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

7 June 2022

Dear Sir,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 59 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:

Ajay Pahuja
Consultant Urologist
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

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

APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 11th July 2022**.

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

Dated this day 6th June 2022

Signed: Personal Information redacted by the USI

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE

[No 59 of 2022]

General

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

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

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

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

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

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, Services, systems, roles and individuals whom you manage/d or had responsibility for.

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

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

Urology services

9. For the purposes of your tenure, in April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:

1.1 INTRODUCTION

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

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

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

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

response to the changing nature of waiting lists, and their successful management.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22. Did you feel supported by the nursing and ancillary staff in the Unit? Please describe how and when you utilised nursing staff in the provision of clinical care

for Urology patients. Did you consider that the nursing and ancillary staff complement available was sufficient to reduce risk and ensure patient safety?

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

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

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

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

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

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

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

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

Engagement with Urology staff

31. Please set out the details of any weekly, monthly or daily scheduled meetings with any Urology unit/Services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

Governance

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

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

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

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

36. How did you ensure that governance systems, including clinical governance, within Urology Services were adequate? Did you have any concerns that

governance issues were not being identified, addressed and escalated as necessary?

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

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

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

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

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

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

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

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

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

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

Concerns regarding the Urology unit

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

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

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

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

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

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

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

(b) Patient safety in Urology Services?

(c) Clinical governance in Urology Services?

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

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

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

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

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

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

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

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

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

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

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

51. What, if any, support was provided to you and Urology staff by the Trust given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr. O'Brien).

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

Mr. O'Brien

53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. Do you now know how long these issues were in existence before coming to either your own or anyone else's attention? Please provide full details in your answer.

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

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

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

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

57. As Consultant urologist, did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

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

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

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

60. As relevant, how did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed? Are there records of you having assured yourself that systems and agreements put in place, to address concerns, were effective?

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

62. Did Mr O'Brien raise any concerns with you regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise (and if not with you, with whom), and when and in what context did he raise them?

63. How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something? How far would you expect those concerns to escalate through the chain of management?

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

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

Learning

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

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

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

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

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

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

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

NOTE:

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

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 59 of 2022

Date of Notice: 7th June 2022

Witness Statement of: Ajay Pahuja

I, Ajay Pahuja, will say as follows: -

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

Post of consultant urologist in SHSCT from 1/11/12 until 5/1/2014

1.1 My role in the SHSCT was that of a consultant urologist as part of the 5 consultant team. My responsibilities were to look after my urological patients under my clinical care (on the wards, day cases, in-patient theatre lists, cross cover colleague sessions if needed (during leave periods),to participate in the consultant on-call rota with existing post holders, to keep up to date with my admin work, to participate in the team/grand ward rounds on Thursdays, to attend meetings, to participate in audits, to supervise junior urology doctors/trainees posted within the urology department and also to support the nursing staff within urology.

1.2 The meetings attended were X-ray meetings every Thursday morning, followed by grand ward rounds and then the Multi-disciplinary meeting (departmental and link with regional MDM in BHSCT) on Thursday afternoons and rolling monthly departmental / business /scheduling meetings.

1.3 Keeping up with the admin work involved dictating results, discharges, scheduling of lists, and consultant triage weekly (1:5 weeks).

1.4 As part of safe clinical practice, systems were in place to discuss difficult cases at Thursday morning X-ray meetings (attended by a radiologist, nurses, registrars and all consultants within the team) and at governance monthly meetings as part of the rolling trust audit calendar. The purpose was to come to a consensus on complex cases and also learn as part of shared learning.

1.5 In relation to concerns raised - I did not have an office to work from (which meant I was constantly looking for a quiet place to do my admin work in Craigavon Area Hospital and this was highlighted to the service manager) but I used hot desks instead to get my admin work completed (signing letters, dictating results, scheduling patients for my theatre sessions, ringing patients if needed). Towards the end of my tenure I was granted access to the stone treatment centre (STC) which had a desk and computer for me to carry out my admin tasks when the STC was not being used for any clinical activity. In addition, the trust made provisions and provided me with a work laptop for remote access.

1.6 In relation to the triage issue please refer to my answer to Q53.

1.7 In relation to learning / reflections – please refer to my answers to Questions 66, 67 and 68.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. If you are uncertain about what documents have been provided to the Inquiry please liaise with the Trust's legal

representatives. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

2.1 All documents referenced in this statement can be located at S21 59 of 2022 Attachments.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

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

4.1 Qualifications:

a) MBBS – Mangalore University, India 1991
b) Master of Surgery (MS) – General Surgery, MAHE, India 1995
c) FRCS Ed– Gen Surgery, Royal College Surgeons Edinburgh 2001
d) FRCS Ed (Urol), intercollegiate Board, UK 2008

