Mr. Michael Young
Consultant Urologist
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

7 June 2022

Dear Sir,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 55 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:

Michael Young
Consultant Urologist
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 15th July 2022.**

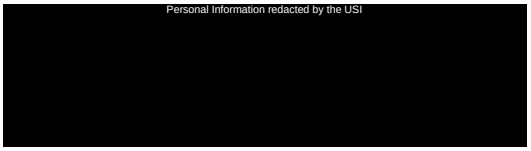
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 5th July 2022**.

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

Dated this day 6th June 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE

[No 55 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, clinical

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 Director, Medical Director, Associate Medical Director, and Head of Urology Service or with any other role which had governance responsibility.

Urology Services/Urology unit – staffing

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

10. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at Consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

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

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

12. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to Urology Consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30. If different to the answer provided at 29 above, in your role 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?

31. 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.

32. 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.

33. 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.

34. 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

35. As Clinical Lead describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within Urology Services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

36. 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 – generally and in your role as Clinical Lead

37. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role as Clinical Lead, how did you assure yourself that this was being done properly?

38. As relevant to your position as Clinical Lead, how did you assure yourself that governance arrangements within Urology were appropriate and effective? Please explain and refer to documents relating to any procedures, processes or systems in place on which you rely on in your answer, and provide any documents referred to (unless provided already by the Trust).

39. How did you oversee the quality of Services in Urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of Services?

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

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

42. 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?

43. How could issues of concern relating to Urology Services be brought to your attention as Clinical Lead/Consultant or be brought to the attention of others? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or

processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

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

45. How did you ensure that you, as Clinical Lead, were appraised of any concerns generally within or relating to Urology Services?

46. 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).

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

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

49. As Clinical Lead, what was your role and responsibilities with regard to the Consultants and other clinicians working in Urology Services, including in matters of clinical governance?

50. Did you ever have concerns regarding governance within Urology Services provided by any of the medics under your lead? If yes, please explain in full and provide all documentation.

51. 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.

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

53. 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.

54. 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

55. The Inquiry is keen to understand how, if at all, you, as Clinical Lead 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 Head of Service;
    (viii) the 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.

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

57. 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 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 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.

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

(a) properly identified,
(b) their extent and impact assessed properly,
(c) and the potential risk to patients properly considered?

59. 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. (Q73 will ask about any support provided to Mr. O'Brien).

60. 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

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

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

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

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

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

64. Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:
    (a) Outline the nature of concerns you raised, and why 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?

65. 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.

66. 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.

67. As Clinical Lead, 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?

68. 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.

69. 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.

70. 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?

71. 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?

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

73. 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.

74. 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

75. 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.

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

77. 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?

78. 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.

79. 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?

80. 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?

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

NOTE:

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

UROLOGY SERVICES INQUIRY

SCHEDULE

[No 55 of 2022]

General

USI Ref: Notice 55 of 2022

Date of Notice: 7th June 2022

Note: An Addendum amending this witness statement was received by the Inquiry on 03 November 2023 and it can be found at WIT-104215 to WIT-104223. Annotated by the Urology Services Inquiry.

Witness Statement of: Michael Young

I, Michael Young, will say as follows: -

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

1.1 This statement has been compiled by me, Mr Michael Young MD FRCS(Urol), retired Consultant Urologist.

1.2 I qualified in Medicine from Queens University Belfast in 1983. After general surgical training, I entered formal urological training and being accredited with the qualification of FRCS (Urol) in 1996 (see detailed account at Q4).

1.3 I was appointed as a Consultant Urological Surgeon with a special interest in Stone Management at Craigavon Area Hospital in May 1998. This post has

been continuously held till retirement at the end of May 2022. I have returned to work on a part time basis for elective care (see detailed account at Q5).

1.4 My role and responsibilities as a consultant were service driven with direct patient contact. This involved the direct provision of daily care for patients, to provide a safe environment and care for patients, and to participate in all activities that up-held these principles. This covered activities in the ward, outpatients, theatre, and on-call for emergency urology cases along with the associated administration and clinical governance meetings. My post had a sub-specialty role and responsibility to supervise and provide the stone service for the Trust area.

1.5 Before retirement, I had been Lead Clinician for 20 years. This role was also service driven in terms of its organizational responsibilities, which focused upon the urology medical team's daily work placement. Other roles held were as a Programme Director for urological trainees in Northern Ireland and as an appraiser (further detail on these roles can be found in Q5, Q6, Q7, and Q8).

1.6 The Inquiry has requested a description of any issues raised with me along with any actions and decisions taken.

1.7 There has been a list of issues raised both by and with me over my 24 year tenure as a consultant and Lead Clinician.

1.8 A theme which has coursed throughout my tenure has been the demand put on the service from the significant numbers of patients requiring investigation and therapy within a deficit in the health care system capacity in terms of both facilities and provision of health care staffing. This has resulted in particularly long urology waiting lists for both outpatient and inpatient assessments. The yet undiagnosed and potential hidden pathology is a distinct concern. For those with a known condition suffer from a lack of intervention.

1.9 As a unit, we appreciated the impact of such high demand, especially from the emergency component of cases being admitted. Early in my tenure as Lead Clinician, this was raised with the Chief Executive after presenting our information on the issue. This resulted in an external review of the urology services of the Southern Trust in 2004 (this is documented fully in Q15). The review was productive. It resulted in a small, purpose-built urology outpatient unit, a urology patient care pathway system (which ultimately became the ICATS service), and there was some increase in nursing and medical staffing (as noted in Q19). In addition, the Trust commissioned an external agency to help with the surgical waiting list for a short period of time (see further Q54 and Q57).

1.10 In addition to the planned centralization of radical pelvic surgery, the Department of Health commissioned a Regional Review of urology services which, in addition to our previous local review, was also focused on the demand / capacity issue. This highlighted issues to be addressed. The Southern Trust team were fully engaged with this Regional Review, as documented in Q9. The Trust set-up a committee to address the various facets identified in the review to attempt to resolve these issues (as noted in Q10). This still proved difficult for a variety of reasons which included a persisting backlog of clinical cases and vacancies in healthcare workers (this is discussed further in Q11, 16, and 17).

1.11 In addition to the general overall demand for urology, it was identified that this also was becoming an issue for the stone service. Our response to this was to apply for a research grant and have an ADEPT fellow investigate ways to improve the patient flow through the system. This investment has had a positive outcome (further detail is recorded in Q23, 39, and 60).

1.12 The onus of the shortfall in medical and nursing staff has been noted throughout my tenure. This affected the on-call rota with a resulting burden on both consultant and junior staff. The emergency service has been felt to be substantive and covering it as a heavy obligation. This was first raised when there was a 1:2 consultant rota for several years after I first joined the

department. This was addressed in part by correspondence with the Chief Executive and Medical Director at that time (as noted in Q15 and 15.2) and then later with the outcome of the McClinton Review of 2004 (as per Q15). On-call issues for the junior staff have been reported and relate to the patient safety issue of hand-over between shifts (as noted in Q57).

1.13 Deficiency in medical staffing numbers, resulting in reduced overall clinical output, has affected the capacity of the unit. This was raised as noted above. The McClinton Report of 2004 noted the high clinical output from the existing team of two consultants and that a similar unit in Scotland would have had substantially more consultants for the same amount of work (see further detail in Q15). The outcome was to employ a GP with Special Interest ('GPwSI') and a consultant. Unfortunately, the suggested fourth consultant post did not materialize at that stage (see further Q15, 16, and 29).

1.14 The Trust's response to the Regional Review was to increase the consultant numbers, however, this still took a number of years to implement and, even then, there was a turnover in the consultant body. This also affected the ability to respond to the demand/capacity of the unit's output (further detail is noted in Q16 and 17).

1.15 Turnover and vacancies in middle grade staff have also been an issue affecting the unit's response to the demand problem as well as potential patient safety in terms of consistency of cover. Despite advertising to fill these posts, it has proven a challenge. It is only recently that a fuller staff complement has been achieved (further detail is recorded in Q16, 17, 59).

1.16 Nursing levels were also deficient for both ward and out-patient services. The nursing posts at ward level have been a more recent issue, as noted in our departmental meeting in 2018 (see Q47 and 72). There has been an increased reliance on agency nurses.

1.17 The out-patient nursing issue dated back further. Again, as part of issues raised leading to the McClinton Report I had insisted on having two Clinical Nurse Specialists as opposed to just one. The McClinton Report followed through with the suggestion of wider nurse involvement in clinical care (as noted in Q15).

1.18 The Regional Review of 2009 again recommended a further increase in CNS numbers; however, our unit has had issues with filling these posts with appropriately trained staff until recent years (further detail is noted in Q9, 11, 15, 25, and 59).

1.19 Medical staffing skills issues have arisen over the years. These have been few in number and related to a deficiency in clinical ability. These were identified, assessed and remedial action taken (as noted in responses to Q55 and 57).

1.20 Triage of referral letters, both in general and with specific reference to one consultant, has been an issue for a number of the years. The volume of administration associated with triaging referrals has been considered to be the predominant feature. The introduction of triage return timeframes was identified as an issue when combining daily elective care with the expectation of triage at the same time (as noted in more detail in Q9.4, 13.2, 16.6, and 57.20). The unit's response to this was to introduce the Urologist of the Week for on-call and triage and drop the elective work for this particular week.

1.21 It was also regarded that there possibly was potential hidden pathology within the cohort of patients within the referrals. There was an appreciation that there was a long wait to be seen at out-patients. The unit's response to this was to introduce a more advanced, detailed version of triage which involved booking preliminary tests (further detail is noted in Q5.3, 13.2, 13.3, 45.3, 72.6, and 72.8).

1.22 For one consultant, it was apparent that the process of triage has been an issue for a considerable number of years. This is despite discussions at departmental meetings and agreement on process with DoH representatives. This is

specifically detailed in a number of the responses within this statement (Q23, 26, 63, 64, 65, 66, 72, and 75).

1.23 The urology team raised the patient safety issue pertaining to the advantage of having a specific urology ward. The dismantling of the ward system was felt to be a retrograde step, especially as this was around the time of the Regional Review of urology service when an expansion of the number of urology beds had been recommended. Our deliberation had been partially successful (this is mentioned in further detail in Q11 and 57.9).

1.24 Other ward issues related to overcrowding and shortages of nursing staff. The nursing hierarchy have had the responsibility in addressing this issue.

1.25 Issues with surgical equipment and processes have been raised over the years. These have been addressed as they arose. Financial constraints may have slowed the process but, on the occasions where patient safety came into the equation, this was resolved quickly; for instance, the regional issue pertaining to the use of glycine (see further Q19.6, 19.7, 45, 46, 57.11, 57.12, and 57.13).

1.26 There have been issues within the uro-oncology service. Its organization and structure have been outside of my role as a consultant and Lead Clinician. However, I am aware of the shortfall in the core members in the initial few years and I understand this has improved. The two recent Root Cause Analysis reports have been directional.

1.27 A personal concern I have raised with the Trust is the place of the email service and its use for transfer of patient information, primarily in relation to patient referral and the capture of this data. This is a recent request and I understand there is a process and it is being reviewed. A further concern is that the volume of administrative work medical staff have had to attend to has increased during my tenure without a corresponding increase of time allocated to address it (see further Q57.21).

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.

4.1 Michael Robert Andrew Young. My GMC number is 2846385.

4.2 My primary and postgraduate qualifications are as stated below.

a.	M.B., B.Ch., B.A.O.	July 1983
b.	F.R.C.S. Ireland.	June 1987
c.	M.D. Queens Univ. Belfast	Dec. 1993

d. F.R.C.S. (Urol) Nov. 1996

Occupational History:

4.3 I commenced medical education at Queen's University Belfast in 1978 and qualified in July 1983 with MB, BCh, BAO degree.

4.4 My House Officer Year, (August 1983-84), covered General Medicine / Cardiology and General Surgery at the Lagan Valley Hospital.

4.5 In the first year as a general surgical Senior House Officer (Craigavon Area Hospital August 1984-85), I obtained the First Part of the FRCS examinations. (Fellow Royal College of Surgeons).

4.6 From August 1985 to August 1987, I was an SHO in the Belfast Surgical rotation. This included six monthly rotation between A/E and Fracture Clinic (Royal Victoria Hospital), Urology (Belfast City Hospital), general surgery (Ulster Hospital) and paediatric surgery (Royal Victoria hospital).

4.7 I obtained the Second Part of the FRCS surgical examinations in June 1987.

4.8 Senior SHO Surgical posts in General Surgery followed for a year each in the Ulster Hospital Dundonald (1987/88) and then the Waveney Hospital in Ballymena (1988/89).

4.9 For six months from August 1989, I had surgical rotation in Neurosurgery and plastic surgery followed by six months of General Surgery in Craigavon Area Hospital as a Registrar.

4.10 After successfully gaining a Royal Victoria Hospital Research Fellowship and Department of Health Research grants, an 18-month surgical research post commenced in August 1990. This culminated in a Medical Doctorate by Thesis in Dec 1993.

4.11 A surgical registrar post from February to July 1992 in the Moyle Hospital, Larne followed the Research post.

4.12 Formal Urological training commenced in the Belfast City Hospital in a registrar post from August 1992 and as a Senior Registrar in Urology from 1994 through to 1998.

4.13 Urological training covered all aspects of adult urological conditions including renal transplantation. During this six-year training post in the Northern Ireland Urology programme, two secondments for further training opportunities occurred. Firstly, there was a two-month mini-fellowship primarily at the Methodist Hospital Stone Center in Indianapolis but also involved visiting the regional testicular cancer surgery centre in the University Hospital Indianapolis. This was during the summer of 1995.

4.14 From January to July 1996, a post as Senior Registrar in Urology at the Institute of Urology, St Peters Hospital at the Middlesex Hospital, University College London was held. This post offered clinical exposure to urological practice not available in Northern Ireland at that time. The post covered the andrology services and radical prostatectomy cancer surgery with exposure to reconstructive urological procedures.

4.15 Fellowship examination for Urology followed in November 1996 and entry onto the specialist GMC register in April 1998.
Throughout surgical training, On-Call commitments had been on a 1:2 to a 1:4 basis.

4.16 The appointment as a Consultant Urological Surgeon with a special interest in Stone Management in Craigavon Area Hospital was gained in May 1998, a position held to date.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job

descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 I was appointed as a Consultant Urological Surgeon with a special interest in Stone Management at Craigavon Area Hospital in May 1998. This post has been continuously held till retirement at the end of May 2022. The Job description I was given at the time for my role as a consultant Urologist was an accurate reflection of my duties. ***(Relevant document located at Relevant to HR/reference no 15/19971200-REF15-Mr M Young UROLOGY Job Description.pdf).***

5.2 Work as a Consultant Urologist covered all adult urological conditions (excluding transplantation) and emergency paediatric urology.

5.3 On-Call commitment was initially on a 1:2 weekly basis until 2006, when an additional Consultant joined the team making the rota 1:3. From August 2012 the unit has expanded with rota commitment being between 1:4 to 1:6 pending vacancies in the posts (see: Q16). Initial On-Call commitment up until the introduction of changes following the Regional Urology Review involved emergency urology care and inpatient ward cover on a 24hour basis in addition to normal daytime activity. This practice continued till the new system post urology review was instigated for Urologist of the Week covering emergency work and triage in 2014. ***(The relevant documents can be located at S21 No 55 of 2022, 1. ACTUAL ROUTINE WORK ACTIVITY Word doc 2002, 2. ACTUAL ROUTINE WORK ACTIVITY 2005-2006 3. ACTUAL ROUTINE WORK ACTIVITY 2007-09 4. ACTUAL ROUTINE WORK ACTIVITY 2010 5. job plan autumn 2006).***

5.4 The Elective care duties for my consultant role covered general and specialist outpatient clinics (urodynamic and stone clinics) in Craigavon Hospital on a weekly basis and fortnightly in the outreach facilities in Banbridge Hospital and Armagh Community Hospital. The commitment to the outreach clinics changed following the Regional Urology Review implementation in 2013 when I discontinued the Armagh Clinic and took on the new Urology clinic in the South West Acute Hospital in Enniskillen. This all-day clinic in the SWAH was also on a monthly basis.

5.5 Operating Theatre lists for Day Surgery were untaken on a monthly basis either in Craigavon Area Hospital or at South Tyrone Hospital throughout my tenure.

5.6 Weekly inpatients operating sessions were solely in Craigavon Area Hospital for 20 years of my tenure, until the Covid period started, when sessions were in Daisy Hill Hospital or NHS facilities at the Ulster independent Clinic in Belfast. Prior to the Regional Urology Review implementation, the theatre lists were primarily all day on a Tuesday but if additional lists became available on an ad hoc basis, these were also availed of. Post Review implementation, my theatre lists were also on a Tuesday but in the afternoon and early evening and, again, ad hoc lists were availed of. Ward rounds to review and assess my patients were generally on a daily basis during the week days, in the pre-urology review period. Review of my post-operative patients were on the first day post procedure as much as possible, in the knowledge that the On-Call team were doing Ward Rounds.

5.7 As part of the stone management service, I designed and set up the ESWL service in the Stone Treatment Centre, Craigavon Area Hospital in 1998. This provided treatment sessions by Extracorporeal Shockwave Wave Lithotripsy and outpatient clinics relating to stone management. The service was provided by myself, a specialist nursing team and radiographers. The principle of the care pathway for the ESWL service and clinics have remained the same until recent years when a more efficient package has been delivered.

5.8 Administrative duties of the Consultant role included triage of referral letters and correspondence with General Practitioners, discharge letters, result sign-off, attendance and preparation for Audit sessions.

5.9 In addition to the Administrative duties, I held the responsibly of a training role as an Educational Supervisor for Urological registrars as well as the general education and monitoring of Junior doctors attached to the Unit. This was a supervisory role covering their education, outpatient assessment and in theatre sessions. It also involved being on the urology panel for the annual urology Registrar assessment for NIMDTA (Northern Ireland Medical and Dental Training Agency).

5.10 During my 24 years as a Consultant Urologist, I have held the post of Lead Clinician in Urology for approximately two decades. This post is a position primarily to organize activities such as the urology rotas for the medical team members. The post also offered a liaison for the urology team members with the administrative team on clinical issues via such forums as the departmental meeting. The post offered a directional facilitating approach for the unit to follow and, as such, help link with the administrative team. The post, however, did not have an official role in the Hospital administrative structure, as it was solely a service post. Other than the role of rota organiser, this post also covered such areas as being on the panels for consultant and Staff grade interviews over the years, vetting of Locum Doctors' CVs for short term posts and being on committees such as the Theatre Users Group.

5.11 The medical roles noted in the Medical Structures Consultation Document of 2007 were recorded as: Medical Director, Associate Medical Director, Clinical Director and Specialty Lead. The overview in the general description of posts note that a job description and person specifications would be made available. As the existing Lead Clinician, I was unaware of actually ever receiving a job description for this post either initially in 2002 nor in 2007 but I do note the document describes the 'role of Speciality Lead records the nature and scope of the post was to bolster medical management capacity and ensure co-ordination within the speciality. The Lead would account managerially and professionally to the Clinical Director of their division'. The document notes that the Specialty Lead was a 'taster' role for those who wanted to try medical management out, acting as a potential stepping stone to a wider management role or may actually prove to be as much as the post holder wished to take on for a longer period. The amount of management-related personal development needed for the role would depend on the career intentions of the holder ***(Relevant document located at S21 No 55 of 2022, 6. medical structures consultation 18 May 07)***

During my tenure in the Trust my sole position on this front was indeed to stay in the same role and not to progress to a higher Management post.

5.12 Other posts held within the Trust included being on the Appraisers panel for the annual Medical Appraisal system.

5.12 External to the Trust, I held the post of Programme Director for Urology Training at NIMDTA (Northern Ireland Medical and Dental Training Agency) for five years from 2004. This post had the responsibility of co-ordinating all the urology registrar training, both in their educational programs, placements and assessments of progress. This post reported to Dr T McMurray, Post Graduate Dean of the Faculty of Medicine Queens University Belfast.

5.13 The Programme Director was appointed by the Deanery to manage specialty training programmes at Deanery level within their given speciality. Responsibility for allocation of specialty trainees to posts, supervision of individual training programmes, regular formal assessment including Rita/ARCP process as well as problem solving and feedback on progress were the main aspects of the post. In addition, the programme director had responsibility for looking after 'doctors in difficulty'. This was to support trainees within their programme and deal with individual issues, support the educational supervisors within their programme and provide advice on resolving issues within the programme. This may have involved moving individual doctors to different posts or to bring more serious problems to the attention of the Trust and/or Deanery. This was a challenging but enjoyable post ***(Relevant document located at S21 No 55 of 2022, 7. Letter terry mcm interview 2007)***

5.14 Having completed my period of time as Programme Director, I continued to be an Educational Supervisor. The responsibility of this role included ensuring the overall progress of the doctor through their training with regular appraisals, collation of work based assessments and providing career advice and support as required. The Educational Supervisor's role again also covered the responsibility for doctors in difficulty. Concerns were to be discussed with the doctor in question with regular appraisals. ***(Relevant documents located at S21 No 55 of 2022, 8. Policy re doctors in difficulty (VERSION 2)-August 2008 and 9. Ensuring PMETB standards are met 12 08 09)***

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 The line management for my roles as a Consultant Urologist and Lead Clinician were to the Clinical Director of Surgery covering Urology, Associated Medical Director, Medical Director and then the Chief Executive (see: Q55).

6.2 The Director of Acute Services and team were also an integral part of the line management structure as an operational management structure. (see:Q55)
My role as a Consultant Urologist had the responsibility for the care of patients from their referral onwards to include outpatient clinics, the operating theatre and their inpatient ward care, along with the administrative paperwork that follows all these activities. I had the specific role of managing the activity of the Stone Treatment Centre for the delivery of the ESWL service. Urological trainees and Staff Grade doctors would have been collectively the responsibility of the consultants in the unit as were other junior doctors in general. This covered their education, training, rostering of activities and monitoring of progress.

6.3 The Lead Clinician role reported to the Clinical Director of Surgery and Director of Acute Services. This role, as a service post, was not responsible for individual team members but was a co-ordinator of activities for the urology team members. Although the Lead Clinician may have co-ordinated activities such as departmental meetings, the role did not manage or have the responsibility for the overall running of the urology unit per se. It did aid the Trust Management structure if asked for clinical direction.

6.4 Those junior doctors in the Staff Grade post were under the collective responsibility of Consultants in the unit, yet led by the Lead Clinician.

6.5 As an Appraiser, the role reports to the Medical Directors Office.

6.6 The Programme Director for Urology reported to the Post-Graduate Dean at NIMDTA and was responsible for the overall training and assessments of Urological trainees in Northern Ireland and the Urological Consultants providing the trainees education. The post-Graduate Dean during my Tenure was Dr T. McMurray.

7. With specific reference to the operation and governance of Urology Services, please set out your roles and responsibility and lines of management, clinical

7.1 My operational role and responsibilities as a Consultant Urologist, Lead Clinician, Programme Director for training in Urology, and Appraiser are recorded in my answer to Q5 and for each role my line manager is recorded in my answer to Q6.

7.2 Governance in Urology as a clinician follows the GMC guidance of safeguarding high standards of care by maintaining competency and revalidation, monitoring of risk and, if a concern is identified, to respond promptly and manage. Mechanisms need to be in place to provide quality assurance for accurate, timely and reliable data that can derive constructive information for continuous improvement or identifying concerns.

7.3 My role in clinical governance was as a doctor in the position of being a consultant. This involved mentoring junior staff and providing a continuous high standard of care for patients by maintaining competencies and partaking in the regular hospital audit, M&M / patient safety meetings . This, on occasions, involved chairing SAI episodes and providing advice on complaints.

