an agency locum consultant. This leaves 2 consultant

posts vacant at present. The Trust has actively attempted to recruit to these vacant posts on a number of occasions without success to date. As a result of the vacant posts, each consultant has an increased burden of triage to action and an increased volume of emergency care provision.

17.3 Although I am 1 of the 4 substantive consultants mentioned, since my appointment as CD in 2016, the agreement for me providing in-reach surgery in Belfast Trust (commenced April 2017), and then my appointment as AMD / Div MD (from October 2017), significant proportions of my job plan have been providing work outside of Southern Trust Urology clinical work, meaning an additional shortfall in the clinical capacity within Southern Trust Urology. Specifically, with regards the in-reach surgery, I commenced this in order to maintain specific specialist surgery in Northern Ireland and prevent loss of specific surgical treatment locally. This approach was agreed in advance with the Trusts / HSCB. Over subsequent years this has enabled the training of a local trainee, who is now a colleague in Belfast Trust providing this surgery. However, my surgical remit has shifted from 'nephron sparing surgery' (removal of part of the kidney to treat kidney cancer) to surgery for advanced kidney cancers and major bladder cancer surgery.

17.4 Throughout my employment in Southern Trust the level of junior doctor support has been challenging at various points. There has always been an incompletely staffed middle grade rota resulting in significant numbers of out of hours shifts being covered by locum doctors who often have limited urological experience, and the middle grade cover stops at 11pm, such that the consultant urologists provide cover without a middle grade doctor from 11pm – 9am (with a core surgical trainee who cross covers with general surgery). This means that the level of direct involvement (and therefore workload) of the SHSCT consultant urologists in emergency care, and particularly overnight management of acute admissions, is far greater than I had experienced prior to moving to work in Southern Trust. The lack of core trainee level junior doctors in covering urology, and the middle grade doctor numbers, also means that all outpatient workload is shouldered by the consultants.

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

18.1 The Trust will be able to provide details of sick leave dates, and periods of consultant and staff grade vacancies during the period I have worked in Southern Trust.

18.2 Managing shortages of staff in a service that is already failing to meet demand is always a major challenge. Locum consultants may from the outside look like an 'easy' simple solution. However, this outlook fails to recognise that, often, locum doctors are not in substantive posts for a reason. Many locum consultants are not on the specialist register (and therefore would not be appointable to a substantive post), they require some oversight upon commencement of work and the degree of oversight required is similar to that required by a specialist registrar. Scope of service they are able to offer may be limited and decision making, while safe, may not be the most efficient and therefore places additional demands on the service (e.g., following up rather than discharging). During my time as Associate Medical Director, I have had to terminate the employment of one agency consultant *(please see 28. 20200924 E re Mr* Personal Information redacted by *, 29. 20200924 E re Mr* Personal Information redacted by *A1, 30. 20200924 E re Mr* Personal Information redacted by *A2, 31. 20200924 E re Mr* Personal Information redacted by *A3 and 32. 20200924 E re Mr* Personal Information redacted by *A4)* because of professional concerns which were highlighted and escalated to the Agency's Responsible Officer.

18.3 In the inevitable service gaps there is always going to be a particular gap where clinical queries and results need to be addressed in the absence of the prior clinician, and during which clinical prioritisation of existing patients on the waiting list needs to be performed. Within the urology consultant team, where queries are received regarding the care of a patient under the care of a consultant who is no longer working in the Trust or who is on sick leave, in the short term we have addressed these in turn as the Urologist of the Week. We have also made provision for management of results (my current electronic

results set up draws results under the names of 3 locum consultants, Mr O'Brien and myself). However, this is not without challenge. This workload is all the patient-related administrative workload of a colleague, the service is already unable to meet demand and so, to free a clinician from clinical duties to conduct this workload, would result in a widening of the gap between capacity and demand. Additional activity (as Waiting List Initiative / WLI) is offered to the team for this activity but, due to a variety of factors, this offer is often not taken up and the activity often conducted during individuals' own time. When vacancies become longer term, and are associated with outpatient and inpatient waiting lists, they create additional challenge as the remaining clinicians cannot absorb the operative and outpatient workload without negative impact on the patients already under their care.

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

19.1 This matter has already been covered, in part, across questions 16, 17 and 18.

19.2 From a personal perspective, it has had a direct impact on the time committed to my role as AMD. Until November 2021, I did not include the full 3 PA requirement in my job plan as I endeavoured to deliver clinical care and this meant that I was not able to deliver fully my role / responsibilities as AMD. Additionally, at various points during my tenure as CD / AMD, all of the clinical management posts (CD / AMD) have been unfilled adding to the workload of the medical managers in post and, upon commencement and due to the events which led to the departure of the previous AMD (Dr McAllister), I did not receive a handover or induction into this role. I also regularly conduct core aspects of my clinical activity (patient related admin) in my own time (typically from approx. 5:15am in the mornings, both weekdays and weekends). I regularly continue to address patient related admin and results throughout periods of annual leave.

19.3 The mismatch between demand and capacity, and the strains of delivering care within current capacity (with consequent bed pressures, increasing

numbers of complaints, and elected representative enquires regarding waiting times etc.), also means the directorate management team (operational managers / Assistant Directors) spend a large proportion of time managing day-to-day pressures and responding to complaints, with consequent negative impact on their ability to function in a strategic / service planning and development role.

19.4 Vacancies within the urology consultant / clinical team also mean that, while all the individuals make every effort to attend patient safety meetings, acute admissions / annual leave / other activities can result in a reduced team attendance on occasion. In particular, personally my Belfast Trust activity (theatre) often continues during patient safety session half days, reducing my ability to attend.

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

20.1 Medical staffing within the unit continually changes with rotation of training grade doctors, sickness / maternity / retirements and career moves. Trust HR would be able to provide detail of personnel and dates etc.

20.2 Responsibilities also inevitably change during the course of medical careers. Again, details of formal roles (e.g., Clinical Directors / Associate Medical Directors) I would expect to be available from the trust HR team.

20.3 With regards to specific additional roles since my appointment in May 2014, Mr Glackin (and now Mr O'Donoghue) have held the 'Patient Safety Lead' role. I do not have the precise date that Mr Glackin ceased to fulfil this role and Mr O'Donoghue took the role on.

20.4 With regards to Urology Cancer MDM lead, Mr Glackin currently fills this role, having taken it on from Mr O'Brien; again, I do not know the exact date this occurred.

20.5 In addition to the Patient Safety Lead and Urology Cancer MDM Lead, additional job-planned (0.5PA each) lead roles within the urology service have been developed and included in job plans from late 2021. These additional roles are 'Rota Lead', 'Education Lead' (both Dr McAuley), 'Quality Improvement Lead' and 'Standards and Guidelines Lead' (both Mr Tyson).

20.6 In April 2017, following the departure on Sabbatical of a colleague who provided specialist kidney cancer surgery in Belfast Trust, and subsequent to meetings with Belfast Trust and HSCB regarding the maintenance of this surgery in Northern Ireland, I commenced delivery of part of my job-planned clinical work in Belfast Trust. This (initially temporary) arrangement has become fixed in my job plan with me delivering clinical activity for bladder and kidney cancer in Belfast Trust as a core member of the specialist multidisciplinary team.

20.7 I am the current NICAN CRG Chair (a regional role), having taken this position after Mr O'Brien left the role, and chaired my first meeting in September 2017.

21. **Has your role changed in terms of governance during your tenure? If so, explain how and why it has changed with particular reference to urology services, as relevant? <u>If so, do changes in your role impact on your ability to provide safe</u> <u>clinical care, minimise patient risk and practice good governance?</u>**

21.1 My role regarding governance changed when I commenced as AMD (and subsequently, Divisional Medical Director) as per the enclosed job descriptions.

21.2 Given the clinical demands on Urology services I did not incorporate the full 3 PA of time for the AMD role into my job plan as to do so would have resulted in a reduction in clinical activity and thereby an increase in waiting times for patients. This continued delivery of clinical work is evidenced as an example in my 2019 CLIP report detailing continued delivery of clinical work in greater volumes than local peer averages for outpatient, and inpatient activity.

21.3 Over time since 2017 my role has developed multiple differing aspects which have progressively increased, in particular since 2020 with the COVID pandemic response and Lookback Review. My clinical activity did not change appreciably in parallel, resulting in progressive challenges for me to be able to meet the multiple competing demands. However, I have always continued to put direct patient care as my first priority and have maintained this.

21.4 In order to minimize patient risk and continue to provide safe care I have progressively, during the course of my employment in Southern Trust, worked significant additional periods of time outside of my job-planned activity in order to ensure patients' clinical results are reviewed and appropriate action taken when required, and to keep up to date with clinical correspondence. My standard working day commences at around 5:15am every weekday and typically lasts between 12 and 14 hours. As I am currently unable to drive [redacted], my commuting times are also greater than they may be as I make use of limited public transport and ride a bike. Weekend mornings also typically include between 2 and 4 hours of work-related activity every week.

21.5 On occasion the timing of Patient Safety Meeting sessions in Southern Trust and Belfast Trust has resulted in me being unable to attend them. In addition, my clinical activity in Belfast Trust continues at the time of Patient Safety Meetings (as it is providing cancer care) and this also reduces my attendance at Patient Safety Meetings. For example, it may have been that the Belfast Patient Safety Meeting was taking place at a time when I had Southern Trust clinical activity, and the Southern Trust meeting at a time when I had Belfast Trust activity, resulting in me being unable to attend either meeting. Alternatively, it may have been the case that the Belfast Trust and Southern Trust meetings were both at the time of Belfast Trust clinical activity (e.g., Theatre) which was not cancelled (due to the nature of my surgical work being major cancer surgery) and therefore I was again unable to attend either meeting. In addition, in my role as AMD, on occasion I needed to attend Patient Safety Meetings of other services relating to significant issues affecting these specialities (e.g., Daisy Hill surgical staffing) which meant that, although I was

engaged in patient safety activity, I was not present at the urology Patient Safety Meeting.

21.6 During the COVID 19 pandemic, the impact of the necessary changes in healthcare to meet the demands of the pandemic also required significant input from me as AMD, as access to surgical inpatient treatment was significantly restrained. In addition to my role in allocating limited available theatre access across surgical specialties and establishing prioritization principles within Southern Trust, I was also part of the regional response as Chair of the NICAN surgical group established in response to the pandemic and sat on the Cancer Reset Cell, I was part of the establishment of the Elective Regional Prioritization Group (RPOG) and Elective Cell with these additional roles resulting further in an increase in the time spent by me working outside of job planned activity.

21.7 This necessary COVID 19 response also coincided with the identification and investigation of clinical concerns regarding Mr O'Brien. Some concerns were identified as a direct result of the changes imposed by the pandemic (see 62.11 below). This also resulted in a further significant increase in workload delivered outside of job planned activity. On occasion since June 2020, these demands did affect the timeliness of my delivery of some of some of my clinical results and clinical correspondence management. However, in general I have ensured that my clinical work, and therefore patients, have not been impacted by the workload demands.

21.8 The subsequent escalation of the clinical concerns regarding Mr O'Brien, with the establishment of the lookback process, have altered the focus of my Southern Trust clinical activity. A focus on providing clinical review of patients previously under the care of Mr O'Brien as part of the Lookback Review has resulted in a marked reduction in the assessment of new patients by me which resulted in reduced capacity in the service and an increase in waiting times (this has now been mitigated by an independent sector contract). Patients awaiting outpatient review with me have also not been able to be offered appointments as my clinical time in outpatients in Southern Trust is taken up with lookback reviews and consultations with patients and families in respect of whose care

concerns have been identified. This lookback-related activity also carries a significant emotional load for me and the CNS team, in particular where consulting patients and families whose care has been identified as deficient and harm has resulted.

21.9 Activity relating to the Lookback Review, in particular during my weeks as 'Urologist of the Week', has meant that in order to attend meetings of the Lookback Review Steering Group, or other activities related to lookback patients (e.g., meeting with relatives, patient reviews, etc.) I have adjusted my input into the day's activity, reviewing all inpatient results on NIECR prior to the start of the day, attending the emergency theatre team brief, and having a handover with the SPR where I advise of my thoughts and plans based on my review. I then do not conduct the ward round personally but receive a further handover / feedback from the ward round and review in person patients where required. This has enabled me to ensure that patient care is not impacted and that the lookback demands have been able to continue to be met, but has displaced my involvement in aspects of unscheduled care into time periods outside of job-planned time.

21.10 With large portions of my own time already utilized in delivery of my day to day activities, and multifaceted demands upon my time, I have found myself increasingly stretched in attempting to provide the time required. I am aware that I have a tendency to put patient care at the forefront of my priorities and have ensured that I maintain this. The Lookback Review and the direct patient input required related to this has also been a priority. I have been the only consultant providing reviews of these patients. While this has been mitigated by my reduced input into new patient consultations, there is additional related work involved, including review of many years' care and patient review forms / SCRR reports in order to prepare for consultations, in addition to a significant emotional load from the consultations with patients and families where harm has occurred. Alongside this, I have continued to work regionally in my capacity as CRG chair attempting to address the challenges affecting cancer care in urology and across specialties in Northern Ireland including input as part of the Cancer Reset Cell, Elective Care Cell, and an external review of NICAN. Much

of this has taken place in my own time. With regard to clinical activity, I have over delivered against the expected number of clinical sessions, with the extra activity replacing the time in my job plan for Supporting Professional Activities (SPA) and this has resulted in me not being able to complete my appraisals as I have not had adequate spare time (with it already being utilized for other non job planned activity). In addition, the urology service now has 4 substantive consultants and one agency locum, meaning that in 2 weeks out of every 7 emergency clinical activity requires backfill. I have regularly covered many of these vacant shifts where my colleagues were not able to provide cover. While additional outsourced clinical activity in the independent sector is maintaining service delivery for patients, there is a resultant workflow of clinical correspondence that returns to the Trust and this has also come to me. Despite a cognisance of the multiple competing demands being placed on me, no significant workload mitigation has been put in place.

22. **Explain your understanding as to how the urology unit and urology services were and are supported by ~~non-medical~~ 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, so please set out in full all assistance and support you receive from administrative to fulfil your role. ~~to the medical and nursing~~ staff. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.**

22.1 I have not been aware of any concerns regarding administrative support availability and have never had any myself, aside from short term issues as a result of sickness / role changes / retirements. I have a secretary who works with me and also conducts activity for the CNS team. In addition, audio typists will provide additional typing support. Although not formally part of her role, my secretary also provides some support to me as Divisional Medical Director. The secretarial and audio typist team function collaboratively, providing cross cover where required. The following is a list of duties which my secretary conducts as

part of our team (I have discussed this with her and the list may not be exhaustive). It is my understanding that these activities are expected to be performed by all secretarial staff in the Trust;

a. Typing;
b. Actioning PAS outcomes from patient episodes (e.g., additions to Inpatient (IP) / day case (DC) waiting list (WL), outpatient waiting list, Discharge awaiting results outcome (DARO) list);
c. IP/DC theatre list scheduling (booking patients, addition to Theatre Management System, communication of planned lists to theatre / pre-operative assessment / ward / anaesthetic teams, including any specific equipment, personnel or post-operative care (e.g., High Dependancy Unit) needs);
d. Coordinating planned admission (with patients / pre-operative assessment, appointments letters, patient transport);
e. Patient / GP / other teams enquiries (telephone and written), including signposting of telephone enquries to, e.g., Clinical Nurse Specialist (CNS) team, radiology appointments) and escalation to emergency (on call team) or me where appropriate (by telephone or email as appropriate / guided by my clinical activity at the time);
f. Filing;
g. Management of DARO list (monthly check of outstanding tests as guided by patient episodes and recorded on DARO list, with escalation of any results which are available but have not been actioned to me);
h. Open post daily, date stamp, and add to electronic post file for action weekly;
i. E-triage – check any follow up on e-triage while consultant is on-call on NIECR;
j. Complete a backlog report monthly and send to management for information;
k. Book urgent outpatient appointments following MDT discussion.

22.2 As an observation, from a very early point in my working life in the Southern Trust, it was apparent to me that Mr O'Brien had a non-standard way of working and appeared to do much of the work that support staff would undertake for

other consultants himself, despite having access to the same secretarial / support staff as did his colleagues.

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

23.1 Yes, there is an expectation of cross cover for administrative staff; in addition, audio typists provide typing support. Secretaries work for a specific consultant (with cross cover as noted). The Monthly Backlog report details secretarial pressures (outstanding dictation for typing, etc.). I am not part of the line management structure for admin and support staff and therefore cannot answer regarding monitoring of workload. The current line management would fall under Anita Carroll (Assistant Director).

24. **In your role as Associate Medical Director and/or Consultant were concerns of administrative support staff, if any, ever raised 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 did in response.**

24.1 I do not have any specific examples that I can provide. If my secretary has any concerns then my experience is that she raises them with me and, if I am not able to address them, I escalate them through the Urology Head of Service.

25. **Do all Consultants have access to the same administrative support? If not, why not? Have you ever sought additional administrative assistance? If so, what was the reason, whom did you ask and what was the response?**

25.1 To the best of my knowledge, all consultants have access to the same level of administrative support.

25.2 Clinical Directors and Associate Medical Directors / Divisional Medical Directors do not have administrative support for their medical management role. I feel that provision of PA support to medical managers would significantly increase the effectiveness of medical managers.

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

26.1 The Nursing and ancillary staff working within urology services across the trust have always been, and continue to be, excellent. The biggest factor impacting on them has been shortages due to vacancies, affecting the number of theatre sessions the Trust is able to staff, and resulting in a need for agency / temporary staff.

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

27.1 The Urology Clinical Nurse Specialist workforce are excellent. They are a fundamental part of the team in Southern Trust, key members of the cancer multidisciplinary team, and in my role as NICAN CRG Chair they are also a key part of the CRG.

27.2 As AMD I do not have any additional responsibilities with regards the CNS workforce beyond those of all consultant urologists. Their direct line managers, to the best of my knowledge, are the Lead Nurse and Head of Service for urology.

27.3 I engage personally with the CNS team in almost every clinical session I deliver (with the exception of inpatient operating lists). In addition to in-person communication, I also communicate with them via text message, telephone calls, email, and, on occasion, by letter, as a urology consultant and AMD. They can be relied on to work entirely in the interests of the patient and, in my experience, have raised issues that need addressing when they become aware of them.

27.4 In the day-to-day management of cancer patients the Clinical Nurse Specialists serve a wide-ranging and essential role. All patients at consultation where they receive a diagnosis of cancer from me are also introduced to a specialist nurse who acts as their key worker. They provide a key point of contact for patients with any concerns / questions and arrange additional consultations with patients and their families where required to aid decision making. In addition, the CNS team in the Southern Trust plays a vital role in our diagnostic pathways, carrying out prostate biopsies, flexible cystoscopies, and intravesical chemo / immunotherapies (from a cancer pathway perspective). They also conduct follow-up clinics for prostate and kidney cancer patients and provide post-MDM review for patients with low and intermediate risk non muscle invasive bladder cancers.

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

28.1 To the best of my knowledge there are no issues with the working relationships between the urology consultants and administrative staff including secretaries. Communication is effective but takes different forms for different

teams. As a urology consultant, my working relationship with my secretary is very effective and she is highly efficient. I have never had an issue with administrative support in my role as Urology Consultant. Cross cover for annual leave is always communicated well and sufficient.

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

29.1 To the best of my knowledge, working relationships between nursing and medical staff were very good and I do not recall having cause to raise concerns on any occasion. Indeed, from a personal perspective it was nursing staff who raised concerns with me in September 2020 regarding a locum consultant (Mr Personal Inform) which led to me subsequently terminating his contract.

30. ~~**25.**~~ **Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? 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.**

30.1 The urology 'unit' does not exist as a separate self-contained entity. The urology service is part of the Southern Trust Acute Directorate, aspects of patient care are delivered in multiple environments (outpatients, inpatient wards, inpatient theatres, day case theatres, emergency, and elective) and on multiple Trust sites.

30.2 The urology service has a dedicated outpatient environment on CAH site (the Thorndale Unit), although this space may also be utilised by other services when not being utilised by Urology. Each area and site has its own staff members in charge of the day-to-day running. Urology services were delivered in Banbridge polyclinic, Daisy Hill hospital, South Tyrone Hospital, Craigavon Area Hospital and South West Acute Hospital. Lists of staff members, day-to-

day management structure, and overall management structure (including names of individuals in those areas where care was / is delivered) can be obtained from the Trust.

30.3 Operationally, the Head of Service acts as the direct link between the urology service and the staff members who managed individual areas / departments within the Trust where urological clinical activity is delivered.

30.4 The Head of Service (Martina Corrigan, and now Wendy Clayton) provided operational day to day management with regards to the activities delivered by the urology team, with support from the Clinical Lead for the service. The Clinical Lead post was undertaken by Mr Young from prior to me commencing employment in Southern Trust until November 2021 and in this role provided clinical input to the planning of clinical activities, coordinated annual leave of medical staff, and coordinated the on-call rotas.

30.5 Structurally, the Urology service is managed within the Acute Services Directorate. The line management for medical staff is Clinical Director for Urology and ENT, Associate Medical Director (now Divisional Medical Director) for Surgery and Elective Care, Medical Director. The professional management line management is Head of Service for Urology and ENT, Assistant Director for Surgery and Elective Care / ATTICS, Director of Acute Services, CEO.

30.5 In addition, within the Acute Directorate a number of additional posts have responsibility for aspects of the service. The following is a list, to the best of my knowledge, of the posts within the Trust which had responsibility for aspects of the urology service. (details of individuals who held these positions and dates can be obtained from the Trust);

a. Head of Service;
b. Assistant Director for SEC/ATTICS;
c. Director of Acute Services;
d. Clinical Director for Urology / ENT;
e. Associate Medical Director Surgery and Elective Care;

f. Medical Director;
g. Additional posts which would have had responsibility / oversight for aspects of the service include;
    i. Assistant Director for Cancer / Diagnostics;
    ii. Assistant Director for Administrative Services;
    iii. Clinical Director for Cancer;
    iv. Associate Medical Director for Cancer / Clinical Services.

31. ~~**26.**~~ **What, if any role did you have in staff performance reviews?**

31.1 I did not have any role (to my knowledge) in staff performance reviews outside of the job planning process. Appraisal and revalidation occurred with trained appraisers and the Medical Revalidation Team. I am not an appraiser. Appraisals are between the appraiser and appraisee and I did not receive copies of medical staff appraisals.

31.2 Where specific issues have arisen regarding medical staff within my responsibility I have been part of the Trust's team in addressing them. This has taken the form of being part of investigations, 'commissioning investigations', exploring issues in 1:1 interviews with staff members, and drawing up action plans where needed. Many of these have been in my scope of responsibility outside of urology services and I have not included the detail of individuals / situations. Where these relate to Urology / Mr O'Brien my role is described later in my responses (Q59 through to Q72).

31.3 With regards to performance management for medical staff, there are a number of strands to this. Appraisal / Revalidation is one strand but does not have a significant quality control aspect. Quality control / performance should be both quantitative and qualitative. Quantitative data has not historically been employed in the performance management of medical staff in Northern Ireland in my experience. It should be incorporated into the job planning process. When I commenced as a Clinical Director in Southern Trust in June 2016, the medical

staff I was responsible for did not have any in date job plans and, during my tenure as CD and subsequently as AMD, we have moved this to a position of most consultants having agreed job plans, with Mr O'Brien being an outlier in this regard. Having now got into a position of the job planning process being embedded in the urology team, along with the HoS and AD we are now working to incorporate some quantitative performance management reports into the job planning process in my role as Divisional Medical Director for Urology Improvement. However, there has been a little delay in this for a number of reasons including work for the Public Inquiry taking up the time of several members of the team, including myself, coupled with the clinical pressures which result from vacant posts within the team.

31.4 Qualitative performance management is more challenging as this relies on data. Surgical quality assurance was commenced across the NHS within urology and coordinated by BAUS. This focussed on some key surgical procedures and involved significant data collection regarding treatments given. I have attached an example of such an output relating to my nephrectomy practice. This data highlighted outliers in key outcome measures and facilitated further assessment of practice where outliers were identified.

31.5 Unfortunately, following the Health and Social Care (Control of Data Processing) Act (Northern Ireland) 2016, clinicians in Northern Ireland have been unable to continue to contribute to this initiative. It is my understanding that this is a policy issue sitting with the Northern Ireland Executive. I am also aware that this impacts on a number of other similar surgical 'quality control' initiatives. Unfortunately, the format for this outcomes monitoring has changed and it is now collated from Trust data in England (the pervious format was clinician collated which clearly is open to critique) and so, even if this barrier to participation was removed, urologists in NI would not be able to take part in this.