4.2 Occupational history (to date):

a. Jan 14 - present Consultant Urologist

Belfast City Hospital, NI

b. Nov 12 – Jan 14 Craigavon Area Hospital, NI	Consultant Urologist
c. Nov 09 – Oct 12 Causeway Hospital, NI	Consultant Urologist
d. Nov 06 – Oct 09 Belfast City Hospital, NI	Clinical Fellow Urology
e. July 06 – Oct 06 Craigavon Area Hospital, NI	Clinical Fellow Urology
f. Apr 06 – Jun 06 Belfast City Hospital, Belfast	Specialist Registrar Urology
g. Feb 05 – Mar 06 Belfast City Hospital, Belfast	Specialist Registrar Urology (LAT)
h. Sep 03 – Feb 05 Ashford & St Peters' Hospitals, Chertsey, Surrey, UK	Senior SHO/Registrar on call Urology
i. Jun 03 – Aug 03 University Hospital Aintree, Liverpool, UK	Clinical Fellow in Urology
j. Feb 00 – Jan 03 Jaslok Hospital & Research Centre, Mumbai, India	Registrar in Urology

k. Aug 99 – Jan 00 Sir H N Hospital, Mumbai, India	Registrar in Urology
l. Jul 98 – Feb 99 Royal London Hospital, London,	Clinical Observer in General Surgery
m. Nov 97 – Feb 98 Kasturba Medical College, Manipal, India	Senior SHO in Orthopaedics
n. Nov 96 – Apr 97 Kasturba Medical College, Manipal	Senior SHO in Head & Neck Surgery
o. Jul 96 – Oct 96 Kasturba Medical College, Manipal	Senior SHO in Cardiothoracic Surgery
p. Jan 96 – Jun 96 Kasturba Medical College, Manipal	SHO in Surgery
q. Jan 93 – Dec 95 Kasturba Medical College, Manipal	Resident, Postgraduate (SHO) in General Surgery
r. Dec 91 – Dec 92	Pre-Registration house officer (Internship)

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 Consultant urologist – 01 Nov 2012 – 05 Jan 2014

5.2 My duties and responsibilities included daily ward rounds of patients under my care, weekly one in-patient theatre, two outpatient clinics per week, one day surgery list per week, supervision and training of junior doctors and urology trainees and supporting the nursing team in the Thorndale Urology Unit and the urology ward.

5.3 In addition there were X-ray meetings every Thursday morning, followed by grand ward rounds and then the Multi-disciplinary meeting (departmental and link with regional MDM in BHSCT) on Thursday afternoons and rolling monthly departmental / business /scheduling meetings. (Details/dates of departmental meetings can be provided Ms Martina Corrigan).

5.4 Keeping up with the admin work involved dictating results, discharges, scheduling of lists and consultant triage weekly (1:5 weeks).

5.5 Yes, the job description (*please see 1. Job Description*) reflects my duties and responsibilities. Please also please see my answer at 9.2.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, Services, systems, roles and individuals whom you manage/d or had responsibility for.

6.1 My clinical director was Mr R Brown and the clinical lead during my tenure (1/11/2012 till 5/1/2014) in SHSCT was Mr Michael Young and my line manager was Ms Martina Corrigan. I reported to either Mr Michael Young or Ms Martina Corrigan depending on the need (clinical or service related).

6.2 My role in SHSCT was that of a consultant urologist as part of the 5 consultant team. My responsibilities were to look after my urological patients under my clinical care (on the wards, day cases, in-patient theatre lists, cross cover colleague sessions if needed (during leave periods), to participate in the consultant on-call rota with existing post holders, to keep up to date with my admin work, to participate in the team/grand ward rounds on Thursdays, to attend meetings, to participate in audits, to supervise junior urology doctors/trainees posted within in the urology department and also to support the nursing staff within urology.

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 as a consultant urologist in SHSCT was to work as part of a urology team, making sure that quality and safety were at the centre of all my clinical activities and to drive continuous improvement in the quality of patient care, keeping my skills up-to-date by participating in continuing professional development. I participated in Trust monthly audit meetings and governance meetings which ensured accountability for delivery of our required standards. These trust meetings discussed many aspects for example good clinical practice or audits from any speciality as part of shared learning. Incidents / SAIs were also discussed as well at the trust M&M meetings. I do not have access to minutes from these meetings but perhaps they can be obtained from the medical directors trust office or service manager Ms M Corrigan.

7.2 My responsibilities included those highlighted above in answer to Question including:

a) Direct clinical care of patients under my care
b) Ward rounds of in-patients and participating in team grand ward rounds every Thursday

c) Dealing with admin work, dictating results, timely discharges, scheduling of lists, consultant triage weekly (1:5 weeks).
d) Discussing all new cancer cases at M&M and difficult cases at x-ray meetings to get a team consensus and learning from each other as part of shared learning.

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

8.1 Each consultant had individual responsibility towards their patients and clinical practice. My role and responsibilities are highlighted in my answers to Questions 6 and 7.

8.2 The role and responsibilities of the clinical lead (Mr M Young) overlapped in relation to direct clinical care of patients, but in addition to that, he had responsibilities as a lead to oversee the running of the department, to chair/attend meetings (for example scheduling meetings, departmental meetings) and to address points like training issues with junior doctors, job planning discussions, appraisals and patient safety.

8.3 The role and responsibilities of the Head of the Urology Service Ms M Corrigan was to provide the team monthly updates on the points covered during meetings as set out in my answer to Question 10.