7.4. As noted in my response to Q8 below, my responsibilities were primarily service driven with direct patient care.

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 Director, Medical Director, Associate Medical Director, and Head of Urology Service or with any other role which had governance responsibility.

8.1 My role and responsibilities as a consultant and as Lead Clinician were service driven with direct patient contact. This involved the direct provision of daily care for patients, to provide a safe environment and care for patients and to participate in all activities that up-held these principles. The governance of the hospital systems is via the Chairperson and Chief Executive of the Trust. This system uses the Medical Director for clear direction on the safest possible healthcare direction. This advice is passed to the Medical Director by internal and external sources. Although Associate Medical Directors and Clinical Directors may have both a managerial and clinical role, Lead Clinicians and consultants can offer clinical expert advice to the Medical Director, as the AMD and CD may not be within the field of expertise being assessed.

Urology Services/Urology unit – staffing

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

9.1 In December 2008, I wrote to Catherine McNicholl, Chair of the Urology Steering Group, expressing my concerns about the alterations in how the urology services were proposed to be changed. This related to the potential significant

'knock on effect' of removing pelvic surgery from the hospitals located outside of Belfast with reference to training and competences required in general urology practice when assisting our Surgical and Gynaecological colleagues and in addition to dealing with complex pelvic emergency urology. I also noted that units covering 500,000 patients still offered a viable oncology approach and felt it unwise to take the 'all eggs in one basket' scenario. This started my involvement in the urology steering group of 2009. ***(Relevant document located at S21 No 55 of 2022, 10. Urology review letter to McNicholl 01 12 08)***

9.2 The Urology review March 2009 covered the reorganization of Urology service provision in Northern Ireland. This was chaired by Mr Mullen, but the Clinical Lead was by Mr Fordham, Consultant Urologist. The Southern Trust team constituted of Ms Joy Youart, Acting Director Acute Services, Jenny McMahon, Nurse Specialist, and myself, as Lead Clinician. From my recollection the other urologists, Mr O'Brien and Mr Akhtar, were also involved in several of the meetings when discussing the future plans.

9.3 The Regional urology review of 2009 recommended that:

a) Urological procedures should be performed by urologists or a surgeon whose work was substantively urological;
b) Referrals to urology had no undue delays;
c) NICaN should have agreed referral guidelines for suspected Cancer;
d) New consultants should take into account special interests;
e) Collaboration with general surgery and A&E for protocols and care pathway for acute admissions;
f) Trusts to provide equity of urology admissions for hospitals without a urological unit namely, Antrim, Erne, and Daisy Hill;
g) Undertake an ICATS review;
h) The Trusts' implementation plans were to evidence the delivery of the key elements of the Elective Reform Programme for capacity, demand and activity;
i) An urgent redesign to enhance capacity to provide single visit outpatient and diagnostic services for suspected cancer;

j) Work toward day of admission for surgery, preoperative assessment and increase day surgery rates;
k) Benchmarking exercise with reference to target length of stay;
l) The implementation action plan was to increase the percentage of elective operations as day cases;
m) Undertake an outpatient redesign of review practices to improve New: Review rates and clinic templates;
n) The NICaN group was to work towards compliance with IOG and that radical pelvic surgery such be undertaken in the Belfast City Hospital solely, with a phased transfer after infrastructure systems were in place. Those performing low volume cases should be immediately transferring cases;
o) There should be an increase in Consultant numbers to 23 for the Province
p) Urological teams to deliver the number of FCE (Finished Consultant Episodes) per consultant as per BAUS guidelines and this may require additional operating sessions;
q) The appointment of 5 Clinical Nurse Specialists for oncology to be appointed and trained and for a review of this to be undertaken in mid 2010;
r) The urology services in Northern Ireland should be reconfigured into 3 teams for long term stability and viability;
s) On-call arrangements were to be clearly defined especially for Teams North and East;
t) Teams to collaborate between Trust on a range of activities.

9.4 The review document noted the level of urologists in NI was 10 in 1999, increasing to 17 at the time of this 2009 review. It recognized the shift from general surgery to solely urologist is case type. The review recognized there were, in addition to core urology, subspecialties of uro-oncology (40% of urology work), Stones/endourology, andrology, reconstruction and female /functional urology. It noted that a specialist in andrology would be beneficial for the more complex cases and that major reconstruction was transferred to London. The review noted the introduction of the ICATS service in 2005/6 in response to the very lengthy waiting times for first outpatient appointment. It noted the possible ICATS steps of: direct to diagnostics, direct to waiting list, return to primary care, non-consultant assessment

and consultant outpatients. The review noted that the Consultants on the panel unanimously considered that triage of referrals should be consultant led as referrals being cancer related were not being recorded as Red Flag or urgent by the referrer. The review noted that the demand and activity in urology was significantly greater than the SBA volumes. It acknowledged the large numbers of additional clinics and theatre sessions funded non-recurrently. It noted the urgent need to increase capacity and redesign. It noted the Scheduled Care Reform Programme 2008-10 for pre-op assessment, increased day cases, optimising theatre usage and booking systems.

9.5 The review did point out the Southern Trust was an outlier with regard to review ratios.

9.6 The review noted the challenges articulated by the stakeholders being increased demand and workload, capacity pressure in staffing, additionality in clinics and theatre extras, infrastructure capacity pressures, impact of on-call commitments on elective work, impact of junior doctors' hours, challenges around the cancer agenda and concerns about how service development tended to take place within and being restricted by Trust/Organisational boundaries.

9.7 The review noted the 'Report of a working group on Urological services in Northern Ireland' in 2000 should be a ratio of 1:100,000 population and that in 2008 the ratio should improve further to 1:80,000 and that by 2018 the number of Urologists should be 38. The review noted that BAUS Council recommended a working pattern of 5+1 fixed sessions with 4 flexible sessions for a urologist.

9.8 The review noted the workload for a consultant should be between 1176 and 1680 total outpatients seen per year with a clinic of 7 new (20 minute consult) and 7 reviews (10 minute consult) taking into account any subspecialty interest. Inpatient and day case activity should be between 1000 and 1250 FCE per annum

9.9 The review noted a lack of oncology nurse specialist in the Southern Trust (point 8.21). It also noted that investment in Radiological services would be required.

A three-team model was the planned reconfiguration with Team South taking on the lower third of Fermanagh in addition to the existing Southern Trust area, a population of 410,00 with a 5 consultant team covering core urology with 2 consultants covering

uro-oncology, 2 consultants for stones / endourology and one for female/ functional urology.

9.10 Trusts and commissioners were to agree a timescale and capital investment needs.

9.11 My involvement in this Review Group was significant as I led our clinical team in the discussions on the principles being put across and trying to endeavour. I agreed with most of the principle statements but did have reservations about our ability to sort our demand / capacity issues and some of the outpatient statements. I did recognise that this was going to be the Southern Trust's main task as other recommendations being put forward were already in hand, e.g., the ICATS service ***(Relevant documents located at S21 55 of 2022, 11. final SHSSB Tier 2 urology update 250406 and 12. CAH6 feb 07 Aldrina.ppt).*** It should be noted that the Urology Review by Mr McClinton in 2004 was not referenced in this 2009 Review document.

9.12 In October 2009, the urology team, which included my involvement, and Management had meetings to take stock of requirements. The issues were listed, actions to be taken, by whom and a timescale applied to this list. The issues covered the topics of equipment, ward reconfiguration, clinical care centre activity, review backlog, Thorndale activity, oncology needs and Team job plans. The team on the Equipment project included Ronan Carroll (AD Cancer and Clinical Services), Mary McGeough (Theatre Manager), Martina Corrigan (Head Of Service), myself, Mr O'Brien (Consultant Urologist), Mr Akhtar (Consultant Urologist), Beatrice Moonan (Head of Governance), and Sandra McLoughran (Head of Decontamination Services). This was primarily relating to theatre endoscopic equipment needs. The ward reconfiguration discussion revolved around the fragmentation of the service between emergencies, longstay and shortstay cases and questioned what was gained by this approach, thinking it was better to have urology patients all on one ward. The safety of potential multiple ward changes for a patient was raised. The discussion team consisted of Heather Trouton (Assistant Director), Martina Corrigan, Noleen O'Donnell (Ward Sister), Catriona McGoldrick (nursing staff), myself, Mr O'Brien, Mr Akhtar, and Sharon Glenny (Operation Services). The move away from ward based to an ambulatory unit for Intravenous antibiotic treatment, intravesical

chemotherapy, trial removal of catheters, ISC teaching and the urodynamic were proposed by the Team of Shirley Tedford (Ward Sister), Jenny McMahon (Clinical Nurse Specialist), myself , Mr O'Brien, Mr Akhtar, and Martina Corrigan. The review backlog data was documented and it was recorded that Mr Akhtar had been doing extra clinics and the GP with Special Interest ('GPwSI'), Dr Rogers, had increased his sessions, as had I, and Mr O'Brien was soon to follow.

9.13 Our assessment at this time regarded the Thorndale Unit (first) as having a deficient number of Out-Patient consulting rooms and waiting area, though it had adequate procedure rooms. I had noted that there was insufficient medical support at all levels, Consultants / registrars and Staff grades, to cover all the clinics. We noted that waiting list initiatives ('WLI') were not a sustainable long term approach. The demand for Prostate biopsies was high and reconfiguration of the haematuria clinic was required as patients were taken to the day Surgery unit for their procedure having been seen in the Thorndale unit and the radiology dept. Decontamination issues also existed in the Thorndale Unit. We noted the MDT meeting was to move to a Thursday afternoon so that all Trusts were meeting at the same time and allowed for complex cases to be discussed via video link. The effect of this on the out-reach clinics were to be defined but it was noted that in a five consultant model that only three consultants may still continue with oncology work and therefore allowing the other consultants to still be able go to the outreach clinics. There was an appreciation that there was a capacity issue and that the Red Flag cases may swamp the system. The patient flow with regard to andrology was discussed.

9.14 An outline of a Team job plan was presented for inpatient theatre, day surgery sessions as well as the number of outpatient sessions. The discussion Team included myself, Mr O'Brien, Mr Akhtar, Sharon Glenny, Martina Corrigan, Judith Anderson (Service Administrator), Jenny McMahon, Kate O'Neill (Clinical Nurse Specialist), Alison Porter (Head of Cancer Services), Mary McGeough, Jerome Marley (Lecturer Nursing Practitioner), Dr Rogers (GPWsI), Alexis Davidson (Radiographer Superintendent), Paula Tally (Head of Best Care Value), Sandra Waddell (Head of Planning), and Heather Trouton ***(Relevant document located at S21 No 55 of 2022,13. Urology meeting 22 10 09)***

9.15 A redesign of the ICATS services was noted as part of the Regional Review. For Team South, we already had an ICATS service as part of our 2004 Review but further redefinition of the ICATS clinic design for the Prostate, andrology service and Haematuria was evolving in 2010 with a more streamlined clinic approach, for instance the haematuria clinic was trying to move toward a single visit approach for scan and cystoscopy at the same sitting. ***(Relevant document located at S21 No 55 of 2022, 14. 100824 re proposed changes to current ICATS clinics 24/8/2010)***

9.16 A visit by myself and Mrs Corrigan to SWAH on 20th May discussed potential DSU activity with the general surgeon continuing N codes but urology taking the M codes ***(Relevant document located at Relevant to Acute/Evidence Added or Renamed 19 01 2022/Acute/Retired Staff/Dr Gillian Rankin/20100527 Action Note from Mtg K).***

9.17 Minutes from 25th May 2010 record that the Consultant to Consultant referrals process (a point specifically mentioned in the 2009 Review document) was actually robust as these referrals went through the central booking office in the same timescale as GP referrals. It also noted the MDT implementation was well advanced, draft job plans were to be discussed between Mr Mackle and Mr Young. Myself and Mrs Corrigan were to draft an acute urology pathway for A/E for those units not having a urology unit. There was to be an enhancement of the current one stop clinic. This meeting also had noted a 7 New and 7 review patients, *which was later a point to be contested*. Further discussion on all FCE were planned ***(Relevant document located at S21 No 55 of 2022, 15. HM700 - ltr to Trust Dir Acute re Uology Review Implementation)***

9.18 These were the initial discussions I was involved in with the Team South following on from the Regional Review document.

9.19 The Regional Review of Urology Services – Team South Implementation Plan of June 2010, outlined the situation, the plan for Team South and a timeline. It recorded the staffing levels as three consultants, two registrars (to drop to one reg and one SHO), two Trust posts (one of which was vacant), GP and two urology specialty nurses grade 7.

9.20 The ICATS service clinics sessions were 14 in total, in addition to having 6 theatre sessions, 5 DSU sessions and 1.5 flex sessions.

9.21 The outpatient volumes are noted and there was a substantial backlog of patients awaiting review of just over 4000.

9.22 It noted that preoperative assessment already existed, a surgical admissions ward had been established in July 2009 and the oncology MDM was already established, *these being part of the Review points to be achieved*.

9.23 Benchmarking of Key Performance Indicators like length of stay, new:review ratios and Day case rates were to be monitored. The table of results for these were actually showing an improvement in the SHSCT over the previous 4 years with new review rates going from 4.04 to 2.09, day case rates were 40% and average length of stay for elective cases had fallen from 3.7 to 2.7 days. *These had already shown an improvement*.

9.24 The addition of South Fermanagh was expected to increase the population bases by 18% and, as such, the projected activity of Team South records outpatient new and reviews, inpatient and day cases with the uplift of 18%.

9.25 It does note the skew from the significant backlog. From the demand the number of sessions to provide the expected service was calculated as 6 consultant outpatients, 14 ICATS, an increase to 9 main theatre sessions with 3 DSU and 3 flexible cystoscopy sessions.

9.26 It was planned to have same day prostate biopsies and same day flexible cystoscopy at the haematuria clinic, with urodynamics moving to the Thorndale unit, and DSU provision in CAH, STH and the Erne.

9.27 Theatre session allocation, due to restriction, was noted to be considering a 3-session day.

9.28 The plan was to advertise the consultant and specialist nurse posts in September 2010 and for them to be in place for February 2011.

9.29 The document recorded the consultant's job plan at the time of the Review.

9.30 Appendix 2 of the document offered the proposal on how to manage the review backlog.

9.31 The section with regards to outpatients in the Appendix, does record that clinical sessions were based on a 48 week working arrangement within the year. Figures for the Prostate cancer pathway, LUTS, Haematuria, Andrology, urodynamics and consultant clinics were defined. There was an assumption that junior doctors contributed to the figures The document did recognise the number of elective cases per list would vary pending the complexity of the case.

9.32 Appendix 6 outlined the draft patient flow and clinical pathways for emergency urology cases presenting to any of the A / E departments the Southern team covered, ureteric colic, retention of urine, ICATS, prostate biopsy ***(Relevant document located at S21 No 55 of 2022, 16. Team South Implementation Plan v0.1)***

9.33 The minutes of 1 July 2010 indicated the Board would have feedback meetings with the Trusts by the end of September 2010.

9.34 At this time when calculating for activity I had factored that 1.75 doctors attended on average each clinic as there were 7 doctors available in the system then. My calculations had identified a shortfall of between 35 and 50 sessions of specialty Doctor per week. I had also suggested that between 2.7 and 3.3 flexible cystoscopy lists would be required per week, based on a 50 week year and between 3 and 3.7 DSU lists per week ***(Relevant document located at S21 No 55 of 2022, 17. urology new model requirement)***

9.35 Information for the discussion meeting of 24th May 2010, when taking on Fermanagh patients were that 1404 new and 4940 review slots for out-patients, 1192 inpatients, and 1664 DSU cases would be the figures ***(Relevant document located at Relevant to Acute/Evidence Added or Renamed 19 01 2022/Acute/Retired Staff/Dr Gillian Rankin/20100527 Action Note from Mtg K).***

9.36 My role in this review process was within the Project Steering Group for the Southern Trust. This group composed of Dr G Rankin, Interim Director of Acute Services as Chair, Mr E Mackle, AMD Surgery and Elective Care, myself as Clinical Lead Urology, Mr R Brown, Clinical Director Surgery, Mrs H Trouton, Acting AD

Surgery, Mrs P Clarke, Acting Director of Performance and Reform, Mr R Carroll, AD Cancer and Clinical Services, Mr D McLaughlin, Assistant Director of Acute Services Western Trust, Mrs H Walker, AD Human Resources, Mrs C Cassells, Senior Financial Management, Beth Malloy, Assistant Director Scheduled Services H&SCB, and Mrs M Corrigan, Head of Urology and ENT Services.

9.37 My participation was on the sub-groups of Clinical Assurance, Equipment and Pathways as noted in the Project Initiation document for the review of adult urology services April 2010. This document notes the regional review being completed in March 2009. It notes the 26 recommendations and the Southern Trust was to take on the lower third of Fermanagh with a total catchment of 410,000 population. There was to be an increase of consultant body to a total of five covering all core urology with the suggestion that the complement should consist of two uro-oncology, two stone/endourology and one functional / female urology services. The key objectives of the project were to carry out a baseline assessment of the Trust's urology service, agree patient pathways, develop an implementation plan for urology services based on the recommendations set out in the regional review, establish bed requirements, review the demand for the service, identify staffing required for the new model of care, identify additional equipment needs and prepare a business case. It did recognise that key constraints were both revenue and capital funding being limited.

9.38 The remit of the Clinical Assurance Group was to develop an implementation plan for the delivery of the key elements of the elective reform programme including admission on the day of surgery, preoperative assessment and increasing day surgery rates. The group was also to develop an implementation plan for the delivery of a single visit for suspected urological cancers and to undertake bench-marking on target lengths of stay for specific urological conditions. In addition, it was to conduct a review of the outpatient review practice, with a view to reducing new to review ratios to the level of peer colleagues, and to undertake a review of outpatient clinic templates and booking practises and to quality assure approved clinical pathways. The Demand Capacity Group was to undertake an assessment of the current service, a review of the demand capacity analysis and to establish the bed requirements for the service. The Human Resource group was to develop team job plans and descriptions for medical staff as well as clinical nurse specialists; in

addition to this, quantifying the support staff requirements to deliver the project and identify training needs. The Pathways sub group would develop care pathways for urology patients requiring admission to Daisy Hill Hospital or the Erne as well as those presenting to Craigavon Area Hospital. Erectile dysfunction, benign prostatic disease, LUTS and incontinence services were to be defined. The Equipment sub-group would identify additional equipment requirements. The project time scales noted that the business case would be completed by the 30th June 2010. As indicated above, my participation was in the Clinical Assurance, Equipment and Pathway groups.

9.39 In 2011 I undertook an exercise to evaluate the needs of the outpatient service that Craigavon Area Hospital would require following the Regional Review of 2009. It was known that the first Thorndale unit was too small in size to cater for the volume of clinics required. The exercise mapped out several options for the Trust to consider and these were presented to Dr Rankin (Director of Acute Services), Mr Mackle (AMD) and Mrs Trouton (Assistant Director) in 2011. This mapping exercise presented several options. It took into account office space for consultants, secretarial staff, the Nurse Specialists, the estimated number of consulting rooms to cover all the requirements of a dedicated outpatient urology day centre including a biopsy and haematuria service as well as urodynamics, with adequate toilets and waiting area. This was to house a complete day care facility to improve efficiency, better care though having dedicated urology staff and improved communication within the unit. ***(Relevant document located at S21 No 55 of 2022, 18. urology day care unit space requirements 2011 all and 19. Urology daycare space requirements oct 12)***

9.40 After discussion in 2012 with regards to the necessary increased size of floor space, the New Thorndale Unit (Mark 2), the Hospital Estates Department in conjunction with an external architect, accepted my proposals. This new facility was to provide an enhanced clinical space to provide the urology service (urology day care unit 2012).

9.41 In 2012 as Lead Clinician I worked on the planning for a Urology consultant group job plan, considering all the activities required, noting the potential interactions of conflicting sessions, the total sessions a consultant might do and where these

sessions were possible. It was a rather complex arrangement and presented as a proposal to the team and Trust. Several options between 10 and 13.5 PA job plan were presented. This took into account weekly, fortnightly and monthly activities, Sessions for MDT, On-call, SPA, Ward, administration, theatre, Day surgery, outpatients in the main and outreach hospitals and specialty sessions. It started with a theatre allocation based on nine sessions per week spread over three days, i.e., two days having evening sessions. Outreach clinic session and then speciality clinic sessions were added and then a third clinic session. Finally, Day Surgery and the MDT activity was added. The rota also included an On-Call week with emergency work in the morning and clinical activity of a clinic, MDT or a theatre session in the afternoon. ***(Relevant document located at S21 No 55 of 2022, 20. Proposal job plan 2012 final draft 1- to be located by Dr Young).***

10. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at Consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

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

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

III. What was your role in that process?

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

10.1 Please also see my response to Q9 above.

10.2 The Team South Implementation Plan records several outlets for outpatient clinics in Craigavon, Banbridge, Armagh, South Tyrone and subsequently in the SWAH. The ICATS service already existed with 14 sessions. The Red flag referrals were managed by the Cancer services team and the stone service in the Lithotripter room. The Trust's plan to deal with the backlog is noted in Appendix 2 as a proposal to manage the urology review backlog. This recorded a total of just over 4000 patients. The proposal was to identify patients who may be at risk and require an

urgent review, identify those that required a consultant reassessment and to cleanse the list to ensure there wasn't any duplication. The Specialist Nurses had agreed to coordinate the process by reviewing the 'Patient Centre' system. Four categories of outcome were defined - urgent appointment, planned review with timeframe, discharge to GP and duplication error. The document notes a reduction in the waiting list by 6% already.

10.3 This Nurse-led activity is too far back for me to remember. I cannot comment on my involvement, implementation nor review of this Nurse-led initiative. I do note that it was a proposal in the document.

10.4 Although there was meant to be a shift from General Surgeons doing urology, the Southern Trust had a very experienced Surgeon in Daisy Hill whose workload was substantively urology and we had agreed for this to continue as it was advantageous to this remit.

10.5 However, the redevelopment planning of the prostate, haematuria and urodynamics were within my remit. The aim was to amalgamate clinic appointments and hence shorten the care pathway and free up slots for other patients, i.e., improve efficiency. This was to be achieved by a one-stop clinic principle with an investigation on the day.

10.6 In addition, I recognized that it was important for the Trust to employ the additional consultants otherwise the volume of cases would not be addressed, hence my work on the job plans. The demand and capacity planning from September 2009 defined 27 new and 95 reviews which took into account the Western Board expected patients and 23 inpatients and 32 DSU cases per week. From my calculations at the time, a five consultant model would have resulted in a requirement of 7.5 new out-patient 25 reviews, 5.75 inpatients and 8 daycases per consultant. For a four consultant model the figures were 9.3 new and 31.6 review outpatients with 7.2 inpatients and 10 day cases. And the existing three consultant model was 12.5 new and 41.6 outpatients, 9.6 inpatients and 13.3 day cases ***(Relevant document located at S21 No 55 of 2022, 21. new urology service model).*** *This showed there was always going to be an issue with the delivery of this plan, in my opinion, as there was an overestimation of the actual workload capable.*

10.7 The report did acknowledge that there was in-house and independent sector activity yet there was still a significant waiting list backlog. I do, however, note that extra waiting list initiative clinics were undertaken by Mr Akhtar.

10.8 Monitoring of the process was provided by the hospital administration with data presented to the department. My recollection is that the Head of Service and Sandra Waddell monitored the situation.

10.9 In my view, the process did not achieve its aims. The roll out of change was slow in my opinion. There was under-staffing of the unit in medical terms and Nursing posts were not advertised to my knowledge or at least not filled. The Consultant posts were slow to be filled. The document notes a 48-week year activity whereas, in practice, with leave it should have been a 42-week year and the consultant clinic template was not correct. The outpatient backlog persisted.