31.6 I am not confident that the data collected from Trust information in Northern Ireland is of sufficient depth or sufficiently robust to provide reliable consultant-

level surgical outcomes monitoring. The data collected elsewhere (e.g., in England) has, in part, been driven by the 'payment by results' system whereby it is imperative for Trusts to collect the information. My lack of confidence comes from experience that the CLIP (Consultant Level Indicator Programme) report provided for appraisal regularly does not detail the actual numbers for the nephrectomy procedure I undertake *(please see 33. Mr Mark Haynes CLIP 2018 and 34. CLIP-Report-Reflection)*

32. ~~**27.**~~ **Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.**

32.1 As a consultant my role is subject to annual appraisal and revalidation processes. The Trust has a number of trained appraisers who carry out appraisals for medical staff and my appraisals are undertaken by one of these individuals. Dr Scullion is appraising me for 2019 and 2020, Dr Craig is conducting my 2021 appraisal *(please see 35. 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff*) Appraisal from 2019 was significantly impacted by the COVID19 pandemic with all appraisals deferred for a period. When they were recommenced my working patterns remained significantly impacted by the pandemic, providing surgical care across multiple sites including CAH, DHH, STH, LVH, Kingsbridge, BCH and RVH, with significant theatre backlogs within urology across Northern Ireland in particular. When appraisals were restarted, I continued to have a significant volume of additional workload including work with HSCB as a member of the Cancer Reset Cell and Elective Care Cell. In addition, the work of the urology Lookback Review and additional clinical demand for patient review has also placed additional workload pressures on me. As a result, I have had limited dedicated SPA time over the past 2 years.

32.2 As detailed previously, large amounts of my own non-job planned time have been utilised by me in order to carry out core aspects of my job (e.g., patient results, clinical correspondence, etc.) and in conducting additional activity relating to the Lookback Review and Public Inquiry responses. Since November 2021, I have agreed a new job plan with annualised expectation for my Southern Trust clinical work (and the remaining time periods dedicated for SPA). This job plan is recognised as too high a workload (13.73 PA = 54hrs 26mins per week). Unfortunately, clinical pressures (sickness, vacant posts) have meant that I have delivered my expected Southern Trust clinical activity within 7 months (i.e., I have done 12 months' expected work in 7 months) and not had the dedicated SPA time, and I have not been able to agree an adjustment in my workload to reduce my hours. Pressures related to the Lookback Review and the Inquiry have compounded this. The loss of my SPA time has meant that I have fallen behind in my own appraisals as the delivery of patient care, medical management responsibilities and the workload demands of the Lookback Review and Public Inquiry. My Responsible Officer has been aware of this issue for me.

Engagement with unit staff

33. ~~**28.**~~ **Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.**

33.1 The urology service is provided across a broad range of shared infrastructure and staff. I have been a member of the urology consultant team in Southern Trust since May 2014. I have engaged with staff within the Southern Trust, at all levels, throughout this time.

33.2 With regards to dedicated urology staff, I engage on a regular basis with my colleagues across the urology team at all levels.

33.3 As a medical manager, as Clinical Director, I did not have any direct line management responsibility for the urology team and so I remained a team member and not a line manager; I was not responsible for job planning and had no role in appraisal for the urology consultant team.

33.4 I have actively engaged with, in particular, our Clinical Nurse Specialist team, developing their skills and, as a result, the services offered and delivered by the CNS team. Examples of skills developed include; TRUS biopsy and more recently US guided transperineal prostate biopsy, flexible cystoscopy and botox injection, and flexible cystoscopy and stent removal.

33.5 As Associate Medical Director I was not the direct line manager for the urology consultant team (the Clinical Director was Mr Colin Weir). When I commenced this role there rapidly became a 'live' issue in relation to Mr O'Brien and, due to the proximity of my direct day-to-day working relationship with him and my role in relation to the identification of concerns, the Medical Director (Dr Richard Wright) did not directly involve me in this process, with the Clinical Director and Medical Director continuing this. I have been involved in the management of other medical staff issues within urology. These have been of a personal, health-related, and therefore confidential nature, and are unrelated to the subject matter the Inquiry and I have therefore not included any detail. The matters have been managed in a satisfactory manner from mine, and the concerned individuals', perspectives.

34. ~~**29.**~~ **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.**

34.1 My personal attendance at the departmental meetings over the past 4 years has been impacted by my working across 2 Trusts, with Belfast Trust activity taking place on Thursdays. In general, the urology team had Departmental Meetings weekly on Thursdays (lasting approx. 1 hour). In addition, there were

(and continue to be) regular monthly Patient Safety Meetings (at various points these may have been termed 'audit' or 'morbidity and mortality' meetings, lasting approx. 2-4 hours)) and the weekly Cancer Multidisciplinary Team meeting (lasting approx. 1-3 hours, depending on patient volumes). Additionally, meetings were held with the HSCB (Urology PIG, quarterly, lasting approx. 2 hours). Minutes of these meetings, where available, have been provided. *Please see:*

36. 20190911 Urology P I G Minutes
37. 20201022 P I G Actions and Date of Next Mtg
38. 20201022 P I G Actions and Date of Next Mtg A1
39. 20201022 P I G Actions and Date of Next Mtg A2
40. 20201022 P I G Actions and Date of Next Mtg A3
41. 20220428 Urology P I G Meeting
42. 20220428 Urology P I G Meeting A1

35. ~~**30.**~~ **Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?**

35.1 As a consultant urologist in Southern Trust I regularly interact with multiple members of staff in the course of my clinical activity. I do not specifically recall any informal meetings outside of these types of interaction. In the course of these interactions, on occasion, questions / concerns have been raised with me, sometimes concerning an individual's wellbeing and, on occasion, relating to patient care / safety. An example of one such interaction was where concerns were raised to me by members of the theatre team regarding the behaviour and potential competence of a locum consultant (*(please see 28. 20200924 E re Mr* Personal Information redacted by *, 29. 20200924 E re Mr* Personal Information redacted by *A1, 30. 20200924 E re Mr* Personal Information redacted by *A2, 31. 20200924 E re Mr* Personal Information redacted by *A3 and 32. 20200924 E re Mr* Personal Information redacted by *A4)*). I followed this up with further investigation, and formal meetings with the consultant which resulted in the individual's contract being terminated and specific concerns

being raised to the agency Responsible Officer as they related to competence and probity.

35.2 With regards to Mr O'Brien, a number of informal meetings have occurred during my time in the Southern Trust, in addition to formal ones, with members of the urology consultant team and between me and the HoS, CD, AD and Medical Director discussing, for example (but not limited to), job planning, triage, notes / clinical correspondence, litigation / complaints responses, and SAIs. My responses to Q59-72 provide additional detail.

36. ~~**31.**~~ **During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.**

36.1 Yes. I have always experienced close, productive working relationships between professional managers and medical managers in the Southern Trust. The presentation to the HSCB in late 2014 ('The vision') is an early example of this close working from early in my career in Southern Trust, before I formally became a medical manager. Recent examples of this would be the rapid reconfiguration of elective surgery in the Southern Trust away from CAH to DHH in response to COVID, the development of the Day Elective Centre for Urology (this has been a regional project involving staff across all trusts including urologists, anaesthetics and professional managers), regionally managed independent sector contracts for surgical treatments which individual Trusts manage (e.g., Southern trust manage Personal information redacted by USI and 352 contracts, Belfast Trust manage the Mater Independent Hospital contract). Any possible disagreements in general relate to the two realities faced by each group – clinicians are appropriately concerned regarding the impact of unacceptable waiting times and the harm they witness as a result, professional managers share these concerns but are not able to resolve them as the underlying problems relate to staff (vacant posts) and space (infrastructure not fit for purpose and / or in need of expansion, requiring large scale capital investment) requirements.

Governance – generally

37. ~~**32.**~~ **What was your role in relation to the Directors of Acute Services and Directors of Human Resources and Organisational Development, the Heads of Service for Urology, the Clinical Directors, Medical Directors, consultants and other clinicians in the unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.**

37.1 The enclosed job descriptions for Clinical Director, Associate Medical Director and Divisional Medical Director provide some information regarding my governance responsibilities in these posts.

37.2 However, I did not receive an induction into my role as CD or AMD. As a result, no information other than a job description was provided to me regarding the reporting structures, roles and responsibilities of the posts identified with regard to matters of patient risk, safety and governance. Of further note in this regard, between October 2016 and October 2017 no AMD was in post within Surgery and Elective Care.

37.3 As a consultant, it is my responsibility to adhere to Trust governance processes including attendance at Patient Safety Meetings, and raising concerns.

37.4 As a Clinical Manager and part of the Trust's professional management team, it is our responsibility to ensure that clinicians are able to engage in the Patient Safety Meetings and that a process for raising governance concerns exists and that, when concerns are then raised, a process for screening / assessment / investigation exists and is followed.

37.5 Within the urology team a Patient Safety Lead (formerly Mr Glackin, now Mr O'Donoghue) takes responsibility for the organisation of the regular Patient

Safety Meetings. The individual team meetings are replaced on a quarterly basis by combined Patient Safety Meetings with the Anaesthetics / ICU and all surgical speciality teams. All inpatient deaths are discussed through this meeting and, where concerns are identified, they are escalated via the IR1 reporting system. In addition, morbitity is also discussed and, again, where concerns are identified they are escalated via the IR1 reporting system. The Patient Safety Meeting also serves as an arena for sharing of SEA / SAI reports relating to urological services and sharing of learning from other specialities / Trusts. The Patient Safety Meetings are attended by medical staff, nursing staff, and the Head of Service (who has to alternate attendance with ENT, as she covers both specialties). I would also take part in / chair SEA / SAI investigations when requested.

37.6 As CD / AMD / Div MD, I take part in IR1 screening, and where clinicians are required for SEA / SAI investigations I nominate clinicians to these panels. I also attend Acute Governance Meetings where SAI reports in draft are discussed / approved prior to circulation, however, my attendance at these has been limited as the meetings occur on a Friday morning when I have clinical activity and so I can only attend intermittently. Where possible, Clinical Directors have attended in my place. We also made an effort to get the timing of the meeting changed but this was not successful. This meeting was chaired by the Director of Acute Services and was also attended by other CDs and AMDs from across Acute Services and provided oversight of SEA / SAI processes, complaints and other matters related to patient risk and safety. I would anticipate that, where required, significant patient risk / safety concerns discussed at this meeting would be escalated to SMT by the Director of Acute Services.

37.7 Outside of the IR1 process, I also engaged directly with the Medical Director and Director of HR where matters of professional concern were raised with me either via the incident reporting process, complaints, or via an alternative route (e.g., a concern raised to me regarding a general surgeon, which was followed by an investigation and report which did not substantiate the concerns raised but did make recommendations about change in working

pattern / practice which we then worked to implement). This also included concerns regarding Mr O'Brien when I became aware of them. These are detailed in responses to Q59-72 below.

38. ~~33.~~ **Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?**

38.1 Oversight of clinical governance arrangements is as per the enclosed job descriptions. As Associate Medical Director SEC / Divisional Medical Director Urology Improvement, I fulfilled my role in this regard related to urology by;

a. Ensuring a Patient Safety Lead for urology was in post (formerly Mr Glackin, more recently Mr O'Donoghue);
b. Assuring myself that regular PSMs took place (including personal attendance as a member of the urology team);
c. Assuring myself a Change Lead in urology was identified for relevant clinical standards / guidelines;
d. Participation in SAI screening (when not rendered unavailable by clinical commitments);
e. Identification of SEA / SAI chairs / clinical panel members;
f. Participation in the Acute Governance Meetings and review of SAI reports / recommendations;
g. Escalation of specific concerns regarding patient safety / governance to Director of Acute Services / Medical Director / Chief Executive (eg Attached emails 'Re_Winter plan' and 'RE_Urology Waiting Lists').

38.2 The Acute Governance meetings, chaired by the Director of Acute Services, provided oversight of the patient safety / governance processes with current standing agenda items covering results sign-off, SAIs, Audit, Patient Safety Reports, complaints and incidents, medicines incidents, risk registers, mandatory training, safeguarding, internal audit, IPC and trust policies. I would anticipate that, where required, significant patient risk / safety concerns

discussed at this meeting would be escalated to SMT by the Director of Acute Services. It is my personal reflection that the time available for this meeting (one hour monthly) was regularly insufficient adequately to discuss and address all of these agenda items. Personally, due to the fixed timing of the meeting which clashed with my clinical commitments I was often not able to attend personally.

38.3 In addition, patient safety / governance was addressed during 1:1 meetings, planned meetings regarding specific issues, and informal meetings with the AD (Ronan Carroll), DAS (Esther Gishkori / Anita Carroll / Melanie McClements) and Medical Director (Richard Wright, Ahmed Khan, Maria O'Kane).

39. ~~**34.**~~ **As AMD, how did you oversee 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?**

39.1 To the best of my knowledge / experience, no robust quality performance monitoring for urological care is in place in Northern Ireland, with the most significant detrimental impact on quality of care being an inability to provide timely access to treatment, in particular inpatient surgical treatment (See also Q47 and Q48).

39.2 Monitoring of quality is currently a reactive rather than pro-active process – it currently relies on complaints / incidents identifying a deficiency in care provided after that deficiency occurs. Changes are then a reaction to the specific deficiencies identified. As AMD, I took part in the SAI process though screening of IR1 forms, and subsequent agreement of SAI report recommendations through the Acute Clinical Governance meeting which I attended as AMD.

39.3 As stated previously, with such a mismatch between capacity and demand, the biggest detrimental impact on quality of care experienced by urology patients in Northern Ireland relates to waiting times which are unacceptable. We see patients come to harm (e.g., emergency attendance while on lengthy waiting list for surgery necessitating emergency treatment; recurrent catheter

blockages, changes and catheter related infection in men awaiting bladder outflow surgery; and so on) regularly, so much so that it is almost normalised. The majority of complaints and elected representative enquiries regarding urology relate to these waiting times. This has an unfortunate impact of potentially hiding other issues if they exist.

39.4 Waiting times for services are monitored by the trust performance team and reported to the HSCB/SPPG. Engagement with HSCB/SPPG with regards the detrimental impact of these waiting times on urology patients has resulted in the funding of independent sector contracts for surgical treatments and new patient assessment which has improved the situation but the mismatch between demand and funded capacity persists and, without continuation of this funded independent sector capacity, the situation will deteriorate. This position is further impacted by the current vacant consultant posts which result in a disproportionate reduction in elective activity capacity as the remaining consultant team utilise an increased proportion of their clinical time providing unscheduled and emergency care.

39.5 I have described in previous answers (e.g., at question 31) the challenge relating to monitoring qualitative performance in surgical care and the data challenges facing us. This applies across to qualitative assessment of services. A good example of a regional quality performance indicator programme is available at; Cancer Quality Performance Indicators QPIs (healthcareimprovementscotland.org). As NICAN CRG Chair, I am actively seeking to commence the bladder cancer QPI for Northern Ireland but, while there is firm support for this throughout NI urology teams, oncology teams and NICAN, there is a significant lack of infrastructure to support the data collection and analysis. Such a QPI programme is required in Northern Ireland and it would, to me, seem best to adopt the Scottish model.

40. ~~**35.**~~ **How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?**

40.1 Performance metrics relating to access times (cancer waiting time performance and general waiting time performance) are monitored by the Trust and reported to the HSCB/SPPG in trust performance meetings of which, as AMD, I am not part. As stated in previous responses (e.g., questions 12 and 13), the capacity:demand mismatch is such that these are poor and, from a urology team / AMD perspective, we are not able to affect change. Performance with regards to waiting times was regularly discussed at Departmental Meetings, Cancer Multidisciplinary Team Meetings and within SEC/ATTICS management meetings.

40.2 Individual consultant performance metrics are presented in the CLIP report provided to individual consultants for their appraisals. This information is not provided to Clinical Directors or Associate Medical Directors (unless they are undertaking the individual's appraisals). Therefore, as AMD I did not have a comparative oversight of these performance metrics for the urology team, or other clinical teams in surgery and elective care.

40.3 Performance with regards to job plan delivery has not been historically monitored in Southern Trust. Commencing in 2021, however, the urology consultants' delivery of clinical activity against job planned expectation has been prospectively monitored.

40.4 Commencing July 2022, a process has been established monitoring urology clinician performance with regard to management of radiology results with weekly data collected and fed back to consultants if backlogs are noted to be developing. This is overseen by the Head of Service and Divisional Medical Director.

41. ~~**36.**~~ **<u>As AMD and Consultant, h</u>ow 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?**

41.1 As stated earlier, the most evident risk in Urology services was the significant mismatch between capacity and demand and the consequent lengthy waiting times for all aspects of the service. In my view, no system can provide assurance regarding patient risk and safety in the face of such significant disparity between the reality of waiting times for urological care in Northern Ireland and clinically appropriate treatment timescales. Unscheduled care requirements, progression, increased complexity of treatment and development of complications of conditions, all as a consequence of a failure to deliver timely care, happen frequently, to the extent that it is effectively normalised in the working expectations of the clinical team across Northern Ireland.

41.2 As AMD, I understood that these risks relating to failing to deliver timely care were reflected in Trust Risk Registers. However, having reviewed these as part of compiling this Section 21 response, I feel that these documents fail to adequately convey the level and potential severity of patient risk.

41.3 As per my response at 39.1 to 39.2 above, no proactive quality performance monitoring is in place for urology services, aside from the access times performance monitoring (as reflected in previous responses).

41.4 Departmental Patient Safety meetings provide a forum where all inpatient deaths and patient morbidities have their care reviewed and discussed and, where concerns are identified, these are escalated via the trust incident reporting processes.

41.5 Concerns escalated via the incident reporting system (IR1) are processed through the directorate governance team and subsequently screened by the Assistant Director for Surgery and Elective Care, and Associate Medical Director. Subsequent SEA / SAI reports highlight any deficiencies identified and provide recommendations for changes to improve patient care / safety and mitigate the risk of a repeat of the same issue. These reports are discussed and signed off through the Acute Governance meeting (see also Q37 and Q38) which is chaired by the Director for Acute Services. Complaints may also result in an incident report and be investigated by this means. However, as the

majority of complaints are with regard to waiting times for treatment, this carries a risk of masking or diluting any patient safety concerns which may otherwise be highlighted (see 42.1 – 42.3 below). In addition, the complaints process does not seek input from clinicians other than those involved in the care episode which the complaint addresses and, as such, there is no 3rd party clinical oversight of the care episode.

41.6 Each of these processes (Patient safety mortality / morbidity discussions, Complaints, IR1/SEA/SAI processes) are reactive processes and not proactive and therefore provide response to issues when identified rather than proactive assurance (or otherwise), with the assumption that the absence of a complaint / patient safety issue raised at the patient safety meeting or the absence of a IR1/SAI/SEA provides an assurance that all is well.

42. ~~37.~~ **How could issues of concern relating to urology services be brought to your attention <u>as both (i) the AMD and (ii) a Consultant?</u> 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?**

42.1 Concerns may be brought to my attention (both as a consultant and as AMD) via a number of routes. These include the Trust complaints processes, incident reporting system / processes, Trust whistle blowing processes, and through Trust legal service (litigation). In addition, individuals are able to raise concerns with me either personally via email or verbally (in person or via telephone). A significant factor for these systems, especially in the context of urology as a specialty, is the capacity:demand mismatch and the resultant lengthy waiting lists which means that the vast majority of complaints relate primarily to the harm experienced by patients as a result of unacceptably lengthy waiting times and this can therefore mask or dilute other important issues which may subsequently go unrecognized. The workload pressures on all members of the team (in attempting to best address the needs of patients but lacking the

resource to do so) also impacts on the likelihood of individuals working within the service to identify and therefore raise concerns.

42.2 Complaints are investigated and managed via the Trust's complaints process. Concerns raised via the Trust IR1 reporting system are screened and, if appropriate, investigated following the Trust's incident reporting / governance process. The Patient Safety Meeting may identify concerns through discussion of mortality and morbidity cases and these are then escalated through the Trust's IR1 reporting process. In addition, where concerns regarding the impact of waiting times / lack of capacity were identified at Patient Safety Meetings, I escalated these to the AD / DAS / MD. Concerns brought to me by members of staff I assessed initially in a conversation and then, where required, instigated further investigation / action.

42.3 Both the Trust's complaints process and the SEA / SAI process (the investigation which takes place when a concern has reached a threshold for additional investigation, a decision which is made at a screening meeting where IR1s are reviewed by a team including the AD and AMD / Div MD) rely on the input of clinicians. In particular with regard to the SEA / SAI process, it can take a long period of time for a report to be completed. A potential weakness of the complaints process is that the primary respondent in most cases is the clinician involved and therefore there is no independent clinician review of the patient care that the complaint references.

43. ~~**38.**~~ **Did those systems or processes change over time? If so, how, by whom and why?**

43.1 I don't specifically recall the processes / systems specifically changing over the time I have worked within Southern Trust. Over the time Maria O'Kane has been MD the process of review of SAIs/complaints through the clinical management structure has been significantly strengthened and they are now a standing item on the 1:1 Meetings between Div MD / MD, with the detail populated by the corporate governance team in advance of the meetings *(please see 43. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE)*

44. ~~39.~~ **How did you ensure that you were appraised of any concerns generally within the unit?**

44.1 As a consultant within the urology service I was part of the team and therefore present at Departmental Meetings and Patient Safety Meetings. In addition, as AMD I regularly met with the HoS operationally, and attended regular meetings with the management team including regular SEC/ATTICS meetings, and Acute Clinical Governance Meetings (when they didn't clash with other commitments) where an overview of complaints / incidents was discussed.

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

45.1 The governance systems in the urology service were the same as those across the rest of the Acute Directorate. I have described, in my response to Question 38, the processes which were in place.

45.2 I believe the Trust is aware of the risk relating to the length of time an SAI process can take to investigate (*please see 44. 20180717 Datix* Irrelevant redacted by the USI*, 45. 20201113 Final Report* Irrelevant redacted by the USI *46. 20210719 Approved Action Plan to HSCB and 47. 20210719 Approved Action Plan to HSCB A1*) and believe there are a number of SAI recommendations over many years which have taken significant periods to implement, e.g. in the case of Mrs Patient 10 *(please see 48. 20160106 Datix Incident, 49. 20170315 Final Report* Irrelevant redacted by the USI *and 50. 20201204 Action Plan SAI* Patient 10*).* With regard to standards and guidelines, a weakness across NI is that regularly these are not able to be implemented in full due to staffing / infrastructure / finance issues, e.g., regional implementation of NICE NG12 *(please see 51. 20190208 59).*

45.3 I was not concerned that governance issues were not being identified and, on reflection, I believe the processes *did* identify the areas of concern relating to Mr O'Brien prior to 2020. However, the important link between each individual issue and the risk of wider issues within his practice was not made. The system and processes failed in that the various patterns of behavior of Mr O'Brien were not adequately addressed over many years. This may have been a failing of the system (including the people who were part of it / upon whom it relied) but I also believe it was significantly contributed to by Mr O'Brien's response and circle of influence (see further my response to Q74). When I commenced work in the Southern Trust, many of Mr O'Brien's working behavior patterns were widely recognised and simply accepted as 'his way' of doing things.

46. ~~41.~~ **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.**

46.1 I have not been able to review all Trust governance documents covering my employment in Southern Trust from May 2014 onwards to reflect on how concerns raised by me or others are reflected in them. However, as stated in previous answers, I have reviewed the Risk Registers and believe these do not adequately reflect the level and potential severity of patient risk related to the mismatch between capacity and demand.

46.2 Where I raised concerns specifically with regards to Mr O'Brien, I did not receive feedback as to how these concerns had been investigated or addressed. For example, I completed an IR1 in October 2015 (Mr Patient 102) regarding the absence of paper clinical notes and the absence of dictated letters following outpatient consultation. I remain unaware of how this concern was investigated, and if any action was undertaken to attempt to resolve this issue. This is the case for all IR1 / SAI processes with no feedback provided to the reporter, and no opportunity for the reporter to review or comment on

subsequent reports or recommendations. I believe this contributed to the failure of the Trust systems to adequately identify and address concerns relating to Mr O'Brien.

46.3 I am of the view that, while SAI/SEA investigations and reports may identify individual clinician failings within the reports, the subsequent recommendations often do not address any action plan to address these individual failings or monitor subsequent performance. For example, the SEA report regarding Patient 92 identified that Mr O'Brien had not acknowledged or responded to an email alert regarding the CT finding, but the recommendations did not give any recommendation relating to monitoring Mr O'Brien's performance with regards to prompt acknowledgment or action of results. There were subsequently similarities in the individual failings with the SAI regarding Mr Patient 5. Had the Patient 92 SEA progressed quicker (the report was approved in November 2020 – see Q45.2) and had it included recommendations regarding monitoring Mr O'Brien's management of patient results, then the issue may have been resolved and thereby prevented the delay which impacted on Mr Patient 5. *Please see 52. 20210428 Final Report* Irrelevant redacted by the USI *to HSCB 22.4.2021.*

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

47.1 As stated in previous responses, patient data collection, specifically with regards to surgical outcomes, has not been adequately collected (in my view) in Northern Ireland, across many specialities, primarily due to the impact of the Health and Social Care (Control of Data Processing) Act (NI) 2016. Additionally, issues in data quality are such that the data that is provided to clinicians for appraisal (CLIP data) is often inaccurate (for example, my personal data regularly does not accurately reflect my case load of renal cancer surgery). As a result, to date, patient data is not adequately sensitive or accurate enough to help identify concerns. Furthermore, CLIP report data is shared with individual clinicians and forms part of their appraisal process but is not shared with

medical managers (Clinical Directors / Associate Medical Directors / Divisional Medical Directors).