8.4 I am unable to comment on the roles and responsibilities of the clinical director, AMD or the MD. Perhaps the medical director's office in SHSCT could provide information on each of their roles and responsibilities. I have had no direct interaction with any of them during my tenure in SHSCT.

8.5 As part of safe clinical practice, systems were in place to discuss difficult cases at Thursday morning X-ray meetings (attended by a radiologist, nurses, registrars and all

consultants within the team) and governance monthly meetings as part of the rolling trust audit calendar. The purpose was to come to a consensus on complex cases and also learn as part of shared learning.

8.6 My role included:

a) Working within the framework structure - fulfilling roles and responsibilities, providing and driving quality of care, reporting incidents via reporting systems like Datix and discussing at Trust M&M meetings.

b) Escalation to clinical lead/director if necessary - like training issues with junior doctors, job planning discussions, appraisals and patient safety.

c) Departmental urology service and scheduling monthly meetings - It was attended by clinical lead Mr Michael Young, all other urology consultants, and nursing leads from ward, clinical nurse specialists and led by manager/ head of urology service Ms Martina Corrigan.

Urology services

9. For the purposes of your tenure, in April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:

1.1 INTRODUCTION

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

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient

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

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

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

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

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

9.1 I cannot recall access to the Integrated Elective Access Protocol (IEAP). The principles/summary of the IEAP pathway (waiting times for outpatients, effective waiting list management, timely communication back to GPs and patients) were discussed at some departmental meetings as part of service improvement meetings (minutes can perhaps be provided by Ms Martina Corrigan).

9.2 Roles and responsibilities for all employed consultants are laid out in the job description published by individual trusts at the time of a job advertisement. I was given a basic working week (nothing in writing) after discussion with my clinical lead Mr M Young although the job kept constantly evolving depending on service needs (for example one of my outpatients clinic was moved to SWAH in Enniskillen on Mondays.

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

10.1 The IEAP provided basic principles for my clinical practice. The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

10.2 Time limits were monitored by feedback given my urology service manager at departmental / scheduling meetings. Some examples of the aspects/points covered during meetings would be as follows, (further details can perhaps be obtained from Ms M Corrigan):

a) Review of waiting times (OPD and theatre) for patients on my list and other pooled lists
b) Regular departmental meetings were in place to discuss waiting times

c) Feedback by service managers on how we are progressing and which areas need addressed for prioritisation

10.3 Actions taken:

a) Options discussed to either create WLI or outsource work or help out each other
b) Prioritise patients according to their clinical needs and urgency
c) Scheduling meetings to cover all sessions / cross cover on leave
d) Reporting of incidents/ M& M meetings
e) Report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvement.

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

11.1 Feedback by urology service manager Ms Martina Corrigan (who should be able to provide further information of this) during monthly departmental business meetings / scheduling / Governance meetings used some of the performance indicators like

a) Waiting times for outpatient appointments for new and / or review slots
b) Waiting times for diagnostic procedures like flexible cystoscopy, prostate biopsies
c) Waiting times for patients waiting for in-patient procedures.

11.2 I cannot recollect or have any information on figures to show changes in performance indicators.

11.3 If waiting times to see a consultant at the outpatient clinic were decreasing then that was a positive indicator or time from GP referral to diagnostic test like flexible

cystoscopy and another indicator that was discussed at these meetings. (Perhaps this information can be provided by Urology service manager Ms Martina Corrigan).

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

12.1 Consultant numbers (5 in post) were adequately staffed during my tenure in SHSCT (1/11/12 till 5/1/14) but there were vacancies for middle grade posts (details of which can be provided by Ms Martina Corrigan urology service manager). Middle grade doctors supported consultants in their outpatient clinics and also carried out day lists such as flexible cystoscopy lists. Deficiency of middle grade staff meant that less patients were seen at outpatient clinics and there was a downturn in clinical activity (example outpatient's clinics, flexible cystoscopy lists or prostate biopsy lists).

12.2 There were two urology nurse specialists – one to support cancer services and one for benign work.

12.3 We discussed staffing and resource issues at monthly departmental service meetings attended by clinicians, nurse leads, secretaries, urology service managers (minutes perhaps can be provided by Ms Martina Corrigan). There were discussions about staff grade and nurse recruitments as part of future planning.

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

13.1. Please refer to answer at paragraph 12.1

13.2 Staffing challenges were managed by prioritising work according to clinical needs, for example arranging to see patients in the order of urgency (red flags, urgent and then routine).

13.3 Staffing challenges were also managed by prioritising certain sessions like main theatre over perhaps outpatients without compromising safety.

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

14.1 The impact included longer waiting times for patients to be seen at outpatients.

14.2 Other impacts included nurse shortages / Bed capacity issues / ability to do more theatre cases.

14.3 I have no recollection of particular incidents.

14.4 Patient safety and clinical care are always the priority - as a team we prioritised according to needs based on most urgent first.

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

15.1 I cannot recollect. Perhaps the service manager Ms Martina Corrigan during my tenure would be best placed to answer this query or provide information.

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

16.1 There was no change in my role during my tenure.

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

17.1 As far I can remember, the urology unit and services were well supported by the administrative staff during my tenure but more information can be sought by the service manager Ms Martina Corrigan during my tenure**.**

17.2 I was given a very efficient secretary Ms Leanne Hanvey during my tenure and personally had no issues.

17.3 My secretary provided me support in the following ways - typing clinic letters, filing results, creating separate folders for triage, taking phone calls and messages, and dealing with emails or other postage.