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

11.1 I wrote to Dr Rankin in September 2010 with regards to the clinic arrangements and the volume of cases per clinic. I did note the 2000 BAUS guidelines etc. but did point out the impact of the introduction of the ICATS service and the prior number of doctors helping at our clinics were now not as sufficient and there was a heavy reliance on patient DNA rates. I pointed out the improved new review rates I had achieved. I had suggested a urologist of the week to be triaging and arrange investigation or contact the GP – this had 'fallen on deaf ears' previously. I had pointed out that CAH urology was instrumental in introducing the DoH ICATS principle as we had started this process before they had raised the possibility ***(Relevant Document located at S21 No 55 of 2022, 22. Urology outpt Gillian Rankin sept 10).***

11.2 Correspondence to Dr Rankin in October 2010 in relation to clinic activity notes our issue with the numbers of patients to be seen at clinics. We noted the difficulty with the volume and recorded the new way BAUS was planning services to

be more all-inclusive in the consultation with activities of pre-assessment and investigation. *Interestingly, this was the way forward in our departmental design some 4 years later*. **(*Relevant document located at S21 No 55 of 2022, 23. dr rankin 27 10 10 letter)***

11.3 The Trust did not follow through with its recognition that, with the closure of the surgical unit in South Tyrone Hospital in 1998, urology were to be given 8 extra beds, instead of what actually happened - a loss of two beds.

11.4 Ward reconfiguration was also undertaken in mid 2009, when the urology ward was to lose 8 beds (a third of our allocation) and was to be absorbed into a new surgical reconfiguration.

11.5 In November 2011, I wrote to Heather Trouton, Assistant Director of Acute Services, with regards to facilitating a meeting to discuss the ward changes which had been instigated four months previously. I had pointed out that a singular completely autonomous urology unit with its own Ward Manager and Sister was the way forward. This had been noted in the recent External Urology review. This was now our opportunity to get it 'right' and be staffed by urologically trained nurses being essential. **(*Relevant document located at S21 No 55 of 2022, 24. Ward reconfiguration Heather Trouton 20 11 09)***

11.6 The Team South Implementation Plan document notes that both nursing and Consultant posts were to be advertised and for them to be in post for February 2011, whereas in fact the nursing posts did not materialize and the three Consultants were not in post till autumn 2012. In the meantime, there were vacancies in the middle grade level posts to a varying but significant degree and Mr Akhtar had left for another post. This all had a very significant impact on delivering the planned changes and especially being able to deal with the already long backlog of outpatients and inpatient elective work.

11.7 I had written to Mairead McAlinden, in the Chief Executive office, expressing concern about the appointment of three consultants all on the one day was unwise and that the construction of the interview panel was not ideal (though still valid). It proved correct as two of the three consultants subsequently left within a short period

of time. ***(Relevant document located at S21 No 55 of 2022, 25. To Chief Executive Office)***

11.8 In 2014 there was a stocktake of the recommendations of the urology review for the Southern Trust. The governance with regards to urological procedures noted a shift in the N code procedures from general surgery to urology and the M code procedures required to be performed by a urological surgeon. The process for internal consultant to consultant referrals to urology required improvement as there appeared to be delays in typing and cases picked up through digital dictation could help the process. Triage and MDT delays were noted as factors to be considered and further streamlining of activities were already ongoing. The summary document does acknowledge the consultant turnover, which appeared to have settled with one post being vacant. There was a plan for improved care pathways but the move towards a Consultant of the Week model was felt that this should improve such aspect of care both for quality and timeliness of treatment. This would also cover phone advice and 7 days a week facility to transfer patients from DHH and SWAH. Due to staff shortages in the middle grade level, i.e., the GPwSI, the ICATS service was not functioning and the Nursing staff were not in a position to fill the void. There were however plans to redesign these clinics. The summary document recognized deficits in both Consultant and middle grade staff. However, pre-operative assessment and day of admission were areas that improved the Team's delivery. It also recognized that the new Thorndale Unit allowed a redesign of services so as not to be compromised by other activity. This allowed a single visit for the prostate and haematuria service. The Elective Admissions ward and pre-operative assessment service were a major advantage to the urology service, resulting in few cancellations on the day.

11.9 The bench marking exercise of procedures and length of stay was yet to be undertaken with a view to move to a high percentage being performed as a day case. At this stage in 2014 the Trust were implementing the proposed NICaN cancer projects.

11.10 The Southern Trust outpatient DNA rates were always low but there was a focus to improve the New : Review ratios towards 1:1.5.

11.11 There was the recognition that operating session time was limited which impeded the 31 and 62 day targets with a knock on affect for non-cancer patients.

11.12 The document notes there should be 5 CNS and the Trust was reviewing the CNS roles. The Trust was responding slowly, in my opinion, to the delivery of more CNS personnel, but this could have also related to inappropriate candidates. I was not involved in this process and the Oncology leads would be best to answer this point. ***(Relevant document located at S21 No 55 of 2022, 26. Urology review recommendations for stocktake April 2014v1)***

11.13 Team South response to the urology review in 2014 by Dean Sullivan logged our difficulties with the 2009 Review as the agenda was really about the centralization of pelvic surgery and the fixed reference point of the 2000 year national document on urological practice, although a good document for its time, it was ten years previously. We recorded the continued variable employment of middle grade doctors, the infrastructure of the day units were stand alone and procedure specific (i.e., dependant on the type of equipment available). Our patients were from a rural community and travelling affected our numbers at clinics with treatment closer to home (doctor travelling to outreach units). We had difficulty defining how many theatre lists were to be required due to diversity of procedures and target times. We regarded the SABA as being based on historical documentation and was uncompromising to changes in need. There was ever changing demand and capacity. We regarded that administrative time allocation to be inadequate and often ran in tandem with other sessions and on-call. The matching of target demands for oncology, urgent and non-oncology cases were conflicting. We also logged a lack of engagement by GP.

11.14 We did record the positive features of the SWAH clinic being up and running well as was the New Thorndale Unit, staffing was appearing more stable with the appointment of two new consultants, ICATS was working when staffed, and the New Review ratio had improved with more instructions being given to GPs ***(Relevant document located at S21 No 55 of 2022, 27. team South response to urology review 2014)***

12. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to Urology Consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12.1 The dissemination of such information was not within my remit as Lead Clinician nor as a consultant.

12.2 This document relates to the booking of patients to clinics. It was the process of recording referrals, giving patients adequate time and options to book appointments known as partial booking system. The document noted daily triage of red flag referrals and 72-hour response to triage of urgent referrals. If a response was not received by a consultant, then the grade as per the referrer was to be used by the Booking Centre. Patients were to be given adequate notice of a clinic appointment and the Trust was to have six weeks' notice in advance with reference to the holiday / study leave of the Medical doctor.

12.3 I am not certain if this document was physically provided but certainly its content in relation to triage return time expectation was discussed at departmental meetings by myself and the Trust management team members such as Mrs Corrigan, Head of Service for Urology, and others such as Mrs Trouton, to the consultant body. Our department was part of the initial pilot exercise for the IEAP in the 'partial booking' of patients to clinics.

12.4 It was discussed as part of the Regional Review in 2009.

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

13.1 Triaging of letters has evolved over the course of time in my tenure. Up until the introduction of the Urologist of the Week, this was undertaken as part of general administration. When I first took up my consultant post the number of referrals did not appear as many as is noted currently. Referrals were sent to the consultant recorded as being on-call that day or sent to a named consultant as per a GP's request. My understanding of the situation was that there had not been a time limit on the triage return timetable prior to the introduction of this Protocol, (this was some time ago, however).

13.2 With the increase in referral numbers and this Protocol introduction, there was indeed an impact on my role as a consultant. The need to return Red Flag and Urgent referrals following triage within a short period of time, impinged on other clinical priorities. For instance, triage was not possible if I had an all-day theatre list, had an all-day outpatient clinic or was in an outreach location and not receiving the letters. Other administration, such as results and responding to urgent communication, may have been regarded as more pressing. The time allocation to administration has remained fairly unchanged in duration throughout my tenure. The precise time specified for administration was job planned and this was not on a daily basis. There had been no increase in administrative time allocated in my job plan to compensate during the early phase of this process. It has only been in recent years that electronic computer-based triage has been used regularly in conjunction with paper-based letters. It is noted that the document does comment on E-triage but this was not used by myself, nor I suspect by the other Consultants, as the mode of communication was solely via hardcopy paper letters for a number of years after this process was introduced. As such, the paper version of returning triaged Red Flag letters within 24 hours was unachievable in my view as was the expectation of returning Urgent referrals within 72 hours. This had been discussed at departmental meetings on several occasions between the consultants and the management, who would have been led by Mrs Corrigan. ***(Relevant document located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 Martina Corrigan/20110819-email triage escalation).*** The reason for this would have been the fact that the letter would have been sent to the booking office and then sent to the consultant. In my case all referrals were known to be sent to my secretary and/or put into my 'Black Triage A4 Box'. This I believe was done daily. After triage my

secretary would return to the booking office or the booking office team member would visit her office, again possibly daily. Any delays in this process immediately resulted in this timeframe breaching. A further point I and others raised was the fact that, even if the letter was triaged in the specified timeframe, the Trust and our department were not in a position to offer a timely clinic appointment in any case. It was appreciated that Red Flag appointments had a distinctly short time between referral and expected clinic appointment, hence the setting of a 24-hour return, but in practical terms, as noted above, this was going to be difficult. The need to have an Urgent category referral returned within 72 hours, when the patient was not likely to be seen for months, did not, however, appear to be a priority specifically for urology. It was, of course, noted that all letters required to be triaged in a timely fashion to identify if there were any upgrades in the triage priority. This was the initial feeling I sensed from my colleagues in the early phase of its introduction and this topic was a significant component to the subsequent arrangements within our system for on-call.

13.3 I did recognize the importance and governance of this document. In addition to the burden developing in the delivery of the emergency urology service, the triage issues were indeed a major component for the changes within the consultants job plan to move to the ‘Consultant Urologist of the Week’ principle, which incorporated triage. The original plan for the Consultant Urologist of the Week was to cover the emergency workload such as Ward Round and theatre cases and in the afternoon to undertake other activities such as clinics or day surgery. This was the initial plan, but it became obvious that the afternoon activities were not practical due to the volume of emergency work and our departmental thoughts that a system of ‘advanced triage’ would be beneficial. This new system at least provided more of an opportunity to perform triage on a daily basis if the emergency workload allowed. The general impression was that the number of referrals were increasing, again contributing to the overall time required to triage. The timeframe to return all letters did not seem as important, as the time from triage to when the patient would be seen was still going to be long, however the point of a timely triage was to spot the particularly urgent case that special arrangements could be made such as to be seen in a Hot Clinic. As a department we regarded the introduction of ‘advanced triage’ as more important than this initial quick turn-round triage. Advanced triage involved the assessment category the patient was to be allocated, namely Red Flag, Urgent and Routine, and

in addition via a rubber stamp box tick a care pathway to a specific clinic and investigation was defined. This aided the booking office process. Also, investigations such as radiological tests could be booked ahead of a clinic appointment or at least have tests booked to help shorten the overall care pathway time. Correspondence to GPs about care that could be offered in the meantime was also a possible outcome of the triage process. Triage upgrading of routine referrals was an important feature to identify patients who might have more serious issues than the referrer had taken stock.

13.4 It was noted that this Advanced Triage would take time and my understanding of the agreed process was that, during the week of on-call, the urologist would triage their assigned referral letters. This would be to the level of detail possible depending upon how busy the on-call week had been. I understood that this meant that the level of advanced triaging to be undertaken may be compromised at the expense of having all letters triaged at the end of my week on call. I appreciated this was not the ideal outcome but it was an improvement in the system. I knew the Trust system wanted all letters triaged and returned to the Booking Office on a timely basis. My understanding is that the other consultants also knew to return all their triage on a timely basis, even if not completely to their full satisfaction of detail. The Consultants knew that, when they came off-call, the opportunity to complete triage timely diminished.

13.5 I also understood that our administration accepted the timeframe of this weekly pattern, as per discussions with Mrs M Corrigan, Head of Service, when noting how this fitted well with the weekly rota arrangements, albeit I acknowledge that this may not have been an official / formal stance.

13.6 The more recent move to the E-triage method has allowed access to referral letters on a more prompt basis and allows the consultant to triage whenever they want, rather than having to wait till the paper version was delivered. The process of triage and arranging investigation is quicker, however I would note that the volume of referrals appears to be the counterbalance. Red Flags are always at the top of the page and can therefore be processed first.

13.7 Monitoring of the Protocol process was outside of my remit. My understanding was that the Trust had accepted that the precise timeframes of the Protocol were

possibly too rigid in terms of days for the Red flag and urgent referrals for the urology team but had expected **all** referrals to be returned after the week on-call and that this was the understanding of the urology team. Since the E-triage system has been incorporated well there has been the expectation that the Red flag referrals have been triaged within a day or two, and all referrals triaged within a day or so of completing the On- call week. This status continued till I retired.

13.8 I am unsure of how the Booking Office monitored the incoming referrals and the return of same, nor am I sure when the Trust Booking system made duplicate copies of referrals. The monitoring of these activities were outside of my remit as a consultant and as a Lead Clinician and were solely under the wing of the Booking Office team who would have reported to the Heads of Service.

13.9 The rota meeting to define a Team member's monthly work allocation was on the last Thursday of the month. This took place with all team members present two months prior to the index month. This in practice resulted in the first week or so of the rota month being 4-5 weeks from this meeting. Allow this was within the six-week rule, the Trust management system allowed our department to continue our process as it had proven advantageous to ensure the least rate of clinic cancellations and define the precise clinic team member to cover a clinic. It also allowed for switching of clinical activity to maximize the overall output of the unit in general.

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

14.1 The performance indicators used within urology were bed occupancy rates, length of stay, day cases rates, elective and emergency rates, waiting list times for Routine, Urgent and Red Flag patients for outpatients and surgery in addition to the individual surgeon's CLIP report of their activity. I understand that these have remained the same indicators of performance throughout my tenure.

14.2 If further detail is required the Trust management system can provide.

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

15.1 The staffing and resources were recognized to be as issue early in my tenure as Lead Clinician.

15.2 As Lead Clinician in Autumn 2002 I wrote to the Medical Director, Dr L McCaughey, on several occasions expressing concern that the Trust had not noted nor acted on the Consultants' concern over the patient safety of our 1:2 on-call rota, excessive workload and the potential for delays in diagnosis of patients ***(Relevant documents located at S21 No 55 of 2022, 28. Staffing issues secretaries, and 29. cons-reg cover admin letter).*** Patient safety from excessive consultant working time covering the registrar on-call work was not recognized nor honoured as per correspondence with the BMA in 2004. Although this correspondence related to renumeration, it does note consultants doing registrar work ***(Relevant documents located at S21 No 55 of 2022, 30 -calvinspence BMA 0604 and 31. cover for spr pay 0704 bma).*** A subsequent request for urology consultant cover was also made for the summer of 2005. Summer cover related to the whole period your colleague was on leave being provided by the remaining consultant **(*Relevant document located at S21 No 55 of 2022, 32. holiday cover request 05).*** Correspondence of December 2004 between Anne Brennan, Planning Manager, to the Urology Review Group and Dr D Corrigan and Mrs M McAlinden Southern Board record the two consultants diary exercise as a 16-18 PA job plan and they would be expecting the third consultant to be doing a 13 PA job plan to cover the activities. ***(Relevant document located at S21 No 55 of 2022, 33. Urology-consultant SHSSB 221204).***

15.3 On taking over as Lead Clinician, a stocktake of Urology activity and its shortfalls was undertaken. It recorded the performance activities and offered suggestion. The admission rates were up 60% over a 3-year period, inpatient waiting list had increased 238%, day case waiting list increased by 69%, and outpatient

numbers by 808%. The BAUS recommendations of the time were recorded against our activity. This document was used to present the issues to the Trust at that time and subsequently initiated the external review conducted by Mr McClinton**.** ***(Relevant Document located at S21 No 55 of 2022, 34. Urology trends D2)***

15.4 In September 2003, as Lead Clinician I wrote to Mr J Templeton, Chief Executive CAHGT, with regards to a list of urological issues from job plans, consultant appointment, the urology cancer implementation group appearing to cease, the significance of the 1:2 rota, apparent disparity in sessional allowances, staff retention and the DoH not attempting to implement the regional Urologist complement to 16 by 2007. We had requested a third consultant but the letter did recognize that there was going to be a review of urology services in the Southern Trust ***(Relevant document located at S21 No 55 of 2022, 35. Templeton sept03).***

15.5 The clinical activity of Elective and Emergency work showed a substantial emergency commitment which was consistent over the three-year period from 2001 to 2004. ***(Relevant document located at S21 No 55 of 2022, 36. Activity on general wards – urology 1 revised excel doc aob2)***

15.6 The Clinical Services Analysis, Priorities for Action and Planning Template for Urology Cancer services, as part of the Trust Delivery Plan 2004 – 2005, records the challenges of lack of facilities from beginning of patient episode to end, excess referrals, limited personnel and bed space, a lack of dedicated urology oncology clinics and difficulty in persuading the administration of the needs. We logged that the service was at full stretch and the Trust needed to listen to the clinicians working directly in the service. ***(Relevant document located at S21 No 55 of 2022, 37. business analysis template urology oncology 04).*** The issues were laid out in a document labelled, 'Defining the Problem', sent to the Trust. ***(Relevant document located at S21 No 55 of 2022, 38. Defining the problem).***

15.7 The Trust agreed to have an External review of the Urology department in Craigavon Area Hospital after my deliberations to Mr Templeton, Chief Executive.

15.8 Mr S McClinton, Vice- President Scottish Urological Society, Member of Council of the British Association of Urological Surgeons, Chairman Urology Special Advisory Board of the Royal College of Surgeons of Edinburgh, produced an

external review of urology services for Craigavon Area Hospital Group Trust in 2004. The executive summary notes the Chief Executive of Craigavon Area Hospital asked the Medical Director to carry out a review of the urology services in CAH. The medical director established a Review Group consisting of members of the management team and clinicians to undertake a comprehensive review of urology services within the Southern Health and Social Services Board. The aim was to improve the service provided to the community and resolve some, if not all, of the challenges facing the current urology service. The key challenges adversely affecting the urology services in the SHSSB were seen as insufficient manpower or capacity to deliver a full urological service, increasing waiting times for outpatients, inpatients and day cases, and noting increasing emergency workload. The external advisor carried out this analysis utilising a series of one-to-one consultations with clinicians, nurses, managers and administrative staff in May and July of 2004, visiting all sites where urology services were delivered in the Southern Board and meeting with the entire Urology Review Group in May, July and August 2004. The information gathered was used to create a comparative analysis picture of what, under the British Association of Urological Surgeons guidelines and NHS norms, one should expect in terms of service delivery given the available resources and infrastructure. Comparison was made to a similar Grampian unit in Scotland. Membership of the Review Group included Dr C Humphrey, Medical Director and Chair, Mr. J Mone Director of Nursing and Quality, Mr Stirling, Clinical Director Surgery, myself, Mrs McAlinden, Director of planning SHSB, Dr D Corrigan, Consultant in Public Health Medicine, Dr G Millar General Practitioner, Miss A Brennan, Planning Department CAH, Mr J Marley, Nurse Lecturer Practitioner Urology CAH, Mr H Campbell, Finance Department CAH, Mr S McClinton Consultant Urologist External Advisor, and Jean Mansfield, Project Coordinator.

15.9 The outcome of the analysis led to the following proposals for the way forward suggested by Mr McClinton: ***(Relevant document located at S21 No 55 of 2022, 39. McClinton urology report 2004 page 4)***

‘a/To give serious consideration to increased levels of staffing to address current critically low levels.

b/ This would require the following with immediate appointment of a locum consultant to address waiting list issues and consultant on call rota,

c/ increased use of available urology nurses to establish direct access clinics and telephone reviews and

d/ appointment of a third consultant urologist and all appropriate support staff.

e/ There should be a redesign and modernisation of urology services and

f/ investment in creating additional capacity with increase in inpatient bed and day case capacity,

g/ a reduction in the new to review ratio of outpatients,

h/ a dedicated urology diagnostic and treatment centre,

i/ the appointment of a fourth consultant urologist and support staff appointment,

j/ dedicated urology specialty nurses and

k/ instigate regular performance review to ensure expected outcomes from redesign and modernisation.'

15.10 In Mr McClinton's commentary on the level of service it notes that, based on the BAUS recommendations, CAH should have 3 urology surgeons currently, rising to four in 2007. It records the current one in two on-call rota often without middle grade cover. His document notes the BAUS recommendations for a population of 500,000 that there should be 6 to 8 urological consultants. He also notes that it is clear that the SHSSB, in conjunction with the other Boards in Northern Ireland, will need to address the provision of urological services across the province in the longer term to ensure that sub-specialization develops in a planned and integrated way.

15.11 Analysis of the outpatient activity notes the BAUS recommendation that 840 patients be seen in the year yet in Craigavon there were over four and a half thousand outpatients reviewed between the two consultants. It does record the high new to review ratio of 1:7 in the years 2003 to 2004 which is higher than the BAUS recommendation. He also records that the stone treatment centre provides an excellent regional service for patients and the facilities offer the potential for further utilisation in dealing with outpatients. The key points note the total number of

outpatients seen is proportionately high by national norms, the number of review patients seen should be reduced by service redesign and unit policy changes, clinic templates should be changed to reflect national norms and partial booking for outpatients would help reduce DNA rates.

15.12 Inpatient services note a bed capacity of 21 which should really be at 24 beds for BAUS recommendation. It notes the bed occupancy rate at over 90% indicating that the unit was working at full capacity and the average length of stay was 3.9 days which is similar to the national figures indicating an efficient use of the resources. The key points note that emergency workload is increasing and impacting adversely on elective activity, additional beds being required, BAUS would expect a consultant to perform a minimum of 750 FCEs per annum depending on case mix. To deal with the expected 3000 FCEs, consultant episodes would require an establishment of four consultant urologists and the current two man unit is clearly working extremely hard and well beyond expected levels. Both in-patient theatre and day case operating time was recommended to be increased.

15.13 The report comments on the uro-oncology issues. The Southern Area Urology Cancer Implementation Group produced a report in 2002 on re-organising urology cancer services. Much of this is still to be implemented and it is clear that local general practitioners feel that the urology service is providing a poor service in respect to oncology patients. The report notes that CAH is a designated cancer unit for the SHSSB area and does have agreed clinical guidelines for urology cancer as laid out in the Urological Cancer Implementation Group Report 2002. However, it is noted that implementation of these guidelines had been incomplete due, in part, to the fact that levels of medical staffing in the urology department are generally lower than recommended by BAUS; in addition, there has been limited development of the role of specialist nurses across the area as a whole with a single part time specialist nurse in post in CAH. Ward nurses have taken on special interest areas but find it difficult to get released from ward work due to lack of staff and backfill during their absence.

15.14 The report comments on the multidisciplinary team approach to cancer MDT and the role of specialist urological nurses being developed and expanded in recent years as being essential in the running of any urological unit.

15.15 The key points note a clear need for the implementation of referral guidelines for each of the urological cancers, that improved definition of the role and function of nurse specialists would enhance the service patients receive, that serious consideration should be given to sharing of examples of good practise in achieving rapid diagnosis for patients with suspected urological cancers, that further work analysing delays in investigation and treatment of patient pathways is essential, and establishing a minimum data set for urology cancer to improve quality of information is required.