47.2 As stated in 39.1 and 39.2 above, to the best of my knowledge / experience, no robust quality performance monitoring for urological care is in place in Northern Ireland. The monitoring of quality is currently a reactive rather than pro-active process – it currently relies on complaints / incidents identifying a deficiency in care provided after the deficiency occurs. Changes are then a reaction to the specific deficiencies identified.

47.3 Multiple systems contain patient data, including, but not limited to, NIECR, SECTRA, PAS, and CAPPS but these function as repositories of patient information rather that data systems utilised in monitoring individual patient care outcomes, or for the identification of concerns.

47.4 The PAS 'DARO' list provides a system whereby record is kept of patients who have results awaited. This is a 'fallback' safety process for where patient results are not received and actioned by consultants via other available means (e.g., e-sign-off or paper results). Patients awaiting results are supposed to be recorded on this list for each consultant, with secretaries conducting a manual check against this list for any results that have not been received / actioned to bring to the consultant's attention. Specifically, and to the best of my knowledge, Mr O'Brien (see email) and his secretary did not utilise this system.

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

48.1 It remains the case that patient data / individual consultant outcomes data is not adequately collated. Surgical outcomes data that was previously collected across the NHS (but not able to be collated for NI clinicians due to secondary use of data legislation) by means of individual clinician data entry, have now changed to a system which collates the data directly from hospital episodes data in England and Wales. I have cited the Scottish QPI programme as an example of a quality assurance programme which could identify and improve patient care. CLIP report data is shared with individual consultants for appraisal, is not robust, and is not provided to CDs / AMDs for oversight within a service – they will only have sight of an individual's CLIP report if they perform the appraisal.

48.2 It remains the case that monitoring of quality is a reactive process and relies largely on the IR1 / SAI process / complaints, and Patient Safety Meeting discussions of mortality and morbidity.

48.3 I believe it remains the case that some secretary / consultant teams do not understand the role of the DARO list and the monthly check against this in preventing potentially significant results from not being addressed, with variable engagement with the process.

49. ~~44.~~ **During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.**

49.1 The largest factor throughout my time in Northern Ireland has been the widening gap between capacity and demand; this gap is such that standard performance metrics regarding patient access (e.g., referral to treatment times,

cancer waiting times, and so on) have become a poor marker. Because the service is commissioned to fail to meet demand (see, in particular, my answer to Q13 above), these times have grown continually and clinicians are left 'prioritising' workload. Setting performance related objectives for clinicians relating to these metrics are meaningless as clinicians cannot effect any change. The urology workforce paper highlights the need in urology and yet we continue to be significantly 'behind the curve'. *Please see 25. Workforce plan.*

49.2 However, performance metrics with regards to job plan delivery should be able to be monitored (for example, number of outpatient sessions delivered). However, the annual job planning cycle was not sufficiently embedded in the culture of the Trust when I started in May 2014 and my first job plan in Southern Trust was not fully signed off until June 2016. When I commenced as Clinical Director in Surgery and Trauma and Orthopaedics, most of the consultants in these teams did not have agreed job plans. This is no longer the case and, as part of my urology improvement role, quantitative performance management is being incorporated into job planning.

50. **~~45.~~ How well did you think the cycle of job planning and appraisal worked and explain why you hold that view? Did you have any issues with your appraisals or any you were involved in for others? If yes, please explain.**

50.1 As mentioned above, annual job planning was not embedded in the culture of the Trust (specifically with regard to surgical specialities) when I commenced in the Trust in May 2014. This position has improved significantly during my time as CD and AMD / Div MD. Having job planning now occurring on a regular basis, we are now incorporating aspects of performance review / management into the job planning process (e.g., monitoring sessions delivered vs. job plan).

50.2 The Trust appraisal process is well organised but, with regard to quality control, is impacted by issues with patient data quality / availability. The CLIP report, which contains data which does reflect patient outcomes, in my experience often does not reflect an individual's practice. Comparative (i.e.,

with peer groups) data is presented in the report, and a reflection and discussion of this data takes place during the appraisal. However, individuals CLIP reports are not shared outside of the appraisal, and specifically not provided to the clinical management team for review / assessment. Historically, individuals were able to select their appraiser and this was a weakness, although since 2020 this has been changed to a process where individuals are now assigned an appraiser. Patient and Client feedback data is also collected. However, this process also has a weakness, with clinicians nominating their own choices for staff member feedback, therefore presenting a risk that individuals may select only staff members who they think are unlikely to raise a concern and, as a result, the feedback reports may not identify concerns (where they do exist). If appraisal is to assess qualitative performance (with quantitative performance assessed through job planning) significant improvements in data collection, validation, reporting, and analysis are required.

51. ~~**46.**~~ **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. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated 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.**

51.1 As per previous responses, governance concerns which have the potential to impact on patient care and safety may be identified via a number of routes including the IR1/SAI/SEA process, complaints, patient safety meetings, via personal communication with me and raised by individuals following the trust whistleblowing policy (I have not yet received any concerns raised to me via this route).

51.2 Matters of concern relating to individual clinician behavior and practice were brought to me regarding Mr Personal Inform. These concerns were raised with me by

members of the nursing team in the first instance. I assessed these and arranged an initial meeting to explore these concerns with Mr Personal Inform, which took place over zoom, also attended by Martina Corrigan as HoS. Following this meeting, I looked into the concerns identified and came to a conclusion that they were significant and required action. We engaged with the Medical Director and HR and arranged a subsequent meeting with Mr Personal Inform, myself and Martina Corrigan where I outlined the findings and concerns, and advised him that such were the significance of the concerns raised and his responses to these, that we were terminating his engagement as a locum with immediate effect, and would be informing his Responsible Officer of the concerns.

51.3 Concerns identified via the SAI/SEA and complaints process and highlighted through these reports are discussed at the Acute Governance meeting, chaired by the Director of Acute Services prior to the report and recommendations being signed off / accepted. I would anticipate that specific concerns identified from this may be escalated to the Trust SMT by the Director for Acute Services. Additionally, as AMD I would escalate specific concerns to the Medical Director either at 1:1 meetings or by telephone / in person informal communication if required between meetings.

51.4 Following this, an action plan is drawn up against the recommendations. Progress against this action plan is within the remit of the operational team (e.g., Urology if urology-specific, Surgery and Elective Care if it relates to all surgical specialities) and progress against SEA / SAI action plans is monitored by the Trust governance team. However, to date this progress (or lack thereof) is not fed back / escalated back through the Acute Governance meeting. As a result, I understand that there are many action plans which have not been completed (an example given previously in this regard is the Patient 92 action plan which has not yet been completed).

51.5 Where concerns identified relate to specific concerns regarding a Trust employed clinician / NIMDTA trainee, these may then be escalated via the MHPS process or through NIMDTA for trainees.

51.6 Within the Acute Directorate, specific risks identified may be recognised on the Risk Register. I have commented elsewhere in this statement (e.g., at Q46) that it is my view that the concerns related to the capacity:demand mismatch are not reflected adequately on the Risk Register. *Please see:*

53. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1. Nov 2016

54. 20180401 Ref 2i - Regional Your Right to Raise a Concern Policy and Procedure

55. Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework

52. ~~47.~~ **Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.**

52.1 As consultant, I have felt supported by the medical line management hierarchy. For example, when I was approached with regards in-reach into Belfast Trust for nephron sparing surgery, the Southern Trust medical and professional management teams were fully supportive of this, despite the local impact of a reduction in the clinical time I spent in Southern Trust, recognizing the system wide benefits.

52.2 When I started as Clinical Director, and subsequently Associate Medical Director, no induction process was afforded to me and, in particular, when I commenced as AMD no handover period or process was in place. In particular, I did not receive any briefing of any prior or ongoing concerns with regards to medical staff. It is notable that no AMD was in post for approximately 12 months between Dr McAllister's departure and me taking up the role.

52.3 During my time as a medical manager, I have raised a concern that no additional administrative support (e.g., PA) is available to clinical managers, although it is provided to professional management colleagues. Certainly, for

me personally this has created a challenge with regard to diary and workload management, in addition to creating a challenge for me to keep on top of issues which require follow-up. Inevitably, this lack of administrative support will have meant that I am likely to have taken longer than ideal to follow up on things where I was not receiving reminders (particularly if other issues were occurring concurrently).

Concerns regarding the urology unit

Note: Where concerns related to Mr O'Brien I have primarily addressed these in Q59-72 rather than in this section of my Section 21 response.

53. ~~**48.**~~ **The Inquiry is keen to understand how, if at all, you liaised with and had both formal and informal meetings with:**

(i) **The Chief Executive(s) during your tenure (the inquiry understand these post holders to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin)**

53.1 I recall meeting Mr Devlin regarding a concern with urology waiting times (but do not have any recollection of the specifics of this meeting). I certainly included him in the circulation list of emails relating to some of these concerns (please see). I met / discussed issues which occurred at the time of the opening of the new paediatric units (which primarily impacted on ENT and general surgery but also impacted on delivery of a small amount of specific elective urological procedures) with Stephen McNally. I recall meeting Francis Rice but do not have any specific recollections of any of these meetings.

(ii) **the Medical Director(s) during your tenure (the inquiry understand these to have been John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane),**

53.2 As a new consultant to the Trust, I met Dr Simpson in his office in Daisy Hill Hospital. I cannot recall the date or content of this meeting.

53.3 I had 1:1 meetings with the Dr Wright, Dr Khan and Dr O'Kane and will have raised concern regarding the impact of the capacity:demand mismatch, and vacant posts, on patient safety and outcomes regularly during these meetings, in addition to concern regarding the impact on the individual clinicians.

53.4 I met with Dr Wright, in early 2017 when the concerns regarding uncompleted triage were identified and escalated to him my additional concerns regarding some of Mr O'Brien's behaviours / practice.

53.5 In addition, I raised concerns regarding waiting times and vacant posts at AMD meetings chaired by the Medical Director.

(iii) **the Director(s) of Acute Services during your tenure (the inquiry understand these may have been Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements),**

53.3 I had contact with Debbie Burns as a consultant during the development of the 'vision' presentation and paper. I met with Esther Gishkori, Anita Carroll and Melanie McClements frequently, formally in 1:1 meetings and at acute governance meetings and informally during my time as CD / AMD. I regularly raised the concerns regarding waiting times and vacant medical staff posts at these meetings and in email communication.

(iv) **the Assistant Directors, namely Heather Trouton and Ronan Carroll,**

53.4 I have no specific recollections of meetings with Heather Troughton as Assistant Director. I regularly meet formally and informally with Ronan Carroll and work closely with him on all matters related to Urology / SEC while AMD.

(v) **the Associate Medical Director during your tenure (the inquiry understand this to have been Damian Scullion)**

53.5 Damian Scullion commenced as AMD for ATTICS at approximately the same time as I commenced as AMD in SEC. Prior to this, the AMD was Dr Charlie McAllister (having left post approximately 1 year prior to me taking up this post) and before him Mr Eamon Mackle. I regularly met with Dr McAllister while I was CD for Trauma and Orthopaedics and General Surgery. Dr Scullion and I would be present at many of the same formal meetings. In addition, we frequently have informal meetings / telephone discussions regarding matters which cover across ATTICS and SEC / Urology.

(vi) **the Clinical Director(s) during your tenure (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)**

53.6 I have no recollection of meeting Mr Brown (in capacity as CD), and limited recollection of any meetings with Mr Hall (as CD). Mr Weir was appointed as CD at around the same time as I became CD for T&O/General Surgery and we met regularly in this capacity**.**

(vii) **(vii) the Head of Service, namely Martina Corrigan, and**

53.7 Martina Corrigan was heavily involved in the development of the 'vision' paper and presentation with me and we met / discussed this regularly; in addition, she attended the Departmental Meetings regularly (up to weekly) and Patient Safety Meetings (monthly, although not all meetings as she covered both Urology and ENT). In addition, as AMD I met her regularly operationally. I would include Mrs Corrigan in email communication regarding concerns in addition to others as I felt appropriate.

(viii) **(viii) the consultant urologists in post during your tenure.**

53.8 As a member of the team I met my colleagues regularly informally. In addition, we met at Departmental Meetings (up to weekly) and Patient Safety Meetings (monthly).

When answering this question, the Inquiry is interested to understand how you liaised with these individuals 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. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (viii) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

54. ~~**49.**~~ **During your tenure, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:**

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

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

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

(d) **If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.**

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

(f) **If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?**

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

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

54.1 Aside from concerns regarding Mr O'Brien's practice (as detailed later), the primary issue of concern to the urology service during my time as AMD was the capacity:demand mismatch resulting in lengthy waiting times and the consequent negative impact on patients which was manifest in a reduced quality of life, and, for many, progression in their condition requiring additional input of healthcare services and / or more complex or higher risk surgery. Examples of emails where I escalated this concern are provided ('Re_winter plan' and 'RE_Urology Waiting Lists' emails), I also escalated this concern to the Director of Commissioning in my role as NICAN CRG chair. *Please see 69. 20191030 NICaN Uro CRG Risks and Current Waiting Times, 70. 20191030 NICaN Uro CRG Risks and Current Waiting Times A1, 71. 20180905 RE*

Tyrone GAA Manager praises CAH staff for care and treatment, 72. 20181019 RE Tyrone GAA Manager praises CAH staff for care and treatment and 73. 20181019 RE Tyrone GAA Manager praises CAH staff for care and treatment A1.

54.2 I made attempts to reduce incoming demand through engagement with the HSCB to come to agreement that outpatient referrals from Fermanagh and the BT80 area were directed to the Western Trust as their waiting times were shorter, and consultant posts filled. Unfortunately, this was prolonged and finally agreed by all parties with BT80 new patient referrals reverting to Western trust in December 2018 and Fermanagh new referrals reverting to Western Trust in December 2019. *Please see 74. 20171006 E re BT80 patients, 75. 20180213 E re BT80 patients and 76. 20181019 E re BT80 patients.*

54.3 Any impact of this new patient referral redirection on patient access / waiting times continued to be monitored by the Trust performance team and reported through the regular performance meetings with HSCB.

54.4 Concern was raised with me regarding Mr Personal Infor (see Q18.2 and Q35.1) which I addressed, ultimately resulting in termination of his engagement as a locum consultant by the Trust and escalating my concerns to his Responsible Officer.

55. ~~**50.**~~ **Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -**

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

55.1 Aside from the concerns regarding Mr O'Brien (which I address elsewhere in this Witness Statement under the series of questions from Q59-72 headed

'Mr O'Brien'), the primary concern within urology services raised with me was the capacity:demand mismatch and resultant waiting times.

55.2 This concern was well recognized within the Trust, both within escalation of concerns by the urology team and me, and in the nature of complaints received by the Trust for urology, of which delay in treatment was the underlying factor in the majority.

55.3 I believed the impact on patients was also clearly understood. This risk I understood to be identified on the Trust Risk Register as it related to many services, not just urology. However, having reviewed the Risk Register, I do not believe the entry to be adequately explicit or specific (e.g., a consequence of delayed definitive surgical treatment with ureteric stents or urethral catheters in place is gram negative sepsis which carries a significant mortality risk; the Register should have explicitly stated that the waiting times risk preventable deaths occurring).

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

56.1 To the best of my knowledge, no concerns have been raised regarding my clinical practice.

57. ~~**51.**~~ **What, if any, support was provided to urology staff (other than Mr O'Brien) by you and 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. (Q71 will ask about any support provided to Mr O'Brien).**

57.1 Concerns were raised regarding a previous consultant colleague, Mr Personal Information redacted by the. I was not AMD at this time and therefore was not part of his medical line management and my role at this time was that of a member of the urology consultant team. *Please see 77. 20151217 - Confidential Meeting* Personal Inform.

57.2 Support was put in place for him and this included identification of a colleague available during periods of out of hours cover. This clinical support was discussed and put in place by the urology consultant team with the support of the HoS. I do not recollect what input was provided to this by the CD / AMD at the time and do not know if HR were involved.

58. ~~**52.**~~ **Was the urology department offered any support for quality improvement initiatives during your tenure?**

58.1 The urology department had an ADEPT fellow funded by NIMDTA (Mr Tyson) who conducted a QI project relating to the Stone Treatment Centre. This work has led onto the establishment / funding of the lithotripsy service as a regional service for all of NI. *Please see 78. ADEPT PROJECT STONE Presentation Finance meeting jan – final, 79. 20160304 Proposal for ADEPT Management Project and 80. 01072018_Stone Centre Quality Improvement Project Team Document.*

Mr. O'Brien

59. ~~**53.**~~ **Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?**

59.1 Mr O'Brien was a consultant colleague from when I commenced work in Southern Trust in May 2014 until his retirement in 2020. As a colleague, we

would regularly have been in contact informally through the course of our normal working week (e.g. both being present in the outpatient department at the same time doing outpatient clinics). We would also have met weekly at the Cancer MDM, and regularly at Departmental Meetings and Patient Safety Meetings.

59.2 As stated elsewhere in this statement, soon after I became AMD the MHPS investigation into Mr O'Brien took place and I was not part of the oversight or monitoring groups with regard to this process and did not therefore have any meetings with Mr O'Brien in this regard. I continued to function as a consultant colleague during this period with interactions as detailed in 59.1 above. Meetings with Mr O'Brien regarding Job Planning and the MHPS monitoring were undertaken by the Clinical Director (Mr Weir / Mr McNaboe).

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

60.1 When I became Associate Medical Director, I became 'second sign-off' on Mr O'Brien's Job Plan. Mr Colin Weir, Clinical Director, was 'first sign-off' and was directly engaged in the Job Planning process for Mr O'Brien. When Mr Ted McNaboe commenced as Clinical Director he took on this role for ENT / Urology and directly engaged with Mr O'Brien.

60.2 In the Job Planning process, there are 3 sign-off stages. The identified 'first sign-off' individual conducts the Job Plan review with the clinician and can edit the Job Plan and agree the Job Plan with the clinician. The second and third sign-off individuals conduct a review of the agreed Job Plan, ensuring there are no discrepancies or issues which require amendment. The second and third sign-off individuals cannot edit a Job Plan. As second sign-off for Mr O'Brien's Job Plan, I did not have any direct engagement with him with regard to his Job Plan.

61. ~~55.~~ **When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?**

61.1 Fairly soon after commencing work in Southern Trust I became aware that Mr O'Brien had different ways of working compared with others. It was apparent that many of these were embedded in his working patterns and widely accepted across the Trust as 'his way'.

61.2 Concerns were regularly voiced by all members of the consultant team regarding the frequent lack of clinical information (in the form of letters) following outpatient consultations as this had the potential to impact on us when patients had unplanned (emergency) admissions. This voicing of concerns would have occurred during informal conversations and within departmental meetings including with the HoS. I also recognised that, regularly, patient notes were unavailable in the hospital when patients were admitted and this, coupled with the lack of dictated letters (which would have been available on the patient's electronic care record even if their notes were unavailable), presented a potential for risk during a patient's emergency care.

61.3 I submitted an IR1 regarding such a case [Patient 102] in October 2015 (please see *87. 20141120 -IR1* [Patient 102] *)* , and also commented in an email regarding another patient ([Personal Information redacted by the]) who, in addition, did not appear to have been added to the waiting list after outpatient appointments *(please see 88. 20170111 E re PATIENT* [Personal Information redacted by the USI] - [Personal Information redacted by the USI] *).* These concerns were also voiced by other members of the urology consultant team and, in discussions, it was apparent to me that these were long-standing issues and were essentially recognised as normal practice for Mr O'Brien. I did not receive any feedback following submission of the IR1.

61.4 There were also issues in relation to timely responses from Mr O'Brien regarding complaints and litigation. I recall these were an issue at the time Dr

McAllister was AMD and they continued to be so when I was AMD. This was escalated to the Medical Director by me. *Please see:*

89. 20180614-email litigation, 90. 20180614-email litagation att, 91. 20180614-email litagation att1, 92. 20180614-email litagation att3, 93. 20180614-email litagation att4, 94. 20180614-email litagation att5, 95. 20180614-email litagation att6 and 95a. – 95p. email litigation att7-att22

61.5 During my Urologist of the Week activity, where the on-call consultant conducts the ward round of all inpatients, it became evident to me that Mr O'Brien was transferring patients from his private practice for NHS care for surgery but their treatment times were expedited compared with patients on the standard NHS waiting list. I raised this in emails *(please see 17. 20151126-email queue jumpers, 18. 20150527-email urology longest waiters' 19. 20150527-email urology longest waiters attachment 1, 20. 20150527-email urology longest waiters attachment 2).* However, I am not aware of the action taken at this time.

61.6 In August 2016, I raised a concern via email (Mr Patient 93) regarding a routine referral which would have been upgraded to red flag (suspected cancer) but had not been returned from triage. *Please see 98. 20160831-email* Patient 93 *and 99. 20160831-email* Patient 93 *attachment 1.*

61.7 I also became aware, through a new patient referral, that there appeared to be an issue with Mr O'Brien receiving and actioning investigations he had requested or that had been requested on his behalf (concerning a patient with a likely kidney cancer on CT scan). I raised this as an IR1 (Patient 92 , July 2018) and a subsequent SEA was conducted.

61.8 I had also raised an IR1 (Patient 10 , January 2016) regarding a further patient with kidney cancer which led to the identification of a significant number of un-triaged referrals in Mr O'Brien's office. *Please see 44. 20180717 Datix* Irrelevant redacted by the USI *45. 20201113 Final Report* Irrelevant redacted by the USI *46. 20210719 Approved Action Plan to HSCB and 47. 20210719 Approved Action Plan to HSCB A1*.

61.9 When I met the Medical Director with regards to this, and as part of my witness statement for the MHPS investigation, I raised each of these previous concerns which were subsequently included in Mr O'Brien's Return To Work Plan. *Please see 100. Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018, 101. 20180928 Email Case Manager Determination AO'B FINAL 280918 attachment, 102. 20170209 - Email - Return to Work Action Plan February 2017 FINAL and 103. Appendix 19 Witness Statement - Mr M Haynes 240517.*

61.10 Additionally:

a. In 2020, I started to become aware of a pattern of treatment with regard to prostate cancer, with patients being on a low dose of bicalutamide. I had come across one such patient during a week as Urologist of the Week in February 2020, and had switched him to an appropriate treatment, making the assumption at the time that this was an error. At a later date (6th October 2020) I reviewed this patient's care and recognised that this fitted with the patterns of prostate cancer management which had been identified as cause for concern regarding Mr O'Brien and escalated these concerns (email 6th October 2020 - Personal Information redacted by the USI).

b. In June 2020, while in Daisy Hill Hospital for a theatre list, I reviewed Perso nal Infor Patient 1 and had immediate concerns regarding the care he had received. Amongst my concerns was that he had been treated with low dose (50mg) bicalutamide and this treatment was not the appropriate management for his prostate cancer. At a later date (I cannot recall the date of this conversation), in discussion with Dr Darren Mitchell, Consultant Clinical Oncologist and Urology MDM lead for Belfast Trust, I became aware that this had been raised directly with Mr O'Brien by the Oncology Team previously (although I am unaware of when this occurred). During the consultation I arranged up to date staging, ensured he was on appropriate treatment, and referred him to the oncology team. I also advised the Medical Director of my concerns by email on 7th July 2020 regarding his and another patient's treatment (Patient 9). After completion of his staging scan, I arranged an outpatient consultation with me where I raised my concerns

regarding his previous care and assured the family that I would be reporting my concerns so that an investigation took place. Having informed them of my concern, I completed an IR1.

Please see:

104. 20200611-email patients to be added to urgent bookable list
105. 20200611-email patients to be added to urgent bookable list att1
106. 20200611-email patients to be added to urgent bookable list att2
107. 20200611-email patients to be added to urgent bookable list att3
108. 20200611-email patients to be added to urgent bookable list att4
109. 20200611-email patients to be added to urgent bookable list att5
110. 20200611-email patients to be added to urgent bookable list att6
111. 20200611-email patients to be added to urgent bookable list att7
112. 20200611-email patients to be added to urgent bookable list att8
113. 20200611-email patients to be added to urgent bookable list att9
114. 20200707-email cases1
115. 20200914 Tab 1 datix
116. 20201006-email a further case 1
117. 20191031 Datix incident form
118. 20201112 Datix Personal information redacted by USI

62. ~~**56.**~~ **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.**

62.1 I do not have contemporaneous records which I kept detailing the dates and times of any informal discussions, telephone calls, or text messages detailing concerns regarding Mr O'Brien. Furthermore, I no longer have access to my Trust phone from prior to late September 2018.

62.2 While I was Clinical Director (Surgery CAH / T&O), with Dr McAllister as AMD, I recall a discussion regarding Mr O'Brien relating to, as I recollect, delays

in his responding to requests for information from the Litigation Department. I cannot recall the approximate date nor the outcome of the conversation which involved myself, Mr Weir (CD for Urology/ENT), and Dr McAllister (AMD SEC/ATTICS). As I recall, Dr McAllister had a notebook that he took to meetings but I do not know if he made notes during this discussion (see response 61.4).