17.4 I did not have an office to work from, which meant I was constantly looking for a quiet place to do my admin work in Craigavon Area Hospital and this was highlighted to the service manager, but I used hot desks instead to get my admin work completed including signing letters, dictating results, scheduling patients for my theatre sessions and ringing patients if needed. Towards the end of my tenure I was granted access to the stone treatment centre (STC) which had a desk and computer for me to carry out my admin tasks when the STC was not being used for any clinical activity. In addition, the Trust made provisions and provided me with a work laptop for remote access.

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

18.1 By and large each consultant had their own secretary but the secretaries cross covered during periods of leave. Administrative workload which was outside of my remit was monitored by the admin lead - details of which can be sought from Ms Martina Corrigan urology service manager during my tenure - and prioritised according to need.

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

19.1 Same as answered in Question 18.

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

20.1 I had adequate admin support but if my secretary was on leave, I would seek or request other admin staff within the team for admin related work.

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

21.1 No concerns raised.

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

22.1 Nursing staff were very good on the ward, theatre, outpatients and our ambulatory Thorndale unit. Nursing staff tried their best to work well within their means and resources available to them. Yes, we were under pressure many a times in a busy unit but

I felt well supported at all levels. I ran joint clinics in Thorndale with CNS and had very good working relationships with all nursing and ancillary staff.

22.2 I felt there was sufficient nursing and ancillary staff available to ensure patient safety as we as a team dealt with patient care based on clinical urgency. Recruitment of more nurses was on the agenda at the departmental meetings (details of which can be sought from urology service manager Ms M Corrigan).

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

23.1 A specialist cancer nurse plays a key role in supporting patients and families and provides that vital link for patients and families with the medical teams involved in the cancer patient pathway. All aspects of care for patients with a cancer of the urinary tract are provided. (b) The Urology Specialist Nurses are involved in the diagnosis, treatment, follow up and management of patients. Both CNS and UNS liaise with individual consultants and discuss patient management plans.

23.2 I engaged with the specialist nurses on a weekly basis in Thorndale unit. The nurses saw the new patients and performed initial assessment (for example flow rates, bladder scans, urine dipstick test) and then patients were directed into my consultant room for examination and discussion of options/management plans. Engagement included:

a) Team work in Thorndale unit
b) Part of Multidisciplinary team working
c) Supported outpatients as part of LUTS assessment clinic
d) UNS supported our cancer services and flexible cystoscopy LA lists

e) Engagement weekly to (review patients plans, management options / follow up plans)
f) Worked well
g) Communicated very well (effectively and efficiently)

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

24.1 Very good relationships and no serious concerns were raised during my tenure

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

25.1 Very good relationships and communication pathways were effective.

25.2 Sufficient admin support for me personally. Had a very efficient secretary.

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

26.1 I assured myself by ensuring all in-patients on the ward under my care were seen in a timely manner and by providing patients with daily updates on their clinical progress.

26.2 I followed through their investigations, discussed their results/management and clinical prioritisation was based on urgency.

26.3 Further, discussion of all new cancer cases at MDM or difficult cases at Xray meetings. Please see my answer to Question 8.

26.4 I also sought support from experienced / senior colleagues for advice on complex cases.

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

27.1 Ms Martina Corrigan urology service manager was in overall charge of the day to day running of the urology unit and Mr M Young consultant urologist was the lead clinician. Mr Young answered to the clinical director Mr R Brown (consultant surgeon).

My clinical lead during my tenure was Mr Michael Young and my line manager was Ms Martina Corrigan. I reported to either of them depending on the need (clinical or service related)

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

28.1 Yes, working relationships were very good.

28.2 Ms Martina Corrigan the urology service manager during my tenure was always available to discuss service needs like arranging or re arranging outpatients' clinics (both on main Craigavon Area Hospital site and outreach clinics like in SWAH in Enniskillen) when I started as a new consultant urologist in SHSCT.

28.3 Ms Corrigan engaged very well with me in trying to settle me into the unit as a new consultant in the unit. The outreach Clinic in SWAH was new to all of us so we (Mr Young, myself and Ms Corrigan) had to meet a few times to ensure the clinic was set up well with appropriate use of time and facility in SWAH.

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

29.1 No appraisal or performance review was carried out during my tenure.

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

30.1 No.

Engagement with Urology staff

31. Please set out the details of any weekly, monthly or daily scheduled meetings with any Urology unit/Services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

31.1 Meetings included:

a) Weekly x-ray-meetings 30-45 minutes each on a Thursday morning

b) Grand (peer reviewed) ward round every Thursday morning which lasted about 2 hours – no minutes available
c) Monthly scheduling / departmental meetings lasted 1-1.5 hours – no minutes but perhaps Ms Martina Corrigan can provide further details
d) Multidisciplinary meetings (cancer) Thursday afternoons lasted 2.5 to 3 hours – no minute's available to the best of my knowledge but outcomes on each patient discussed from each MDT may be available (perhaps Ms Corrigan or MDM coordinator may be able to provide it)
e) Trust M&M/audit meetings monthly (rolling calendar) – lasted 2.5 – 3 hours

Governance

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

32.1 Every clinician has individual responsibility for their patients. The overall responsibility of quality of services in urology during my tenure lay with the clinical lead Mr M Young and the service manager Ms Martina Corrigan. They both provided assurances by meeting the rest of the team at the monthly departmental meetings (minutes or agenda can perhaps be provided by Ms Martina Corrigan) and discussing what was on the agenda for example waiting times for patients to be seen at the outpatient clinics, covering of theatre, day procedure or outreach sessions, work force planning etc.