15.16 The recommendations of the review, to be actioned by the Chief Executive and the Board, included: an increase in staffing covering an additional one to two consultants, support staff, radiology and pathology, nursing specialist and registrars over a one to three year period; changes in the infrastructure of the booking of outpatients; increase in bed capacity and number of operating lists; to utilise other facilities like South Tyrone Hospital; instigate nurse-led consultant supported direct access clinics and telephone follow up; service redesign of standard referral proforma; establish a system to regularly update GPs on management; and implement advanced booking of investigations for out-patients (McClinton Urology Report 2004).

15.17 Following the External Review in August 2004, I wrote to the Medical Director, Dr Humphries, commenting on the Review highlighting our prior concerns about deficiencies in infrastructure and manpower. We noted the Review offered a five-year plan. There was to be an immediate appointment of a third consultant and a fourth by 2007. The department recognized the need for an alternative method for delivering outpatient assessment. It was pointed out that the increase in Urology bed allocation agreed by the Chief Executive in 2003 had not occurred. The department recognized the issues around the provision of uro-oncology but had felt that the implementation at that time related to a lack of staff and facilities. The Review seemed to agree with this point. We agreed that the principle of a service involving and delivered by Nurse Practitioners would substantially develop the Unit. This response letter to the Medical Director noted that the Review did not cover the aspect of urology being a ‘high technology’ speciality. I highlighted the safety aspect of the urology theatre facilities, which had previously been reported to the Trust. This

feature related to the purchase of a Laser machine for stone surgery, which was commonplace in many other units. I also suggested the appointment of a Service Manager to co-ordinate the changes required and to run the unit. ***(Relevant document located at S21 No 55 of 2022, 40. MY response to external review 0904)***

15.18 The Trust produced a 'Proposal for the appointment of a locum Urologist (6 months duration)' document in October 2004 ***(Relevant document located at S21 No 55 of 2022, 41. proposal for the appointment of a locum urologist 10 04 A similar version was produced in August 2004).***

15.19 The proposed establishment of an inpatient endoscopy session document of August 2004 however did not include urology sessions ***(Relevant document located at S21 No 55 of 2022, 42. proposal for the establishment of an inpatient endoscopy session 290304).***

15.20 In April 2005, a detailed document was produced with reference to the proposal for the development of a urology Nurse Specialist Led Clinical Service at Craigavon Area Hospital. This had been produced after a series of departmental meetings involving medical, nursing and management staff. This primarily focused on the prostate services as it was considered that this area of health care would have a significant impact **(*Relevant document located at S21 No 55 of 2022, 43. 050405 Proposal for the development of urology nurse specialist).***

15.21 A letter to J Templeton in June 2005 from myself as Lead Clinician records the inertia of the Board and the Trust in the implementation of the External Review. The correspondence notes the Board reopening the service without engaging with the clinicians first. The letter records the Dr Connor presentation of when capacity being reached then the responsibility of provision falls on the commissioning body. The external review had noted that the CAH unit was performing at twice the level of an equivalent in Scotland. The Trust's response at this stage was to employ a Locum GP. ***(Relevant document located at S21 No 55 of 2022, 44. letter to JT re reopening may 05).***

15.22 From this point the Trust did engage with a series of meetings and a Project Lead with the creation of a new urology service which subsequently became our ICATS service under the DoH scheme.

15.23 Although from inception the Thorndale Unit helped with floorspace to provide a urology outpatient unit, Nursing staff levels remained fairly similar with the use a dedicated ward staff to perform certain duties. Expansion of the senior level of nursing did not occur. The fourth Consultant post, from memory, was never offered nor pursued. This may have been because a Regional Review had been discussed.

15.24 Following the Regional Review of 2009, there was the expectation of an increase in Consultant and Clinical Nurse Specialist from February 2011, however, this was delayed till Autumn 2013. The urology unit had engaged with the Trust and the DoH on setting up the new service, however the process took a longer time than expected to be completed. Despite repeated efforts by the Trust to employ middle grades, there was always a vacant position. The CNS posts were under the auspices of the Oncology re-design team led by Mr Akhtar and then Mr O'Brien and was not under my remit. The re-organization of the urology service which followed the Review was chaired by Dr Rankin who had the responsibility of providing the outcomes of the Review for the Southern Trust. She had the integral part to play in our plan and delivery.

15.25 I had pointed out to Dr Rankin that the resource of the 'first' Thorndale Unit had always been deficiency in floor space, albeit that we had been grateful to have had it at all. I had noted that, during Mr Templeton's tenure, we were meant to have been allocated a significant area in the Ramone building, but this was given to the Dermatology department. I pressed for added floorspace, which was duly heeded in our response to the 2009 Review outcome with the Second Thorndale unit within the main building ***(Relevant document located at S21 No 55 of 2022, 45. urology day care unit 2012).***

15.26 The deficiency in the CNS numbers were noted in departmental meetings. This has now been resolved by the Head of Service, Mrs Corrigan, and Mr Glackin, MDT lead, having interviewed suitably qualified personnel.

15.27 The Trust has endeavoured to advertise vacant posts on a regular basis without my specific prompting.

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

16.1 The McClinton review of 2004 recommended that a locum Urologist be immediately employed followed by a substantive post with a further post being advertised in 2007. When the independent sector work in the South Tyrone Hospital had been completed, as a result of this Review, the Trust offered the Resident Consultant Urologist, Mr Batstone, the post of Locum Urologist. He held this post till the third substantive Consultant post was taken by Mr Akhtar in September 2007. The fourth post recommended in the McClinton Review never materialized.

16.2 Although the Regional Review was dated 2009, by the time the Review had been assessed by the Trust, and there was a plan for the extra urologists to be in place for February 2011, it wasn't until late 2011 before one locum Consultant had taken up post before the substantive five urologist team was in place for the end of 2012. Three urologists were appointed on the same day - Mr Glackin, Mr Connolly and Mr Pahuja. There was a short spell when there were only two substantive urologists working in 2012 after Mr Akhtar had resigned to take up a post in England.

16.3 In 2013, two of the most recent consultant appointees (Connolly and Pahuja) left for posts in Belfast, and there was only one applicant when their posts were initially re-advertised, this being filled in December 2013 by Mr Suresh. However, a subsequent advertisement was more productive for the fifth vacant post. There were two strong candidates, Mr Haynes and Mr O'Donoghue, who were both offered posts, with the Trust going 'at risk' on the sixth post. From August 2014 the Southern Trust Urology team had six consultants until Mr Suresh left in October 2016. A Locum Consultant followed the next year. There had been no applicants for the substantive post until February 2019 when Mr Tyson joined the Team. Mr Tyson had a pre-arranged one-year fellowship appointment in New Zealand from autumn 2019

and, due to Covid, was unable to return to his Southern Trust post until January 2022. Also in 2019, Mr Haynes' tenure to the Southern Trust team reduced to a three-day week work schedule with the other days in Belfast.

16.4 Although the substantive post allocation to the Southern Trust had increased to seven, in reality during the latter part of 2020, it was down to four as Mr Tyson was in New Zealand and Mr O'Brien had retired, in addition to Mr Haynes being part-time in our Trust. Two Locum consultants were appointed, one remaining for a year. Mr Tyson returned in January 2022 and I retired in May 2022.

16.5 There has only been a brief period between 2014 and 2016, when the unit has had a complete substantive Consultant body. Before this, the number of consultants were deficient as defined by the McClinton Review of 2004 and the Regional Review of 2009. Spells of either a shortfall in numbers or filled by locum consultants were the norm. Some Locums were employed longer than others (some only for a few months).

16.6 The shortfall in the expected numbers of consultants results in a deficit of provision in overall output of FCE, outpatient, elective surgeries episodes and hindered target achievement potential. The turn-over results in reduced productivity and disjointed patient care in terms of when a consultant leaves then their patients are left in a degree of limbo till the post is replaced. The new personalities have to be engaged and learn how the system functions. The Trust made regular advertisements in the national press for replacements, mostly without success until recently. With the team being short of members, it resulted in the added onus of extra On-Call commitments and the work that follows in the triage of letters etc. In-House Waiting List Initiatives both for outpatients and theatre activity combined with external private sector work were the only remedies possible.

16.7 Not only was there a shortfall in the consultant complement, there was also a deficit in the middle grade level of urological staff. There were three funded Staff Grade posts from 2009 till recently. With extra funding, following the Covid period and in recognition of the further recent needs of the urology unit, more posts have been created.

16.8 From 2009 to 2011, although funded, two posts had remained unfilled. The GPwSI (7 sessions) and a senior Nurse Practitioner (2 sessions) provided one post's activity.

16.9 In 2012, there was one filled staff grade post and in one of the two remaining posts three different doctors had been employed at various points during the year.

16.10 When the GPwSI resigned in 2013, this post was not replaced. For the period August 2013 to October 2014 all three staff grade posts were vacant.

16.11 From autumn 2014 to 2016, only one of the three staff grade posts was filled, but, again, all three posts were vacant for six months in the latter part of 2016.

16.12 There was one staff grade for most of 2017 who then reduced to part-time; however, a further full time staff grade joined in 2018. These two staff grades remain in post to date.

16.13 From 2020 three additional medical staff, who were at an early stage in their surgical exposure, were employed.

16.14 The vacant posts were advertised on a regular basis to my knowledge (if further clarity on frequency of advertising is required, Mrs Corrigan, Head of Service, could supply this information) ***(Relevant document located at S21 No 55 of 2022, 46. 2009-2022 - non-consultant grades in post).***

16.15 In my opinion, the Staff Grade level employed from 2009 to October 2014, were particularly junior or only covered specific areas of urology. For instance, the GPwSI only provided clinical outpatient sessions and even then this was for 7 sessions. The Nurse practitioner had two specific clinics. The turnover in staff during 2012 was high and, in the second half of 2013 and 2016, all three of the Staff Grade posts were vacant. Only from 2014 has there been some consistency in staff who could cover the unit in its entirety, in terms of Staff Grade level of covering outpatient, ward and emergency level work. From 2018, there have been two senior Staff Grades who remain in post to the present time. This has been a positive feature with their involvement in independent clinical care in helping to run the stone and prostate services. The three recent additional junior staff contribute to the ward and emergency workload helping the urological trainee registrars, again a positive

feature giving an improved patient experience and aiding the busy workload of the registrars.

16.16 The impact of either a post not being filled or there being an interruption of service with a turnover of staff which were not immediately replaced resulted in a disjointed, staccato provision of clinical care, with a resultant downturn in activity especially in outpatient cover as this was the predominant clinical arena for their activity. There was a distinct lack of consistent adequate middle grade cover resulting in the onus being placed on the trainee registrars and the consultants. The two Clinical Nurse Specialists were not in a position to take up this slack as they had their own work. This did not give consistency to the booking of clinics, hindering the amount of cases seen and, with such junior levels, the review rate was higher than wished.

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

17.1 Staffing issues contributed negatively to delivery of a timely service. There were delays in providing a clinic appointment due to a deficiency in consultant numbers. This had led to a prolonged outpatient and inpatient waiting time without knowing what was happening to the patients within this wait period. Unfilled posts results in a backlog of work. This backlog was added to the work list of the current activity, and ‘catch-up’ then becomes a significant problem. Patients on long waiting list for elective surgery or those with a time dependant procedure can become emergency cases with poorer outcomes. This feature can equally apply to a deficiency in service provision e.g., theatre time.

17.2 The inpatient and emergency urology service has always taken precedence over other parts of the service. The Consultant team would have backfilled and covered locum nights and emergency day cover by dropping elective sessions if required. Employment of Locum Consultants aided the situation. This also impacted on the elective services.

17.3 Junior staff of speciality doctors and registrars were originally doing clinics on their own but a Training review by the Royal Colleges and NIMDTA stopped this activity. (Mr Glackin, as Programme Director of Training, could define when this was precisely). The vacancies and the change-over of middle grade staff would result in the decreased number of patients at a clinic, which puts further delay on other patients being seen.

17.4 Undoubtedly, the times of shortfall in the consultant number have had a significant impact and the burden of the backlog has never been adequately addressed (either by the Trust or the DoH, in my opinion). This feature related to volume and timeliness of provision. An interruption from a lack of a consultant's presence also delayed the 'hidden oncology cases' being defined at an earlier stage, potentially. The lack of overall numbers on the team also delayed the known oncology throughput. Sepsis rates are well known to be higher in men with a catheter in situ awaiting prostate surgery. This also certainly applied to the stone service where sepsis rates are increased in relation to delays in intervention for patients with a ureteric stent in situ. Other factors such as theatre availability were also part of equation but staff shortages are certainly a major contributor to the delay in a timely service.

17.5 A further feature is when a Consultant leaves, their workload and waiting list is generally put on hold until the post is filled. If the post is indeed re-filled promptly then patient care continues, however, if unfilled or significantly delayed then this group of patients are potentially at risk from not being seen in outpatients or offered surgery.

17.6 The shortfall in the Clinical Nurse Specialists numbers has hindered the progression of the oncology program and MDT. I understand, that despite advertising, there had been difficulty in finding suitable candidates until recently. The overall provision of the MDT has been enhanced by the presence of this team and certainly has allowed follow up provision to have been tightened up as well as improving patient experience.

17.7 The Trust has, however, endeavoured to fill these posts by multiple applications over the years. After the initial apparent slowness following the Regional Review of 2009, the Trust has had difficulty in recruiting the appropriate staff. In-patient care

has always been paramount and this has been covered by existing staff and supported by the Trust. Staffing deficiency has impacted on the outpatient and elective care with the resultant decrease in clinical attendances exacerbating the extent of the waiting lists. With the filling of both medical and nursing posts recently, there has been an observed increase in clinical output.

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

18.1 My role throughout my tenure in Craigavon Area Hospital has remained the same. I was a Consultant Urologist for 24 years. In addition to my general urology workload, I was in charge of the Stone Service. I was Lead Clinician for the last 20 years of my tenure.

18.2 Mr O'Brien and Mr Akhtar started the oncology MDT meetings, initially led by Mr Akhtar and then Mr O'Brien took over in 2012 when Mr Akhtar left. Mr O'Brien was in charge of setting up the NICaN urology system for Urology.

18.3 Mr Glackin joined the department as a consultant in August 2012 and took over the Oncology MDT lead after Mr O'Brien. He also ran the patient safety audit until recently when Mr O'Donoghue took on this latter role in late 2021.

18.4 Mr Haynes joined the department in May 2014 as a Consultant, became a Clinical Director for surgery and then AMD in October 2017.

18.5 The complexity of the unit has expanded so that there has been the need for individuals within the unit to take on additional roles relating to governance. I remained Lead Clinician and focused on the rota arrangements until my retirement in May 2022. From approximately November 2021, Mr O'Donoghue has been in charge of the Patient Safety and Audit meeting. Mr Glackin is the Programme Director for Urology training in NI and is the Cancer MDM Lead for urology. Mr Haynes continues as an AMD with the specific role of implementing improved governance in urology. Mr Tyson is to review quality improvement measures along with the role of Standards and Guidelines Lead. (Although aware of these roles, I have checked

these points and dates with the Heads of Service, Mrs M Corrigan and Ms W Clayton).

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

19.1 Throughout my tenure as Lead Clinician my role was as a service posting for day to day medical arrangements of the urology team's activities. The post gave opportunity to be a facilitator for projects. If a team clinical issue arose in urology, this was an opportunity to address and raise with the Trust Management system.

19.2 After bringing our concerns about the level of emergency needs, increasing referrals and reduced elective care to Mr Templeton in 2004 and the Review of Urology in 2004, I facilitated the changes in the urology outpatient service with the first Thorndale Unit and the subsequent development of the ICATS service.

19.3 In November 2006, the Southern Area Urology ICATS Implementation Plan was published. This had noted the phased introduction of the GP with specialist interest outpatient clinic in July 2005, the Nurse-led LUTS clinic in October 2005, and the Nurse-led Prostate Diagnostic and Haematuria in April 2006. There were three phases and the last to be implemented in 2007. The Project Team consisted of Claire Kelly, Planning manager; Barry Haughey, Finance manager; Deborah Burns, Acting Director of Operations; myself as Lead Consultant Urologist; Mr O'Brien, Consultant Urologist; Mr Brown, Consultant General Surgeon; Kate O'Neill, Urology Nurse Specialist; Jenny McMahon, Urology Nurse Specialist; Jerome Marley, Lecturer Practitioner in Urology; Dr P Rogers, GPwSI Urology; Shirley Tedford, Ward Manager; Louise Devlin, Outpatient improvement Manager; Sharon Glenny, Project Manager; Alexis Davidson, Radiology Services Manager; Katherine Robinson, Medical Records Manager; Brian Beattie, Head of Physiotherapy; and Brian Magee, Pathology Services manager. My role was as a member of the Programme Management Structure Group. This was an oversight role for progress of the project ***(Relevant document located at S21 No 55 of 2022, 47. urology ICATS Implementation document v0.6 final version 031106).***

19.4 The 2004 Review also resulted in an independent surgical provider coming to South Tyrone Hospital to do elective urology procedures to deal with the backlog. My role involved the vetting of the surgeon and the service. I had a meeting with the Chief Executive and the Hospital Chairman to confirm my positive finding and explain the cover that the team in Craigavon would provide, if necessary, from a patient safety view point. As Lead Clinician, I covered the stewardship oversite of the Independent Sector provision of this elective urology waiting list surgery in South Tyrone Hospital in 2005. The Lead Clinician role led on the subsequent setting up of the ICATS urology services and defining the entity of the Thorndale Urology Outpatient Unit ***(Relevant document located at S21 No 55 of 2022, 48. urology ICATS implementation Document draft v0.5).***

19.5 I was a member of the THUG committee. This is the Theatre Users Group and, in latter years, I was the deputy Chair. This was an oversight committee, monitoring theatre expenditure and sanctioning new equipment.

19.6 When it became evident that the DoH wished endoscopic resections to switch from the use of glycine to saline for irrigation, I facilitated our unit's conversion to this method by having meetings on same, purchasing the correct equipment, ensuring staff were trained and a monitoring process was in place

19.7 We actually went further into looking at this safety issue. A report to assess a fluid pump management system was compiled in 2014 after a visit to a Berlin Urology unit by myself, Dr Morrow, Consultant Anaesthetist, and Sister England, Senior Urology Theatre Sister. This related to the patient safety issues around irrigation fluid use during endoscopic procedures. We had suggested that one dedicated nurse should be allocated to look after the fluid management system in totality, as highlighted in an audit carried out in the urology theatre and backed by our observation during the visit***. (Relevant document located at S21 No 55 of 2022, 49. report infusion pump system urology).***

19.8 With regards the stone service, the purchase of a new lithotripter was necessary in 2013 from an effectiveness point of view. I oversaw this process. Also, when the burden of volume of cases for the clinic and treatments became excessive,

the oversight of the changes to the new model designed by our ADEPT fellow , Mr Tyson, was under my wing.

19.9 I do not believe my role has changed appreciably over the years. I facilitate the departmental meetings when they occur. My role is service driven and when an issue relating to patient safety within the department has arisen I have facilitated the process (examples as above).

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

20.1 The urology unit and service is supported by several administrative staff levels. Over my 24-year tenure, each Consultant has had a personal secretary assigned to their work. This would cover all aspects of the Consultant's workload where typing was specifically required. The Consultant's secretary would also have an organizational role to co-ordinate such activities as theatre lists, filing of letters, collate results, correspondence, and diary entries. This, to my knowledge, has remained fairly stable over the years. (For a more comprehensive comment on the activities of a Consultant's secretary please refer to Mrs Kathleen Robinson, Booking Centre Manager).

20.2 Audio-typists helped the secretaries with the letter generation from dictation. My understanding is that the Audio-typists were assigned to the urology unit but would cover several consultants' work. An Audio-typist would focus on letters generated from particular clinics in general rather than specifically to one particular consultant. (Again, a more comprehensive comment on the activities of audio-typists please refer to Mrs Kathleen Robinson, Booking Centre Manager). Prior to the Regional Urology Review of 2009, I had written to the Medical Director, Dr P Loughran, on my view about the Trust's apparent lack of focus on the importance of

secretarial and audio-typist input into facilitating timelines to meet breaching deadlines ***(Relevant document located at S21 No 55 of 2022, 50. audio typist paddy Loughran 01 12 08).*** Post review of 2009, this appeared to improve.

20.3 Administrative staffing in specialist urological areas would cover the Oncology MDT meeting and the Stone Service. (For further clarity on the Oncology administrative staff, it is suggested that this is commented upon by the Chairman of the MDT, Mr Glackin (Consultant Urologist). My personal view of the oncology administration via the Cancer Centre was that it was well supported and responsive, albeit that communication may have been from different people and, as such, not recognising it was from the cancer trackers.

20.4 With regards to the Stone Service, the administration of this has been run and co-ordinated by my general secretary till recently when this role has been taken over by a secretary solely allocated to the unit. This workload covers the co-ordination of appointments for the therapy, letter generation, preparation for the weekly Stone meeting and clinic typing. The work to cover my general practice combined with the Stone Service was becoming ever more intense. With the recent changes in the Stone Service design, the service has been better provided with administrative support.

20.5 Secretarial staff will endeavour to cover each other when a colleague is on leave.

20.6 General Clinic bookings for patients are co-ordinated via the Booking Office. After the monthly Rota meeting (which defined which medical staff would be present), the Booking Office Team allocate patients to a time slot and inform the patient. This has remained a stable arrangement throughout my tenure and appeared to work well, other than when the clinics still managed to get overbooked.

20.7 Front Desk clerical staff are present at all clinics to co-ordinate charts and advise patients on their arrival. This has remained a stable arrangement throughout my tenure.

20.8 With regards to administrative management level staff allocated to the urology unit and the service for its governance of managing and directing on a daily basis, there have been several arrangements during my tenure. I do not recall these during

my initial few years. Following the Urology Review for the Southern Trust in 2004, an Administrative Lead for the development of the ICATS service, Ms A Brennan, was appointed. Mrs M Corrigan joined the service in 2008 as Head of Service for Urology, ENT and Outpatients. More recently, Ms W Clayton has been in this role.

20.9 With regards to the degree of administrative support and staff allocation provided to myself as a Consultant so that I may properly carry out my duties, it would be noted that I have a personal secretary solely attached to my practice, who completes this task fully and efficiently. I am unaware of the level of support she has from the Trust to complete her role and whether she feels there is an excessive pressure from volume of administration. It should be noted that the volume of work from my general urology practice combined with the Stone Service over the years has resulted in these two entities being split into two separate jobs now. Overall, the burden of work on the secretarial staff appears high but their team spirit in my personal opinion (which has been asked for in this Inquiry question), is that they have a high allegiance to the service and have had continuous added work to their job plans over the years.

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

21.1 Albeit that an individual secretary was allocated to a consultant, there was the expectation that there was cross-cover between secretaries, when necessary, for instance to cover holidays or sick-leave. There may have been occasions when they helped each other with arranging lists or typing clinics etc. There was a sense of some collective workload approach but with a distinct allocation to one consultant's practice. In the last three years or so, due to service redesigns in the Stone Service and Oncology work, there has been a more collective approach with a secretary having a more predominant role but other secretaries helping in the provision of the service or covering as necessary. An example being when the Stone Service secretary is off then there is the availability of two other secretaries to provide cover

for the running of the weekly Stone meeting and sorting the administration that has resulted. The prostate biopsy service is co-ordinated by two secretaries who work for the consultants, collectively providing the service.

21.2 The Audio-typists' service had a collective approach to their provision, however, one Audio-typist may have focused on one particular area.

21.3 Administrative staff, such as Heads of Service, work collectively within the unit.

21.4 Administrative workload was monitored by the secretary's line manager. (For further information on monitoring, Mrs K Robinson and their current immediate line manager Orla Poland could provide more details).