62.3 As detailed above in answer to the previous question, I had previously raised concerns relating to Mr O'Brien's preferential treatment of patients he had seen initially as private patients and I expect that I would have also discussed this in person with various individuals but cannot remember any specifics.

62.4 I have also detailed that issues with regards to a lack of letters on patients' electronic care records and a lack of notes had been raised by consultant urologists, including me, specifically with regard to the impact on our ability (as a team of urologists) to provide care to emergency admissions and review patients awaiting review with Mr O'Brien. These concerns would have been raised in regard to emergency admissions and have been described in previous responses (e.g., 61.3 and 61.5 above). This was also discussed in departmental / consultant meetings throughout my time in Southern Trust, in particular when discussing review of long waiting patients who had previously seen Mr O'Brien, with recognition that review of these patients would take longer due to the paucity of information regarding previous attendances. I recall an occasion where Mr O'Brien challenged the need for contemporaneous correspondence detailing each consultation stating words to the effect of, '*… the only two people who need to know the content of the consultation and plan are me and the patient.*'

62.5 I had escalated concerns regarding absence of notes on IR1 (Mr Patient 92, Patient 102 see 61.3).

62.6 I had also escalated concerns regarding lack of triage and apparent inaction on radiology reports containing significant findings (CT showing renal cancer – see: IR1 Patient 92). *Please see 44. 20180717 Datix* Irrelevant redacted by the USI*, 45. 20201113 Final Report* Irrelevant redacted by the USI *46. 20210719 Approved Action Plan to HSCB,*

47. 20210719 Approved Action Plan to HSCB A1 and 119. 20190331_RE Urology backlogs Confidential.

62.7 When I commenced as AMD, I did not receive any handover from the outgoing AMD and so was not aware of any prior issues or investigations relating to Mr O'Brien. Relatively soon after starting as AMD, Mr O'Brien had a period of sick leave. I recall that it was during this period of sick leave that the concerns regarding non-triage of referrals escalated with a significant number located in Mr O'Brien's office. It is my memory that this was identified as a potential issue in the course of the Patient 10 SAI investigation (following an IR1 submitted by me relating to a patient who was referred with regards a renal lesion - the primary issue of this IR1 was a misreported MRI scan but it was noted during the SAI that the referral had not been triaged). At this time and following on from this, I recall a number of meetings with urology consultants (primarily operationally identifying capacity for triage of all the untriaged referrals and the subsequent patient assessments required). I also had a number of conversations with the HoS (Martina Corrigan), AD (Ronan Carroll), Director of Acute Services (Esther Gishkori), and the Medical Director (Richard Wright) regarding this issue and the additional concerns relating to absence of dictations, medical records being in Mr O'Brien's house, and preferential management of private patients were also investigated. I do not have notes from these informal meetings / discussions.

62.8 As a result of these concerns an MHPS investigation was opened and I was interviewed as part of that investigation. I do not recall when the discussion was held but, as part of the conversations with the Medical Director, it was agreed that, given my proximity to Mr O'Brien as a working colleague and given that I was the individual who had raised IR1s and concerns regarding Mr O'Brien, it would not be appropriate for me to be party to the MHPS process for Mr O'Brien. As a result, I was not part of the MHPS discussions nor was I party to the subsequent report, recommendations and monitoring.

62.9 Soon after commencing as Medical Director, in early 2019 Maria O'Kane spoke to me regarding Mr O'Brien and the MHPS investigation and concerns being escalated to the GMC. However, I do not know/recall whether this

conversation took place before or after the concerns were escalated to the GMC. I became concerned that the secretarial 'backlog report' was being used as part of the monitoring of Mr O'Brien and I remained concerned that Mr O'Brien was not always dictating on outpatient attendances at the time of the clinic. I was also concerned that there was a high likelihood that he was not acting on all results requested in his name and this was not being adequately monitored in the backlog report. I raised concerns regarding the robustness of the data contained therein – namely, the 'results awaiting dictation' and 'clinics awaiting dictation' and raised these on a number of occasions; indeed, some of these concerns pre-dated the use of this report as part of the MHPS monitoring process. I am aware that, as a result, Mr McNaboe (as CD) did meet with Mr O'Brien with regard to lack of compliance with the requirement to dictate after every clinic attendance. I do not recall being involved in the out-workings of this meeting. *Please see 120. 20170617-email clinical correspondence backlog report, 121. 20170620-clinical correspondence backlog and 122. 20170701-email clinical correspondence backlog report.*

62.10 During my on-call week in late January 2020, Mr Personal Information redacted by the was admitted with complications relating to local progression of a prostate cancer. In managing him I noted that his prostate cancer management to that point was suboptimal, with him having been prescribed a low dose of bicalutamide. I switched him to an alternative treatment and made an assumption at this time that this was perhaps an error (noting that the MDM outcome had recommended he be commenced on an LHRH analogue, and initial treatment with bicalutamide 50mg for a 28-day course is given upon commencing an LHRHa to cover testosterone flare). Subsequently, when reviewing Mr Personal Information redacted by the's care in October 2020, I recognised that the treatment he had received fitted the same pattern as other patients and escalated this as an IR1.

62.11 In early June 2020, I received an email from Mr O'Brien which included green waiting list forms for a number of patients. This was sent to me as part of my role in the managing of the limited theatre capacity available in the Trust due to the challenges of the COVID19 pandemic. The email made me concerned that, in addition to the concern that Mr O'Brien may not be completing his consultation dictation at the time of outpatients clinics, he may

also not be completing the necessary additional patient related admin relating to the consultation and its outcome (note: at the completion of a consultation a number of tasks require completion, including requesting radiological investigations, dictating letters to GPs / referrals to other teams, and completion of the waiting list form where a patient is to be added to the waiting list - it is this form that provides the information which adds a patient to a waiting list, and which triggers pre-operative assessment [and identifies the management plan for any anticoagulants]). I escalated concern regarding this issue at this time via the attached email (please see *114. 20200707-email cases1)*.

62.12 On 22nd June 2020, while conducting a ward round in Daisy Hill Hospital, I reviewed a patient, Mr Patient 1, who had undergone prostate surgery and had a history of prostate cancer. In my review, I identified that he had been treated with a low dose of bicalutamide. I switched him to an appropriate treatment and arranged up to date staging investigations. In addition, I referred him to the oncology team. Upon receipt of the results of the staging investigations, I escalated concerns regarding his management to the Medical Director *(please see 114. 20200707-email cases1).* I organized an outpatient consultation with Mr Patient 1 and his family, which took place on 14th July 2020, where I advised him of my concerns with his treatment to date and, unfortunately, advised him that his cancer had spread. I completed an IR1 at this point (please see . At this point I was also aware of a further patient (Mr Patient 9) whose prostate cancer management also raised cause for concern. A deeper lookback review of Mr O'Brien's care commenced at around this time, with initial focus on cancer patient management post MDM, Radiology and pathology report sign-off / action, and clinic outcomes / additions to waiting lists. We identified additional patients who had significant findings on imaging which had not been actioned (Mr Patient 5), pathology showing cancer which had not been put through MDM and the patient was unaware (Mr Patient 8), delayed oncology referral (Mr Patient 3), and issues with prostate cancer management. As there were at least two patients who had been treated with low dose bicalutamide, as a matter of urgency an audit of patients currently receiving bicalutamide was conducted and this identified a number of additional patients who were receiving low dose bicalutamide and required their prostate cancer management reviewed and

switching to a standard management strategy. I am of the understanding that the detail of this audit has been shared with the Inquiry in previous disclosures.

62.13 Subsequently, the Lookback Review process was established. I am significantly involved in many aspects of this as follows:

a. conducting case record reviews;
b. member of screening team when case record review identifies concerns;
c. providing outpatient reviews as part of lookback;
d. providing patient and family consultations where concerns have been identified;
e. delivering ongoing care to patients impacted by identified deficiencies in care previously provided;
f. providing clinical input and guidance to the Trust Lookback Team;
g. providing input to enquiries to the trust from the Public Inquiry;
h. providing input to GMC enquiries.

62.14 To a large extent I continue to provide a significant amount of the urological guidance and expertise into the lookback process, in addition to carrying out the patient / family consultations where concerns have been identified. From the inception of the Lookback Review process, I have regularly voiced concerns regarding the pivotal position of me within this process, and a requirement for additional expertise to provide challenge, reduce the risk of me failing to recognize an issue of concern / blindspot, and provide assurance with regards planning and direction. I also had an underlying unease that my role in raising concerns and subsequently guiding the investigative process, conducting aspects of the investigation and providing clinical expertise regarding implications for patients, could be open to challenge, in particular given the knowledge of Mr O'Brien's familial links to the legal profession. Recognizing this, Professor Sethia has been engaged by the Trust to feed into and assist in much of this process, conducting large numbers of patient lookback reviews (paper/NIECR based not in person consultations) and taking part in the screening of cases for potential SCRR investigation along with me. This has been invaluable in providing me with support and an independent expert opinion. In addition, the Royal College of Surgeons have been engaged in

conducting an audit of practice, expertise for providing SCRR is identified through links with the British Association of Urological Surgeons. I remain a key part of the process and, in particular, am currently the only consultant who is providing consultations for patients identified through the lookback review, supported by the urology Clinical Nurse Specialist team.

63. ~~**57.**~~ **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.**

63.1 I believe that my response to Question 62 details the above issues.

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

(i) **what risk assessment did you undertake, and**

(ii) **what 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.**

64.1 Each time I raised concerns regarding Mr O'Brien I was concerned regarding patient care and safety.

64.2 The first IR1 that I submitted (Mr Patient 102) regarding these concerns was submitted by me in October 2015, raising concerns regarding the absence of notes for a patient and the absence of any dictated letters and the risk this posed to patients admitted for treatment.

64.3 Further IR1s submitted by me related to the absence of action on significant results (Patient 92) and, although not the initial concern, the IR1 submitted in the case of Patient 10 identified the lack of triage.

64.4 In addition to these IR1s, concerns regarding the practice of admitting patients who had been initially seen in the private sector ahead of patients waiting longer and at the same urgency on the NHS, were raised verbally and via email, and I had also expressed concern regarding the absence of notes and absence of letters both verbally and in email (as set out in paragraph 61.3 above). *Please see 17. 20151126-email queue jumpers, 18. 20150527-email urology longest waiters, 19. 20150527-email urology longest waiters attachment 1, 20. 20150527-email urology longest waiters attachment 2 and 124. 20191011 E re Emergency Admissions of Pts on Waiting Lists.*

64.5 The Investigation and outworkings of the IR1 submissions followed the standard process and I would anticipate that, where these confirmed the risk posed by the issues raised, these would have been brought to Mr O'Brien's attention by his line management (CD / AMD). The clinical management team (CD / AMD) together with the professional management team (HoS / AD) would be expected to put in place a plan to mitigate these risks.

64.6 Soon after I became AMD, the absence of triage for a large number of patients was identified. At the time Mr O'Brien was on sick leave. This was escalated to the Medical Director and an initial decision to exclude Mr O'Brien while the issue was further investigated was made. This followed the MHPS process. Due to my position / proximity to the issues (I had raised concerns, was a close clinical colleague, and was heavily involved in the remedial measures required to appropriately triage, investigate and assess the patients affected) I was not part of this process (I also subsequently was part of the SAI review team for the patients impacted by the lack of triage). It is my understanding that due to an absence of evidence of any issues with his clinical decision making, Mr O'Brien was allowed back to practice and a Mitigation / Action Plan (covering the issues identified at the time) was put in place along with monitoring arrangements set against this action plan.

64.7 Although I was not part of the monitoring of Mr O'Brien, I became concerned regarding the monitoring of Mr O'Brien and the validity of some of the data being used to provide reassurance and raised this (see: 62.9 above). This subsequently was escalated and raised with him by the Clinical Director, I believe.

64.8 However, I remained concerned that Mr O'Brien's patterns of work / behaviours were continuing and, in June 2020, when I received the email from Mr O'Brien which included a number of waiting list forms, I was concerned that this evidenced that, in addition to the issues raised previously, Mr O'Brien may not have been completing required patient related administration at the time of consultations and thereby running a significant risk of patients becoming lost. This concern was escalated and led to further investigation. Very soon after this I identified a patient who had not been treated according to standard management guidelines or MDM recommendations and who had come to harm (Mr Patient 1) and I escalated this to the Medical Director and, following consultation with the patient where I advised him and his family that I had concerns regarding his previous care, I submitted an IR1. Subsequent investigation of the factors related to these cases led to the identification of significant concerns regarding Mr O'Brien's practice. Please see *104. 20200611-email patients to be added to urgent bookable list, 105. 20200611-email patients to be added to urgent bookable list att1, 106. 20200611-email patients to be added to urgent bookable list att2, 107. 20200611-email patients to be added to urgent bookable list att3, 108. 20200611-email patients to be added to urgent bookable list att4, 109. 20200611-email patients to be added to urgent bookable list att5, 110. 20200611-email patients to be added to urgent bookable list att6, 111. 20200611-email patients to be added to urgent bookable list att7, 112. 20200611-email patients to be added to urgent bookable list att8, 113. 20200611-email patients to be added to urgent bookable list att9*

65. ~~**59.**~~ **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.

65.1 As highlighted above, as Clinical Director I was not responsible for urology and therefore was not Mr O'Brien's clinical line manager and so was not party to direct discussions with Mr O'Brien during this time with regard to any concerns identified.

65.2 Soon after becoming AMD, the MHPS investigation took place and, as also highlighted above, I was not party to this for the reasons explained. My only direct discussion with Mr O'Brien regarding issues took place on the telephone, in the presence of Mr Ronan Carroll, in early summer 2020 (unfortunately, I cannot recall the date and have no notes from the call), when I advised him that, due to a combination of factors, the Trust would not be taking up his offer of returning to practice on a part time basis post-retirement.

66. ~~**60.**~~ **What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? 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 and/or indicate where the Inquiry may find a record of any oversight.**

66.1 I was not part of the monitoring of Mr O'Brien following the MHPS investigation, although I note that Dr Khan's Case Manager's Determination report, at page 8, suggests that I had a potential role in that issues with adherence to the action plan, where identified by the CD / AD, could be escalated to me. For the reasons already identified, I was not part of the MHPS process (aside from being interviewed in the investigation). I was also not aware of the MHPS investigation findings or recommendations until much later (2019, I believe). I understood that the monitoring team included Martina Corrigan, Siobhan Hynds, Ronan Carroll and Ahmed Khan. When I became aware of the detail of the monitoring process, I raised concerns (as detailed

above at, e.g., 62.9) regarding the validity of the data being utilized in the monitoring process to provide assurance.

67. ~~**61.**~~ **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? <u>Are there</u> <u>records of you having assured yourself that systems and agreements put in</u> <u>place to address concerns were effective?</u>**

67.1 As stated previously, I was not part of the monitoring process following the MHPS investigation. When I became aware of the detail of the process, I raised concerns regarding the validity of the data being utilized to provide assurance. These concerns are noted in email communication from me as detailed above.

68. ~~**62.**~~ **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?**

68.1 I believe the post-MHPS agreement led to the cessation of Mr O'Brien's practice of expediting care of patients initially assessed privately ahead of patients on the waiting list.

68.2 The MHPS action plan did not remedy the remaining issues. As reflected previously, the failure to dictate after outpatient consultations continued as was identified on the backlog report. Mr O'Brien also did not meet the timescales for triage as identified in the action plan. Following retirement, Mr O'Brien returned a further 13 sets of patient notes from his home to the Trust illustrating that he had also continued to store trust patient records at home. *Please see:*

125. 20191011 E re Emergency Admissions of Pts on Waiting Lists
126. 20191003-email AOB concerns
127. 20191004-email AOB concerns1

128. 20191004-email action note from meeting

129. 20191004-email action note from meeting att1

130. 20191004-email action note from meeting att2

131. 20191004-email action note from meeting att3

132. 20191004-email action note from meeting att4

133. 20191004-email action note from meeting att5

69. ~~**63.**~~ **Did Mr O'Brien raise any concerns 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 with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?**

69.1 Mr O'Brien, like all the urology team, regularly expressed concern regarding the waiting times urology patients experience, the impact on patients' quality of life, and the harm being experienced by them.

69.2 At a departmental meeting in September 2018, Mr O'Brien tabled a written account of concerns *(please see 134. 20180924 Urology service development meeting pages 3-9)* It is, in my view, notable that this came after / during the MHPS investigation, and while the SAI investigation was ongoing with regard the patients whose initial referrals had not been triaged by Mr O'Brien. In the account and during the meeting he outlined his thoughts / perspectives on a number of issues including conduct of the 'Urologist of the Week' activity, triage and waiting times. Each of these were discussed openly in the meeting.

69.3 Mr O'Brien's understanding of the outcome of the discussion of these issues differed to that of my own (and I believe others), as reflected in an email to his CD, where he stated that the team had agreed to job planned weekend routine ward rounds whereas this is not reflected in the handwritten notes or subsequent typed meeting minutes. *Please see 135. 20180927-email – jobplan.*

69.4 The concerns relating to waiting times, and particularly theatre access / waiting time comparisons across specialties, I had raised with the Acute Services Management Team prior to the meeting in relation to the Trust 'Winter Plan'.

69.5 Within the note he presented, Mr O'Brien alleged patients were experiencing harm as a result of the action / inactions of other members of the consultant team . Mr O'Brien also alleged harm in his comments to the draft RCA report (the Julian Johnson report). He did not raise any examples, nor did he complete any IR1 forms, or to my knowledge bring examples to the Patient Safety Meeting for discussion *(please see 136. 20200103-email Confidential SAI, 137. 20200103-email Confidential SAI att1, 138. 20200103-email Confidential SAI att2, 139. 20200124-email response meeting request AOB, 140. 20200222-email confidential SAI, 141. 20200222-email confidential SAI att1, 142. 20200222-email confidential SAI att2 and 143. 20200222-email confidential SAI att3).* I was asked regarding investigation of these allegations but, in my position as a member of the team, advised that any assessment / investigation should be undertaken by the CD and another AMD (given that I was a member of the consultant team and therefore one of the individuals he may be alleging to be responsible for putting patients at risk). To the best of my knowledge, these allegations were not formally investigated.

69.6 On a number of occasions during my time working in Southern Trust, Mr O'Brien expressed concern regarding the disparate numbers on each consultant's waiting list for surgery. He did not acknowledge (as is illustrated in his 2018 CLIP reports, *please see 144. 20171211-email for immediate response attachment 4*) that he saw fewer new outpatients than his local peers, nor did he recognize that his practice of transferring private patients to his NHS waiting list (and, in some instances, expediting their care ahead of patients seen initially in the NHS) was contributing to his waiting list (It is my understanding that Mr O'Brien did not practice in NI independent sector hospitals, e.g., Kingsbridge, Ulster Independent Clinic, etc., and therefore was not in a position to offer private surgery).

69.7 Mr O'Brien also expressed concern at various points regarding the amount of time it took him to arrange things (e.g., elective admissions). It was clear from his descriptions that the issue he was facing was as a direct result of him not engaging with the wider support team available to him and electing to undertake many of the administrative tasks himself (e.g., phoning patients to advise them of planned admission dates / times, a task that the secretarial team undertake for all others). This was not due to a lack of available support but an unwillingness / inability to delegate these tasks appropriately to members of the wider team.

69.8 He expressed concern regarding volume of patient and GP enquiries, and yet could not recognize that, if he provided comtemporaneous written documentation to GPs, many of these enquiries would not have been necessary. As has subsequently been identified it would have also been the case that if he had ensured that every cancer patient had been seen with a CNS, many patient enquiries would have been able to have been addressed through the CNS team.

69.9 Mr O'Brien had raised a concern in an email regarding the DARO process (*please see 145. 20190207-email-patients awaiting results*). This is a 'safety-net' process whereby patients who have investigations requested are added to a list on the Patient Administration System which is then reviewed on a regular basis by secretarial staff to check if the investigation has been done and, when result is available, that it is passed on to the consultant for review and action. Although this email was not directed at me, I replied advising that the process was required for patient safety and should be followed. It has since become apparent that, despite this, Mr O'Brien and his secretary did not utilize the DARO list, and I believe this is a factor in patients who did not get test results reviewed and acted upon in a timely manner (e.g., Patient 5, Ms Patient 92).

69.10 In August 2015, HSS(MD)14/2015 required trusts to take action with regard to a regional policy on the surgical management of endoscopic tissue resection. For urology teams this related to switching from monopolar transurethral resection (in glycine) to bipolar resection (in saline), with the work on the policy having been commissioned following a coroners verdict in October 2015. Mr

O'Brien engaged in the process of assessment of new bipolar resection equipment. However, he subsequently expressed the view that he would be continuing to use monopolar resection in glycine, thereby not conforming with the policy. On reflection, this unwillingness to conform with recommendations from others should have provoked concern regarding wider aspects of his practice, especially with regards to delivering treatment in line with NICE guidance / MDM recommendations. *Please see 7. 20181205 E re Transperineal Prostate Biopsy Equipment, 8. 20171120 E re Saline TUR, 9. 20171120 E re Saline TUR A1, 10. 20171120 E re Saline TUR A2, 11. 20171120 E re Saline TUR A3 and 12. 20171120 E re Saline TUR A4.*

69.11 Previously, concerns regarding the clinical decision making relating to emergency admissions were raised within the consultant urology team regarding a former consultant colleague (Mr Suresh). I believe it was Mr O'Brien who raised this concern following an emergency re-presentation of a patient he had operated on. These concerns were also backed up by some concerns from other members of the consultant team regarding some emergency admissions. These concerns were raised with the consultant in question and additional support was provided in addition to the consultant attending some educational courses regarding emergency urology. *Please see 77. 20151217 - Confidential Meeting* Personal Inform.

70. ~~**64.**~~ **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 it was 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, why did you not?

70.1 Beyond what I have outlined in previous answers, I do not recall raising any additional concerns regarding Mr O'Brien

71. ~~**65.**~~ **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 option, such as, for example, Human Resources?**
If yes, please explain in full. If not, please explain why not.

71.1 As stated above, until I became AMD I had no line management responsibility for Mr O'Brien.

71.2 When I became AMD, I did not receive a handover and was not made aware of the existence of previous issues / concerns regarding Mr O'Brien, or the steps taken regarding these.

71.3 Soon after I became AMD, the MHPS investigation commenced and I was not part of the team involved in this or the oversight of Mr O'Brien following these concerns. I was therefore not part of discussions regarding support and am not aware of what was offered or put in place.

72. ~~**66.**~~ **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. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.**

72.1 The primary concern raised by Mr O'Brien related to waiting times for urology patients. As per my prior comments regarding commissioning, the service was never in a position to meet patient demand and therefore growing waiting lists were inevitable. This failure to meet demand and the risk associated with lengthy outpatient and inpatient / daycase waiting lists were reflected in Risk Registers. As per my earlier answers regarding the Trust Risk Registers, however, I do not believe that these adequately reflected the level of risk posed by the waiting times.

Learning

73. ~~**67.**~~ **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.**

73.1 I have already commented on the issues in relation to capacity:demand mismatch (e.g., at Q12, 13 and 16 above) and the primacy of this as a governance concern.

73.2 I have also commented on the lack of robust individual clinician performance data, collection, and review with regards specific parameters of performance (e.g., at Q31 and 50).

73.3 Medical staff have traditionally been approached from a position of trust and an expectation that they are doing things correctly, and additional investigation only instigated when an issue arises which identifies a deficiency. Resultant remedies to each individual concern result in a potential inconsistent patchwork of performance monitoring.

73.4 Specific to Mr O'Brien, I am aware that issues with regard to many of his practices had been recognized in the Trust over a prolonged period; notes being in his house and absence of dictated letters following consultation appear to have been accepted as 'normal practice' for Mr O'Brien. Triage had been an issue historically and, despite this, a consistent mechanism for monitoring it was not developed, and no formal policy including how this would be monitored and how it would be escalated was in place until the Return To Work Action Plan of 2017, although it remains the case that no formal triage policy / SOP covering all other consultants in the Trust is in existence. However, non-triage has not been an issue for any member of the urology team other than Mr O'Brien.

73.5 No mechanism exists to monitor any individual clinician's decision making in outpatients. Issues only come to light when concern is raised by another clinician – be it a GP or a colleague. In Mr O'Brien's case, the ability of GPs or consultant colleagues to identify issues will have been impaired by the absence of letters. Additionally, the workload placed on the consultant urologists by virtue of the capacity:demand mismatch would have impacted on their ability to recognize issues. Single consultant practice also impacts, as for many outpatient conditions only one consultant may see a patient during a long disease natural history.

73.6 The absence of an induction process or handover for incoming AMDs was also a factor. For example, it was only after the identification of the untriaged referrals in 2017 that I was made aware that this had been an issue previously with Mr O'Brien. The resultant lack of continuity within the system resulted in, effectively, a clean slate each time there was a change in the medical management personnel at Clincial Director and Associate Medical Director level.