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

33.1 The overall responsibility of clinical governance in urology during my tenure lay with the clinical lead Mr M Young who in turn reported to his clinical director Mr Robin Brown and with the service manager Ms Martina Corrigan. They both provided assurances by meeting the rest of the team at the monthly departmental meetings (minutes or agenda can perhaps be provided by Ms Martina Corrigan) and discussing what was on the agenda for example waiting times for patients to be seen at the outpatient clinics, covering of theatre, day procedure or outreach sessions, work force planning etc.

33.2 I assured myself that this was being done properly by attending the departmental/scheduling and M&M meetings as part of team working.

33.3 I was provided with assurance regarding the quality and safety of urology services by discussions at the departmental / service meetings – for example prioritising patients according to their clinical needs (red flags, urgent and routine), making sure on calls were covered (emergencies), ensuring ward patients were seen in a timely way, by grand ward round every Thursday, by X-ray meetings to discuss complex cases, by discussion of all mew cancer cases at the MDM, by discussion of any incidents, morbidities/mortalities at monthly trust M&M meetings and by having adequate Administrative (secretarial support).

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

34.1 Please refer to my answer to Question 11.

34.2 Ms Martina Corrigan was responsible for overseeing performance metrics.

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

35.1 Please refer to my answer at paragraph 33.3.

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

36.1 Please refer to my answer to Question 33.

36.2 I did not have any concerns (to the best of my knowledge) that governance issues were not being identified, addressed and/or escalated during my tenure in SHSCT.

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

37.1 Any concerns were discussed at monthly departmental meetings.

37.2 The Trust had systems in place where patients could raise concerns or be signposted via the formal complaints process with timelines and feedback by the Trust under the governance framework. Any incidents or concerns could be raised via the Datix platform. Depending on the nature of the incident or complaint there were processes in place to discuss at SAI meetings or Trust M&M monthly meetings. The systems were efficient during my tenure in SHSCT.

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

38.1 I cannot recollect but as far as I am aware there was no change during my tenure.

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

39.1 I was appraised of any concerns in relation to the urology service via the departmental monthly meetings or via the Trust monthly M&M meetings (minutes can be provided by service manager Ms M Corrigan if available).

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

40.1 Concerns were raised either via the departmental meetings or via systems like the Datix and then discussed at the governance meetings or the Trust M&M meetings (minutes of which can be requested by service manager Ms Corrigan).

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

The systems in place included:

a) Patient administration system (PAS) – I am only aware of the PAS system in SHSCT (NHS) used by NHS trusts to enable them to know when a patient has arrived, who they are, who they were seen by, what treatment they received and what happened to them. This core functionality, needed by every trust, covers admission, discharge and transfer.

b) Audits – collecting data as part of service improvement, measuring current practice and comparing to national standards.
c) Incident reporting via datix platform and outcomes on feedback and learning/reflections.
d) Discussing and learning from SAIs at the monthly departmental meetings or trust M&M meetings.

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

42.1 I have personally not used the PAS as it's the admin team that use it to support the patient management, including tracking patients and managing admissions, ward attendances and appointments.

42.2 Unsure if systems changed over time.

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

43.1 I am unsure if performance objectives were set during my tenure. Mr M Young my clinical lead at the time may be able to provide information on this.

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

44.1 I had a basic working week (job plan) as described in my answer to Question 5. I did not have a formal job plan meeting during my tenure as my working week was still

evolving/changing by the time I left the Trust. I also did not have an appraisal during my tenure in SHSCT.

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

45.1 Please refer to my answers to Questions 32, 33, 40 and 41.

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

46.1 Yes.

46.2 The service manager and the clinical lead were always available to discuss any issues or improvements. Please refer to my answer to Question 28.

Concerns regarding the Urology unit

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

(i)The Chief Executive(s); Mrs Mairead McAlinden

(ii) the Medical Director(s); Dr John Simpson

(iii) the Director(s) of Acute Services; Dr Gillian Rankin

(iv) the Assistant Director(s); Mrs Heather Trouton, Assistant Director of Surgery and Elective Care, Mr Ronan Carroll Assistant Director of Cancer and Clinical Services

(v) the Associate Medical Director; Mr Eamon Mackle

(vi) the Clinical Director; Mr Robin Brown

(vii) the Clinical Lead; Mr Michael Young

(viii) the Head of Service; Mrs Martina Corrigan

When answering this question please name the individual(s) who held each role during your tenure. When addressing this question, you should appreciate that the Inquiry is interested to understand how you liaised with these post-holders in matters of concern regarding Urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding Urology services which are the subject of this Inquiry. You should refer to all relevant documentation (and provide that documentation if not previously provided), dates of meetings, actions taken, etc.