21.5 An example of monitoring available to Consultants in recent years is the 'outstanding administration report' ***(Relevant document is located at S21 55 of 2022, 50b. Outstanding Administration Report (1).*** This defines the administrative documents yet to be processed .This report documents the number of outstanding correspondences there are for each consultant's team, i.e., discharges and clinic letters to be dictated and/or to be typed.

21.6 This is my understanding of how the secretaries and their support staff worked collectively.

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

22.1 It is my understanding that all Consultants have had the same access to administrative support to run their general practice. Where the Consultant provides other specialist areas of care, there has been administrative staff allocation. Examples would be for the oncology MDT and the recently redesigned Stone Service, where there is additional staffing.

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

23.1 I have questioned the volume of work expected to be completed as excessive for the secretaries in general and my secretary in particular. The nature of the work expected has increased over the years with added commitments. Prior to the Stone Service redesign, my secretary covered my general urology practice as well as the Stone Treatment Centre's activities. I personally regarded this as an already full job and it was not appreciated that additional work was then being excessive and stressful. I held a meeting with Katherine Robinson and separately with Wendy Clayton on this issue and the responses were that the workload would be monitored. It was realized that the Stone Service was going to be re-designed and the administrative component would be reassessed. Funding from the research grant has paved the way. This has had a positive outcome. ***(Relevant document located at S21 No 55 of 2022, 51. Q23 stc administration).***

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

24.1 The secretarial staff, via a verbal nature of communication, had raised concerns about the amount of additional work being added to their daily tasks. This was generally about added tasks to arrange for patients, but generally taken in their stride. This is best addressed by the secretaries' line manager.

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

25.1 Throughout my tenure I have always felt supported by all levels of nursing and ancillary staff in all the facilities used.

25.2 In the theatre environment I worked in (Craigavon Area Hospital main theatre and Day Surgery as well as South Tyrone Day Surgery) the theatre teams were highly trained, accommodating, and efficient. They supported the endeavour to provide a high standard of care and often would remain at work to finish a list. In the emergency theatre, which is used by all specialties, there was an open and fair approach to case selection order. I would regard that the provision of urology theatre time was deficient throughout my tenure, however those sessions actually undertaken were provided by the nursing staff entirely safely. If there were times of nurse shortage, then the theatre session was closed. For the reason of overall staff shortages (as opposed to lack of willingness or training), this has compromised the provision of urological care and contributed to the long waiting list times. This is in addition to the overall under-provision of urological theatre time.

25.3 In-patient ward staff were very supportive, even during difficult times when there was a loss of the specific urology ward and the urology patients were spread out over several wards. Staff were open to discuss cases and asked questions at relevant points if they were unsure. The urology ward is a specialized unit dealing with the intricacies of managing the urinary tract and the post-operative care. Urologically trained nursing and ancillary staff were aware of the finer points of care. At times when the urology ward was disbanded, care became disjointed. Staff were willing to learn but I sense junior medical staff were called upon more frequently. The effect of the ward disbandment was discussed with the management structure. Ward staffing on occasion was deficient and beds had to be closed. On other occasions there were excess patients on the ward for the number of allocated nurses. This put added pressure on the care to be provided. Throughout these difficulties I regarded the staff as always professional and supportive of the medical staff and the medical support was reciprocal.

25.4 Nursing and ancillary staff in the outpatient setting during my tenure has evolved from general out-patient facilities to having a specialized urology day care facility. Ancillary staff attended to patients at the reception desk and performed certain base line assessments such as patient documentation, chart handling, urine and blood pressure tests. General nursing staff in outpatients provided chaperone duties and the running of the clinic. The specialized urology outpatient facilities

(referred to as the Thorndale Units) provided a more in-depth urological nursing input. These have evolved with time, from the inception of the ICATS service in 2005 through to the current Urology outpatient unit within the main hospital. The urology outpatient nursing contingent involves ancillary staff, staff nurses, nurses with additional urology expertise and Clinical Nurse Specialists. All staff offer a chaperone service and basic tests for urinalysis and blood test. Additional specialist tests include urine flow rate testing and bladder scans to assess bladder volumes pre and post voiding. Nursing staff can also provide additional information either verbally or with BAUS information leaflets to back up the consultant's consultation.

25.5 The unit offers a catheter changing service, often for the more challenging cases. Our Specialist Nurses undertake investigative tests of flexible cystoscopy and urodynamics under the supervision of the consultant. There is a close liaison between the Nurse Practitioners undertaking these tests and reporting on their findings with consultants. Other nurses within the unit offer intravesical therapies of chemotherapy for bladder cancer management and therapies to reduce the incidence of urinary tract infections. Again, this facility has the opportunity of a close contact with the consultant, if necessary.

25.6 The Stone Treatment Centre is located in a separate location to the Thorndale Urology outpatient facility. It is staffed by a urology trained Staff Nurse, an ancillary staff and a radiographer. At inception of the unit the treatments were performed by myself, a Nurse practitioner and a radiographer, however, for approximately the last fifteen years a radiographer has been the sole practitioner delivering the ESWL therapy. The Nurse provided pre and post procedure care and monitoring. If there had been an issue the Nurse would contact either myself or the on-call team. This system worked throughout my tenure. In the last 4 years a service improvement program has been undertaken which has focused on patient safety, efficiency and quality of care pathways. Like other areas of care there was a belief that the staffing of the unit was deficient but due to efficiency of the system the team worked well together. Some sessions did require to be cancelled due to lack of staff but these were few.

25.7 Overall, the various units worked well in what they provided because of their commitment to the service. Patient safety has always been at the forefront of care on

the daily tasks and in the planning of services, however, understaffing issues were frustrating.

25.8 For instance, understaffing inhibited the full delivery of the intravesical chemotherapy pathway, the level of CNS provision for MDT follow-up was delayed, outreach location CNS provision was never considered, training and provision for the andrology service did not get off the ground, delays in the stone nurse led services and ward-based urology being fragmented are a few examples of where patient-based services are lacking and the associated risks are defined. This is not necessarily a Trust point but an underfunding of the overall service from a higher level than the Trust.

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

26.1 The ethos of the urology service has been to encourage nurse training in the advancement of their careers. This may have been to different levels, from taking on specific roles though to the level of independent practice. Education has been via courses, attending meetings, in-house mentoring and degree courses. All the specialist nurses are encouraged to work in teams and not alone. The environment of having a dedicated urology unit in the Thorndale Unit, and more recently also in South Tyrone Hospital, has promoted, provided and encouraged this principle.

26.2 The Specialist Urology Nurses are in two groups with a little overlap. My understanding of the role of the Specialist Cancer Nurse is to provide a nursing angle to the care and support of patients with an oncological diagnosis. This can be a holistic provision, to provide additional information and back-up the consultation the patient has had with their consultant, to help in the consultation when the

consultant is with the patient, provide a contact point for the patient if they request further information at a later date, to ensure there is a follow-up plan and the patient is aware of their planned care pathway, to attend the oncology MDT meeting and engage to know the planned pathway. The role has evolved with time from initially having an holistic role and providing information leaflets through to the current provision of partnering of oncology care along with the consultant in patient consultations and performing diagnostic and follow-up tests such as flexible cystoscopy and prostate biopsies.

26.3 With regards to my oncology practice, the nursing input has evolved. The introduction of the ICATS service in 2005 provided a Specialist Nurse for the oncology section of the service as well as general urology and this role progressed as noted above ***(Relevant document located at S21 No 55 of 2022, 52. Proposal for urology nurse specialists 060505).*** With the Urology review of 2010, this role became more solely focused on oncology but there was only one post at the CNS level and an independent workload was not part of the provision. It was, as noted, a holistic and information provision service. My clinic for oncology patients following their MDT discussions was on a Friday afternoon in the Thorndale Unit, Craigavon. If the Oncology CNS was not available (due to work rostering or leave) then a senior Staff nurse took over this role. If the CNS was not available the patients were given contact details and vice versa, is my understanding. With the employment of additional Oncology CNS staff in recent years, there has been a significant improvement in the provision of Oncology CNS to cover the clinics. The CNS for Oncology work in partnership with myself at these Thorndale Craigavon clinics. If they are not physically in the room at the time of the consult then I specifically ask for their presence at the end of the consult to firstly introduce the CNS to the patient and family members and secondly to summarize the outcome and information discussed with the patient so as the CNS and the patient have a clear understanding of the care pathways. This clinic is booked on a weekly basis but the CNS team have access to speak with myself whenever I am in Craigavon Hospital, which would be anything between 3 to 5 days per week. The same applied if I needed to liaise with a CNS. A CNS is present in the Thorndale Unit most of the sessions a week and messages are easily left if necessary. Clinics in Banbridge and the South West Acute Hospital did not have a CNS presence which is failing in the system. These

clinics, however, were general clinics and the oncology patients on these clinics were usually already on an established review pathway and not requiring a CNS presence in person in my opinion. However, there would have been a few patients attending the SWAH for their initial tests results. The CNS in recent years, having attended the MDT, would have had their details.

26.4 The second set of Urology Nurse Specialist cover the benign pathological conditions. Although these nurses work more independently, they had easy access as I offered an open-door policy to discuss cases. This would primarily be for the benign prostate assessment service or catheter care. The Urodynamic investigation for detailed studies of bladder function had more interaction between myself as a consultant and the Specialist Urodynamic nurse performing the test. There would be clear discussion between patient, nurse and myself with regards the test findings and the care pathway the patient would be offered.

26.5 Prior to the recent re-design in the Stone Service, the clinic in the stone treatment centre was purely for a patient consultation with regards a new diagnosis of having a stone or a follow-up appointment after therapy. This consult involved myself, the stone specialist Nurse and a radiographer. A consult, blood and urine tests along with either an x-ray or ultrasound were performed at the clinic. A major service redesign of the service was required due to the volume of the caseload. There is now a weekly Stone conference meeting, where stone referrals and case discussions to define a care pathway are discussed. This involves the Specialist Nurse in the discussions with the Stone assigned Staff Grade Doctor and 2-3 of the Stone Consultants. The team is involved in planning a care pathway and in the completion of the relevant forms relating to patient safety for their ESWL therapy. Outside of this meeting, communication with the Stone team of Nurses and radiographer was by phone or direct contact when required to discuss care. This was usually with myself or the on-call team. In more recent times, from the re-design structure, our Staff Grade may have been involved also. However, with the service re-design, the necessity for contact outside of the meeting has diminished in comparison to before when it could have been several times a week, in my opinion.

26.6 I do consider that the specialist cancer nurse, and indeed all nurses within Urology, worked well with all the Consultants as well as myself as Clinical Lead.

They communicate effectively and efficiently, in my opinion. If there were concerns or questions these were verbalized without any feeling of being pressurized. If they regarded that patient's findings were not matching the patient's history or tests, then they would give their opinion. If they foresaw gaps in the Rota, this would be reported to myself. In my opinion, I sensed that they felt the environment they worked in gave the aura of ease and willingness to discuss matters. Certainly, this was my view as the Lead Clinician.

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

27.1 I regard the working relationships between nursing and medical staff throughout the hospitals in the Southern Trust as excellent, trying to work as one team. There is a sense of understaffing in the nursing complement with the feeling of a resultant overworking of those in the system. Despite this, I regard that the nursing team still 'go out of their way' to accommodate and help. I feel the medical staff are appreciative of this fact. There is a good sense of camaraderie, albeit the services are stretched at times.

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

28.1 In my view, the relationship between Urology Consultants and administrative / clerical staff as well as secretaries was healthy. I feel that the relationships were open and mutual. Conversations were held in a friendly environment. The Consultant body would have known all the secretaries and their administrative staff. Although

each Consultant had a dedicated secretary, there were frequently other occasions when communication would have been between a consultant and another consultant secretary. This might have included information to be passed on between the team, backfilling for leave, or passing on messages. Other opportunities to record this openness were at the monthly rota meeting where the secretaries would be open in verbalizing if they knew their consultant had a competing diary event. This would be taken in good humour. Communication both verbally and by the email system was used. Messages would be passed on easily and quickly by the clerical and secretarial staff, in my opinion. I personally found the volume of communication burdensome and difficult to keep up with but this point is not relating to relationships nor communication pathways. On a personal note, I have always had particularly efficient secretarial support. They have been exceptionally diligent, making the service efficient and safe. Their training and commitment has been important. Although I personally regarded as having enough support in general terms, I was aware that, with time, the volume of work for my posts in general urology and for the Stone Service had expanded significantly. It was outstretching one secretary's ability to complete the job to her full satisfaction. I did have conversations with Mrs K Robinson about the expected volume of work to be completed. There always appeared to be more 'put on their plate' without a relief from other activity. It was recognized that the Stone Service with the redesign had to have a separate secretarial service.

28.2 As Lead Clinician, my main link to the management structure on a daily basis was with the Head of Service, Mrs M Corrigan. Undoubtedly, her appointment to this post has been crucial for the department's development and daily running. This post covered not only urology but the other departments of ENT, outpatients and ophthalmology. This, in my opinion, resulted in an excessive workload to cover all these team departments. I felt Urology, with all its difficulties, would have benefitted from her sole attachment to the one unit. She was often called to other meetings, resulting in either not being able to attend our departmental meetings or only being able to attend for a short time. This was a system issue and I regarded that she was overworked. I was amazed she was able to complete so much work.

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

29.1 My role as Clinical Lead, and likewise my role as a Consultant, are service roles, as opposed to management posts. As a senior doctor there is the responsibility to ensure your patients, and patients in general terms, have a high standard of care provided in a safe environment. The following systems, structures, and practices provided me with some assurance regarding patient care and safety in urology.

HOSPITAL SYSTEMS

29.2 Reports provided by the Trust management on a variety of issues were provided on a regular basis, for instance, Waiting list times, ward compliance to infection control, antibiotic prescription compliance, etc.

AUDIT

29.3 The Trust has a calendar monthly Audit meeting. This is for one session per month and has a rolling day date, so as to not affect the same session each month. The Audit session is known as the Mortality and Morbidity meeting or, more recently, the Patient Safety Meeting. This is the opportunity to discuss the deaths of patients and any other issues relating to patient care. The meeting also provided the opportunity to present audits on patient care and research. The meeting is co-ordinated by an assigned Consultant for this role (for a more detailed description, Mr Glackin has held this post till recently, when Mr O'Donoghue has taken over as Chair). These meetings have allowed for an open discussion and, having attended these meetings, I am reassured about the openness and depth of the discussions held.

29.4 Audit meetings in the early part of my tenure involved the surgical and anaesthetic departments as a whole. During the last ten years, they have been mainly involving the individual units with a quarterly joint main meeting. This approach allowed detailed appropriate focused discussions on individual unit issues

yet significant learning points from other departments could be distributed via the joint meeting. These joint meetings also gave the opportunity for the Trust and other departments, like pharmacy and microbiology, to speak to the surgical and anaesthetic departments as a complete body when required.

WARD ROUNDS

29.5 Urology ward rounds are performed on a daily basis by senior medical members of the urology team. Before the introduction of the Urologist Consultant of the Week, when there were only 2 or 3 consultants, there was what was known as the 'Grand Round', which occurred weekly on a Thursday morning. This involved all the consultants and registrars reviewing all the urology inpatients in the ward. The cases were presented. This gave the opportunity to discuss patients care and gain agreement if there were finer points of debate. Ward rounds during the rest of the week were co-ordinated between the on-call registrars and the consultant. Individual consultants may have reviewed their own patients as well. Consultant visible presence was generally high and their offices close to the ward (mine being in the ward).

29.6 Following the introduction of the Urologist of the Week, the On-Call Consultant oversaw the daily ward rounds. This has helped with the direct patient care from a consultant on a daily and often twice daily basis as well as improving the throughput of patients in the unit.

DEPARTMENTAL MEETINGS

29.7 During my tenure there have been several major opportunities for detailed meetings as a department with the Hospital Trust with regard to care and safety. The first was in 2004, when there was a external review of the Urology service of the Southern Trust. This was commissioned as both Mr O'Brien and myself had informed the Trust of our concerns over patient safety. We had noted an excessively high emergency workload and, due to our commitment to outreach clinics, it was not always possible for someone to be on site. The Trust listened to our concerns and commissioned as external review which resulted in the introduction of the ICATS service and gaining an extra Consultant with the expectation of a fourth consultant

after a few further years**. *(Relevant document located at S21 No 55 of 2022, 48. Urology ICATS implementation Document Draft v0.5).***

29.8 The regional urology review for Northern Ireland in 2009 and our internal redesign of the Thorndale outpatient unit offered an enhanced safety aspect to care as it was under one roof. The redesign of the Stone Service in the last few years has also aided clinical care and safety with a timelier provision of patient management.

29.9 Our system of internal urology departmental meetings, albeit rather erratic, were portals for gaining reports on urology activity from the management team, with all team members being given the opportunity to attend at a known precise time.

ROTA MEETING

29.10 The urology team schedule meeting has been running for many years. The meeting is held approximately 5 weeks before the month that was being defined. This is slightly within the 6-week rule defined by the Trust with regards to holiday time definition. The Urology Management Lead administrators have been content with this approach as the explanation is that a doctor should really have defined their leave requests by this stage. This avoids late changes to the rota. The full urology team are expected to attend and, if a member is missing, their potential participation for the month is recorded by their appointed spokesperson (i.e., their secretary or another secretary taking notes). The rota will have already been circulated and the meeting is a final check on the allocation of sessions. Each day of the month's events are recorded and the team member(s) assigned to the sessions are defined. This ensures that a particular session can proceed and defines how many patients can be allocated to a clinic for instance (i.e., not over-booking a clinic when there is only one doctor instead of two).

THEATRE

29.11 Patient safety in the theatre environment involves several checks, starting with the patient being logged for surgery in pre-operative assessment unit and the admissions ward initially through to the recovery ward. The hospital system records patients' details, health care number, and procedure to be undertaken on the 'Green Form' and the secretary puts the patient on the waiting list database. The consultant

or senior doctor defines the cases to be performed on the theatre lists. The day-case lists (such as the check flexible cystoscopy list for the monitoring of bladder cancer follow-up), are defined by the secretaries on most occasions, though some consultants did arrange their own lists. The number and nature of cases are to suit the time frame available for the theatre session and the seniority of the doctor performing the cases. The system records patients by date of being put on the waiting list, the urgency of the procedure (Red Flag oncology, urgent, routine and planned). The planned cases are generally the check flexible cystoscopies for bladder cancer monitoring. A planned date for this procedure is defined by the doctors which then allows the secretary to know the diary template for each patient. This system allows secretaries to inform the patient's Consultant if the patient is not getting their procedure on time, if the slot allocation is overbooked for instance.

29.12 Cases involving an anaesthetic are referred to the Preoperative Assessment Team. This is a team of senior nurses and consultant anaesthetist who review the patient's chart and may offer a Face-to-Face consult for further evaluation. Further tests and medication reviews may be required to make the patient as fit for surgery as possible. Once passed fit, surgery can proceed, however this fitness status has a time span placed upon it and it can expire if the patient has been on the waiting list too long. If this occurs, then the pre-operative assessment begins again.

29.13 Patients have been admitted to an Admissions Ward prior to surgery for several years. Previously, it was a direct admission to the Urology or Surgery ward. A nursing check list is undertaken on the ward and again at the main theatre entrance and in theatre. The List begins with a team brief, when the team individually introduces themselves by name and role. The order of the list, equipment required and checked is defined. At the end of a procedure, the surgeon confirms the operation performed and following this the patient is transferred to the recovery ward. Audits of team briefs are available. I am assured of the clinical safety of this process by being directly involved in the process.

ASSOCIATED CLINICAL DEPARTMENTS

29.14 During the first decade of my tenure, there was a weekly pathology meeting. Although this did not discuss all the cases passing through the department, it did focus on the salient cases of the week's work that either the pathologist or us as

clinicians wished to discuss in further detail ***(Relevant document located at S21 No 55 of 2022, 54. Job Plan 2008).*** The pathology for all the oncology cases became more formalized with the introduction of the Urology MDT meeting. This was a structured meeting where all the oncology cases were discussed and outcomes recorded for actioning. Following the regional review of 2009, the MDT became a regional body. It was appreciated there had been some teething issues with radiologist and oncologist presence, but this was known and resolved with time. I am uncertain of the precise duration of the radiologists and oncologist issue but it was over a period of years. (The MDT chairs could confirm this point). This would result in the discussions about patients being 'rolled over' to another date when the radiologist was present.

29.15 In addition to the weekly pathology meeting, the urology department had a weekly Radiology meeting for an hour on a Thursday morning before the Grand Ward Round. Cases that were interesting, complex, for advice on the care-pathway or for an explanation of findings were logged for this meeting via the Consultants or registrar. Sometimes, the radiologist would bring cases to the meeting. Initially, this discussed all types of cases but, with the Uro-oncology MDT introduction in 2009, this meeting focused more on the benign sector of the service. Unfortunately, this meeting discontinued a few years ago due to a radiologist issue of being able to attend but the facility of consultants having the ability to gain an opinion to discuss cases continues on an individual basis with any of the radiologists in the Craigavon Hospital.

THE CANCER MDT

29.16 The NICaN review of urology oncology provision and pathways has developed and has been fully adopted by the Southern Trust team with the weekly MDT meeting which links to the regional meeting also.

OTHER

29.17 The hospital consultant and middle grade appraisal system has been in place for many years. This is divided into the domains defined by the GMC, which include good medical care, maintaining good medical practice, working relationships with colleagues, relations with patients, teaching and training, probity, health and any

other points. The Trust revalidation team provide CLIP reports on the individual consultant's activity in relation to clinical output which included mortality rates of patients under their care. They also provided what is known as the 'Passport' which lists all the statutory training course and logs an expiratory date, if appropriate. They also supply a document recording any complaints and the outcome. SAIs, I am informed by the revalidation team, are enclosed in the complaint / incident/ SAI report sent to doctors for their appraisal form. I am not sure when this was commenced but certainly the SAIs are sent to the M&M / Patient Safety meeting ***(Relevant documents located at S21 No 55 of 2022, 55. S21 q29.17 2 and 56. S21 q29.17).***

29.18 There is a clear mechanism for patients' care pathways to be discussed in detail if there was thought to be an error via the SAI (Serious Adverse Incident) system. More minor incidents can be recorded via the Datix system, and this allows the Trust the opportunity to see if there are trends occurring. SAI reports return to the appropriate department's Patient Safety Meeting for discussion and the learning points.

30. If different to the answer provided at 29 above, in your role as Consultant Urologist, how did you assure yourself regarding patient risk and safety and clinical care in Urology Services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

30.1 See my response to question 29.

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

31.1 The Urology department is composed of several component units which function mainly independently of each other but do liaise with each other. These include the urology ward, general surgery ward, Main theatres in Craigavon Area

Hospital, Day surgery facilities in Craigavon Area Hospital and in South Tyrone Hospital, outpatients in Craigavon Area Hospital and outreach outpatient facilities in Banbridge Polyclinic, Armagh Community Hospital and the South West Acute Hospital.

31.2 My tenure spanned 24 years.

31.3 During my tenure the daily running of the main Theatres in Craigavon were the Theatre Sisters in T2, then T4, and more recently T6.

31.4 Initially, Sister G Reilly till 2002, then Sister Argue till 2014, and finally Sister England till 2022. The Theatre Sisters would report to the Theatre Superintendent who were: Sister McCaffrey, then Sister McGeough, followed by Sister H Murray and Sister P Johnston, who holds this post currently.

31.5 Out-Patients in Craigavon initially was in the general Outpatient Department, till the Urology clinic moved to the first Thorndale Unit and then the second version of Thorndale within the main hospital in October 2013. The general running of the Thorndale Unit was by the Specialty Nursing Sisters K. O'Neill and J McMahon. They reported to Martina Corrigan, Head of Urology services, via the Lead Nurse for outpatients. In the last 2 years, the running of the outpatient component of the Thorndale Unit is back under the general outpatient wing run by Sister J Pericival, who reports to Mrs Corrigan, Head of Service.