73.7 Being aware now of the clinical issues, in particular with regard to Mr O'Brien's prostate cancer management, it is in my opinion clear that conformance with external recommendations / guidance was a factor – be they MDM recommendations, NICE Guidelines or other external recommendations. I am told individual oncologists had raised concerns directly with Mr O'Brien regarding his use of low dose bicalutamide but Mr O'Brien did not change his practice. On reflection, other behaviours (such as his continued use of monopolar / glycine for transurethral surgery despite external recommendations) should have alerted others to the likelihood that he was not following other forms of external guidance. I am aware that similar behavior from Mr O'Brien regarding external recommendations was encountered following the 'Improving outcomes guidance' which recommended centralization of specific cancer related surgery within cancer networks. For Urology this covered Cystectomy for bladder cancer, radical prostatectomy for prostate cancer, penile cancer surgery and nephron sparing / IVC thrombectomy surgery for kidney cancer. After cystectomy surgery was centralized to Belfast, despite (I understand) having been told that no further

cystectomies were to take place in CAH, I believe Mr O'Brien admitted a further patient to Craigavon for a cystectomy and had to be prevented from undertaking the surgery with the patient discharged and referred to Belfast Trust. I have no knowledge of what actions were undertaken at this time regarding Mr O'Brien's behaviour but this may be a further example of Mr O'Brien's unwillingness to change his practice in response to instruction / guidance from elsewhere. Penile cancer and Nephron sparing surgery have only been formally commissioned / centralized to a single center since I commenced at NICAN CRG chair.

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

74.1 I believe the primary factors which explain the current position are:

a. insufficient capacity to meet demand,
b. failure of the Trust processes to link concerns over time and address concerns when first identified, and
c. the behaviour of Mr O'Brien.

74.2 The capacity:demand mismatch meant it was less likely that Mr O'Brien's colleagues would identify concerns. In addition, the consequences of some of the issues identified with respect to Mr O'Brien's practice may have been rendered more significant because of the long waiting lists. For example, the consequence of a failure to triage a referral (and upgrade it from routine or urgent to red flag) would likely be much less if the waiting times in general were within the access targets set out in 'Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD)' which states;

'4.11 By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.
4.12 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.13 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.'

Put another way: the state of our waiting lists currently and over the last number of years renders the principle of timely and appropriate triage (and indeed 'advanced' triage where patients have appropriate investigations arranged on triage) of critical importance in minimising the harm that can potentially occur to patients as a result of these waiting lists.

74.3 A failure to manage Mr O'Brien adequately, likely going back many years in his career, subsequently emboldened and likely reinforced his behavior patterns. Looking at the issues identified in the Lookback Review, warning flags of their existence were present in earlier concerns which had been identified. The absence of a handover / briefing to incoming medical managers regarding prior concerns in relation to staff under their line management weakened the sensitivity of the system to link concerns when new ones were raised.

74.4 However, it is notable that other consultants function within the same system and processes that Mr O'Brien worked with, but the concerns noted with Mr O'Brien have not been identified with them.

74.5 Mr O'Brien's approach to external guidelines / recommendations (e.g., monoplolar / glycine transurethral resection), his unwillingness to engage in Trust processes (e.g., DARO process for results), his delayed interaction with Trust Legal Services when requested to provide involvement reports, his lack of dictation after outpatient consultation and unwillingness to change this practice, his failure to recognize that storing patient notes at his house impacted on the care of patients when they attended other consultants, amongst the various issues identified, were, to the best of my knowledge and belief, all unique to him. I believe that Mr O'Brien's response to many of these issues illustrates that he was resistant to changing how he did things in response to being told what or how to do something by others and this may also have been a factor in respect of his private patient management and referral triage issues identified above, both of which were behaviours that were also, to the best of my knowledge and belief, unique to Mr O'Brien. This issue regarding his

approach / behaviours was subsequently not adequately addressed and his behavior continued. I also became aware at some point (I don't know when or from whom) of Mr O'Brien's familial links within the legal profession and his close social links with the previous Chair of the Board and I have a suspicion that this wider circle or network of influence, and the perceived threat posed by his links to it, impacted on the actions taken in response to concerns when they were identified. An example of Mr O'Brien's behaviour was in November 2016 when he and members of his family made direct contact with Mr Young, Mrs Corrigan and Mr Weir, independently regarding the investigation talking to Mr O'Brien taking place at this time (*please see 146. 20161116-email AOB MDH*). I even understand that the previous Chair of the Trust Board may have personally made contact with a previous AMD regarding his management of concerns regarding Mr O'Brien.

75. ~~**69.**~~ **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?**

75.1 Performance monitoring across all aspects of care requires a significant overhaul to be fit for purpose. Patient data is at the base of this and robust, contemporaneous patient-level data collection is required for specific conditions as well as individual surgeon performance monitoring.

75.2 In addition to this, robust process monitoring data collection and analysis is required for clinical processes such as triage and clinical results management. Processes for the monitoring of clinician performance with regard to this workload are being developed and a monitoring process for radiology results has commenced which is now providing assurance that results of all radiological investigations requested under the care of the Southern Trust Urology clinicians are reviewed, signed off and actioned.

75.3 From a cancer perspective, I believe NICAN should be critical to the quality performance monitoring. I believe monitoring of access times should be a key part of the NICAN CRG function (where, to date, it has been monitored through trust performance teams) and changes are being made to incorporate this as a

standing item for trust reports on the CRG meetings. With regard to quality of care delivered, I believe Northern Ireland should follow the Scottish Quality Performance Indicator Program *(please see 147. LETTER NICaN to Primary Care-re Suspect Cancer Referral Guidance_ Aug_2022 and 148. NICaN GP Suspect Cancer Referral Guidance Revised Aug 2022)* and this should be led through NICAN and its Specialty Clinical Reference Group structure. This would be a significant expansion of the role of NICAN and would require expansion from its current infrastructure / staff levels. This is supported by a recent external review of NICAN.

76. ~~**70.**~~ **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.**

76.1 Mr O'Brien's underlying patterns of behavior were longstanding. Historically, I believe attempts were made to address these, unsuccessfully. I believe Mr O'Brien's personality and circle of influence made it extremely difficult to address issues and this was a major factor. Mr O'Brien did not change his behaviours where concerns were identified (e.g., with regard to dictated correspondence following outpatient consultations). Many of the concerns identified prior to 2020 may potentially be grouped into 'administrative issues' with regard to Mr O'Brien – delayed triage, non-action of imaging results, non-engagement in the DARO process, failure to provide outcomes / conduct administrative tasks (e.g., completion of waiting list form) after consultations, absence or significant delay in dictating letters after outpatient consultation, delayed engagement with litigation / complaints processes, storage of patient records at home, and non-chronological management of patients initially seen in private practice. There was a failure to connect all of these administrative issues, the response of Mr O'Brien when these issues were raised with him, and the risk of additional uncovered issues within his practice. As a result, a more comprehensive review of his practice did not take place at an earlier point.

76.2 In addition, I am aware from colleagues in the oncology team that concerns had been raised directly with Mr O'Brien previously with regard to his management of prostate cancer and, in particular, his use of low dose bicalutamide in patients with early prostate cancer but, as has become evident, Mr O'Brien did not change his practice. To the best of my knowledge these concerns did not come to the Southern Trust governance systems / processes.

77. ~~71.~~ **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?**

77.1 I regret not recognizing in late 2017/early 2018 that, in addition to the factors investigated in the MHPS investigation, there was a likelihood of additional issues that had not been identified but which required investigation. The fact that some aspects of good clinical practice were absent in Mr O'Brien's working patterns I feel, in retrospect, ought to have raised the concern that other deficiencies of good practice may also have been present. If this had been recognized, and a comprehensive review of practice been carried out at the time, I feel it is likely that the clinical practice which was identified in 2020 (and which led to the Lookback exercise) would have been identified earlier.

77.2 I am currently developing monitoring processes for data collection / monitoring for the factors monitored for Mr O'Brien in order to roll out across services to provide reassurances that, for the future, similar issues, particularly with regard to clinic outcomes, clinical correspondence, triage, and results management, do not go unidentified in any other clinicians.

78. ~~72.~~ **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?

78.1 It is notable that Mr O'Brien's colleagues function within the same system, same resource, and same governance arrangements and concerns regarding their practice have not been identified.

78.2 However, and as stated above, I believe significant improvements in data collection of performance indicators is required across conditions and processes in order to improve patient care and to prevent a similar problem.

79. ~~**73.**~~ **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?**

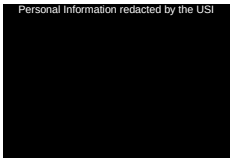
79.1 On the basis of the information I currently have, I confirm that I have nothing to add at this time.

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.

Statement of Truth

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

Signed: 

Date: 16th September 2022

Section 21 Notice Number 6a of 2022

Witness Statement: Dr Mark Haynes

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32. 20200924 E re Mr Personal Information **A4**

33. Mr Mark Haynes CLIP 2018

34. CLIP-Report-Reflection

35. 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff

36. 20190911 Urology P I G Minutes

37. 20201022 P I G Actions and Date of Next Mtg

38. 20201022 P I G Actions and Date of Next Mtg A1

39. 20201022 P I G Actions and Date of Next Mtg A2

40. 20201022 P I G Actions and Date of Next Mtg A3

41. 20220428 Urology P I G Meeting

42. 20220428 Urology P I G Meeting A1

43. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE

44. 20180717 Datix Irrelevant redacted by the USI

45. 20201113 Final Report Irrelevant redacted by the USI

46. 20210719 Approved Action Plan to HSCB

47. 20210719 Approved Action Plan to HSCB A1

48. 20160106 Datix Incident

49. 20170315 Final Report Irrelevant redacted by the USI

50. 20201204 Action Plan SAI Patient 10

51. 20190208 59

52. 20210428 Final Report Irrelevant redacted by the USI **to HSCB 22.4.2021**

53. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1. Nov 2016

54. 20180401 Ref 2i - Regional Your Right to Raise a Concern Policy and Procedure

55. Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework

56. 20180510 Request for Meeting with Shane Devlin

57. 20180608 E re Urology Waiting Lists

58. 20180720 Request for Meeting with Shane Devlin

59. 20180905 RE Tyrone GAA Manager praises CAH staff for care and treatment

60. 20181019 RE Tyrone GAA Manager praises CAH staff for care and treatment

61. 20181019 RE Tyrone GAA Manager praises CAH staff for care and treatment A1

62. 20171212 1 to 1 with Dr Wright Calendar Entry

63. 201971116 E re 3S Winter Plans

64. 20181028 E re 3S Transfer to 3N

65. 20181018 Email re Proposed Winter Plan

66. 20181028 Email re Proposed Winter Plan

67. 20180921 E re Winter Plan

68. 20180921 E re Winter Plan A1

69. 20191030 NICaN Uro CRG Risks and Current Waiting Times

70. 20191030 NICaN Uro CRG Risks and Current Waiting Times A1

71. 20180905 RE Tyrone GAA Manager praises CAH staff for care and treatment

72. 20181019 RE Tyrone GAA Manager praises CAH staff for care and treatment

73. 20181019 RE Tyrone GAA Manager praises CAH staff for care and treatment Att1

74. 20171006 E re BT80 patients

75. 20180213 E re BT80 patients

76. 20181019 E re BT80 patients

77. 20151217 - Confidential Meeting Pers onal Infor

78. ADEPT PROJECT STONE Presentation Finance meeting jan – final

79. 20160304 Proposal for ADEPT Management Project

80. 01072018_Stone Centre Quality Improvement Project Team Document

81. 20150618 agenda urology dept meeting

82. 20220608 urology performance

83. 20150723 - Urology Departmental meeting agenda

84. 20151008- urology departmental meeting agenda

85. 20160922 - Urology Departmental meeting

86. 20190219 - urology performance paper

87. 20141120 -IR1 Mr Patie nt 102

88. 20170111 E re PATIENT Personal Information redacted by the USI

89. 20180614-email litigation

90. 20180614-email litagation att

91. 20180614-email litagation att1

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95n. 20180614-email litagation att20

95o. 20180614-email litagation att21

95p. 20180614-email litagation att22

96. 20190310-email [redacted] **complaint**

97. 20190314-email [redacted] **complaint**

98. 20160831-email [redacted]

99. 20160831-email [redacted] **attachment 1**

100. Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018

101. 20180928 Email Case Manager Determination AO'B FINAL 280918 attachment

102. 20170209 - Email - Return to Work Action Plan February 2017 FINAL

103. Appendix 19 Witness Statement - Mr M Haynes 240517

104. 20200611-email patients to be added to urgent bookable list

105. 20200611-email patients to be added to urgent bookable list att1

106. 20200611-email patients to be added to urgent bookable list att2

107. 20200611-email patients to be added to urgent bookable list att3

108. 20200611-email patients to be added to urgent bookable list att4

109. 20200611-email patients to be added to urgent bookable list att5

110. 20200611-email patients to be added to urgent bookable list att6

111. 20200611-email patients to be added to urgent bookable list att7

112. 20200611-email patients to be added to urgent bookable list att8

113. 20200611-email patients to be added to urgent bookable list att9

114. 20200707-email cases1

115. 20200914 Tab 1 datix

116. 20201006-email a further case 1

117. 20191031 Datix incident form

118. 20201112 Datix 128057

119. 20190331_RE Urology backlogs Confidential

120. 20170617-email clinical correspondence backlog report

121. 20170620-clinical correspondence backlog

122. 20170701-email clinical correspondence backlog report

123. 121045

124. 20190930-AOB concerns escalation1

125. 20191011 E re Emergency Admissions of Pts on Waiting Lists

126. 20191003-email AOB concerns

127. 20191004-email AOB concerns1

128. 20191004-email action note from meeting

129. 20191004-email action note from meeting att1

130. 20191004-email action note from meeting att2

131. 20191004-email action note from meeting att3

132. 20191004-email action note from meeting att4

133. 20191004-email action note from meeting att5

134. 20180924 Urology service development meeting

135. 20180927-email – jobplan

136. 20200103-email Confidential SAI

137. 20200103-email Confidential SAI att1

138. 20200103-email Confidential SAI att2

139. 20200124-email response meeting request AOB

140. 20200222-email confidential SAI

141. 20200222-email confidential SAI att1

142. 20200222-email confidential SAI att2

143. 20200222-email confidential SAI att3

144. 20171211-email for immediate response attachment 4

145. 20190207-email-patients awaiting results

146. 20161116-email AOB MDH

147. LETTER NICaN to Primary Care-re Suspect Cancer Referral Guidance_ Aug_2022

148. NICaN GP Suspect Cancer Referral Guidance Revised Aug 2022

Application Form

An Equal Opportunities Employer

Application Ref: (office use only)

- Canvassing will disqualify
- Only applications containing all the information that has been sought will be considered
- You are strongly encouraged to complete the equal opportunities section of this form which is used only for monitoring /statistical purposes and is not made available to the panel
- Applications received after the closing date and time will not be considered

Job Reference: 73813109
Job Title: Consultant Urological Surgeon (with a special interest that will complement the Urological team)
Submission Date: 05/12/2013 13:55:55
Closing Date: 05/12/2013 16:30:00

For administrative purposes indicate planned holiday arrangements **From** **To**
We are under no obligation to take account of your holiday arrangements

Surname	**Haynes**	Title	**Mr**
First Name	**Mark**	Previous Surname	
Correspondence Address	Personal Information redacted by the USI		
Postcode			
Contact Phone Number		Mobile Number	Personal Information redacted by the USI
Email Address		Nat. Insurance No.	

Do you hold a current full driving licence valid in the UK?	If required, do you have access to a car, or a form of transport which will enable you to undertake the duties of this post?
Yes	**Yes**
Would you be willing to receive correspondence by email AND SMS/TEXT? **Yes**	

Please name two referees (not relatives) at least one of whom should have knowledge of your present work and be in a supervisory/managerial capacity. (Please note that we will always seek a reference from the last HSC/NHS employer).

Title	Personal Information redacted by the USI	Title	Personal Information redacted by the USI
Name		Name	
Occupation		Occupation	
Address		Address	
Postcode		Postcode	
Phone Number		Phone Number	
Email Address		Email Address	
Can we contact this referee prior to interview?		Can we contact this referee prior to interview?	

Chat with applicant 21/1/14 - See email from Mr Haynes - Refs e-mailed 21/1/14

Education

Medical or Dental and other degrees, memberships, fellowships etc, with particulars of medical or dental school, date of obtaining qualifications and particulars of honours and distinctions.

Cert/Diploma/Degree	Result	Date Obtained	Exams yet to be taken
MB BCh	Pass	01/07/1999	none
MD	Pass	01/05/2009	none
FRCS (Urol)	Pass	31/05/2009	none
MRCS	Pass	01/12/2001	none

GMC/GDC Registration

Registration Type:	Full
Registration:	Specialist Register Urology 4th Mar 2010
GMC/GDC Number:	Personal information redacted by USI
Medical Defence Union Number	None (Indemnity with other provider)

No doctor may be employed unless he/she is registered or holds limited registration with the General Medical/Dental Council. Evidence of this must be produced prior to commencement of employment.

Specialist Register Status

I am currently on the Specialist Register?	Yes
I have applied for entry onto the Specialist Register?	Yes
My expected date of issue of CCST is:	04/03/2010
Speciality in which now engaged:	Urology

Membership of Learned Societies

BAUS Member

Under-Graduate/Post-Graduate Prizes/Distinctions/Research/Publications

Undergraduate; Dr Ken Wheeler Presidents Prize 1998 MB BCh: Merit in Community Medicine, Anatomy, Biochemistry, Physiology and Sociology Postgraduate; BUF / Schroder Scholarship 2004/5 Research; As a consultant I am involved in recruitment of eligible patients to clinical trials including POUT, SORCE, RADICALS, CARMINA, and STAMPEDE. Period of laboratory based research (MD), data collection for patients in the CAPRIx trial. Audit; As MDT Chair I am responsible for data collection/outcomes monitoring and subsequent submission to the cancer registry, COSD, and BAUS database. I supervise FY1, CST and SpRs in clinical audits which have been presented regionally. Publications; Transurethral resection biopsy as part of a saturation biopsy protocol: a cohort study and review of the literature. Urol Oncol. 31(5): 542-8, 2013 Claudin-11 decreases the invasiveness of bladder cancer cells. Oncol Rep. 25(6): 1503-9, 2011. Renal Cancer. Surgery. 28(12): 605-609, 2010.

Employment

Have you ever been referred to the Independent Safeguarding Authority as a result of misconduct involving children and / or vulnerable adults? If yes please provide full details below. **No**

Present Post

Employer Name	**Sheffield Teaching Hopitals NHS Foundation Trust**
Employer Address	**Royal Hallamshire Hospital Glossop Road Sheffield**
Job Title	**Consultant Urological Surgeon**
Period of Notice	**3 months**
Salary/ Wage	Personal Information redacted by the USI
Job Dept/ Location	**Urology**
Start Date	**01/04/2010**
Reason for Leaving	**Currently in post.**
Duties	**Sub-specialist interest in urological oncology, performing both laparoscopic and open surgery for cancers of the upper urinary tract, prostate, bladder and testes. Also FY1 educational supervisor, MDT Chair and Clinical Lead for inpatient activity.**
Employment Status	**Permanent**

Previous Posts

Name & Address of Employer	Job Title	Start Date	End Date	Reason for Leaving	Duties
Sheffield Teaching Hospitals NHS Foundation Trust Royal Hallamshire Hospital Glossop Road Sheffield	Specialist Registrar in Urology - North Trent rotation	06/10/2008	31/03/2010	Appointment to consultant post	Sub-speciality training in urological oncology as SpR to Mr DJ Smith, Mr JB Anderson, Mr JW Catto, Mr N Oakley, Mr DJ Rosario and Mr PE Cutinha. Specific surgical training in open and laparoscopic surgery for renal, prostate, bladder and testes cancers.
Sheffield Teaching Hopitals NHS Foundation Trust Spinal Injuries Unit Northern General Hospital Sheffield	Specialist Registrar in Urology - North Trent rotation	07/04/2008	05/10/2009	Rotation to next training post	Training in the urological management of spinal injuries patients in dedicated spinal injuries unit as SpR to Mr PR Tophill and Miss SV Reid including video urodynamics and functional / reconstructive surgery.
Sheffield Teaching Hospitals NHS Foundation Trust Royal Hallamshire Hospital Glossop Road Sheffield	Specialist Registrar in Urology - North Trent rotation	01/10/2007	~~30/09/2007~~ 6/4/08	Rotation to next training post	Training in urological oncology as SpR to Mr DJ Smith, Mr JB Anderson, Prof FC Hamdy, Mr JW Catto, Mr DJ Rosario and Mr PE Cutinha
Sheffield Teaching Hospitals NHS Foundation Trust Royal Hallamshire Hospital /Barnsley District General Hospital Sheffield / Barnsley	Specialist Registrar in Urology - North Trent rotation	02/04/2007	30/09/2007	Rotation to next training post	Training in Renal transplantation as SpR to Mr BM Shrestra, Mr AT Raftery and Mr V Chidambaram-Nathan including live and cadaveric renal transplants / donor nephrectomies and dialysis access. General Urology training 1 day per week at Barnsley DGH.
Sheffield Teaching Hospitals NHS Foundation Trust	Specialist Registrar in Urology -	02/10/2006	01/04/2007	Rotation to next training post	SpR to Mr DJ Smith, Mr JB Anderson, Prof FC Hamdy, Mr JW Catto, Mr DJ Rosario and Mr

Royal Hallamshire Hospital Glossop Road Sheffield	North Trent rotation				Cutinha. Training in general urology and urological oncology.
Sheffield Teaching Hopitals NHS Foundation Trust Barnsley District General Hospital Gawber Road Barnsley	Specialist Registrar in Urology - North Trent rotation	03/04/2006	01/10/2006	Rotation to next training post	SpR to Mr D Smith, Mr PE Cutinha, Mr J Hall annd Mr V Natarajan. Training in General Urology.
Sheffield Teaching Hospitals NHS Foundation Trust Royal Hallamshire Hospital Glossop Road Sheffield	Specialist Registrar in Urology - North Trent rotation	14/09/2005	02/04/2006	Rotation to next training post	SpR to Prof CR Chapple, Mr RD Inman, Mr J Hall, Mr N Oakley, Mr KJ Hastie and Mr V Natarajan. Training in general urology / endourology and functional / reconstructive urology.
Cardiff and Vale NHS Trust University Hospital of Wales Heath Park Cardiff	Specialist Registrar in Urology - Locum Appointment for Training	02/01/2005	13/09/2005	Appointment to SpR training rotation	SpR to Mr G Kynaston, Mr B JJenkins and Miss V Agarwal. Tarining in general urology, urological oncology, reconstructive urology and andrology.
Cardiff and Vale NHS Trust University Hospital of Wales Heath Park Cardiff	Clinical Research Fellow	06/08/2003	01/01/2005	Appointment to LAT SpR post	Laboratory based research supervised by Mr PN Matthews resulting in MD with one day per week clinical duties in Urology including on- call (SpR rota), outpatients clinics and theatres.
Cardiff and Vale NHS Trust University Hospital of Wales Heath Park Cardiff	South East Wales Basic Surgical Training rotation	02/08/2000	05/08/2003	Appointment to clinical research fellow post	Basic surgical training including attachments in General Surgery, Urology, Trauma and Orthopaedics and Accident and Emergency At University Hospital of Wales, Llandough Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.
Cardiff and Vale NHS Trust Llandough Hospital Penlan Road Penarth	Pre-Registration House Officer	02/02/1999	01/08/2000	Appointment to basic surgical training rotation	PRHO to Mr AP Smith (respiratory Medicine) and Dr P Beck (general medicine / diabetes).
Cardiff and Vale NHS Trust University Hospital of Wales Heath Park Cardiff	Pre-Registration House Officer	04/08/1999	01/02/2000	Rotation to Medical PRHO post	PRHO to Mr RG Mills (ENT), Prof MH Wheeler (Endocrine surgery) and Mr BI Rees (General / Colorectal Surgery).

If you have any gaps in your career history, please include and explain these in the box below:

Additional Information

Please include any other information which may be relevant to this application, detailing how you meet each of the criteria as outlined in the personnel specification.

Clinical;
In my current post I sub-specialise in the management of all urological cancers and chair the regional uro-oncology MDT. I perform approximately 140 major surgical procedures a year including open and laparoscopic nephrectomy / nephroureterectomy (including IVC thrombectomy) and partial nephrectomy, open radical cystectomy, laparoscopic radical prostatectomy and para-aortic / caval node dissections. In addition I undertake general urology work and benign upper tract laparoscopy including laparoscopic pyeloplasty and laparoscopic ureteric reimplantation.