47.1 My clinical director was Mr R Brown and clinical lead during my tenure in SHSCT was Mr Michael Young and my line urology service manager was Ms Martina Corrigan. I only liaised with Mr M Young or Ms M Corrigan (paragraph 8.2c) and none of the other post holders during my tenure in SHSCT.

47.2 Please refer to answer at paragraph 8.2C

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

48.1 No concerns were raised regarding my clinical practice.

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

(a) The clinical practice of any medical practitioner in Urology Services? No

(b) Patient safety in Urology Services? No

(c) Clinical governance in Urology Services? No

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

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

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

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

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

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

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

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

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

50. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether in your view these issues of concern were -
(a) Properly identified,
(b) Their extent and impact assessed properly, and (c) The potential risk to patients properly considered?

50.1 See answer to Question 49.

51. What, if any, support was provided to you and Urology staff by the Trust given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr. O'Brien).

51.1 See answer to Question 49.

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

52.1 No (from my recollection). Maybe Ms Corrigan can provide information on this.

Mr. O'Brien
53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. Do you now know how long these issues were in existence before coming to either your own or anyone else's attention? Please provide full details in your answer.

53.1 During my tenure in SHSCT, I was not made aware of any specific concerns regarding Mr O'Brien's practice. There were e-mails during my tenure in SHSCT (I cannot recollect the exact dates but copies of these emails can perhaps be obtained from Ms M Corrigan urology service manager) exchanged by the service manager about timely GP triage to all the consultants, but there was no indication of patient safety concerns that I was made aware of by the Trust or the directorate or of any concerns regarding Mr O'Brien during my tenure in SHSCT.

53.2 We (5 consultants at the time) had a rota to triage GP referrals on a 1:5 rotational basis. I am aware of e-mails (copies of which can be provided by Ms Corrigan) sent out by our service manager Ms M Corrigan regarding timely urology triage as reminders to all consultants and that there were delays in return of some triage.

53.3 Mr O'Brien was a very good clinician with a vast experience under his belt, respected by his peers. Junior consultants like myself, Mr Connolly and Mr Glackin often sought his opinion when needed. However, Mr O' Brien managed his practice differently for example, he maintained his own waiting lists to schedule patients for theatre - I believe although I never saw this myself. Another example would be that he admitted patients with history of recurrent urinary tract infections for Intravenous fluids and Intravenous antibiotics every few months on the urology ward, which was not the normal practice of others or any consultant that I had worked with in the past in any unit.

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

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

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

54.1 No I did not have or raise any concerns about the conduct/performance of Mr O'Brien.

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

55.1 I was not involved in or informed about any such meetings or discussions during my tenure in SHSCT in relation to Mr O'Brien.

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

56.1 I was not aware of any such concerns during my tenure and I am therefore not in a position to answer this question.

57. As Consultant urologist, did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

In what way may concerns have impacted on patient care and safety?

(ii) When did any concern in that regard first arise?

(iii) What risk assessment, if any, did you undertake, to assess potential impact? And

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

57.1 Please refer to my answer to Question 53.

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

58.1 Not applicable.

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

59.1 Not applicable.

60. As relevant, how did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed? Are there records of you having assured yourself that systems and agreements put in place, to address concerns, were effective?

60.1 Not applicable.

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

61.1 Not applicable.

62. Did Mr O'Brien raise any concerns with you regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise (and if not with you, with whom), and when and in what context did he raise them?

62.1 No.

63. How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something? How far would you expect those concerns to escalate through the chain of management?

63.1 Not applicable.

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

64.1 I was not aware of any concerns during my tenure and therefore I was not aware of any support provided by the Trust.

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

65.1 Ms Martina Corrigan the urology service manager and/or Mr M Young the clinical lead during my tenure in SHSCT may be able to provide information on this if Mr O'Brien raised any concerns.

Learning

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

66.1 I am now more aware of the triage issues within urology in SHSCT than I was before during my tenure in CAH.

66.2 I should have been made more aware of the triage issues. Delayed triage of GP referrals can put patients at risk (patient safety) as their investigations, diagnosis and eventually their management can be potentially delayed.

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

67.1 Governance concerns were raised after my tenure in SHSCT. On reflection, it appears there were significant delays in return of triage letters which understandably puts patients at risk (delayed assessments, potentially delayed diagnosis and treatment). Also reading the Oral Statement to the Assembly by Health Minister Robin Swann – Tuesday 24 November 2020

published by the DOH it appears patients were listed for surgery but they were not on the patient administration system (PAS).

67.2 Please also see my answer to Question 68.

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

68.1 Patient safety is paramount. I feel if there was a recurring issue (example delayed triages) with any consultant, it should have been escalated to the clinical director or even the medical director if needed.

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

69.1 Please refer to my answers to Questions 66 and 67.

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

70.1 I am unable to comment whether mistakes were made in handling of concerns as the concerns were raised only after my tenure in SHSCT.