31.6 The Lead Nurse for the daily running of the Banbridge Clinic, Armagh Community, and South Tyrone clinics was Connie Connolly from 2007 to 2017, and from then Josie Matthews, with Band 7 Nurses Marilyn Mulligan, Judith Mulligan, Cathy Rocks, Joanne Percival and Jacinta McAlinden. The SWAH is not the operational responsibility of the Southern Trust but the Band 7 Nurses are Mary McCullagh and Laura Finlayson.

31.7 The Band 7 Nursing Sisters for the urology ward from 2009 were John Thompson, Shirley Tedford, Sharon Kennedy, Cathy Hunter, Patrick Sheridan, Cherith Douglas, Gayle Magill and Laura White.

31.8 The Nursing Sisters for the general Surgery wards were Sheila Mulligan, Emma McCann, Tracey McGuigan and Ashlene Kelly, with the Elective Admission Ward being run by Sister Nichola McClenaghan.

31.9 As a consultant, my immediate direct clinical line managers were the Clinical Directors: Mr I Stirling till 2009, Mr R Brown till 2013, Mr S Hall till 2016, Mr C Weir till 2018 and Mr T McNaboe till the present.

31.10 Operationally, on the day to day matters I reported to the Head of Service, Mrs M Corrigan, and if necessary to Assistant Directors or Directors of Acute Services. The Heads of Acute Services were Joy Youart 2007 -2009, Dr G Rankin December 2009 to March 2013, Mrs D Burns to August 2015, Mrs E Gishkori to June 2019 and Mrs M McClements to present ***(Relevant document located at S21 No 55 of 2022, 57. Line Management)***.

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

32.1 In my opinion, medical managers and the administrative managers in urology worked well as a team in general terms. During my initial decade as a Lead Clinician, although we had differences with the Chief Executive (Mr Templeton), who was our main point of contact when discussing urology matters, he was always open and would listen. As a result, the McClinton review was produced. The managers worked extremely well with the nursing and medical staff as a result of this review in obtaining our first Thorndale Unit and setting up the ICATS service in urology, which was the first of the urology ICATS teams in Northern Ireland.

32.2 Following the Regional Urology Review of 2009, the medical and administrative managerial structure appeared more structured. Certainly, consultants and myself as Lead Clinician had a healthy relationship with our Head of Service, Mrs M Corrigan. Conversations were open, frank, polite and informative. There was always an easy path for both sides to request a meeting. It was our Head of Service, Mrs M Corrigan, who had recommended and sponsored our Thorndale outpatient

service for the Southern Trust Annual Award in 2016. Not only did we win the section award but we won the overall top award for the year.

32.3 The Directors and the Assistant Directors of Acute Services, along with the Head of Service, appeared to work well with the Associate Medical Directors and Clinical Directors. I was not aware of any conflict. Any meetings I had attended with them, albeit business-like, were polite and forward thinking. This question is probably best answered by each of the individuals themselves.

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

33.1 As a Consultant, I underwent annual appraisals. My first record is from 2002. The Trust have these documents. My Consultant appraisal would have logged my role as Lead Clinician but it was not separately appraised. The objective would have been enclosed in the appraisal document under the Personal Development Plan. These objectives were not focused upon specific targets in terms of patient volume or throughput but were more targeted at facilitating new activities within the unit and maintaining my continued education. My appraisals were undertaken by Mr Mackle between 2010 and 2016. Subsequent appraisals by McNaboe for two years and then Dr S Murphy and Dr Holmes till 2020 were unremarkable **(Relevant documents located at S21 No 55 of 2022, 58. 2011 appraisal E Mackle 280113, 59. appraisal mr e mackle 060613, 60. 2013 appraisal mr e mackle 311214, 61. 2014 appraisal dr michael young (dr e mackle)221215, 62. 2015 appraisal mr m young(mt e mackle)28-07-16, 63. 2016 appraisal dr michael young (dr e mackle)241017, 64. 2018 appraisal dr m young (dr T McNaboe)191219, 65. 2019 appraisal dr m young(dr s Murphy) 220321, 66. 2020 appraisal dr M young (dr ej holmes)041121, 67. Appraisal dated 27.10.10 received 8.11.10 (e mackle), 68. dr m young(dr e Mcnaboe) 2017 appraisal 300418).**

33.2 The Southern Trust appraisal scheme for medical staff framework document covers the appraisal process and was dates as July 2014 ***(Relevant document located at Relevant to MDO/reference no 2t/20140701 Policy Southern Trust Appraisal Scheme for Medical Staff)***

34. 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.

34.1 My role as a Urology Programme Director involved the annual appraisal of the training urology registrars. This was with a panel of training Consultants and an Extern Royal College Assessor and reported to the Post-Graduate Dean.

34.2 With regards to Consultant appraisal, I was involved in several of the Urologists' appraisals for a period of years.

34.3 I undertook Mr Akhtar's appraisal in 2009, 2010 and 2011 without any issues being defined.

34.3 Mr Glackin's appraisals for 2013, 2014, 2015 and 2018 were undertaken by myself.

34.5 Mr Brown, Consultant Surgeon with interest in Urology in 2014, asked me to undertake his appraisal as he had had a GMC referral. He wished an independent view. I did not find any issues with his appraisal. Appraisals for 2013 and 2015 were performed as well.

34.6 Mr Suresh Kothandaraman appraisal were in 2014 and 2015.

34.7 Mr O'Donoghue appraisals for 2015, 2017 and 2018 were undertaken by myself

34.8 I did several appraisals with Mr O'Brien over the years.

34.9 The appraisal of 2010 recorded a resolution to the IV fluids and antibiotic issue. He noted the ward reconfiguration of 2009 as being disruptive as well as the DoH imposing the centralization of radical pelvic surgery as a negative consequence for patients. He was concerned about the significant knock-on effect of the regional

review. There were no particular issues to note. ***(Relevant document located at Relevant to MDO/evidence uploaded December 2021/no 77 appraisals/20100101 Appraisal AOB).***

34.10 In 2011, it records a good relationship with colleagues and patients. The Job Plan was clearly set out and he was an integral participant in the development of the urology unit. Complaints had been addressed and his appraisal noted the probity issue relating to the inappropriate disposal of patient information which had resulted in an informal Trust warning and the PDP noted the full documentation for the next appraisal. This appraisal was in fact dated April 2013. ***(Relevant document located at Relevant to MDO/evidence uploaded December 2021/no 77 appraisals/20110101 Appraisal A'OB).***

34.11 The Appraisal for 2012 and 2013 are combined and record the extended ten hour in-patent theatre session and taking over the Chair of the Southern Trust urology MDT in April 2012. He records that he was reviewing all aspects of each case, presenting each case and signing off the plan for each case. He notes the parallel clinic with a Nurse Specialist in the SWAH. The job plan section does comment on facilitation and variable quantum of PA / Program Activity due to flux in the unit of sessions and the number of team members. He notes that the main issues compromising care were his workload and priority given to new patients at the expense of review patients. He notes he provided at least nine clinical sessions per week with inpatient and administration work arising from same as being conducted outside of these sessions. He logs his concern about the cancer backlog for review. This appraisal, dated April 2014, is predominantly completed in the ‘first person’ dialogue by Mr O’Brien. It is a detailed and frank account of his work over the prior two years. A significant quantum of cases was personally reviewed for the oncology MDT. He had been appointed Lead Clinician and Chair of the Northern Ireland Cancer Network Site Specific Group in Urology from January 2013 and was preparing guideline documents. It records that Mr O’Brien participated fully in departmental meetings. Complaints related to waiting times as a consequence of inadequate capacity relative to demand are recorded and it notes difficulty keeping up with email correspondence. The PDP was based on delivering an operational policy for urological oncology. GMC requirement was complete.

34.12 In his 2014 appraisal, he logs that he did not have the opportunity to review or agree his job plan. He records the relentless increase in patient activity figures and hence the waiting list and such impact. Again, the appraisal is mainly in the 'first person' dialogue but my additions log reasons for issues and suggested more reflective template documents. Safety and quality domain record the mandatory passport documents and a statement of endeavouring to provide a safe service to patients under his care. He records that, during 2014, he was preparing for a major Peer Review of urological oncology visit in 2015. The document was signed December 2015.

34.13 The 2015 appraisal was signed on the 23 December 2016. His Job Plan was enclosed with it. He notes a significantly higher waiting list for his patients than some of his colleagues. On this occasion the commentary in all domains is via my input. It was noted that Job Plan had been updated and adjusted after a meeting with the Clinical Director. CLIP report domains had improved (*a particularly minor issue*). Reflective template documents appeared to indicate his and others role in their input into oncology care. In the safety and quality domain, the appraisal did indicate an engaged reflection on several aspects of the patient management systems. The communication section shows a detailed pathway guide for the prostate cancer therapy course. The PDP again notes the long waiting list issues.

34.14 I did not do any subsequent appraisals for Mr O'Brien.

34.15 Of the Staff Grades, I have documentation on:

34.16 Dr Rogers' 2009 appraisal recorded that the Occupational Health issue of the previous year had not recurred as was also recorded in the 2010 form.

34.17 Dr J Martin, Staff Grade, for 2015, and Dr Sabahat Hasnain, for 2017, were both unremarkable.

34.18 I am unaware of having any issues with my appraisals, but my appraisal for 2015/16 records a GMC referral by a patient which, after review, was erased (see further Q56 in this regard).

Engagement with Urology staff

35. As Clinical Lead describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within Urology Services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

35.1 As Clinical Lead I would have engaged with all the staff members in the Unit, but as a service post I was not responsible for their post's activity. The Clinical Lead was a figurehead link between the team groups and the initial point of contact for the Trust management to liaise with the members of the urology team and vice versa. This team incorporated the consultants and their secretaries, Thorndale nursing and ancillary staff, the Stone Treatment Centre staff and the Urology ward senior nurses. Our Head of Service, Mrs Corrigan, was also within this team. Most communication was usually on a verbal basis and related to the general day to day activities. The rota management and clinical question were significant components of the day to day activity. I would have been the first point of contact from nurses and management if there was an issue about an unfilled last minute work placement of medical staff. I would endeavour to reallocate work within the medical team to cover the vacant session. If the nursing staff had a question in relation to a junior doctor management plan of a patient, they would have reported it to me as a consultant if the patient's consultant was not available. This contact would have been in person at the Thorndale Unit to verbally discuss the issue. If there had been an equipment issue in theatre, the Theatre Sister would have contacted me for advice. If the lithotripter was malfunctioning, I would have been the first point of contact. This would have been verbally per phone call usually.

35.2 My interaction with our Heads of Service was on the operational issues of the department. This may involve being asked for advice in relation to clinical issues. For instance, if there had been any complaints my opinion might be sought. I was often the first point of contact in relation to Patient Flow issues if there were bed pressures. As Clinical Lead, I would have been asked to vet the applications for locum and substantive posts of juniors and consultants. I would have been on most

of the panels for interviews over the years. Such conversations were generally ad hoc but there was the opportunity to discuss topics at the weekly consultants' departmental meeting. This was planned on a seasonal basis, i.e., for a few months at a time, but unfortunately was rather erratic. It did give the opportunity for all the consultants to meet together as a group, albeit informally, to discuss a range of issues which were either rostered to discuss or something a consultant or the Head of Service wished to draw to others' attention. It was a good forum when everyone attended. Attendance was better when the Trust and DoH had an agenda to address.

35.3 For the last year and a half, the Departmental meeting has been scheduled on a weekly basis and is attended by consultants, Urology Staff Grades and all the Clinical Nurse Specialists. The meeting is Chaired and minuted by the Head of Service, Ms W Clayton.

35.4 I chaired the Rota Scheduling Meeting on a monthly basis. This involved all the consultants and their secretaries, junior medical staff, the senior outpatient / Clinical Nurse Specialist and Head of Service being present at the meeting, when possible. This meeting has run for many years and was designed to solely lay out the daily rostering of activities and the clinicians attached to the event. This would take into account Leave requests. The Rota schedule would have been predefined by myself and distributed to all before the meeting and the actual Rostering meeting was to ratify the situation. This was important as changes often occurred. We would discuss changes such as if I had double booked someone's session or had got a week 'out of sync' but usually it was to move sessions about so as to gain or take advantage of spare available clinical sessions, for instance unfilled Urology or other available theatre sessions that the Head of Service was aware of being free. This enabled me to gain as much as possible urological activity out of the department's team. It was important for the team members to be present so that they knew what exact clinical commitment they had agreed to perform. The team members would have appreciated they had a job plan but this was their option to vary their activity if desired. The team engaged with this ethos well. There was plenty of opportunity to vocalize an opinion on scheduling issues. Sometimes, it would stray to other topics and I had to bring the conversation back to the topic of the schedule. In leading this

meeting, I would have taken a broad oversight of activities to either suggest a change of a member's activity or indeed on occasions note that a member was committing to more activities and suggesting that they might be overstretched. The meetings were open and interactive, yet focused. The final schedule would be supplied to the Head Of Service, Mrs Corrigan and more recently Ms W Clayton, as well as the Thorndale lead so that the booking centre could be informed of the planned dates of clinics and how many doctors per clinic, the Thorndale team could plan activities around this allocation more precisely, i.e., oncology and urodynamics, and Theatre managers would know the surgeon assigned to each list. Secretaries could also plan their month's activities.

35.5 On a monthly basis I was the urological representative on the Theatre Users Group. I would discuss the urological issues relating to main and day surgery that had been brought to my attention.

36. 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.

36.1 I did not have any daily scheduled meeting as a Lead Clinician, outside of the Covid period.

36.2 As a consultant I might have liaised with my secretary on a daily basis with regards to mail or if she had any questions for me.

36.3 Following the Regional Review of 2009, we held weekly Monday afternoon meetings with reference to the implementation of Team South's response to the Review. This continued for approximately a year.

36.4 After this period, we would have endeavoured to have had a Weekly departmental meeting. This was seasonal and used 'Term Times'. It was scheduled for approximately one hour on a Thursday lunchtime just prior to the oncology MDT meeting.

36.5 The weekly uro-oncology MDT meeting was on a Thursday afternoon for approximately two hours.

36.6 Since 2018 there has been a weekly Stone meeting to discuss patient management (similar to the oncology Meeting)

36.7 The Rota Scheduling Meeting was on a monthly basis at Thursday lunchtime and lasted slightly longer than an hour (more information on this point is recorded in Q45).

Governance – generally and in your role as Clinical Lead

37. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role as Clinical Lead, how did you assure yourself that this was being done properly?

37.1 Clinical governance was overseen primarily by the Director of Acute Services and the associated management team. This would have been shadowed by the higher management structure and the Associate Medical Directors.

37.2 This would have encompassed the Patient Safety Meeting along with the Medical Lead for this meeting.

37.3 The Lead Clinician role was service driven and the assurance for governance responsibility would have been as with that of the other consultants.

37.4 I assured myself that the Patient Safety Meeting was effective by attending and partaking in the discussions.

38. As relevant to your position as Clinical Lead, how did you assure yourself that governance arrangements within Urology were appropriate and effective? Please explain and refer to documents relating to any procedures, processes or systems in place on which you rely on in your answer, and provide any documents referred to (unless provided already by the Trust).

38.1 There were several systems in place to assure myself that there were mechanisms available for governance to be presented or discussed. The Patient Safety / Audit meeting was a regular monthly meeting with a quarterly full surgical / anaesthetic meeting for the whole theatre, ICU and surgical teams to meet and

discuss a variety of points. Other departments like Microbiology and pharmacy attended regularly as well. These meetings were minuted and the minutes distributed.

38.2 The monthly Scheduling meeting defined a precise team workplace allocation for its members. This would define the appropriate number of patients that could be seen or have had a procedure. For instance, a pre-defined number of patients to be booked to a clinic or day surgery list would depend on the level of seniority of clinician attending and also the number of clinicians attached to the individual session. This way, sessions would theoretically not be overbooked, or indeed be booked at all if there were absent sessions. This scheduling meeting was effective and ensured as productive a use of members time as possible.

38.3 Our Departmental meetings have given team members opportunity to discuss and raise any point they wished. These meetings may have had an agenda but often would include pressing issues a consultant would like discussed with his colleagues or with the Head of Service. Although these meeting often were not minuted, it was the opportunity for one of the team or the Head of Service to take issues forward. Minuting was an issue as either a clinic or the MDT immediately followed this meeting. The Departmental meeting over the past 18 months is better structured and run by W Clayton, Head of Service.

38.4 My specific governance role in the unit I regarded as maintaining the work schedule for the whole medical team, and as such this was operational. My line management is recorded in Q7-8 for my roles. Assurance of governance was as a hospital consultant but the responsibility of governance lay with management structure and the Medical Director’s team.

39. How did you oversee the quality of Services in Urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of Services?

39.1 I, as a consultant, was part of the urology team and as such had a responsibility to maintain the general quality of the urology service. This was

overseen by the Director of Acute Services and the associated management team, who oversaw the operational governance of the unit. The Medical management of Clinical Director, Associate Medical Director and the Medical Director were, in addition, responsible for oversight of the clinical aspects.

39.2 Following the regional urology review our department endeavoured to move to the one stop clinic principle to aid quality and throughput of patients. This was primarily for the haematuria service but did also applied to the prostate biopsy service. As noted in Q32, this was part of the reason our department won the overall / main Southern Trust award in 2016. Our Head of Service continues to produce regular data reports on the wait times for these services and, if they stray, extra clinic or outsourcing of the activity is undertaken as necessary

39.3 An application for a Trust research grant was made in 2018 so assess the outcome of stone clearance rates for kidney and ureteric stones using the lithotripter in the Stone Treatment Centre in Craigavon Areas Hospital. The objectives were to assess patient demographics, pre-treatment stone factors and ESWL parameters that affected outcomes in addition to patient satisfaction. Pain relief assessment project and an important component of this research was to assess the changes in care following the introduction of the Stone MDT. Qualitative and quantitative assessments were made with a team approach for this research involving Stone centre research Nurse, a radiographer and medical input of a senior Urology Adept Fellow, staff grade and myself as the Lead Consultant ***(Relevant document located at S21 No 55 of 2022, 69. Assessment of Kidney and ureteric stone clearance).***

39.4 Evaluation of the recently introduced Stone Meeting Pathway identified significant progress in the timeliness and completeness of the necessary data information with the introduction of a Stone MDT principle. The Stone Meeting processed patients on their care pathway at a quicker rate than before. Areas assessed included wait time for first urology contact after ED presentation, wait time from referral date to definitive plan for ureteric stone, assessment of completion of key biochemical workup for patients within six months of presentation, assessment of signposting of patient to information regarding self-care and risk reduction for further stone formation, capacity assessment of stone clinic versus stone meeting, cost savings, patient feedback questionnaire and ED staff feedback. This project

review data was from 2016 onwards with the introduction of the STC meeting in 2018.

39.5 Care pathway for Emergency department referrals of patients with ureteric stones was clarified more precisely in 2018 with the introduction of a direct referral form with the salient clinical features being documented on a specific Southern Trust ureteric and renal stone pathway form ***(Relevant document located at S21 No 55 of 2022, 70. a.e referral STC 30 1 18).*** This was updated in 2021 with additional items on the form which had further safety features incorporated into the form ***(Relevant document located at S21 No 55 of 2022, 71. ESWL referral form mar 21).*** Prior to referral, a ureteric and renal stone pathway plan of investigation and 'roadmap' of assessments to take pending patient finding was produced for ED staff to follow. This was based on diagnostic test including CT scan requesting and taking other important differential diagnosis into account as a possible origin for similar symptoms. A care pathway of when to contact the urology team, when to admit and how to refer as an outpatient ***(Relevant document located at S21 No 55 of 2022, 72. guidelines a+e).***

39.6 As part of the Stone Meeting pathway, a nurse led review clinic was set up with specific criterion for patient and stone type pathways with a mechanism for easy referral back to the consultant clinic / oversight. ***(Relevant documents located at S21 No 55 of 2022, 73. nurse led clinic flow chart Jul 2021 and 74. pathway and proforma for nurse led stone clinic 19 4 22).***

39.7 The quality improvement project for the ESWL service was presented to SMT laying out the status at the time and how improvement in the overall service, patient experience and cost savings were presented ***(Relevant document located at S21 No 55 of 2022, 75. ADEPT PROJECT STONE presentation finance meeting – long version 23 1 18).***

39.8 Our research team has compiled our data looking at several factors in assessing response to the therapy. Skin to stone distance, stone density measured via different parameters, initial stone size, location and number of treatment sessions and complication rates were assessed. This detailed study confirms our commitment to ensuring patient safety and best treatment principle has been applied to their care as well as producing a more timely treatment pathway ***(Relevant document located***

at S21 No 55 of 2022, 76. Retrospective review of audit patients treated by eswl 20 4 22).

39.9 In addition to the Research proposals, a business case to enhance the ESWL service in Craigavon Area Hospital was made to the Trust. This was based on documents of the British Association of Urological Surgeons and NICE – 'Standards for the Management of Acute Ureteric Colic', September 2017 and 'Renal and Ureteric stones: Assessment and Management consultation 20 January to 17 February 2017'. A detailed document was produced for the Trust recording a request to increase the number of sessions to reduce the waiting times for the procedure in general and to offer an emergency service ***(Relevant document located at S21 No 55 of 2022, 77. stone treatment centre 2018-19 MY 'changes 1').*** This was updated with a 2021-22 IPT submission document ***(relevant document located at S21 No 55 of 2022, 78. stone Treatment centre 2021-22 IPT).***

39.10 The project of re-designing of the Stone Service pathway was submitted and accepted for the HSJ Value awards ceremony in Manchester in 2021 ***(Relevant document located at S21 No 55 of 2022, 79. HSJ Value awards submission).***

39.11 Since this submission, the Regional Day Elective Care project from the Department of Health project (which incorporated the day care principle for stone surgery) has now defined that the Stone Centre in Craigavon Area Hospital will be the regional Northern Ireland Centre for ESWL stone therapies.

39.12 All the facets of this research project have helped to confirm continued high quality care, which will continue to be monitored via the data collection from the weekly Stone Meeting. There has been a cohort of three consultants attending the weekly stone meeting. This adds reassurance to the monitoring of the service.

39.13 Other quality improvements in the service included the management of ureteric stents. In 2018 there was a change in practice with regards to stent management of patients following ureteric stone surgery. This related to the stent having strings attached to allow easy and an early removal. This avoided the need for a cystoscopy slot to remove the stent. Importantly, it reduced the time the stent was in situ and reduced the risk of patients getting lost or delayed in the system and reduced the overall risk of sepsis and stent irritation ***(Relevant document located at***

S21 No 55 of 2022, 80. Proposed stent removal service Craigavon area hospital 4 12 18).

39.14 Other quality improvement and assurance activity relates to the change from transrectal needle biopsies of the prostate to a transperineal approach which is a safer method with less infection risk and better quality pathological sampling. This has been introduced over the last couple of years. This service is monitored by the uro-oncology team members, who record the results and any side effects via the oncology MDT and the Patient Safety Meeting.

39.15 Quality of service is also assured via the oncology MDT process. This is undertaken every Thursday afternoon, with only a few days lost from such events as Patient Safety Meeting or a Bank Holiday. This is multidisciplinary and I understand that the cohort of the team has improved in recent years (the Chair of MDT could be more precise on this point). The uro-oncology MDT has had difficulty with its cohort of specialists for the meetings. This has been logged via the attendance record. This may result in patient discussions being rolled over. The cancer tracker system, however, records the patient journey in terms of time from initial referral through investigation to treatment. The mechanism of the system highlights delays.