Managerial;
Most recently I have taken on the role of regional uro-oncology MDT chair and am Clinical Lead for urology inpatients acting as deputy clinical director and member of the directorate executive team. I was sponsored by the trust to undertake an MBA in Medical Leadership which started in 2010. I completed the first year of this but unfortunately due to conflicting time demands was unable to continue with this course. Some specific posts I have held include:
Clinical Lead (inpatients), October 2013 - present.
Regional Specialist Uro-oncology MDT Chair, August 2013 - present.
Hospital at Night protocols / SOPs STH trust Lead, December 2010 – present.
Hospital at Night Implementation group Member, April 2010 – present.
Hospital at Night F1 group rota organiser, August 2010 – present.
Urology Foundation Drs clinical lead, April 2010 – present.
Urology / General Surgery / Plastics F1 daytime rota organiser, August 2010 – present.
Trainee Representative regional STC, March 2008 – March 2010.
Rota Organiser / Lead SPR, March 2008 – March 2010.
Chairman Sheffield Teaching Hospitals Junior Doctors Forum, 2008.
Junior Doctors Representative, Hospital at Night Project, University Hospital of Wales, March 2002 – September 2005.
Llandough Hospital Junior Doctors Mess President, Feb – Aug 2000.
BMA Junior Doctors representative, UHW / Llandough Hospital, 2000-2001.
Welsh Representative, BMA Students Committee, 1998-1999.
President of the University Of Wales College Of Medicine Student's Club, 1997-1998.
Clinical Medical Students President, UWCM, 1996-1997

Teaching;
I am an educational supervisor for F1 doctors in Urology and also act as a clinical supervisor for SHOs and SPRs and have mentored advanced nurse practitioners.I teach all grades of trainee doctors in formal and informal teaching sessions. In the operating theatre I look to maximise the teaching opportunities for junior trainees. As SPR I coordinated undergraduate urology teaching at the Royal Hallamshire hospital redesigning the timetables for the urology attachment and established a number of core teaching sessions to cover the undergraduate curriculum. Feedback was excellent with urology receiving the highest feedback scores of all sub-specialities in this year. I am an active participant at regional SPR training days and act as an examiner at the mock FRCS(Urol) viva day. I am also involved in the teaching of nursing staff and other healthcare professionals and have provided lectures and workshops at education days for these healthcare workers.

Personal Information;
Family is an important aspect of my personal life and [redacted]. Outside of work I have a interests including gardening, cake decorating and camping / caravanning .I am a keen sportsman with my principle sports being swimming and running. I competed up to national level in cross country running and swimming and at my peak was ranked 3rd in England at 1500m freestyle and was a member of the amateur swimming association South West regional development squad. I have recently started competing in triathlons and completed a middle distance triathlon (1900m swim, 90km ride, 21.2km run) in 4 hours 48 min in September.

Fitness to Practice

STATEMENT OF POLICY AND PERSONAL DECLARATION STATEMENT REGARDING CRIMINAL INVESTIGATIONS IN THE UK OR OVERSEAS, FITNESS TO PRACTICE PROCEEDINGS BY A LICENSING/REGULATORY BODY AND OTHER UNRESOLVED OR PENDING ISSUES

Registration with the General Medical Council or General Dental Council imposes on doctors and dentists a duty to provide a high standard of medical care for, and behave appropriately towards patients. Employers within Health and Social Care also have a duty to ensure that patients receive a high standard of medical care and ensure as far as possible the safety of patients. The Trust therefore needs to establish if you have been found guilty of a criminal offence, been bound over or cautioned or are currently the subject of proceedings which might lead to a conviction, an order binding you over or a caution, in the UK or any other country.

The Trust also needs to establish if you have been the subject of any fitness to practice proceedings in the past, or if any fitness to practice proceedings are being contemplated, by a licensing or regulatory body in the UK or another country and this is also reflected in the Declaration together with the need for the Trust to be made aware of any professional or personal, unresolved or pending issue that might undermine your standing or ability to do the job.

This information will be treated in confidence and will not debar you from appointment unless the selection panel considers that it renders you unsuitable for appointment. In reaching such a decision the Trust will consider the nature of the conviction/action/issue, how long ago it took place and any other factors, which may be relevant.

Failure to disclose a criminal offence, having been bound over or cautioned or that you are currently the subject of criminal proceedings which might lead to a conviction, an order binding you over or a caution, or fitness to practice proceedings undertaken or being undertaken by an appropriate licensing or regulatory body, may disqualify you from appointment, or result in summary dismissal/disciplinary action and referral to the General Medical Council or General Dental Council for consideration if such a discrepancy came to light.

If you would like to discuss what affect any previous convictions, police investigations or fitness to practice proceedings taken or being taken either in the UK or by an overseas licensing or regulatory body might have on your application, you may contact the HR Department in confidence, for advice.

In relation to:

(a) criminal offences, being bound over or cautioned, or current proceedings which might lead to a conviction, an order binding you over or a caution, (this includes Road Traffic or Motoring Offences)and

(b) fitness to practice proceedings taken or being currently contemplated by a licensing/regulatory body, and

(c) any other professional or personal, unresolved or pending issue that might impact on your standing or ability to do the job

1. Have you been convicted of a criminal offence, (including Road Traffic or Motoring Offences), been bound over or cautioned or are you currently the subject of any police investigation, which might lead to a conviction or order binding you over or a caution in the UK or any other country?

No

Note: Applicant for posts in Health and Social Care are exempt from the Rehabilitation of Offenders (Northern Ireland) Order 1978. You are required to declare prosecutions of convictions, including those considered 'spent' under this Act.

If yes, please provide details of the criminal offence, order binding you over or caution or details of any current proceedings which might lead to a conviction, an order binding you over or a caution, including the approximate date of the offence and the authority and country which dealt with the offence.

2. Have you been or are you currently subject to any fitness to practice proceedings by an appropriate licensing or regulatory body in the UK or any other country?

No

If yes, please provide details of the nature of proceedings undertaken or contemplated, including the approximate date of proceedings, the country where proceedings were undertaken and the name and address of the licensing or regulatory body concerned.

3. Have you been involved or are you currently involved in any professional or personal, unresolved or pending issue that might undermine your standing or ability to do the job?

No

If yes please provide appropriate dates and details in the box below.

Medical History

Whether you have been in employment or not, please give details and dates of all periods of sickness/absence over the past 3 years up to the date of this application.

Nature of Sickness/ Absence	Date From	Date To	No of Days	Did you consult a doctor?

Have you ever had to resign, retire or been dismissed from a post due to ill health? **No**

Disability

Do you require a reasonable adjustment for reasons related to a disability to allow you to:

(a) attend for interview? **No**
If yes, please give details:

(b) undertake the duties of this post if successful? **No**
If yes, please give details:

Personal Declaration

1. I declare that all the foregoing statements are true, complete and accurate
2. I understand that if I give wrong information or leave out important information I could be dismissed if I take up this job
3. I understand that to take up this job I must have satisfactory references, health assessment and Access NI checks (if applicable)
4. I understand that I may be asked to show some formal identification and evidence of qualifications if required
5. I confirm that as far as I know there are no medical reasons that would stop me from carrying out the duties of this job
6. I agree to you making any necessary enquiries during the recruitment and selection process
7. I understand that canvassing will disqualify me from the selection process for this job
8. I consent to the information I have provided being used within the context of the Data Protection Act 1998
9. I consent to my ISA registration being checked based on the information included in this form

Signature..... Date.....

Immigration Status

PLEASE COMPLETE THIS SECTION FULLY – FAILURE TO DO SO WILL RESULT IN YOUR APPLICATION BEING REJECTED

Your eligibility to apply for this position will be determined by your immigration status on the closing date for applications for this post

(1) Are you a United Kingdom (UK), European Community (EC) or European Economic Area (EEA) national? (please select as appropriate) **Yes**

(2) If not, do you have evidence of entitlement to enter and work permanently in the United Kingdom i.e. settled status? (please select as appropriate)**No**

If you have selected no to both of the above please mark with a cross those boxes below that define your immigration status and complete start and expiry date of your permit:

Personal Status

Cross	Status	Start Date	Expiry Date
☐	Highly Skilled Migrant Programme (dates of endorsement stamp in passport)		
☐	Tier 1 – Points based system – no restrictions on working		
☐	Tier 1 – Points based system – restrictions on working as a trainee		
☐	Permit Free Training		
☐	Fresh Talent: Working in Scotland		
☐	Refugee in the UK		
☐	Work Permit		
☐	UK ancestry		
☐	SEGS / IGS visa holder		
☐	Student visa holder		
☐	TWES / MTI visa holder		

Partner/ civil partner/ spouse status

☐	Partner / civil partner or spouse of UK / EEA citizen
☐	Non EEA national partner / civil partner or spouse of EEA citizen exercising a treaty right
☐	Partner / civil partner or spouse of HSMP holder
☐	Partner / civil partner or spouse of Tier 1 – Points based system – without restriction
☐	Partner / civil partner or spouse of Tier 1 – Points based system – with restriction
☐	Partner / civil partner or spouse of student visa holder – student visa holder must have 12 months or more visa time
☐	Partner / civil partner or spouse of other immigration categories i.e. refugees, work permit holders, Overseas government employees, Innovators etc.

Other - please specify

False

Nationality:

If you are shortlisted, you will be required to produce the original documents (passports, page with the stamp and letter from the Home Office) on the interview day.

Please indicate how you became aware of this vacancy: Professional Journal

*** END OF APPLICATION FORM ***

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							
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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							
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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							
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			Clinic		
13:15							
13:30			Continuous professional development.				
13:45							
14:00				Surgery MDT			
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19:00							
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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11:00							
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				
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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18:45							
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 the 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.

Southern Health and Social Care Trust

Quality Care - for you, with you

Ref No: 73816020

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Clinical Director – Surgery & Elective care (2 posts)

BASE: Craigavon Area Hospital / Daisy Hill Hospital

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Services

OPERATIONALLY RESPONSIBLE TO: Associate Medical Director – Surgery and Elective care

ACCOUNTABLE TO: Chief Executive

HOURS: Salaried Part-time position

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of Surgical Services in the Southern Health and Social Care Trust.

There are 2 posts available;
He/She will:

- Participate as a member of the Surgery and Elective Care Divisional Team;
- Be responsible for medical operational issues within Surgery across the Trust.
- Provide professional advice to the Associate Medical Director and Divisional team on professional medical issues of the Division.
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY RESPONSIBILITIES

Setting Direction:

- To support the Trust in the development of a high quality, responsive scheduled and unscheduled care services, ensuring that regional and local targets are achieved.
- To advise the Management Team of Divisional priorities and pressures across the Division.

- Provide leadership and direction to consultants and other medical staff within the specialty.

Service Delivery:

- To function as a member of the Divisional management team with responsibility for medical operational and professional issues within Surgery and Elective care.
- Work with the Associate Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the Division.
- Work with the Divisional Team to use the resources of the Division to deliver, in both quality and quantity, the activity and targets agreed for the Division.
- Work with the Surgery and Elective care Divisional team to deliver efficient, effective services within the agreed financial budgets and to provide advice and guidance on the costs and benefits of planned developments.
- Work with the Surgery and Elective Care Divisional Team in supporting the modernisation of related services.
- To support the Trust in planning a response to major incidents and outbreaks.

Quality, Communication and information management

- Provide clinical leadership to ensure the implementation of patient safety initiatives.
- Support the Associate Medical Director to ensure a programme of multi-professional clinical audit is implemented within the Division that supports the Southern Trust integrated governance strategy and support the development of benchmarking activities within the Division.
- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the specialty.

Professional Leadership

- Support the Associate Medical Director to ensure the highest standards of clinical effectiveness and medical practice in the Division, including the consideration / implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines, SAI recommendations and Regional and National Reports
- To place Patient Safety at the centre of specialty activity

Medical Education and Research

- Work with the Associate Medical Director to support the development and delivery of Education and Research within the specialty, ensuring the appropriate Governance arrangements are in place

Leading the Medical Team

- Support the Associate Medical Director in the implementation of the consultant contract within the specialty, ensuring the contract supports modernisation, quality improvement and achievement of access targets.
- Support the Associate Medical Director in the effective implementation and monitoring of modernising medical careers (MMC) and EWTD for junior doctors.
- Support the Associate Medical Director in co-ordinating the appraisal of all grades of doctors, including locum tenens, in line with regional guidance.
- Where required, take part in the recruitment process for new doctors or ensure that other colleagues do so effectively.
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- Work with the Associate Medical Director to ensure a system of induction is in place for all doctors within the specialty.
- Work with the Associate Medical Director to develop and lead a team of Specialty/Site Leads to assist the Trust in the redesign, modernisation and improvement of service delivery.
- Support the Associate Medical Director in the appraisal of all grades of designated doctors, including locum tenens, in line with regional guidance.
- Ensure that doctors within the specialty comply with arrangements for the assessment of fitness for clinical work.
- Work with the Associate Medical Director and Assistant Director of Surgery and Elective Care to ensure the equitable and fair management of annual, discretionary and study leave process which meets the needs of the service and the development needs of the medical workforce within the Trust.

Collaborative Working

- Actively promote the development of clinical and professional networks between the Trust hospital sites.
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated.
- Support the development of effective multi-professional team working and communication across both acute hospital sites

General Responsibilities

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.

- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS code of conduct.

Responsibility Allowance

- Responsibility Allowance: Personal Information redacted by the **per annum** (This is a pensionable allowance)

- Dedicated time within job plans between 0.25 PA and up to a maximum of **1 PA per week.** This time allocation will be timetabled into the job plan as additional HPSS responsibilities and will be proportionate to the demands of the role, size of the division etc.

- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE: Clinical Director – Surgery and Elective Care (2 posts)

DIRECTORATE: Acute Services

Ref No: 73816020 **January 2016**

Notes to applicants:

1. *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 clearly demonstrate this for both the essential and desirable criteria.*

***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. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration and specialist accreditation (CCT)
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

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.

Prior to interview all shortlisted applicants will be required to meet with Dr Richard Wright, Medical Director to allow him to further discuss the role of Clinical Directors in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Dr Wright directly on Personal Information redacted by the USI as soon as possible.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are short-listed for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from *http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/*

The successful candidate will be appointed for a period of 1 year subject to satisfactory performance.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Quality Care - for you, with you

TITLE: Associate Medical Director

DIRECTORATE/ DIVISION: Acute Services – Surgery / Elective Care

REPORTS OPERATIONALLY TO: Director of Acute Services

REPORTS PROFESSIONALLY TO: Medical Director

ACCOUNTABLE TO: Chief Executive

COMMITMENT: Maximum of 3 PAs - to be agreed with Director

LOCATION: Craigavon Area Hospital / Daisy Hill Hospital

JOB SUMMARY

The Associate Medical Director (AMD) will as a member of the Directorate Senior Management Team, play an active role in contributing to the strategic direction and the on-going provision of high quality services which are safe and efficient.

Specifically, the AMD will be responsible and accountable for the medical staff within the specialty and their role in the provision of services. As a senior medical leader within the Trust the AMD will work closely with the Director / Assistant Directors of Acute Services to provide medical management within the Directorate and contribute to the overall vision, direction and performance of the organisation with respect to the medical staff and their role in service delivery. The AMD will also be responsible for the safety and capability of the medical workforce within the specialty, providing the Director of Acute Services with defined information for assurance purposes to the Medical Director. The AMD will demonstrate a commitment to lead by example with regard to clinical and social care governance.

The post will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

KEY RESPONSIBILITIES

1. LEADERSHIP & MANAGEMENT RESPONSIBILITIES

The AMD will work closely with the Director/ Assistant Directors of Acute Services to provide effective leadership within the Directorate**.**

The AMD Surgery & Elective Care will work closely with the AMD's MUSC, ATICs and Cancer & Clinical Services to ensure effective clinical interfaces and patient pathways for out of hospital care, ambulatory care and admission for inpatient care are in place, reviewed and actioned.

The AMD Surgery & Elective Care will work regionally on behalf of the Trust in the development of quality and safety standards for the service and will hold responsibility in the Trust for clinical leadership of these standards.

He / she will also contribute to effective service delivery within the department by managing implementation of the following policies;

Appraisal

- Co-ordinate the approved appraisal system, ensuring a process is in place and operating within guidelines.
- Ensure necessary training (within the agreed budget) is available for medical staff (non-training grades) within the Directorate / sub Directorate, manage the approvals process for same and oversee the Division's utilization of the budget for medical training and development.
- Monitor the implementation of appraisal within recommended timescales.
- Undertake appraisal for Clinical Directors.
- Prepare an annual Directorate / sub Directorate Appraisal report for the Director of Acute Services to submit to the Medical Director (in relation to required Annual Trust Board Report).

Job Planning

- Provide leadership and support for Job planning within the Division for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors and Lead Clinicians and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Division / Directorate's service capacity needs and Service and Budget Agreement with our Commissioner

Implementation of HR policies for Medical Staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support

Education and Training

- Liaise with the Associate Medical Director for Education and Training and College Tutors to ensure a plan is in place by specialty for the training of junior doctors in keeping with NIMDTA and GMC requirements (including managing the balance between service delivery and training demands).
- Provide leadership in implementing and achieving compliance with the European Working Time Directive.

2. CLINICAL GOVERNANCE RESPONSIBILITIES

The AMD in conjunction with the Assistant Directors and Director of Acute Services will be responsible for having systems and processes in place to review and manage remedial action emerging from incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators. The AMD will have responsibility for the specialty M&M meetings and to ensure emergency medicine contributes to other specialty M&M meetings.

The AMD will be directly responsible to the Director Of Acute Services for patient safety. This includes ensuring processes are in place to identify, review and take remedial action when patient safety issues arise.

The AMD will be responsible for managing potential underperformance of medical staff within the Directorate. With full assistance from HR, the AMD will be responsible for leading the Trust's process for Maintaining High Professional Standards within the Division.

OTHER CLINICAL GOVERNANCE RESPONSIBILITIES

Divisional Governance Forum

- Chair the Divisional Specialty Governance Group and participate as agreed in Directorate governance arrangements.
- Work with the Trust / Directorate Governance Co-Ordinator to ensure effective governance of services.

Standards

- Provide advice to the Director of Acute Services and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc.
- Work with relevant managers and colleagues on required implementation plans and lead the implementation of such plans in relation to the medical workforce and clinical practice.
- Act upon the recommendations of any external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) working on the development and roll out of an implementation plan in conjunction with the Director/ Assistant Director of Acute Services.
- Assist in the preparation for external inspections.

Public Health and urgent operational issues

- Provide advice to Director of Acute Services, Medical Director and colleagues (e.g. swine flu, HCAIs).
- Contribute as appropriate to the development and implementation of contingency plans and lead the implementation of these plans in relation to the medical workforce.

3. CORPORATE RESPONSIBILITIES

As a senior medical leader within the Trust the AMD will participate and contribute to the corporate performance of the Trust. He / she will share responsibility with other senior managers in the Trust for Trust activities and for the overall performance, clinical and service strategy.

The AMD will also be required to:

- Attend meetings of the Directorate Management team and / or regular meetings with the Director of Acute Services.
- Contribute to the Business Plan of the Directorate to help achieve Trust Delivery Plan priorities.
- Monitor activity against the plan and determine / advise on required actions in conjunction with Director / Assistant Directors of Acute Services
- Lead the implementation of such plans as they apply to the medical workforce and / or clinical practice.

OTHER CORPORATE RESPONSIBILITIES

Service Development & Improvement:

- Maximise the effectiveness and efficiency of the services within the Division across the Trust's hospital network.
- Regularly review key service data in conjunction with Director / Assistant Director / Heads of Service of Acute Services and advise on delivery options.
- Provide a medical perspective on protocols / pathways related to service improvements.
- Provide input to decisions on the medical capacity required for service developments.
- Provide clinical leadership on service reconfiguration within the Division and Directorate.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's specialty collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

Communication

- Facilitate good communication with medical staff, (through planned meetings with consultant staff and other opportunities).
- Provide effective communication with other clinical and non-clinical managers in support of good multidisciplinary team working.
- Actively promote the development of clinical and professional networks across the Trust's hospital network.
- Actively participate in the AMD Forum which is led by the Medical Director.

GENERAL REQUIREMENTS

The post holder will be required to:

- 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.

- Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

- 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 not intended to be rigid and inflexible but should be regarded as providing guidelines within which appointee will work.

- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Associate Medical Director – Surgery / Elective Care Division

DIRECTORATE Acute Services

Notes to applicants:

1. *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 clearly demonstrate this for both the essential and desirable criteria.*
2. *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.*

***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. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with licence to practice and specialist accreditation (CCT)

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

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.

Prior to interview all shortlisted applicants will be required to meet with Dr Richard Wright, Medical Director to allow him to further discuss the role of Associate Medical Directors in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Laura White on Personal Information redacted by the USI.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are short-listed for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/

Please note that interviews for this post will be held as soon after the closing date as possible.

The post will be for a period of 1 year (3 sessions per week) and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Interim Divisional Medical Director – Surgery and Elective Care (Up to 24 Months Initially)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- On behalf of the Medical Director represent the Trust in regional service development discussions including the development of regionalized surgical services
- Represent the Trust on the Surgical Regional Priority Operational Group

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full

potential.

- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:

  (a) delivery of safe, high quality and effective person-centred care

  (b) secures activity and performance

  (c) maintains ongoing financial viability

  (d) is aligned to corporate goals

  The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of DivMD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. 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.

2. 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.

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

- Smoke Free policy
- IT Security Policy and Code of Conduct

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. 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.

8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

1. *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 clearly demonstrate this for both the essential and desirable criteria.*
2. *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.*

***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. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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.

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow further discussion of the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the USI.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/

Please note that interviews for this post will be held week commencing 5th July 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA's and a fixed management allowance of £14,800 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director – Urology Improvement (Temporary post – 2 years initially)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Urology Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- Provide medical leadership and direction regarding strategic development of Urology Services within the Southern Trust.

- In conjunction with the AD Surgery and Elective Care lead on the Urology review lookback and coordinate clinical resources as appropriate.

- In conjunction with the AD Surgery and Elective Care provide clinical leadership on the development of business cases to involve independent sector support for lookback reviews as required.

- Be the Trust key clinical contact for liaising with external bodies such as the Royal College of Surgeons and BAUS to gain independent expert advice on urology lookback and quality improvement proposals.

- Review and provide input into the modification of the department to improve and expand Urology services and have an active involvement in the implementation of quality improvement initiatives. This includes specifically:

  - Chairing the urology quality improvement group designated with responsibility for ensuring effective, high quality care is provided.

  - Co-Chairing the Urology SAI task and finish group responsible for ensuring compliance with SAI recommendations made in the 2016 and 2021 urology SAI reviews regarding urology and cancer services.

- Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

- Ensure Southern Trust policies and procedures in relation to Urology services are reviewed and updated regularly, and develop short term and long range plans for the department to maintain standards, implement improvements, define and measure progress to meet Southern Trust objectives.

- Provide oversight to senior management to ensure compliance with established practices, to implement new policies and to ensure employees are aware of changes and current standards

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
    (a) delivery of safe, high quality and effective person-centred care
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- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.

- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
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SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director – Urology Improvement

DIRECTORATE Acute

Notes to applicants:

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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;

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4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/

Please note that interviews for this post will be held week commencing 5th July 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA's and a fixed management allowance of £14,800 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Stinson, Emma M

From: Haynes, Mark <[Personal Information redacted by the USI]>
Sent: 05 December 2018 13:52
To: Corrigan, Martina; Carroll, Ronan; Gishkori, Esther; Magwood, Aldrina
Cc: Brown, Martin; McCaul, David; Glackin, Anthony; Tariq, S; Haughey, Mary
Subject: Transperineal prostate biopsy

Afternoon

I met some of you a number of weeks ago to discuss Urology pressures. During this meeting I highlighted some equipment areas which are leading to difficulties in delivering urological services. Separate discussions are ongoing regarding the flexible cystoscope issue. The purpose of this email is to again highlight the situation we are in regarding prostate biopsy. As I highlighted and some of you have been aware, I also chair the Urology NICAN CRG and over the past 18 months we have been redesigning the prostate diagnostic pathway for patients in NI. As I intimated at previous discussions, local anaesthetic transperineal prostate biopsy an integral part of this pathway and is to be the recommended route of biopsy. This is due to the lower risk of complications and more accurate targeting of MRI abnormalities that this technique offers. This new prostate diagnostic pathway is to be presented to the NICAN board on 12th December 2018.

Presently, Southern Trust is the only trust that is does not have the ability to perform local anaesthetic transperineal prostate biopsies and this is down to a lack of the required equipment.

For many years, Trans rectal ultrasound guided biopsy has been the cornerstone of the prostate cancer diagnostic pathway. However this procedure carries significant risks most notably of sepsis and patients receive a course of ciprofloxacin as antibiotic prophylaxis. Despite this there is a sepsis risk of 2-5% with associated hospital admission, on occasion to the critical care environment. Aside from the sepsis risk, the use of Ciprofloxacin also carries risks. Over the past few years local anaesthetic transperineal biopsy techniques have been developed and importantly this technique does not entail a risk of sepsis – reported risk <0.1%, in 260 patients biopsied by this technique in the Western trust 0 patients have been treated for sepsis.