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

71.1 Yes, overall governance arrangements were fit for purpose during my tenure.

71.2 I did not have concerns about the governance arrangements and did not raise any concerns.

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

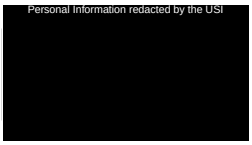
72.1 Nothing further.

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: **3/10/2022**

Section 21 Notice Number 59 of 2022

Witness Statement: Ajay Pahuja

Index

Attachment	Document
1	Job Description

73812021

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB TITLE:	Consultant Urological Surgeon (3 posts)
DEPARTMENT / LOCATION:	Urology – Southern Health and Social Care Trust
REPORTS TO:	Mr E Mackle, AMD, Surgery & Elective Care Division
ACCOUNTABLE TO:	Dr G Rankin, Director of Acute Services
SPECIALTY:	Urology
BASE:	Craigavon Area Hospital

INTRODUCTION

These are two new posts which have been identified as part of the Regional Review of Adult Urological services and one replacement post. The successful candidates will join 2 other Consultants to provide the full range of inpatient and outpatient urological services. While the posts will be mainly based at Craigavon Area Hospital, there are also existing and potential commitments to South Tyrone Hospital, Armagh Community Hospital, Daisy Hill Hospital, Banbridge Polyclinic and Erne 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.

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 Speciality 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 M Akhtar (due to leave April 2012)
2 new posts

2 Specialist Registrars

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.

CONSULTANT JOB PLAN

(POST 3) - INTEREST IN ONCOLOGY (Replacement Post)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	09.00 – 13.00	Admin	CAH	4.0				7.5	
	13.00 – 17.00 14.00 – 17.00	Emergency Urologist **(Weeks 2 & 4)** OPD teaching/service development **(weeks 1, 3& 5)**	CAH CAH	2.0 1.0	0.5				
Tues	08.30 – 09.00 09.00 – 13.00	Travel to STH **(weeks 2 & 4)** Day Surgery Unit – **(weeks 2 & 4)**	STH	0.25 2.0				4.0	
	14.00 – 17.00 17.00 – 17.30	OPD - STH **(weeks 2 & 4)** Travel from STH **(weeks 2 & 4)**	STH	1.5 0.25					
Wed	09.00 – 13.00 09.00 – 13.00	SPA **(weeks 1, 3 & 5)** OPD teaching/service development **(weeks 2 & 4)**	CAH		2.0 2.0			7.5	
	13.00 – 17.00 14.00 – 17.00	Emergency Urologist **(weeks 2 & 4)** Prostate Biopsy **(weeks 1, 3 & 5)** (Teaching)	CAH	2.0	1.5				
Thurs	09.00 – 13.00	SPA	CAH		4.0			7.0	
	14.00 – 17.00	MDT – weekly	CAH	3.0					
Fri	09.00 – 13.00	Theatres	CAH	4.0				8.0	
	13.30 – 17.30	Theatres	CAH	4.0					
TOTAL HOURS				**24**	**10**			**34**	
TOTAL PROGRAMMED ACTIVITIES				**6**	**2.5**			**8.5**	

Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly

EMERGENCY WORKLOAD

On-call availability Supplement	
On-call Category:	A
Agreed on-call Rota Frequency:	1 in 5 (Medium Frequency)
On-Call Availability Supplement:	5%

Type	**Day/Time**	**Location**	**Allocated PAs**
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	**1.00**
TOTAL PA's for ON-CALL:		**1.00**	

SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	**7.00 (includes 1 PA for Ward rounds)**	
Supporting Professional Activities:	**2.50**	**Specific Role:**
On-Call Allocation:	***Total including Predictable & Unpredictable***	
	1.00	
Any Additional HCS Responsibilities:		**Reason:**
Any External Duties:		**Reason:**
Any Annualised Activity & Reason		**Reason:**
TOTAL PA's:	**10.5**	

- **Job plan will be reviewed within 3 months of appointment**

(POST 4) – Consultant Urologist (New Post) A subspecialty interest in an area that would complement the service would be desirable e.g. Uro-oncology/ Andrology/ Female Urology.

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	09.00 – 13.00	SPA **(weeks 1, 3, & 5)**	CAH		2.00			7.56	
	09.00 – 13.00 07.45 – 09.00 09.00 – 13.00	OPD **(week 2)** Travel from CAH to Erne **(week 4)** Day surgery unit **(week 4)**	CAH CAH EKN	1.00 0.31 1.00					
	14.00 – 17.00 14.00 – 17.00 17.00 – 18.15	Admin **(weeks 1, 2, 3 & 5)** OPD – Erne **(week 4)** Travel EKN to CAH (**week 4)**	CAH EKN	2.25 0.75 0.25					
Tues	08.00 – 12.00	Theatre – **(weeks 2 & 4)**	CAH	2.00				7.5	
	12.00 – 19.00	Theatre – **(weeks 1,3 & 5)**	CAH	3.50					
	13.00 – 17.00	Emergency Urologist - **(weeks 2 & 4)**		2.00					
Wed	09.00 – 13.00	SPA	CAH		4.00			7.5	
	13.00 – 17.00 14.00 – 17.00	Emergency Urologist **(weeks 1,3 & 5)** Prostate Biopsy **(weeks 2 & 4)**	CAH	2.00 1.50					
Thurs	09.00 – 13.00	OPD teaching/service development **(weeks 1, 3 & 5)**	CAH		2.00			5.0	
	14.00 – 17.00	MDT weekly	CAH	3.00					
Fri	09.00 – 13.00 09.00 – 13.00	Admin **(weeks 1, 3 & 5)** Theatres – **(weeks 2 & 4)**	CAH DHH	2.00 2.00				6.83	
	14.00 – 17.00 17.00 – 17.40	OPD – teaching/service development **(weeks 2 & 4)** Return travel from DHH **(weeks 2 &4)**	DHH		1.50 0.67				
TOTAL HOURS				**23.56**	**10.17**			**33.73**	
TOTAL PROGRAMMED ACTIVITIES				**5.9**	**2.5**			**8.43**	

Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly

EMERGENCY WORKLOAD

On-call availability Supplement	
On-call Category:	A
Agreed on-call Rota Frequency:	1 in 5 (Medium Frequency)
On-Call Availability Supplement:	5%

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	**1.00**
TOTAL PA's for ON-CALL:		**1.00**	

SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	**6.9 (includes 1 PA for Ward rounds)**	
Supporting Professional Activities:	**2.5**	**Specific Role:**
On-Call Allocation:	***Total including Predictable & Unpredictable***	
	1.0	
Any Additional HCS Responsibilities:		**Reason:**
Any External Duties:		**Reason:**
Any Annualised Activity & Reason		**Reason:**
TOTAL PA's:	**10.5**	

- **Job plan will be reviewed within 3 months of appointment**

(POST 5) –Consultant Urologist with an interest in stone management (New Post). A further subspecialty interest in an area that would complement the service would be desirable e.g. Andrology/Female Urology.

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	08.30 – 09.00 09.00 – 13.00 09.00 – 13.00 13.00 – 13.30	Travel CAH to ACH **(week 2)** OPD – ACH **(week 2)** SPA **(week 1, 3 4 & 5)** Travel ACH to CAH **(week 2)**	 ACH CAH 	0.125 1.0 0.125	 3.0 			**7.25**	
	14.00 – 17.00 14.00 – 17.00	Speciality clinic **(Weeks 2 & 4)** Admin **(weeks 1, 3 & 5)**	CAH CAH	1.5 1.5					
Tues	09.00 – 13.00 09.00 – 13.00	Day surgery unit **(weeks 1, 3 & 5)** Admin **(weeks 2 & 4)**	CAH CAH	2.0 2.0				**8.0**	
	13.00 – 17.00 13.00 – 17.00	Emergency Urologist **(weeks 1, 3 & 5)** SPA **(weeks 2 & 4)**	 CAH	2.0	 2.0				
Wed	08.00 – 12.00	Theatres **(weeks 2 & 4)**	CAH	2.0				**6.5**	
	12.00 – 19.00 13.00 – 17.00	Theatres CAH **(weeks 1, 3 & 5)** SPA **(week 2)**	CAH CAH	3.5	 1.0				
Thurs	09.00 – 13.00 14.00 – 17.00	Stone Treatment D/Cs **(weeks 1, 3 & 5)** OPD – weekly	CAH CAH	2.0 3.0				**5.0**	
Fri	09.00 – 13.00	Flexible Cystoscopies teaching list	CAH		4.0			**8.0**	
	13.00 – 17.00 13.30 – 17.30	Emergency Urologist **(weeks 1, 3 & 5)** Theatres **(weeks 2 & 4)**	 CAH	2.0 2.0					
TOTAL HOURS				**24.75**	**10**			**34.75**	
TOTAL PROGRAMMED ACTIVITIES				**6.18**	**2.5**			**8.68**	

<u>Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly</u>

EMERGENCY WORKLOAD

On-call availability Supplement	
On-call Category:	A
Agreed on-call Rota Frequency:	1 in 5 (Medium Frequency)
On-Call Availability Supplement:	5%

Type	**Day/Time**	**Location**	**Allocated PAs**
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	**1.00**
TOTAL PA's for ON-CALL:		**1.00**	

SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	**7.18 (includes 1 PA for Ward rounds)**	
Supporting Professional Activities:	**2.50**	**Specific Role:**
On-Call Allocation:	***Total including Predictable & Unpredictable***	
	1.00	
Any Additional HCS Responsibilities:		**Reason:**
Any External Duties:		**Reason:**
Any Annualised Activity & Reason		**Reason:**
TOTAL PA's:	**10.75**	

- **Job plan will be reviewed within 3 months of appointment**

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 028 3861 2559.
- 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 29 March 2012**

- 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 (3 Posts) – Craigavon Area Hospital**

DIRECTORATE: **Acute Services**

HOURS: **Full-time**

Ref No: **73812021** **March 2012**

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

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. You should note that CV's will only be accepted in support of a properly completed application form.*
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.*
3. *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. Have possession of or be within 6 months of gaining CCT in the specialty at the date of interview, or be eligible for inclusion on the Specialist Register of the GMC.
4. Hold a full current driving license valid for use in the UK and have access to a car on appointment.[1]

[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.

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.

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