39.16 The uro-oncology service has been enhanced by the addition of a number of Clinical Nurse Specialists. This had been an issue before and now allows more time with patients for advice and assessment of holistic needs.

39.17. As part of the Patient Safety Meeting, audits on clinical care are presented by the Urological trainees and the staff grade doctors. This is as part of their training programme. These predominantly relate to standards of care provided to patients and these have helped to identify areas where improvement in care or a process could be gained. This has been a productive mechanism of highlighting areas where improvement could have been gained. ***(Relevant document located at Relevant to Acute/Document Number 27/20191016 Urology Department Patient Safety Meeting 16102019 minutes).***

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

40.1 Performance metrics included the benchmarking of certain activities. These included New to Review ratios, Day surgery cases rates and length of stay for elective and emergency cases. These were recorded between the Trusts and against national figures. These would have been presented at the regional review meetings or when DoH teams had visited when assessing progress. ***(Relevant document located at S21 No 55 of 2022, 81. 20100603 – urology benchmarking).***

40.2 More pertinent performance metrics to our Southern Trust issues were the Waiting List times for surgery of the different categories of urgency, with outpatient waiting times for the different categories of clinics and the number of review patients requiring to be seen. These would have been produced and discussed at Departmental meetings regularly by the Head of Service, Mrs Corrigan.

40.3 We had noted that our New Review outpatient rates had improved considerably over a number of years leading up to the Reviews and length of stay did not appear an issue. Improvement areas were the day surgery rates. Our discussions noted that the outlet for day cases were limited to Craigavon mainly but South Tyrone Hospital opportunities could be enhanced. This has certainly been the case with a regular theatre session for a decade and the prostate biopsy service in the last year or two. This has all been overseen via our involvement with the Trust management system. We also recorded that, although certain procedures could be performed as a day case, our facilities did not allow for them to be undertaken. A prime example was ureteroscopic surgery as this required x-rays for fluoroscopic pictures to be taken. The theatre design in the day units were not radiation protected. This meant all such surgery had to be performed in the main hospital in Craigavon and resulted in a lower day case rate. A further point we had noted was the recording of a day case was pre-defined by when the patient was originally booked for their surgery. So, if a patient was booked as an inpatient but when it came to their surgery they went home that night (i.e., a day patient), they were still recorded as an

inpatient admission. I personally felt that this performance meter was not necessarily that important as a record of activity.

40.4 The important performance meters of all the Waiting Lists were regarded by the Craigavon Team as the most important. The Trust produced these figures regularly and presented to us as a group by the Head of Service, Mrs Corrigan. We would discuss methods of trying to address these issues within the constraints that existed in the department at the time, always recognising that expansion of the team was necessary. Availing of extra theatre, weekend theatre waiting list initiatives, extra evening outpatient and weekend sessions, and outsourcing activity to the independent sector were all actions suggested by our team and taken advantage of by the Trust.

40.5 The responsibility for these performance metrics were the Trust management system and not mine as Lead Clinician nor as a consultant.

41. 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?

41.1 All medical clinics have an assigned Consultant who would attend the session. Urology trainees would always be supervised and not left to do a clinic on their own. Only the senior Staff Grades, after an appraisal on their ability to run a specific service, would have a standalone clinic. The senior Speciality Nurses also run specific clinics, again with a pre-defined group of patients.

41.2 The Patient Safety meeting was a significant forum that was specifically designed with reference to identifying issues that may affect patient risk and safety.

41.3 The SAI system deals with specific incidents to identify where care could have been better and define if there was a learning point for others. The resultant document could have been for internal use only but regional examples were also published.

41.4 All general risk and safety issues, whether defined as minor or major, can be logged via the Datix IR1 system. Major issues can be identified early, but this system allow trends to be identified.

41.5 The Theatre Users Group (THUGS) meeting is a portal for each department to place requests for a trial of equipment and gain approval for the urology team to have first-hand exposure to equipment before potential purchase. The safety and benefit of such equipment would be discussed at these meetings and approval given or not by the committee. I generally represented the urology department at these meetings, though occasionally Mr Glackin would stand in when I was not available to attend. I also acted as the deputy chairman. Each surgical team would have a representative at this meeting which was made up of these Leads, the senior nursing staff of theatres, recovery ward and the day units along with senior management staff.

41.6 The Trust has a mechanism of recognising national alerts via National Patient Safety Reports. One of these related to the insertion of suprapubic catheters. I helped with Caroline Beattie, Standards and Guidelines Manager, to produce our own Suprapubic catheterization guidelines in 2014 (and updated in 2017) for the Trust in response to the National Patient Safety Report ***(Relevant Document located at S21 No 55 of 2022, 82. suprapubic catheterization guideline 2017 draft and 2014 updated).***

41.7 Department of Health alerts were a safety issue source of information. An example for urology was the Saline irrigation to be used in resection surgery.

41.8 As part of the Stone Service Research Project, the medication and the processes surrounding the prescription of analgesia and antibiotics were reviewed. A detailed review of the pharmacokinetics of the various analgesics was undertaken to define when the peak effect of a drug would be. The patient's Electronic Care Record was reviewed at the Stone Meeting to assess the safety aspects of medication and the planned therapy. The pathway process has been scrutinized by the Hospital Pharmacy team and we now post medication to patients in advance of their therapy for the patient to take at home before they arrive for their treatment.

42. 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?

42.1 My answers at Q38 and Q39 are also relevant here.

42.2 The regular Patient Safety Meeting has been the main portal for discussion about clinical governance points. Not only are the causes of mortality discussed to define if the death was expected, but also the case is scrutinized to identify any learning points or to consider if care could have been improved in any way. The meeting gives the opportunity to bring forward cases or issues in the hospital systems where care could have been potentially better. The meeting includes the reports on SAI (Serious Adverse Incidents). Trust reports are also enclosed for reading and these would include, for instance, pharmacy issues that had been identified.

42.3 The departmental meetings and the THUG meetings were also portals for raising issues with the Trust and these would have been escalated by the Head of Services.

42.4 Governance issues such as the long waiting lists were reported to the urology team and we were assured that the Trust Management system of Directors and the SMT were fully aware of the dilemma. The process of escalation was in place. The governance issue in relation to this Inquiry in part relates to delayed triage of letters and SAI reports. Both these were identified and escalated. In the case of triage, following the consultants' evaluation of the untriaged letters in January 2017, our assessments were reported to the Director of Acute Services and onwards to the Medical Director. Likewise, the individual cases for the SAIs in 2016 were amalgamated into a Root Cause Analysis, albeit that I was not aware of this being undertaken, I was assured that there was a mechanism for such activity to be undertaken.

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

43.1 The Trust could be alerted externally to Urology issues from the National Patient Safety Alert system (see Q21). Another external trigger for alerts was our own Department of Health. An example was the commissioning of a review of irrigating fluids in urology. This originated and was highlighted after the case of a death of a young lady undergoing a gynaecological procedure. The Trust took an action plan to reduce this risk from occurring on the Southern Trust sites. ***(Relevant documents located at S21 No 55 of 2022, 83. hyponatriaema report 20 12 13, and 84. hyponataemia report 5 2).*** The Urology team responded in 2015 with several points but took cognisance of the Report by Dr Julian Johnston who had reviewed the hyponatraemia case for the Department of Health. Since then, Saline use for TUR work was introduced in CAH. ***(Relevant document located at S21 No 55 of 2022, 85. irrigation fluid response document 06 03 15)***

43.2 The Minister of Health and the Chief Medical Officer DoH have portals to inform. Some of this information would been in written form only but, if there were significant concerns emanating from these levels, they were discussed at Patient Safety, Departmental and usually via a specific arranged meeting chaired by the Director of Acute Services or a medical manager such as an AMD or CD.

43.3 Patients could write to consultants, the Directors of Service, the Chairman and Chief Executive or the usual route was the Complaints Officer. The secretaries often were the patient first point of contact also. Most patients are directed to the Complaints Officer. A complaint report was generated and sent to the Head of Service. A time frame for a response was defined. The consultant in charge of the case or myself would have been asked for comments if that was deemed appropriate and the Director of Acute Services would write to the patient. If the patient wished to take the complaint further, there was a process in place to do so via the Complaints

Office. Often, a meeting with patients and family was viewed best. The Trust has a complaints procedure mechanism. ***(The relevant document can be located at relevant to cscg, reference no 2c, 20210212 policy for the management of HSC complaints 2019)***

43.4 Internal mechanisms relating to concerns could be a direct conversation or written correspondence between a member of the nursing, ancillary or secretarial staff, a fellow colleague within the department or from the wider Trust community or from the Trust managerial system. The direction course for the concern may depend on its nature. It may be clear that the issue should be directed to the Complaints Officer. Other concerns are referred to the individual's clinical or organizational line manager and processed further up the ladder as necessary. If the concern had been raised at a higher level, then dissipating this concern would have resulted in speaking / writing to the individual involved or the department as a whole. On such occasions where the higher management team had been informed, they usually (but not necessarily) would have informed me as Lead Clinician pending the issue.

43.5 Concerns could be discussed at the Patient Safety or Departmental Meetings.

43.6 When concerns were escalated to Directors of Acute Services, Assistant Directors or AMD or a CD, they had the facility to call an extemporaneous meeting with the individuals the concern involved.

43.7 The Patient Safety meeting is also a portal to trigger an SAI event.

43.8 The Departmental meetings were a route for consultants, nursing staff and Management to converse on issues they wished to raise.

43.9 The Datix system has been a good system for all staff to report all grades of issues and the more serious is covered by the SAI mechanism. Where there is a trend appearing, then the facility of a Root Cause Analysis can be implemented.

43.10 The efficacy of the processes in gaining the desired information and outcome, I would regard, as working well. For instance, the DoH concern with regard to irrigation fluids in endoscopy has been fully and quickly addressed. The Trust has a Standards and Guidelines Manager who has been involved in the National Patient Safety Alert System. Complaints have a timeframe within which to be addressed

and, importantly, an opportunity to accept or request further clarity. Specific Datix issues may be brought by the Head of Service to departmental meetings.

43.11 The SAI system has a significant role as it reflects on events by a panel. It considers the case with its potential causes and offers learning opportunities. It may identify trends which can stimulate a more in-depth assessment such as a Root Cause Analysis, as has been evident in this Inquiry. I do appreciate there is an escalation chain but how far an individual issue passes up the chain of command is not precisely clear in my opinion. The Trust management system would be in a better place to answer this point.

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

44.1 The systems available to raise concerns have improved over time. The mechanisms of logging issues via the Directorate Governance Office and reporting to Assistant Directors and Directors of Acute Services has been more efficiently installed. As noted, the SAI system has been observed to be used more frequently as a tool for assessment.

45. How did you ensure that you, as Clinical Lead, were appraised of any concerns generally within or relating to Urology Services?

- 45.1 I was appraised of any concerns via the portals of the Patient Safety Meetings, Departmental meetings or via conversation / correspondence from the Head of Service, Directors of Acute Services or the Medical Director's team***. (Relevant documents located at:***
- ***Relevant to Acute, Document Number 2 m and Document No 39, SEC ATICS, Urology Patient Safety MM Notes***
- ***Relevant to Acute, Evidence after 10 December Acute, Ref 77 Patient Safety Meetings***

- ***Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, SEC, Document No 2M and 39)***

45.2 The departmental meeting was a good source of being appraised of concerns in general. These were initially with consultants and Head of Service but the department moved towards the full involvement of all the urology team with 'Away Days' or 'Development Days'. The full team is now regularly meeting on a Thursday lunchtime.

45.3 An example of the Development Days were in September 2018. The consultants discussed the importance of the consultant's presence for inpatient ward rounds and activities, issues of triage and the recognition of the time constraints of the advanced triage system and, in fact, wondering if triage and on-call should be decoupled. A list of pressing topics were listed to be discussed at a future meeting. In this way, the important concerns were defined as a group. The meeting then involved the nursing staff of the ward and Thorndale. This covered topics of concern relating to outlying of urology patients on other ward, staff retention, caring for medical patients on the urology ward and interruptions to ward rounds. The Thorndale topics covered equipment issues, endoscopy case mix at clinics and provision of bladder cancer intravesical chemotherapy. All of this gave the full team and myself an understanding of the others' concerns and was an open forum with frank discussion with a list of recommendations being produced ***(Relevant documents located at S21 No 55 of 2022, 86. 20180924 urology service development meeting, 87. DEPARTMENTAL MEETINGS SUMMARY OF ACTIONS FOR SUMMER 2008, 88. MINUTES OF UROLOGY DEPARTMENTAL MEETING CAH BOARDROOM 18th April 2013, 89. MINUTES UROLOGY DEPARTMENTAL MEETING 6 JUNE 2013, 90. MINUTES FROM UROLOGY DEPARTMENTAL GOVERNANCE MEETING 19th AUGUST 2015, 91. Urology dept meeting 9.11.17, 92. Urology departmental meetings autumn 2017, 93. 20161027-Dept Meeting Minutes, 94. 20160922 - mins urology departmental meeting, 95. 20160922 - mins urology departmental meeting, 96. 2016- Dept topics autumn - M Young Hard Copy, 97. Urology Departmental Meetings Spring 2018, 98. Urol Depart Autumn 2018).***

46. 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).

46.1 The 2012 Trust Risk Register records the approval of the Urology review for the Trust in July 2011. It records the increased trends in outpatient numbers due to access targets. This is logged in red, meaning high risk. ***(Relevant document located at S21 No 55 of 2022, 100. 20120911 CRR).***

46.2 The 2013 Risk Register report logs the largest volumes of waits were in Urology and ENT. Cleansing of the lists and Specialist nurses were working with relevant consultants on urgent and long waiters. Some funding was provided to address review backlog. ***(Relevant document located at S21 No 55 of 2022, 101. 20130910 CRR).***

46.3 In 2014 the Risk Register records the additional 5th and 6th Urologist and records a general increase in the backlog of outpatients over the whole system. There was a urinary catheter project to reduce UTI rate logged. The Risk Register records being unable to recruit middle grade staff. ***(Relevant document located at S21 No 55 of 2022, 102. 20140909 CRR a, 103. 20140909 CRR c).***

46.4 The 2015 Risk Register report again highlights the risk of the review backlog but not specifically. Funding would be redirected ***(Relevant document located at S21 No 55 of 2022, 104. 20150908CRR).*** This same one line reference to urology is mentioned in the December report and again in the 2016 report where it logs the longest waits were in urology ***(Relevant documents located at S21 No 55 of 2022, 105. 20151208 CRR, 106. 20160204 CRR, 107. 20160908 CRR).*** In the Risk Register reports of 2017 and 2018, I do not see the specific word 'urology' mentioned.

46.5 The excel spreadsheet for the Acute Directorate Risk Register 2008 to 2021 records only having two flexible ureteroscopes in 2008 and the need for two more, which were purchased.

46.6 In December 2014 the Register records that cancer targets were being met at the expense of the routine patients. Haematuria appointments improved due to Saturday work. Urology waiting times were extending through NI and a further review was planned. ***(Relevant document located at S21 No 55 of 2022, 108. acute directorate risk register 2008 to 2021).***

46.7 For April 2011 the urology cancer pathway delays are recorded as the only urology entry in the document ***(Relevant document located at S21 No 55 of 2022, 109. divisional CCS 2008 to 2022).***

46.8 Other Trust documents would include minutes from Patient Safety / Audit monthly meetings, SAI reports, Departmental meetings, Theatre Users Group and the Capital Equipment List.

46.9 Departmental urology meeting topics would be listed for discussion as previously noted, for example, the saline resection system ***(Relevant document located at S21 No 55 of 2022, 96. 2016 – dept topics autumn – m young hard copy).***

46.10 The Capital Equipment List logs and ranks in order of importance the list of equipment the various departments need. Only a small proportion of this equipment is purchased, in my opinion.

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

47.1 The hospital systems that collected data on patients included PAS, NIECR, Patient Centre, SECTRA and the laboratory data system. These are the general but patient specific data information sites that solely define input information and, as such, do not highlight concerns. However, the oncology databases appear to highlight how long a patient is on their pathways and, as such, do highlight when they are likely to breach the timeframes for expected treatment. This is a system that can identify concerns. (*I am not well enough versed in the oncology system to know if this is a manual or computer system to define these breaches – I recommend the Inquiry asks a member of the Cancer tracker team to comment*).

47.2 The waiting list reports log patients by name, procedure and date placed of the waiting list, the patient's consultant and the category of urgency. The DoH have produced waiting time targets. Comparison of these targets against the waiting list breaches highlights the concern in terms of individual patients but also the overall numbers in each of the priority categories. For instance, one of the category groups may be on target at the expense of another. Even within a category group (for instance, the Red Flag service) there may be variations in the waiting time for treatment. The waiting list report can therefore identify concerns.

47.3 The radiology and laboratory reporting systems recorded on NIECR do produce a collective report of patients under the care of individual consultants in the 'sign-off' box. This gives a list of patients where the results have become available each day.

47.4 Outpatient and Inpatient data records the time frame a patient has been on a Waiting list.

47.5 Other forms of data collection will include more personalized or departmental collections for audit and research.

47.6 The theatre system records patient pathway time. This records the patient's details, procedure and all the key times the patient is at during their journey through the theatre environment.

47.7 Incidents are defined by the DATIX and the SAI systems.

47.8 Theatre outcome sheets were completed at the end of each list and sent to my secretary from 2015. This would include the patient's name, the procedure actually performed and importantly the post operative action plan for follow up. In more recent times (i.e., the last few years), I have dictated a letter on the patient's operative procedure and follow up plan. This would have been available to the GP and on the patients ECR NHS system. Outcome sheets from Outpatients are similar to the theatre record.

47.9 Most of these systems are for the individual patient records and, as such, offer clinical data. The collective data of waiting list numbers and the timeframes associated with a patient on such a list, the Datix, and the SAI systems are the

databases associated with identifying concerns. These collective data systems of waiting lists, datix and SAI are a productive mechanism in highlighting specific areas of concerns for groups and in identifying individual areas of concern, as raised later in the Mr O'Brien section of this statement.

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

48.1 Generally, these systems collect a lot of data but only on the individual patient as opposed to overall trends. However, it is the methods that offer the overall collective assessment of the data which identifies trends and this is where the Datix system is meant to contribute. For instance, if there are repeated Datix reports on patients admitted with sepsis and this group of patients are identified to be overdue a surgical treatment, this produces a trend report. SAIs may also identify common themes. Albeit that the triage issue had already been identified, I believe that the Datix system would have highlighted the point by the booking system at an earlier stage and flagged to the governance team in charge of this system, which is an independent system to the Booking Office. The Datix system, I believe, did define the trend in the inappropriate dosage of the prostate cancer drug being prescribed. The SAI reports also suggested a trend and were the trigger for the subsequent Root Cause Analysis. These two data collecting methods have been introduced in recent years and are showing their efficacy.

48.2 I am unaware of any other significant upgrade in these hospital systems.

49. As Clinical Lead, what was your role and responsibilities with regard to the Consultants and other clinicians working in Urology Services, including in matters of clinical governance?

49.1 As noted previously the Lead Clinician role is service-based and did not have a direct responsibility for other consultants other than a working relationship alongside them as colleagues on a daily basis and offering support and advice.

49.2 With regards to Staff Grade Urology doctors and urology trainee registrars, I, like the other consultants, have a mentoring and supervisory role. The degree of governance cover was dependent on their seniority and, with this, their experience to work independently.

50. Did you ever have concerns regarding governance within Urology Services provided by any of the medics under your lead? If yes, please explain in full and provide all documentation.

50.1 This is also covered by my responses to Q57 below.

51. 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.

51.1 Annually, the Trust provides consultants with their individual CLIP report. This documents activity that covers number of cases treated in the year for elective inpatients, emergencies, day case rates, length of stay, mortality rates amongst others and compares to a Peer group.

51.2 The consultant's Personal Development Plan in their appraisal folder may indicate goals to achieve within a time frame.

51.3 The job plan will define the number of clinical sessions. The number of patients expected to be seen at a clinic or a day list is usually pre-defined.

51.4 Performance objectives were originally set out in the BAUS 2000 document, which McClinton referred to in his 2004 Urology Review of the Southern Trust. This noted the expected clinical output for outpatients and inpatient workload (see Q15 above). In practice, in the early part of my tenure, the Trust set the goal high for our elective work but, due to such constraints as personnel and theatre time, the

performance targets were hard (if not impossible) to attain. Following the 2009 Review, the outpatient targets were set above the level we could provide, as we were trying to introduce new methods to the clinic design. As part of performance, the 'DNA' (did not attend) rate was in fact good and we were able to substantially improve the New to Review ratios. These were good objectives as it helped the efficiency and the productivity of the unit. Our system at present does define the expected number of patients per session. This takes into account the seniority of the clinician. Such sessions are duly amended if necessary. This data is all recorded and can be supplied by the Trust.

51.5 Objectives are also set out in the Personal Development Plan of a Doctor's Appraisal. These are generally educational and/or to address a specific project as opposed to target clinical driven output. Outcome is assessed at subsequent appraisals.

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

52.1 The cycle of job planning and appraisal were two separate entities, albeit they were meant to be linked.

52.2 The appraisal system has been performed yearly for the last 20 years. It is hospital and regionally based. The system is generic and not skewed towards a particular service. It is a global assessment yet allows an individual to log the information they wish to enclose as well as the necessary governance documentation to confirm fitness to practice, evidence of engagement and clinical activity as well as potential needs. The cycle of appraisal is annual and refers to the year before it is completed. The appraisal meeting and the documentation for an individual can be performed at any stage in that year though the Trust does now have deadlines for its completion. This has been tightened in recent years to be completed in the early half of the year. However, to gain all the information necessary for an appraisal, it can take well into the next year to collect, e.g., the CLIP report may take months to be sent. The appraisal meeting is often mid-year. This means that the discussion about the Personal Development Plan, and possibly

performance, will not be fully valid because part of the year in question will already have passed. In my opinion, it should really apply to the year after the appraisal has been undertaken. However, I do think that the current cycle of Appraisal is correct.

52.3 The cycle of Job Planning is different. This has been haphazard until recently. Over the last two years, formal meetings have occurred with dialogue and agreement. When I first joined the Trust, there was a Job Plan upon which subsequent activity was applied. I often recorded the activity myself and would submit the information. The Trust PA sessions often did not match my calculations, however, I worked the sessions that I had recorded to be my Job Plan. During the first ten years or so of my tenure, I am uncertain how frequently a Job Plan review was performed but do note that, for the Urology Reviews of 2004 and 2009, a Job Plan had been supplied for these documents.

52.4 I was aware of a job planning document (produced with joint agreement between the BMA, HPSS employers and the DHSSPS) that had been issued to all Northern Ireland Trusts. It noted the Job Plan should cover the consultant's main duties and responsibilities, scheduling of commitments, accountability arrangements both professionally and managerially, with agreed personal objectives and the support needed to fulfil the Job Plan. The Job Plan review should be annually. A checklist was provided in the document. This covered the previous year's Job Plan, workload figures, teaching, CPD, Personal Development Plan, other duties of the main employer, external duties, audit and governance and support required. A diary exercise of all activities and on call was recommended ***(Relevant document located at S21 No 55 of 2022, 111. step by step guide to job planning 13 6 05).***

52.5 The proposed Prospective Job Plan allocation in 2004 was 15.6 Pas. The form however was not signed ***(Relevant documents located at S21 No 55 of 2022, 112. profroma mYoung-requiring 10+Pas, 113. prospective job plan initial 04).***

52.6 Job planning issues arose in 2006 where SPA and Programme Director activity was not being fully recognized. I wrote to Mr Templeton at the time to record this point ***(Relevant document located at S21 No 55 of 2022, 114. new contract JT letter march06).***

52.7 Job plan issues continued till 2007. I had written to Dr S Hall, Medical Director, noting that the PA allocation of 12.5 did not match the activities covered nor correspond to other units in the province. ***(Relevant document located at S21 No 55 of 2022, 115a. let to Stephen Hall re 08 job 11 12 07).***

52.8 Subsequent to the 2009 Review, Job Planning was more frequent but did not appear to me to be annually. The Clinical Director covering Urology did review my Job Plan and, recognizing my activity, had my PA allocation adjusted and agreed. I am not sure if this ever got signed off at a higher management level.