In the 4 urology teams the position with regards delivery of this procedure is such that Western are already delivering it for all their patients, South-Eastern commence delivery this week, Belfast have recently started limited delivery. Only Southern is in a position where it is unable to deliver this procedure. The key reason for this is that we do not have a US machine available that has a compatible bi-planar brachytherapy probe which is required to perform the procedure. This machine needs to be available for use in the urology OP department 5 days a week (can't be shared, the demand for prostate cancer diagnostic service is so high). The most commonly used US machine for this procedure is the BK Medical Flex focus 500. This is the machine used in Western and Belfast trusts I believe and should be on the NHS supply chain. I am able to perform biopsies using our current machine via a transperineal route but the limitations of the equipment mean that it would not be deliverable under LA and I currently perform this under a GA, which in turn adds to demand for our theatre lists (all current TRUS biopsies and when we are able to offer, LA TP biopsies would be performed through our OP procedure rooms).

If we wish Southern trust to offer a comparable level of care to men with suspected prostate cancer to that offered to patients from the rest of NI, then we need to invest in this US machine and the required probes. Until we do this our patients will receive a different level of care to that offered across the rest of NI and be exposed to an increased risk of potentially life threatening sepsis, along with the population based risks of the fluoroquinolone use.

How is investment in this equipment to be taken forward?

Mark

Stinson, Emma M

From: Haynes, Mark [redacted]
Sent: 20 November 2017 09:23
To: Conway, Barry
Cc: Young, Michael; Carroll, Ronan; Gishkori, Esther
Subject: Fw: Saline TUR
Attachments: Trust Action Plan against the Surgical Management of Endoscopic Tissue R....docx; HSS MD 14 2015 - POLICY ON THE SURGIVAL MANAGEMENT OF ENDOSCOPIC TISSUE ....pdf; REVISED Policy on surgery for endoscopic tissue resection V0 5 after PHA....pdf; Letter to Trusts Surgical Policy 17 Sept 15.doc

Morning Barry

Apologies, I should have included you in this email.

Mark

Sent from my BlackBerry 10 smartphone.

From: Haynes, Mark [redacted]
Sent: Sunday, 19 November 2017 07:42
To: Gishkori, Esther; Carroll, Ronan
Subject: Saline TUR

Morning

With regards recent capital expenditure decisions with respect to saline resectoscopes / infusion pumps, attached is the guidance issued to the region following a patient death and subsequent review. I also attach the trusts response to this guidance including the action plan. You will note the following two standards and the trust response / timelines (I have highlighted the specific actions / timelines).

1. Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.	Within Gynae services bipolar resection equipment is in place within CAH and DHH (with the exception of one Consultant). Glycine is not used at all. The only exception to this is when there is a failure of the bipolar equipment and there is a need to revert back to the monopolar equipment. In the event of this rare occurrence there is strict monitoring of glycine in compliance with recommendation 5.		Ensure robust and monitored control measures are in place for the use of Glycine within urology services	Mrs Mary McGeough (Head of ATICS)	Ongoing
	Within Urology Services a trial of bipolar resection equipment is currently being undertaken by all of the Urology Consultants. Glycine is still in use.		Complete trial of bipolar equipment - There are 4 pieces of equipment being trialled for 6 weeks each to allow the Team to agree which is the most suitable.	Mr Young (Lead Consultant Urologist)	31/03/2016
			Commence procurement process if equipment is deemed suitable	Mrs Mary McGeough (Head of ATICS)	31/03/2016

7. Investigate instilling irrigation fluid by using a pressure controlled pump device and purchasing flow/pressure controllers.	Infusion pumps are used by gynae teams Infusion pumps are not used by urology teams because at present the pumps are not deemed suitable		No action required Work is currently being carried out by Lead Urology Consultant and equipment supplier to improve the efficiency of the pumps for urology purposes – at present the pumps are not suitable. In the meantime flow is being regulated as per 6(a) and 6 (b) If the equipment is deemed suitable sufficient funding will be required to ensure procurement can proceed	- Urology Consultants led by Mr Young Dr Wright Medical Director	- 31/12/2015 31/03/2016

From a region wide perspective, Southern Trust is the only urological team that are unable to meet this guidance with Saline resection being routine in the other units.

I note Mr Young's recent email regarding this issue. As he states the ST urology team are in a vulnerable position were a TUR syndrome death or significant morbidity to occur where glycine was used as a resection medium.

Given the above information (which I am unsure was reviewed at the time of recent capital expenditure decisions), I wonder whether there is any potential for reconsideration of this issue?

Mark

Southern Health and Social Care Trust

ACTION PLAN

Reference	HSS (MD) 14/2015
Title of Clinical Guideline / Standard	Policy on the surgical management of endoscopic tissue resection, for example during urological, gynaecological and other relevant surgery
Date of Endorsement and Issue from External Agency:	18/08/2015
Submission Date for Assurance Response / Action Plan to HSCB:	31/10/2015 was the initial deadline date Letter from Dr Little (DHSSPSNI) received 03/11/2015 requesting an update Two week extension given – new deadline for submission 23/11/2015
Directorate/s affected by guideline recommendations	Acute Services
Operational Director	Mrs Esther Gishkori
Identified Change Leader	Mrs Mary McGeough – Head of ATICS Mrs Wendy Clarke – Acting Head of Midwifery & Gynaecology Dr G. McCracken – Clinical Director IMWH Mrs Martina Corrigan – Head of ENT and Urology Mr Young – Lead Consultant Urologist

Actions for Trusts					
Recommendation	**Current Control Measures**	**Current level of compliance (%)**	**Action plan**	**Designated Lead**	**Deadline for completion**
1. Preoperative workup **must** be geared towards prevention of the TUR syndrome.	All of these patients are optimised for surgery and as part of the pre-operative work up, the risk factors pertaining to TUR syndrome are identified and managed. Within Urology all patients are provided with a BAUS information Leaflet and at clinic appointment are advised verbally of the risk factors. All patients have standard haematology and electrolyte analysis completed and have careful consideration regarding blood grouping and cross matching.		An audit will be carried out to review the consent process for patients to determine if the patients have been "*truly made aware of the hazards of endoscopic resection using irrigation fluids*". Patients will be identified from Theatre Management System. Recent Investigations aimed at establishment of pathological anatomy and degree of Surgical risk to be scoped Availability of reports of such investigations prior to commencement of surgery to also be scoped	Mrs Mary McGeough (Head of ATICS)	31/12/2015
2. Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.	Within Gynae services bipolar resection equipment is in place within CAH and DHH (with the exception of one Consultant). Glycine is not used at all. The only exception to this is when there is a failure of the bipolar equipment		Ensure robust and monitored control measures are in place for the use of Glycine within urology services	Mrs Mary McGeough (Head of ATICS)	Ongoing

	and there is a need to revert back to the monopolar equipment. In the event of this rare occurrence there is strict monitoring of glycine in compliance with recommendation 5. Within Urology Services a trial of bipolar resection equipment is currently being undertaken by all of the Urology Consultants. Glycine is still in use.		Complete trial of bipolar equipment - There are 4 pieces of equipment being trialled for 6 weeks each to allow the Team to agree which is the most suitable. Commence procurement process if equipment is deemed suitable	Mr Young (Lead Consultant Urologist) Mrs Mary McGeough (Head of ATICS)	31/03/2016 31/03/2016
3. Engineer changes in the type of procedures performed. More secondary procedures for management of heavy menstrual bleeding as per NICE recommendations.	Within gynae secondary procedures are applied but there is skills maintenance of first generation procedures so that the skill base is maintained for abnormal uterine pathology		On-going monitoring and review	All staff working within ATICS, Gynaecology	On-going
4. Increase vigilance when significant haemorrhage is a feature	The need for increased vigilance when significant haemorrhage is a feature is standard practice across all theatre environments. Trust guideline for the management of Blood Loss (2012) is in place and accessible by all staff on the Trust intranet		On-going monitoring and review	All staff working within ATICS, Gynaecology and Urology services	On-going

	Emergency theatre drills carried out on an annual basis and learning from this drill exercise is fed back to the clinical teams and to the Haemovigilence Team for monitoring / action planning				
5. If continue to use glycine, the following **must** be used. a. Measure point-of-care testing (POCT) serum sodium, i. preoperatively. ii. if the surgery is longer than 30 minutes as a routine. iii. intermittently throughout the surgery. iv. if there is a 1000 ml fluid deficit.	Compliant Compliant Compliant Compliant		Ongoing monitoring and review	All staff working within ATICS, Gynaecology	On-going
5b. Dedicated staff for transporting specimens and results.	This recommendation is not complied with. A member of staff who is available when specimens / results from specimens need to be transported will carry out this task. In October 2015 the Trust's Point of Care Committee has just approved the purchase of 5 POCT machines for ATICS – 4 to be used within CAH theatres / DPU and 1 for use within DHH theatres.	N/A	To purchase 5 POCT machines funding of £27k will be required. IPT is currently being completed for review and approval. When the 5 POCT machines are purchased blood results can be obtained within the theatre environment negating the need for a dedicated member of staff to carry out this task	Mrs Mary McGeough Head of ATICS Mr Ronan Carroll AD - CCS	31/03/2016

5c. Surgery, including TURP, TCRE & TCRF must be performed in a 'main' theatre where POCT equipment is immediately available	When the funding is allocated and equipment purchased 1 of the 5 ISTAT machines will be provided to Day Procedure Unit (CAH) to facilitate the carrying out of these surgical procedures		To purchase 5 POCT machines funding of £27k will be required. IPT is currently being completed for review and approval. When the 5 POCT machines are purchased blood results can be obtained within the theatre environment negating the need for a dedicated member of staff to carry out this task	Mrs Mary McGeough Head of ATICS Mr Ronan Carroll AD - CCS	31/03/2016
5d. Accurate fluid input & output measurement and deficit calculation	Within Theatres CAH a dedicated Fluid Balance Nurse has been appointed ATICS have developed their own fluid management documentation sheets and these are currently in use.		The regionally agreed perioperative fluid recording chart is to be implemented within all relevant theatre areas. To be appendiced within the new Standard Operating Procedures for the Management of irrigation fluids for patients undergoing TCRE / TCRF / TURP /TURB/TART	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015

6. For both mono- and bi-polar techniques, limit the distension pressure by, a. maintaining it below the mean arterial pressure (MAP).	A draft Standard Operating Procedure for the Management of irrigation fluids for patients undergoing TCRE / TCRF / TURP /TURB/TART procedures is currently being developed		These draft standard operating procedures need to be reviewed in line with the requirements of the new regional policy, agreed and then implemented within the Trust.	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015
With continuous-flow gravity systems, b. limit the height of the irrigating solution container to 60 cm above the patient and certainly never above 100cm; c. theatre teams must have a procedure for checking and maintaining an agreed height; d. not applying pressure bags to the irrigation fluid bag.	A draft Standard Operating Procedure for the Management of irrigation fluids for patients undergoing TCRE / TCRF / TURP /TURB/TART procedures is currently being developed		The draft standard operating procedures need to be reviewed in line with the requirements of the new regional policy, agreed and then implemented within the Trust.	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015
7. Investigate instilling irrigation fluid by using a pressure controlled pump device and purchasing flow/pressure controllers.	Infusion pumps are used by gynae teams Infusion pumps are not used by urology teams because at present the pumps are not deemed suitable		No action required Work is currently being carried out by Lead Urology Consultant and equipment supplier to improve the efficiency of the pumps for urology purposes – at present the pumps are not suitable. In the meantime flow is being regulated as per 6(a) and 6 (b)	- Urology Consultants led by Mr Young	- 31/12/2015

			If the equipment is deemed suitable sufficient funding will be required to ensure procurement can proceed	Dr Wright Medical Director	31/03/2016
8. The theatre team **must,** a. be aware of the distending fluid input & output and deficit; b. contain a dedicated nurse for fluid balance and deficit calculation, who remains in theatre for the duration of the procedure	Within Theatres CAH a dedicated Fluid Balance Nurse has been appointed ATICS have developed their own fluid management documentation sheets and these are currently in use.		The regionally agreed perioperative fluid recording chart is to be implemented within all relevant theatre areas. To be appendiced within the new Standard Operating Procedures for the Management of irrigation fluids for patients undergoing TCRE / TCRF / TURP /TURB/TART	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015
9. If continue to use glycine, the following **must** be used, throughout the procedure, a. accurate irrigation fluid input & output measurement and deficit calculation	This monitoring process is in place irrespective of whether glycine or saline is being used		On-going monitoring and review of both glycine and saline	All staff involved in this clinical task	On-going
10. Preoperatively, for each individual patient, there **must** be an agreed maximum fluid deficit threshold for action. The surgeon and anaesthetist **must** be informed by the nurse when the threshold is reached.	Within the SHSCT there is no specified individualised threshold. Within the Gynae and Urology teams, the surgeon and anaesthetist must be notified when the maximum fluid deficit threshold		The draft standard operating procedures need to be reviewed to ensure the agreed maximum fluid deficit threshold for notification and stopping surgery is	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015

	is over 500 and then go no further when the maximum fluid deficit threshold is at 1000		specified.		
11. Operations should, if possible, not last longer than 60 minutes, a. Theatre teams **must** have an established mechanism for measuring time and procedures for alerting surgeon and anaesthetist.	The recording of resection time is adhered to. It is also a required field within the ATICS fluid management documentation sheet		The draft standard operating procedures need to be reviewed to ensure this requirement is specified prior to implementation within the Trust.	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015
12. Completion of the standard WHO surgical checklist **must** be adhered to. Adoption of a modified WHO checklist for this kind of procedure should be investigated and piloted	Completion of the standard WHO surgical checklist is adhered to.		The Trust has taken the stance that the WHO checklist will not be modified for this kind of procedure since deviance from the standardised WHO checklist could create its own set of risks for the organisation	Ongoing	Ongoing

Identified Limiting Factors for preventing full compliance against guidance recommendations:
1. Required funding for the purchase of 5 new ISTAT point of care machines – cost is estimated at £27k 2. Complete trial of bipolar resection equipment within Urology services to ascertain if it is feasible to remove the need to use glycine – amount of funding required if trial outcomes are favourable is to be determined 3. Ascertain if infusion pumps can be used within urology Services. If deemed suitable for use within Urology Services, funding needs to be prioritised and allocated for the procurement of these devices. Amount of funding required if trial outcomes are favourable is to be determined 4. Finalisation of the Standard Operating Procedure for the Management of Irrigation Fluids for patients undergoing TCRE / TCRF / TURP /TURB/TART procedures 5. Need to replace the existing fluid management documentation with the new regional perioperative fluid recording chart and advise staff of any changes to recording requirements. This new recording chart is to be included within the new standard operating procedure referenced in point (4)

Compliance Scale:

100% Compliance	70-99% Compliance	40-69% Compliance	0-39% Compliance	Pending	Not Applicable

From the Deputy Chief Medical Officer
Dr Paddy Woods

HSS(MD)14 /2015

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

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Tel: Personal Information redacted by USI
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Your Ref:
Our Ref: HSS(MD)14 /2015
Date: 18 August 2015

For Action:

Chief Executives HSC Trusts
Chief Executive HSCB
Chief Executive PHA
Chief Executive RQIA *(for dissemination to independent sector organisations)*

Dear Colleague

POLICY ON THE SURGICAL MANAGEMENT OF ENDOSCOPIC TISSUE RESECTION

ACTION REQUIRED

1. HSC Trusts and independent providers should process this regional policy template for endorsement by the organisational board, or equivalent;

2. HSC Trusts and independent providers should develop action plans to implement the various elements of the endorsed policy;

3. HSC Trusts should work with commissioners to address resource issues arising from these implementation plans in a phased, consistent and timely manner; and

4. the Public Health Agency should report on progress by 30 November 2015.

As a result of the verdict of the Coroner into the cause of death of [redacted] in October 2013, work was commissioned on ensuring the safe and effective management of procedures involving the use of distending fluids in endoscopic procedures. In recognition of the limited guidance available on the management of these procedures, local work was commissioned, led by Dr Julian Johnston, Assistant Medical Director in Belfast Health and Social Care Trust.

The attached outline policy is the product of that work and we are now commending it for regional implementation.

The policy covers relevant issues including:

- appropriate preparation of patients prior to operation;
- selection of equipment and associated distending medium;
- precautionary measures associated with the distending medium selected;
- necessary measurements prior to, during and after these procedures;
- a good theatre environment in terms of team dynamics; and
- use of the WHO surgical checklist.

We believe this policy covers all aspects of concern raised by the Coroner in light of his findings in this tragic case.

We welcome your full assistance in this matter.

Yours sincerely

Dr Paddy Woods
Deputy Chief Medical Officer

Mrs Charlotte McArdle
Chief Nursing Officer

Cc HSC Trust Medical Directors
HSC Directors of Nursing Services
Chief Executive, BSO
Executive Medical Director/Director of Public Health PHA/HSCB
Dean Medical Faculty, QUB
Dean of Life and Health Sciences, UU
Chief Executive NIPEC
Chief Executive NIMDTA
Director of Safety Forum

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

Insert Trust LOGO

Reference No:

SAMPLE POLICY

Title:	Policy on the surgical management of endoscopic tissue resection, for example during urological, gynaecological and other relevant surgery.			
Author(s)	List name and titles of lead and additional author(s) or group responsible for drafting policy Include contact details			
Ownership:	Insert name of Director / service area / group / directorate			
Approval by:	Insert name of Trust committee / group responsible for approval		**Approval date:**	Insert date each committee approved
Operational Date:	May 2015		**Next Review:**	May 2017
Version No.	V0.5	**Supercedes**	Any legacy policies.	
Key words:	Endoscopic, Resection, Prostatectomy, Myomectomy, TUR syndrome			
Links to other policies				

Date	Version	Author	Comments
20/11/2013	0.1	SE Trust	Initial Draft
03/12/2013	0.2	JR Johnston	Amalgamation of protocols from 5 Trusts.
01/02/2015	0.3	JRJ	Following 3/11/14, 19/01/2015 MLF meetings
20/03/2015	0.4	JRJ	Following regional feedback, NICE publication
August 2015	0.5	PHA	Review by PHA

Recommendations

This policy is part of a region-wide 'collegiate' improvement programme for surgical endoscopic tissue resection, including:

- a plan to use the safest resection technique currently available and its attendant irrigation fluid.
- establishing a set of safe practice standards and precautions to minimise the risk of intravascular absorption.

1. Preoperative workup **must** be geared towards prevention of the TUR syndrome.
2. Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.
3. Engineer changes in the type of procedures performed.
    a. More secondary procedures for management of heavy menstrual bleeding as per NICE recommendations.
4. Increase vigilance when significant haemorrhage is a feature.
5. If continue to use glycine, the following **must** be used.
    a. Measure point-of-care testing (POCT) serum sodium,
        i. preoperatively.
        ii. if the surgery is longer than 30 minutes as a routine.
        iii. intermittently throughout the surgery.
        iv. if there is a 1000 ml fluid deficit.
    b. Dedicated staff for transporting specimens and results.
    c. Surgery, including TURP, TCRE & TCRF must be performed in a 'main' theatre where POCT equipment is immediately available.
    d. Accurate fluid input & output measurement and deficit calculation.
6. For both mono- and bi-polar techniques, limit the distension pressure by,
    a. maintaining it below the mean arterial pressure (MAP).

    and with continuous-flow gravity systems,
    b. limit the height of the irrigating solution container to 60 cm above the patient and certainly never above 100cm;
    c. theatre teams must have a procedure for checking and maintaining an agreed height;
    d. not applying pressure bags to the irrigation fluid bag.
7. Investigate instilling irrigation fluid by using a pressure controlled pump device and purchasing flow/pressure controllers.
8. The theatre team **must,**
    a. be aware of the distending fluid input & output and deficit;
    b. contain a dedicated nurse for fluid balance and deficit calculation, who remains in theatre for the duration of the procedure.
9. If continue to use glycine, the following **must** be used, throughout the procedure,
    a. accurate irrigation fluid input & output measurement and deficit calculation.
10. Preoperatively, for each individual patient, there **must** be an agreed maximum fluid deficit threshold for action. The surgeon and anaesthetist **must** be informed by the nurse when the threshold is reached.
11. Operations should, if possible, not last longer than 60 minutes,
    a. Theatre teams **must** have an established mechanism for measuring time and procedures for alerting surgeon and anaesthetist.
12. Completion of the standard WHO surgical checklist **must** be adhered to. Adoption of a modified WHO checklist for this kind of procedure should be investigated and piloted.

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Some endoscopic surgical procedures require the use of an irrigating fluid to distend the operating field to enable a suitable field of vision and to wash away debris and blood. This includes operations such as,

- resection of prostate (TURP) and bladder tumours (TURBT);
- transcervical resection of endometrium (TCRE), transcervical resection of fibroids (TCRF);
- removal of uterine septum, polyps, endometrial ablations;
- cystoscopy, arthroscopy, rectal tumour surgery, vesical ultrasonic lithotripsy and percutaneous nephrolithotripsy.

Endoscopic operations where there is tissue resection can lead to serious complications such as haemorrhage, fluid overload, hyponatraemia, cerebral oedema and death. This policy concentrates on a subset of these, the transurethral resection (TUR) syndrome[1], when systemic intravascular absorption of irrigation fluid can cause serious symptoms.

This policy sets out the steps needed to improve the safety profile of this type of surgery. Using national policies, guidelines and evidence identified in section 7 along with on-going work within the province, its aim is to establish a regional 'collegiate' improvement strategy for all surgical (urology, gynaecology) teams in NI practicing this type of surgery to,

- use the safest resection technique with its attendant irrigation fluid;
- agree a programme of change for the cessation of glycine use;
- develop or adopt techniques that do not rely on glycine as an irrigant;
- use equipment designed to control or reduce vesical or uterine pressure;
- establish a set of safe practice standards and precautions to minimise the risk of intravascular absorption.

Some of the recommendations can be instituted now and some will depend on purchase of equipment.

1.2 Irrigation fluids used

The irrigation fluid used for these electrosurgical procedures should,

- have neutral visual density so that the surgeon's view is not distorted;
- be non-haemolytic and will not lead to haemolysis if it enters the circulation.

Until relatively recently, the standard equipment used to resect tissue was of a **monopolar electrode** design which requires an electrically nonconductive irrigating fluid so the electrical current is not dissipated and can remain concentrated at the cutting point. As described below, use of this type of fluid bears the risk of the TUR syndrome.

Recently introduced **bipolar resection equipment** is different to the monopolar type in that it incorporates both active and return poles on the same electrode. This allows a conductive fluid medium (normal saline) to be

used for the irrigating fluid instead of a 'conventional' nonconductive irrigation fluid (glycine, sorbitol or mannitol).

Irrigating fluids
In the past, **sterile water** was used as the irrigant but was associated with significant morbidity because of water intoxication and intravascular haemolysis.

Modern non-electrolytic solutions containing glycine 1.5%, mannitol or sorbitol are optically clear and were introduced to prevent haemolysis, without dispersing the electric current used for cutting with the resectoscope. Their use in irrigation solutions has reduced the occurrence of significant haemolysis and death.

The most commonly used irrigation fluid has been 1.5 % **glycine solution,** a non-essential amino acid with a low cost and lack of allergic reactions**.** However, it has an osmolality of 200 $mOsm.kg^{-1}$ which is much lower than that of blood [Plasma = 290 $mosmol.kg^{-1}$] and large amounts of this hypotonic irrigation fluid, required to facilitate the procedure, may be absorbed systemically through a vascular bed[2]. This may cause several serious complications known as the **TUR syndrome** which can occur in a variety of surgical disciplines.

Normal saline is used for irrigation with the bipolar resectoscope. It is associated with fewer unfavorable changes in serum sodium and osmolality than is the case when electrolyte-free media are used with monopolar systems[3] e.g. glycine. Its use, however, does not eliminate the need to prevent excess absorption or to closely monitor fluid balance, as overload can occur. Pulmonary oedema is a reported consequence.

1.3 TUR syndrome[4]

The transurethral resection (TUR) syndrome is an iatrogenic form of acute water intoxication from a combination of fluid overload and hyponatraemia. While first recognised in urology, hence its name, it can occur in other surgical specialties e.g. gynaecology.

It is manifested mainly through a classic triad of,

- fluid overload - acute changes in intravascular volume leading to circulatory overload, pulmonary oedema, cardiac failure and even cardiac arrest;
- dilutional hyponatraemia causing central nervous system (CNS) effects such as cerebral edema leading to agitation, confusion, convulsions and coma;
- direct toxicity and metabolism of glycine which may also cause CNS symptoms, most commonly transient blindness and CNS depression, as it is an inhibitory neurotransmitter. Its metabolism yields water (worsening fluid overload) and ammonia.

The incidence of TUR syndrome for TURP appears to have reduced over the last two decades with recent studies demonstrating incidence rates of 0.8% -

1.4%. The occurrence of the TUR syndrome following bladder tumour resection (TURBT) is thought to be rarer but can occur, probably via either an intraperitoneal or extraperitoneal bladder perforation.

There is a observation that the incidence and effects of this syndrome are more pronounced in gynaecological than in urological surgery. Fluid absorption is slightly more common during TCRE than during TURP, with transcervical resection of fibroids (TCRF) being at a further increased risk over TCRE. Whereas hyponatraemia occurs with equal frequency in men and women, it is more likely to produce severe complications in premenopausal women[3]. Nevertheless, the necessity to constantly seek best and safest practice and to encourage change and improvement is the same for both specialties.

1.4 Purpose

This policy outlines a set of principles designed to reduce the development of the TUR syndrome.

1.5 Objectives

To reduce the likelihood of developing the TUR syndrome through,

- correct patient selection and preoperative preparation;
- selection of an appropriate surgical technique;
- electing to use surgical equipment which allows the use of irrigation fluid which will not give rise to the TUR syndrome;
- the application of monitoring aimed at detecting the early warning signs of the TUR syndrome;
- establishing a theatre regime based on good theatre practice principles aimed at reducing the development of the TUR syndrome.

2.0 SCOPE OF THE POLICY

This policy applies to all staff who may be involved in the care of a patient in theatre who receives irrigating fluid into the bladder or uterus or any other organ where significant fluid absorption is a realistic possibility.

It applies to medical staff, nursing staff, midwives, operating department practitioners, technical staff, physicians' assistants (anaesthesia) and other theatre healthcare workers.

This policy does not cover the methods of treatment of the TUR syndrome.

3.0 ROLES/RESPONSIBILITIES

Medical staff to,

- ensure they are fully cognisant of the risks of the TUR syndrome;
- undertake careful consideration of the therapeutic choices when planning the service for endoscopic resection in order to reduce the likelihood of the development of the TUR syndrome.

Management – actively supporting the introduction of therapeutic modalities that aim to reduce the incidence of the TUR syndrome.

All staff involved in the care of the patient, especially in theatre, are responsible for implementing and adhering to the policy principles.

Each ward/theatre sister/charge nurse/clinician involved with this kind of surgery is responsible for ensuring staff comply with this policy and all relevant staff have the responsibility to ensure that they read and comply with the policy contents.

In the event of an untoward incident an adverse incident form must be completed by either the medical officer or nurse in charge of the patient's care.

4.0 POLICY PRINCIPLES

4.1 Definitions

Osmolality: The concentration of osmotically active particles in a solution.

Hypertonic: Higher osmolality (concentration of particles) than that found in normal cells.

Hypotonic (or hypo-osmolar): Lower osmolality (concentration of particles) than that is found in normal cells.

Hyponatraemia: Lower sodium concentration than normally found in plasma.

Resectoscope: An endoluminal surgical device comprising an endoscope (hysteroscope or cystoscope), sheaths for inflow and outflow, and an ''element'' that interfaces a specially designed electrode (or pair of electrodes) with a radiofrequency (RF) electrosurgical generator which can be either monopolar or bipolar.

4.2 Policy Principles

An irrigating fluid is most frequently absorbed directly into the vascular system when a vein has been severed by electrosurgery. The driving force is the fluid pressure; the volume of fluid absorbed depending on the,

- duration of the procedure and resection time;
- degree of opening of blood vessels during surgery;
    - vascularity of the diseased prostate, uterus, fibroid;
    - surgical disruption of the bladder, uterine vessels;
    - capsular or uterine wall perforation or apparent damage to a venous sinus;
- pressure of the distending fluid within the bladder or uterus;
    - height of the irrigation fluid bag above the patient;
    - distension pressure applied to the irrigation fluid.

For safe endoscopic resection using irrigation fluid, consideration of the following topics needs covered,

a. Preoperative workup;
b. Selection of surgical technique;
c. Identification, control and management of haemorrhage;

d. Control of the absorption of irrigation fluid;
    a. Dilutional Hyponatraemia;
    b. Fluid overload;
    c. Glycine toxicity;
e. Theatre environment;
    a. Decision making processes;
    b. Team dynamics;
    c. Knowledge of potential complications.

4.2.1 Preoperative workup

Careful preoperative workup of the patient must include, for example,

- a robust consent process leading to a truly informed patient aware of the hazards of endoscopic resection using irrigation fluids;
- a thorough physiological assessment with attention paid to risk factors such as hypertension, ischaemic heart disease, cardiac failure, anaemia;
- standard haematology and electrolyte analysis - to include a recent haemoglobin, serum sodium;
- careful consideration regarding blood grouping and cross-matching;
- recent investigations aimed at establishing the pathological anatomy and degree of surgical risk especially haemorrhage e.g. ultrasound scan;
- the ready availability of reports of such investigations before surgery commences.

Recommendation 1
Preoperative workup **must** be geared towards prevention of the TUR syndrome.

Urology

These procedures are carried out on a predominantly elderly population with a high incidence of coexisting disease. BPH affects 50% of males at 60 years and 90% of 85-year-olds and so TURP is most commonly performed on elderly patients, a population group with a high incidence of cardiac, respiratory and renal disease.

Gynaecology

Consideration should be given to the timely commencement of any adjuvant therapy prior to the surgery[3], especially if it helps to reduce the risk of haemorrhage and/or causes a reduction in tumour size.

4.2.2 Selection of surgical technique

Urology

Absorption in excess of 1 litre of glycine solution, which is associated with a statistically increased risk of symptoms, has been reported in 5–20% of the TURPs performed[1].

One of the most important recent improvements in this field has been the introduction of bipolar electrode technology (B-TURP). This addresses the

fundamental flaw of monopolar equipment (M-TURP) by allowing resection in a normal saline irrigation. Therefore, the adoption of bipolar TURP/TURBT allows NS irrigation and permits the removal of glycine and its inherent risks from theatre. The risks of the hyponatraemic and hypo-osmolar aspects of the TUR syndrome are eliminated.

There are several manufacturers who have developed bipolar endoscopy systems. Early local adopters of this type of equipment have experience of several of them and have observed a progressive and continuing development cycle which has now resulted in really excellent systems. They also observe that some other manufacturers have not kept pace. It is important that views on the performance of these bipolar systems are based on the most modern examples and on those manufacturers who have managed to develop the most efficient systems.

B-TURP is the most widely and thoroughly investigated alternative to M-TURP[5]. There is now increasing recent evidence[6 - 9] for the effectiveness of bipolar systems as their technical performance has been developed and improved. Indeed there is some evidence[9] that bipolar may be better at improving urine flow rates and also reducing bleeding related complications as well as eradicating the TUR syndrome. With reduced bleeding and improved visibility, resection time can be decreased.

Moreover, recent systematic reviews[7, 9] are not only repeatedly describing equal effectiveness between monopolar and bipolar techniques but are also pointing out the significantly improved safety profile for bipolar.

Significantly, the TUR syndrome has not been reported with bipolar equipment[5]. A recent systematic review and meta-analysis[9] comparing traditional monopolar TURP with bipolar TURP established in 22 trials that the TUR syndrome was reported in 35/1375 patients undergoing M-TURP and in none of the 1401 patients undergoing B-TURP. Even taking into account that one study alone was responsible for 17 of the 35 cases, the accompanying editorial states, "*the elimination of TUR syndrome alone has been a worthy consequence of adopting bipolar technology."*

This is supported by recommendations within the European Association of Urology guidelines[5] on TURP management of April 2014. "*B-TURP has a more favourable peri-operative safety profile compared with M-TURP."*

In 2012, NICE recommended[10] that bipolar techniques are associated with lower rates of complications and in October 2014 they opened up support[11] for the use of transurethral resection in saline which eliminates the TUR syndrome and may also reduce length of stay as well as having cost benefits.

In February 2015, they published their medical technology guidance[12] on a transurethral resection in saline system. They point out that the case for adopting the transurethral resection in saline (TURis) system for resection of the prostate is supported by the evidence.

They also indicate that,

- the TURis system can be used instead of a surgical system called 'monopolar transurethral resection of the prostate' (or monopolar TURP);
- Healthcare teams may want to use the TURis system instead of monopolar TURP because,
    - there is no risk of a rare complication called transurethral resection syndrome;
    - it is less likely that a blood transfusion after surgery will be needed.

NICE used an External Assessment Centre to analyse the clinical evidence and concluded that their meta-analysis found a statistically significant effect in favour of TURis: relative risk 0.18 (95% CI 0.05 to 0.62, p=0.006), corresponding to a number needed to treat to prevent 1 case of TUR syndrome compared with monopolar TURP of 50 patients.

The External Assessment Centre did not identify any special additional training needs for a switch to the TURis system from monopolar transurethral resection of the prostate (TURP). The NICE Committee received expert advice that confirmed that little training is needed for surgeons who are already performing monopolar TURP procedures.

The sources of evidence considered by the NICE committee included expert personal views from at least 5 clinical experts from the British Association of Urological Surgeons (BAUS).

NICE, in February 2015, also issued guidance for the public on this topic. They indicated that, "*the TURis system can be used instead of a surgical system called 'monopolar transurethral resection of the prostate'. Healthcare teams may want to use the TURis system instead of monopolar TURP because there is no risk of a rare complication called transurethral resection syndrome and it is less likely that a blood transfusion after surgery will be needed."*

Therefore, the case for moving from a monopolar to bipolar technique for resection of the prostate would appear to be well established as safer with regard to the development of the TUR syndrome. However, it should be remembered that the use of NS is not without risk because there will still be fluid absorption with plasma volume expansion.

Also, queries have been expressed over a potential degradation of pathological specimens with the use of this new technology which might have staging implications for bladder tumour management. However, the experience of both surgical and pathology staff within the BHSCT has been that they have not noticed any major difference. There is also no evidence based literature to support the view that bipolar resection causes any more damage and in fact the incidence of severe cautery artefact was significantly lower in the bipolar resections[13], a view subsequently supported in an accompanying editorial[14] which also exhorts, "*as urologists we have shown again and again that we are quick to adopt new technologies in routine practice*".

Therefore (as long as they are proven to be safe and effective as judged by the NICE interventional procedure programme), bipolar RF systems and other techniques e.g. laser systems, should be introduced regionally. By introducing the, as effective, but safer bipolar equipment, this should, by necessity, reduce and curtail the use of glycine as an irrigation fluid. Its continuing use should be strictly monitored and eventually terminated when there ceases to be circumstances when its use is considered the safest.

Recommendation 2
Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.

Gynaecology
The first generation endometrial ablative techniques including transcervical resection of endometrium (TCRE) and rollerball endometrial ablation (REA) are all endoscopic procedures. Fluid absorption is slightly more common during TCRE than during TURP, with transcervical resection of fibroids (TCRF) being at a further increased risk over TCRE. As TCRE often evolves into a TCRF when fibroids are found during hysteroscopy, it means the same safety procedures need to be put into place for both TCRE and TCRF.

Their effectiveness in the management of heavy menstrual bleeding (in comparison with hysterectomy - the existing gold standard) has been demonstrated in a number of randomised controlled trials. Although less morbid than hysterectomy, they are associated with a number of complications including uterine perforation, cervical laceration, false passage creation, haemorrhage, sepsis and bowel injury and, importantly, the fluid overload and hyponatraemia associated with the use of 1.5% glycine irrigation fluid resulting in the serious and occasionally fatal consequences discussed above.

However, there are now second generation ablative techniques which do not require the use of electrocautery or the use of glycine or other distension fluids. They avoid the serious risk of hyponatraemia and represent simpler, quicker and potentially more efficient means of treating menorrhagia.

A Cochrane Collaboration review (2013)[15] concludes that "*Overall, the existing evidence suggests that success, satisfaction rates and complication profiles of newer techniques of ablation compare favourably with hysteroscopic techniques.*"

NICE[16] in their online guidance for Heavy Menstrual Bleeding recommend,

- First-generation ablation techniques (e.g. rollerball endometrial ablation [REA] and TCRE) are appropriate if hysteroscopic myomectomy (TCRF) is to be included in the procedure;

- All women considering endometrial ablation should have access to a second-generation ablation technique.

Recommendation 3
Engineer changes in the type of procedures performed. • More secondary procedures for management of heavy menstrual bleeding as per NICE recommendations.

If hysteroscopic procedures such as TCRE and TCRF are considered to be the best options and a distending fluid is required, the choice of fluid then comes under the same scrutiny as above for Urology. The choice of using a monopolar scope system using glycine versus bipolar equipment using saline becomes the choice. Evidence is now emerging from gynaecology units in Northern Ireland that are measuring the serum sodium intraoperatively during every case, that there can be concerning incidences of acute hyponatraemia when glycine is used as the distending agent during TCRE[17]. With the development of newer bipolar systems it is recommended that saline has a better safety profile[3].

Therefore, this policy recommends that, (as long as they are proven to be safe and effective as judged by the NICE interventional procedure programme,) the use of second generation ablative techniques and bipolar RF systems should be introduced regionally and the use of glycine as a irrigant curtailed, strictly monitored when it is still used and eventually terminated when there ceases to be circumstances when its use is considered the safest.

4.2.3 Identification, control and management of haemorrhage.

Blood loss can be difficult to quantify and may be significant. Close attention to the patient's clinical state and good communication between surgeon, anaesthetist and the theatre team is vital.

Because of the generalised physiological effects of haemorrhage and the increased likelihood of fluid absorption when using irrigation fluid in the presence of 'open' vasculature, the presence of significant bleeding should act as a trigger for,

- increased vigilance for development of fluid overload, hyponatraemia;
- additional help from medical and nursing staff to assist by scrubbing in;
- increased frequency of haemoglobin and/or haematocrit measurements;
- preparation of blood for cross matching;
- control of the bleeding which may need cessation of the operation.

Recommendation 4
Increase vigilance when significant haemorrhage is a feature.

4.2.4 Control of the absorption of irrigation fluid

To control the effects of fluid absorption, the theatre team should pay particular attention to,

a) Hyponatraemia;
b) limiting the volume of fluid absorbed.

a. Hyponatraemia

The uptake of 1000 ml of fluid would generally correspond to an acute decrease in the serum sodium concentration of 5-8 mmol/L.[2] Encephalopathy, seizures and even cerebral oedema may develop when the sodium concentration falls below 120mmol.L^{-1}. However, even markedly hyponatraemia patients may show no signs of water intoxication. The crucial physiological derangement of CNS function is not just hyponatraemia *per se*, but also the presence of acute hypo-osmolality[4].

Also, a patient's serum sodium concentration and osmolality may continue to decrease for some time after the procedure because irrigant can be slowly absorbed from the perivesicular and retroperitoneal spaces. Therefore, the TUR syndrome can start 4 to 24 hours later – postoperatively, in the recovery ward or back in the ward.

Whereas hyponatraemia occurs with equal frequency in men and women, premenopausal women are 25 times more likely to die or have permanent brain damage than men or postmenopausal women, most likely an oestrogen effect[3]. This effect is compounded because fluid absorption is slightly more common during TCRE than during TURP, and especially so with TCFR.

Serum Sodium measurement

Monitoring serum sodium concentration during TURP is common practice and a low value will confirm the diagnosis of hyponatraemia and is effective for assessing intravascular absorption. Significant decreases from a normal preoperative level can occur after just 15 minutes of starting resection. Levels below 120mmol.L^{-1} are invariably symptomatic and a rapid fall is more likely to produce symptoms.

Point-of-care testing (POCT) is defined as medical testing at or near the site of patient care. It brings the test conveniently and immediately to the patient increasing the likelihood that the patient, physician, and care team will receive the results in minutes, enabling diagnosis of hyponatraemia as early as possible and allowing immediate clinical management decisions to be made. They can be used to measure haematocrit, determine haemoglobin and measure serum electrolytes.

Serum sodium is often only measured at the end of surgery but, in the surgical settings pertaining herein, this monitoring technique is best applied before and repeatedly during surgery so that it can act as a warning system for hyponatraemia. Trusts already operating this method of monitoring have uncovered episodes of unsuspected hyponatraemia; highlighting the need to be wary of glycine and to monitor accordingly. Previous audits that have not

measured serum sodium as part of their audit criteria are thus likely to have given a false sense of security when using glycine.

Any patient receiving glycine in theatre **must** have such POCT equipment readily available and a measurement(s) made,

- as a preoperative baseline prior to the start of surgery;
- if the surgery is longer than 30 minutes;
- intermittently throughout a case as a routine;
- if there is a 1000 ml fluid deficit.

Staff must be readily available who are trained to use this POCT equipment and indeed immediately available to transport the samples and result to and from the machine.

NOTE: Measurement of serum sodium is not required when using a bipolar technique and saline[8].

Recommendation 5
If continue to use glycine, the following **must** be used. a. Measure POCT serum sodium, i. preoperatively; ii. if the surgery is longer than 30 minutes as a routine; iii. intermittently throughout the surgery; iv. if there is a 1000 ml fluid deficit. b. Dedicated staff for transporting specimens and results; c. Surgery, including TURP, TCRE & TCRF must be performed in a 'main' theatre where POCT equipment is immediately available; d. Accurate fluid input & output measurement and deficit calculation.

b. <u>Limit the volume of fluid absorbed.</u>

The choice of surgical technique and equipment may reduce the complications from irrigation fluid by limiting the use of glycine but continued attention to controlling fluid absorption will still be needed if normal saline is used as the distending fluid.

Basic principles govern the amount of fluid absorbed[18].

i. The hydrostatic driving pressure of the distending fluid. This is often a feature of the height of the container but the pressure may be controlled mechanically.
ii. Measurement, monitoring and documentation of the fluid volumes and deficits.
iii. The length of the surgical procedure.

i. Hydrostatic driving pressure of the distending fluid

Surgeons have a vital role in minimising absorption by keeping the cavity distention pressure at the lowest pressure necessary to distend, consistent with good visualisation. Even though the disruption in the vascular system is venous, the best strategy is to measure arterial pressures (which is easy to

do) and to maintain distending pressure below the mean arterial pressure (MAP).

It is estimated that approximately 40mmHg distending pressure is required to obtain clear vision. At pressures between 40mmHg and approximately 100mmHg (MAP), blood will continue to escape from disrupted capillaries until it is stopped by the tamponade. At this point, when continuous flow is used through the resectoscope, the blood within the cavity will be removed and a clear field of vision will be maintained. Dropping the pressure permits further bleeding. If the pressure is raised above the MAP, the pressure not only prevents the flow of blood out of disrupted vessels but actually forces the distension fluid medium in the reverse direction into the vessels.

There exist a number of fluid delivery systems, ranging from those based on simple gravity to automated pumps that are designed to maintain a pre-set intra-cavity pressure. Methods of instilling the distention fluid include,

- continuous-flow by gravity;
- continuous-flow infusion pump;
- pressure-controlled or pressure-sensitive fluid pumps.

Continuous-flow by gravity

In continuous-flow gravity systems, pressure is controlled by the height of the fluid source above the bladder or uterus and is measured from the height of the highest portion of the continuous column of fluid (fluid bag) to the level of the uterus or bladder – approximately 30 cms height is equivalent to 25 mm Hg pressure[19]. If the bag is 60 cms above the patient's uterus, this results in approximately 50 mm Hg of pressure.

Height of fluid column	Pressure exerted
12 inches ≡ 30 cms	25 mmHg
24 inches ≡ 60 cms	50 mmHg
36 inches ≡ 90 cms	75 mmHg

Gravity based systems are very simple to assemble and operate, but require vigilant patient monitoring and frequent manual intake/output calculations, which can be imprecise.

Recommendation 6

For both mono- and bi-polar techniques, limit the distension pressure by,

a. maintaining it below the mean arterial pressure (MAP).

and with continuous-flow gravity systems,

b. limit the height of the irrigating solution container to 60 cm above the patient and certainly never above 100cm;
c. theatre teams must have a procedure for checking and maintaining an agreed height;
d. not applying pressure bags to the irrigation fluid bag.

Continuous-flow infusion pump
Continuous-flow fluid infusion pumps provide a constant flow of distention fluid at the in-flow pressure determined by the operator, delivering the same flow rate regardless of the out-flow conditions. Continuous flow pumps do not usually monitor or calculate the intracavity pressure. Significant fluid absorption and complications can occur with these types of systems because the team is unaware of the actual pressure being used during a prolonged or invasive procedure.

Pressure-controlled or pressure-sensitive fluid pumps
Pressure-controlled infusion pumps can be preset to maintain a desired in-flow pressure. By adjusting the in-flow pressure setting on the pump, it can be maintained below the MAP, thus reducing the likelihood of intravasation.

These pumps can weigh the fluid volume before infusion, which allows them to account for the overfill often found in fluid bags. Weight of fluid before installation and then after, accounts for the deficit, which provides a more accurate measurement of the fluid retained by the patient (fluid deficit). A continuous automated weighing system provides an easy, less time-consuming and valid method of monitoring fluid deficit[2] and an automated fluid management system is recommended[3].

Recommendation 7
Investigate instilling irrigation fluid by using a pressure controlled pump device and purchasing flow/pressure controllers.

ii. Measurement, monitoring & documentation of the fluid volumes & deficits.
If continuous irrigation using fluid filled bags and gravity continue to be used, volumetric fluid balance is based on counting the number of empty fluid bags and then subtracting the out-flow volume in the collection canister and fluid in the drapes to determine irrigation fluid deficit. Positive values are regarded as absorption. The surgeon should be notified about ongoing fluid absorption early enough for steps to be taken to prevent excessive absorption.

However[1], calculation of systemic absorption is complicated by 4 factors,
1. It may be difficult to collect all of the media (fluid, urine and blood) that passes out of the operative area, including that which falls on the procedure or operating room floor;
2. the actual volume of media solution in 3L bags is typically more than the labelled volume;
3. difficulties in estimating the volume of media left in a used or ‘emptied’ infusion bag;
4. systemic absorption that in some instances may occur extremely rapidly.

While these factors can make volumetric fluid balance measurement an unreliable tool, it is considered a minimum necessity when using fluid filled bag systems that the whole theatre team are aware of the distending fluid

input & output and the irrigation fluid deficit. This is especially true for cases where glycine is used.

A member of staff must be assigned to this duty before the start of every case. They will need to be proficient and practiced in this technique and must take responsibility for measuring the input and output, calculating the deficit and recording these details. They should remain in theatre for the duration of the procedure, in the same fashion as the surgeon.

Recommendation 8
The theatre team **must**, • be aware of the distending fluid input & output and deficit; • contain a dedicated nurse for fluid balance and deficit calculation, who remains in theatre for the duration of the procedure.

When using a pressure-controlled infusion pump to control the distension fluid with their associated continuous automated weighing system, the monitoring of the fluid deficit is easier[2], less time-consuming and thus an automated fluid management system is recommended[3].

Documentation

Each patient who has any irrigating fluid used must have documentation in the way of a dedicated fluid management chart (appendix 1) commenced. This can be either the measurement of input & outputs and calculating the deficit or recording the readings off an automated machine.

This should be done as a minimum every time a bag (often 3 litre) is hung up and the details clearly expressed verbally to the surgeon and all other theatre staff. These details should be recorded on the dedicated fluid management chart. They might also be displayed on a white marker board in the theatre.

At the end of the procedure, the final calculations or readings must be made; the inputs, outputs and deficit. These should be expressed clearly to the surgeon and anaesthetist and recorded on the chart. The operating surgeon should include the fluid deficit in the *Operative Findings* when writing the operative notes.

The fluid management chart must follow the patient into the recovery ward. All fluid balances must be handed over to recovery ward staff as part of the normal nursing and medical handover. The chart is then to be filed in the clinical record.

Recommendation 9
If continue to use glycine, the following **must** be used, throughout the procedure, • accurate irrigation fluid input & output measurement and deficit calculation.

Maximum fluid deficit

Prevention of the TUR syndrome requires that the team have a protocol for responding to any escalating fluid absorption and there must be agreed volume thresholds for action. These thresholds may necessarily vary depending on the,

- nature of the surgery;;
- nature of the media (isotonic or hypotonic);
- patient's baseline;
- intraoperative medical condition e.g. presence of haemorrhage.

Considering glycine use, a 500 ml threshold may be appropriate for those who are older and/or medically compromised while for healthy individuals absorption of up to 1000 mL can generally be tolerated. Greater than 1000 mL of glycine intravasation results in a significant decrease in serum sodium, sufficient to bring a normo-natraemic patient into the abnormal range[1, 2, 3].

The surgeon and anaesthetist must be informed by the nurse when there is a 1000mls glycine deficit. Surgery must be brought to a close unless continuation of surgery is absolutely necessary to control the haemorrhage. The nurse must ensure that the surgeon and anaesthetist acknowledge that they have received this information. This must be documented in the notes along with any action taken.

Considering normal saline use, the maximum limit is unclear, but 2500 mL has been advocated[3]. Surgery must be brought to a close unless haemorrhage needs controlled.

Recommendation 10
Preoperatively, for each individual patient, there **must** be an agreed maximum fluid deficit threshold for action. The surgeon and anaesthetist **must** be informed by the nurse when the threshold is reached.

iii. The length of the surgical procedure.

Estimates of the amount of fluid absorbed range from 10 – 30 mls per minute of resection time; over a 45 – 60 minute case that could equate to 1 – 1.8 litres.

Procedures that last longer than 60 minutes and those that require large amounts of tissue resection are more likely to lead to fluid volume overload. Theatre teams must have an established mechanism for measuring time and procedures for alerting surgeon and anaesthetist.