52.9 Overall, the Job Planning sign-off was, in my opinion, rather difficult to obtain an agreement in the first decade of my tenure. I performed the work recorded on the Job Plan documents but the official sign-off and agreed payment was slow in its co-ordination.

52.10 I therefore would regard the cycle of Job Planning to have improved significantly, but it has taken a long time to do so in Urology. It is now, in my opinion, at the level it should be at.

53. 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.

53.1 As noted previously, my role as Lead Clinician was as a service post in the Urology Department. If there was a concern, my first contact would have been the Head of Service, Mrs M Corrigan. A concern may cover medical process matters such as beds and cover of the unit. This was usually raised verbally. From there, if management required a higher level, then it would pass up the ranks. This would be for the Head of Service to comment upon. Concern with regard to the doctors would

also be raised with the Head of Service and possibly with the Clinical Directors. In more recent times, the Associated Medical Director would have been an early contact point as Mr Haynes, Consultant Urologist, was in this role. An example of this would have been when I recognised an issue with Personal Information redacted by USI operating capability, I mentioned this to both Mrs Corrigan as Head of Service and Mr Haynes as AMD. Initially, I had thought that Personal Information redacted by USI was just trying to get familiar with our theatre equipment but highlighted my potential concern nonetheless. This initiated a closer review of Personal Information redacted by USI practice amongst all the consultants. This process ultimately resulted in his dismissal, as detailed further below at Q57. This identified that my concerns delivered verbally were addressed. ***(Relevant document located at S21 55 of 2022, 115b. 20200309 11:19 Patient 12 in confidence).***

54. 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.

54.1 During my initial ten years or so in Craigavon, it was evident that there was a struggle for the Trust to appreciate the level of need the urology department required. It was not until the External Review of the Southern Trust Urology in 2004 that this was understood. It was always an uphill and slow process. In saying this, Mr Templeton was very supportive when I had specific concerns about patients and when I hosted the BAUS national endourology meeting in the hospital in October 2003. On recognition of the issue, the ICATS service and the independent medical service of ASPEN was engaged on his instruction. The Clinical Director, Mr Stirling, and Medical Directors, Dr McCaughey, Dr Orr, and Dr Hall, were all supportive of my role as Lead Clinician and as a fellow consultant colleague. It was my opinion that the block in progress was therefore at a higher level in the management hierarchy or in the DoH.

54.2 Following the 2009 Review, I felt my role as Lead Clinician was very much supported by the immediate line management system of Heads of Service and Clinical Directors covering Urology. They have been supportive and deeply involved in all the projects our department have put forward. The immediate period following

the 2009 Review, it was my opinion that Dr Rankin, Director of Acute Services, although Chairing our steering group, was not as supportive of our department's personal thoughts on the recovery plan. This is my personal opinion as she did not fully follow my suggestions. I had thought her approach to appointing three consultants on one day unwise in 2012 and especially in the way the interview panel had been constructed. ***(Relevant document located at S21 No 55 of 2022, 25. letter to chief Executive).*** She also did not agree to the outpatient clinic template we had suggested at the time which actually did ultimately became our template (Ref: see Response in Q11). Subsequent Directors of Acute Service were supportive.

54.3 The redesign of the Stone Service has been led by the provision of an ADEPT fellow, Mr Tyson, and myself. We have been very well supported by the immediate management team of Head of Service, Mrs Corrigan, Clinical Director, Ted McNaboe, and AMD, Mr Haynes. Although a presentation to the Senior Management Team (which is an unusual opportunity as I had not done so before) appeared to be accepted with apparent positive comments, nothing came of it until the DoH (as part of the day elective care centre project) incorporated our unit in the regional ESWL service into the overall plan for day surgery for stone patients.

54.4 In conclusion, I felt well supported in my role by the immediate levels of management within the Trust in the Acute Services Division.

Concerns regarding the Urology unit

55. The Inquiry is keen to understand how, if at all, you, as Clinical Lead 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 Head of Service;

(viii) the 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.

55.1 The list below are the Chief Executives of the Southern Trust (as supplied by the Trust – E. Stinson)

Mr Colm Donaghy Apr 2007- Sept 2009
Mrs Mairead McAlinden Sept 2009 – March 2015
Mrs Paula Clarke Mar 2015-Mar 2016
Mr Francis Rice Apr 2016 – Mar 2018
Mr Stephen McNally Jan 17 – Jul 17 Nov 17 – Mar 2018
Mr Shane Devlin Mar 2018 – Jan 2022
Dr Maria O'Kane

Jan 2022 – present

55.2 As Lead Clinician and as a service post and not part of the official management system, I had little direct contact with any of the Chief Executives in this Trust era. Governance issues would have been at a lower level. I did however on a few occasions make direct contact with some of the Chief Executives. I spoke directly to Colm Donaghy on one occasion in relation to my concern about the centralization of pelvic surgery, noting that this provision would impact negatively on the general ability for urology to cover pelvic surgery for the Trust services of surgery and gynaecology as well as the negative principle of 'all eggs in one basket'. It was clear he was going to follow the DoH approach. The date of our meeting is unknown to me now and I do not have a record of it, only the above recollection.

55.3 I spoke directly to Mrs M McAlinden with regards to the constitution of the Consultant interview panel when we were appointing three consultants. I pointed out that appointing three colleagues on the one day was an exceptional event and careful consideration should be given. From my recollection, I was to be the only urologist on the panel initially but had felt it much more appropriate that the full team be involved and to include Mr Brown as a representative of urology from the outreach units, as we had been planning for expansion of services beyond the Craigavon site. I was concerned about team unity and flux of personnel (as was the case when two consultants left within the year). As it was, Mr O'Brien and myself represented the Unit ***(Relevant document located at S21 No 55 of 2022, 25. letter to chief Executive).***

55.4 I may have spoken with Mrs P Clarke but have not had any contact with any of the other Chief Executives apart from with Dr M O'Kane, which related to the processes around this Inquiry.

55.5 Pre-dating this Trust period and soon after I took over as Lead Clinician in the early 2000s, I had significant contact with the Chief Executive, Mr J Templeton. (1998 to 2007) His office was in the Main Hospital building on the Administration Floor. We had many meetings and correspondence with regards to all urology governance. This is documented previously and covers the McClinton report,

ASPEN independent surgery and the ICATS / Thorndale period. (see Qs 15, 54, and 57).

55.6 I remember clearly a meeting with him and the Chairman of the Trust in the Board Room with regards to my approval, support and a sense of onus of responsibility put on me for the Independent sector unit doing surgery in South Tyrone.

55.7 Contact with the subsequent Chief Executives to Mr Templeton was significantly less. The details are noted above but conversations about staff and other urological issues were not discussed. With reference to the issues raised within this Inquiry, I have not had any communications.

Medical Directors (as supplied by Trust – E. Stinson)

Name & Dates in Post
Dr Paddy Loughran Apr 2007 – Jul 2011
Dr John Simpson Jun 2011 – Aug 2015
Dr Richard Wright Jul 2015 – Aug 2018
Dr Ahmed Khan Apr 2018 – Dec 2018
Dr Maria O'Kane Dec 2018 – May 2022

55.8 The Medical Directors in the early 2000's were Dr L McCaughey and Dr Orr. As per the Chief Executive of the time, liaison with both of these Medical Directors was more involved on a personal basis as part of the broad team within the hospital setup – the ICATS era. Dr Orr did specifically address our concerns with regards to the Trust's recognition of our work volume ***(Relevant documents located at S21 No 55 of 2022, 115c. Dr Orr urology increased PA 2006, 28. Staffing issues secretaries, 29. cons-reg cover admin letter).***

55.9 The Medical Director system from 2007 onwards with regards to my role as Lead Clinician was generally one directional. If there was an issue, the Medical Director would liaise with me directly or more likely through the Acute Service leads. This was infrequent with specific reference to urology. The Medical Director's Office does however issue general patient safety documents on a frequent basis and the principle of 'office door was always open' applied if a physician wanted a conversation. As Lead Clinician, if I noted a governance issue, it would be raised first with the Head of Service and/or Director of Acute Services of the time.

55.10 Specific incidents of the Medical Director liaising with myself were when Dr Loughran, after consulting with the microbiology departments, resulted in the elective admissions to the urology ward for intravenous antibiotics and fluids were to cease. This dialogue was via meetings and correspondence. (Ref: see Q 63)

55.11 During Dr R Wright's tenure, he oversaw the governance of the temporary suspension of Mr O'Brien in 2017. Interaction between the Medical Director's Office and myself was via the Acute Services Director, Mrs E Gishkori, though I had spoken with Dr Wright in reference to Mr Suresh (see Q57). The same principle has applied to Dr M O'Kane and dialogue has been via the departmental meetings which have resulted from this Inquiry.

55.12 Apart from the issues pertaining to Mr O'Brien (detailed further below), contact with the Medical Directors in relation to other staffing or urological safety issues was minimal.

Directors of Acute Services

Name & Dates in Post
Ms Joy Youart Apr 2007 – Dec 2009
Dr Gillian Rankin Jan 2010 – Mar 2013
Mrs Debbie Burns Mar 2013 – Aug 2015

Mrs Esther Gishkori Aug 2015 – Apr 2020
Mrs Melanie McClements Jul 2019 – July 2022

55.13 Interaction with Acute Services Directors were via meetings that were not a regular calendared event but occurred when a decision on a significant urology pathway was required. For instance, Ms Youart and myself were on the Regional Urology 2009 Review committee and with Dr Rankin as part of the Southern Trust's response to the Review. These were always group discussions with management administrators and clinicians. ***(Relevant document can be located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100520 Uro Review Project Mtg K, 20100609 Action Note Uro Team Mtg K).***

55.14 From Dr Rankin's time onwards, all the Directors of Acute Services were appraised and were fully aware about the waiting list issues for outpatient and inpatient care in addition to the insufficient facilities. This was a two-way conversation in that both myself and the other urologist, if present, would discuss the predicament with the Director and her team. Such interactions were in person to assess the situations and that the governance and urology issues were within the ownership of the management team and where the clinician could help, they would do so. An example would be taking on extra work such as clinics and theatre lists. My main interaction on governance issues related to the Trust's response to the Regional Review (as logged in Q9 and Q11).

55.15 Specific patient safety issues such as triage had been brought up by Mrs Burns and Mrs Gishkori with myself. Mrs Burns spoke with me in relation to Mr O'Brien's difficulty with triaging on time and in my role as a colleague knowing the other work he had taken on, I offered to help do his triage for a period of time.(Ref: See Q 64) This, I believe, was on two occasions. This was a Trust governance issue rather than a service post issue to sort. My interaction with Mrs Gishkori was as part of the team's intervention to help with the acute situation when it was found that Mr O'Brien had a significant number of untriaged letters at home. In an office

conversation she had asked me, from a personal perspective as I had known Mr O'Brien longer than most as well as from the point of view of a Lead Clinician, if I thought that Mr O'Brien might use this as an opportunity to retire and my thoughts on the way forward.

55.16 My interaction with Mrs McClements has mainly been via the Acute Services Covid management team and the urology pathway associated with the day to day running of the service. However, I also recently raised the issue of the email system and its role in the hospital governance as a general topic ***(Relevant documents located at S21 No 55 of 2022, 116. email concerns, 117. response to email concerns MMcC).***

55.17 I do not remember specifically discussing the middle grade issues (as noted in Q57 below) with these Directors. Any other issues, such as the ward or consultant problems, were verbal and as part of a group discussion.

Assistant Directors

a) Mr S Gibson 2007 – 2009,
b) Mrs H Trouton 2009 to March 2016
c) and Mr R Carroll from April 2016 to present.

55.18 It was appreciated that the Assistant Directors were the intermediatory person between the Acute Service Director and the Head of Service, however in practice from my perspective as Lead Clinician, the working relationship and liaison was more visible with Mrs Trouton and Mr Carroll because of the issues involved with triage/charts. Dialogue on governance and urology issues of a clinical / medical nature they wished discussed were brought to my attention via the Head of Service. This was predominantly a verbal form of communication. They would have been aware of my concerns about junior and senior staff as well as ward issues via my prior conversations with the Head of Service.

55.19 The governance issue and resolution was discussed with Mrs Trouton in relation to the 'Urology ward' and its dismantling (see Q11).

55.20 The specific concerns of Mrs Trouton's in relation to Mr O'Brien's triage, as mentioned above and dealing with the acute situation of untriaged letters and misplaced charts, was subsequently led by Mr Carroll with our clinical advice ***(Relevant documents located at S21 No 55 of 2022, 118. 20170103 E re informing Consultants and 119. 20131126- email missing triage)***

55.21 Mr Carroll and myself are on the THUG committee.

55.22 The Assistant Directors and the Head of Service were the two main direct points of contact I would have had to discuss governance and urology issues in the first instance. This was predominantly verbally or by an email.

Associate Medical Directors

Name
Mr Eamon Mackle Jan 2008 – Apr 2016
Dr Charlie McAllister Apr 2016 – Oct 2016
Mr Mark Haynes Oct 2017 – Jan 2022
Mr Ted McNaboe Acting AMD Jan 2022 – present

55.23 Communications with the Associate Medical Directors were in relation to clinical issues. Attendance at joint Patient Safety / M and M Meetings would have been a forum for urology points to be discussed. Other occasions would have been topic-specific with a direct meeting. Examples were with Mr Mackle when defining the finer points of the urology 2009 Review with the setup of the service and the prior discussions about the junior cover of the unit in the mid 2000s (as noted in Q57). The plan of action to address cover for Mr Suresh was co-ordinated by Mr Mackle with myself and the other consultants. ***(Relevant document located at S21 No 55 of 2022, 120. 20151217 – confidential meeting RS).*** With Dr McAllister, we

produced our Trust's response and actions to the hyponatriaemia / saline irrigation requirements ***(Relevant documents located at S21 No 55 of 2022, 83. hyponatriaema report 20 12 13, 84. hyponataemia report 5 2 and 85. irrigation fluid response document 06 03 15).***

Mr Haynes is one of the urologists within the Trust and therefore was fully aware of urology governance and issues of the time. Mr McNaboe has only taken over this role as I retired.

Clinical Directors

55.24 These were: Mr R Brown, Sept 2009-Dec 2013; Mr S Hall, 2014 to March 2016; Mr C Weir, June 2016 to December 2018; and Mr McNaboe to December 2021.

55.25 My interaction with the Clinical Directors predominantly related to medical personnel. Any staffing issues on this front such as unfilled posts, ward cover, house officer and junior staffing issues were discussed along with asking for job plan issues to be addressed. In relation to the urology issues of this Inquiry, my interaction was in fact minimal. I had discussions with Mr Brown in regard to a plan of action for the untriaged letters (as noted in Q64) and in relation to a staff grade's performance (see Q57 re: Amino). I had spoken to Mr Weir about family members ringing me on my personal phone, which were difficult conversations and I had found it inappropriate. He also had the same experience.

Heads of Service

55.26 During the mid-2000's, Anne Brennan would have been the administrator filling this post. She headed the management structure during our phase of urology recovery following the McClinton report and oversaw the ICATS development. We would have met regularly at the meetings when defining the unit's structure. Mrs M Corrigan took on the official role of Head of Service in 2009 and has been in post till secondment in 2021, when Ms W Clayton has taken over this role.

55.27 Mrs M Corrigan has been the first point of contact with regards to any issues within the department relating to governance and urology issues of safety and patient care, both from a medical and nursing perspective. She would attend our Patient Safety /M&M meetings and departmental meetings ***(relevant document located at S21 No 55 of 2022, 121. 20130513 email attachment of mins of uro dept meeting 14 4 13).*** She would meet with the Thorndale nursing team and liaise with theatre managers and our Staff Grades. Ward issues, including staffing and patient flow for beds, were under her remit. As such, everything of a day to day nature, as well as the overall planning for the urology unit, was under her wing. We would converse most days to identify if there were any running issues within the unit. This was a verbal communication. Medical staffing, if deficient resulting in cancellation, she would sort. We would define the Theatre and outpatient rostering together. We would attend meetings, such as the PIG regional urology planning, so as to be jointly aware of the outcomes. Daily bed space updates and patient flow would be discussed – if someone was in ED needing to be seen, she would either inform myself or the on-call team. Updates on patients breaching target times would be sent to all consultants to see if there was any space on a theatre list. Regular waiting list information times would be produced.

55.28 The excessive waiting times for outpatient assessment and therapy has been and continues to be a particularly pressing issue. The Head of Service has kept both management and clinicians informed of the relevant figures and endeavoured to be as productive as possible with the available facilities and personnel. Complaints from patients are addressed by the Head of Service and I may be asked for my opinion ***(Relevant documents located at S21 No 55 of 2022, 122. 20170803 new complaint for investigation , 123. 20170803 new complaint for investigation CM A1, 124. 20170803 new complaint for investigation CM A2).*** There has been an issue with regards to the triage of referral letters ***(Relevant document located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 Martina Corrigan/20140219-email cancer performance MC).*** Although triaging of these letters can be a challenge from its volume, one consultant had found it more so than others. The Head of Service, Mrs M Corrigan, noted the return of triaged letters to be fairly consistently delayed from Mr O'Brien's office. Acknowledging that this was a Trust governance issue, and not a service issue for the Lead Clinician, I

did still aid to help the problem by doing the consultant triage for a period of time (this is commented upon in subsequent responses in Q63 and Q64). Triage and its associated issues have been a topic discussed at several Departmental Meetings including those attended by DoH administrators (Dean Sullivan) in 2014. It was noted that the Head of Service, Mrs M Corrigan, had raised the topic of delayed return of referral letters with her management colleague for some time and it had been intermittently resolved. The issues of untriaged letters and misplaced charts were brought to the urology consultants as a team by the Director of Acute Services in January 2017. This had 'come out of the blue' to the team over a short period of time, namely a week, but was addressed promptly as the urology team worked together with the Head of Service to collate the information. I was kept abreast of the plans to monitor the follow-up arrangements for triage (see further detail in Q69). Interaction with the Head of Service covered the Staff grade posts and their governance of employment. Head of Service would provide updates on vacant posts and was on the subsequent interview panel. On other occasions we, together, would have been involved in disciplinary action (as noted in Q57 for Personal Information redacted by the USI). The Head of Service also aided the urology team and the AMD in providing clinical cover for a colleague needing support (as noted in Q57 for Mr Suresh).

55.29 Other governance issues that the Head of Service and myself would jointly cover were safety issues affecting the unit, such as theatre equipment and the saline irrigation initiative from the DoH (as noted in Q57).

Consultants

55.30 The Consultants in the Unit have been able to discuss governance and patient safety in several forums: Pathology, radiology, MDT, Patient Safety, research, departmental, regional meetings as well as other arena such as ward rounds. With specific reference to concerns raised about the urology service, this has vented over twenty years and revolves around deficiencies in the number of clinicians and facilities. My role as Lead Clinician is as a fellow consultant when discussing with the administration of the Trust and with the DoH on such points. In relation to triage, I as Lead Clinician have had the opportunity to discuss this with my colleagues in several of our departmental meetings. This portal for a Lead Clinician has been a productive venue to clarify and gain agreement on outstanding issues

amongst consultants, which is independent of whether the Trust administration follows with our decisions or not. It was my clear understanding that all the consultants found the triage to be taxing by the volume of referrals. They also noted the potential detail as a challenge. Our discussion at the time of moving to the Consultant of the Week was that it was going to allow us time to perform, not only triage, but some more advanced planning by booking scans and preliminary tests. The fact of not having a full elective workload would allow this activity and complete the necessary triage on time. This was agreed by all the consultants and the Head of Service. So, my role as Lead Clinician was to gain a consensus amongst the consultants on a triage process.

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

56.1 The Trust has a complaints record system. Complaints have mostly related to waiting times.

56.2 A patient whom I had been treating for many years had complained about the care of her intravenous access, antibiotic duration and specific antibiotic being used. Case conferences about her care pathway had previously been undertaken due to its complexity. A meeting with the patient and her advocate was held to discuss the difficulties with her intravenous access. She was aware that timing of antibiotic dosages were important and therefore an intramuscular regimen was used on occasions. Her main issue is that she did not want to be given a particular antibiotic because of its known side effect of immunosuppression. This indeed was an important potential feature of her medical condition. It was an unusual feature if used over a short duration and she had had this particular antibiotic before with success. We came to the agreement that this drug would only be used as a last resort. ***(Relevant document located at S21 No 55 of 2022, 125.*** Personal Information redacted by the USI ***sept 17 doc).***

56.3 A child had presented with testicular pain after being hit in the groin the day before. When examined by myself he was not sore. I was appreciative of the family history and gave advice for continued examination by his parents for the next few

days. They did not wish an ultrasound and this was agreed as it was at the beginning of the Covid period and patients were reticent to enter the hospital. Having been well for a few days, he returned five days later with new pain and on this occasion testicular torsion was evident, requiring the testis to be removed. The patient's mother wrote a complaint letter and the Trust responded. The case was discussed at the Patient Safety Meeting without specific comments***. (Relevant document located at S21 No 55 of 2022, 126. response to*** Personal Information redacted by the ***complaint 09 06 2020).***

56.4 A patient complained after developing a perforated bowel following the insertion of a suprapubic catheter in 2015, having had the procedure six years previously. The standard Seldinger technique had been used under anaesthesia so as to gain as full a bladder as possible. This case was presented at the Patient Safety Meeting ***(Relevant document located at S21 No 55 of 2022, 127. response to complaint by*** Personal Information redacted by the USI ***24 04 2018).***

56.5 A case of a recurrent stricture formation after a urethroplasty resulted in a negligence lawsuit in 2014. This was settled without admission for a modest sum

56.6 A further negligence case resulted after primary treatment surgery in another hospital. I subsequently looked after the patient which then became part of proceedings. This was also settled without admission for a modest sum. The patient still continued to be under my care.

56.7 There are two SAI events. One related to a round-a-bout way of referring a patient to oncology. I should have made a direct referral rather than via the cancer tracker service (which was not the normal way) ***(Relevant document located at Ongoing Discovery/Ongoing Discovery May 2022/Document Number 20 iv/datix reference number/71988).*** The other was a delay in referral of four months. There had been a plan for the patient to be reviewed in the clinic but this was cancelled with the expectation of a letter being sent instead. (Ref: Datix w 64932 ID 69307). ***(Relevant document located at Ongoing Discovery May 2022/Document Number 20 iv/datix reference number/69307).***

56.8 I was referred by one patient to the GMC in 2015 for alleged delay in his investigations. The GMC investigation concluded there was not a case to answer

and the case was erased. ***(Relevant document located at S21 No 55 of 2022, 128.*** Personal Information redacted by the USI ***AS185).***

57. 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 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 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.

Other Medical Practitioners in Urology

57.1 There were four doctors with whom concerns were raised with me in addition to Mr O'Brien (who I shall deal with later, from Q61 onwards). A further doctor was under supervision.

Personal Information redacted by the USI

57.2 I produced a competency assessment report on Personal Information redacted by the USI for Mr Brown, Clinical Director, in July 2012 noting that, although he had interviewed for the post of a staff grade in urology, he had subsequently not been proven to be up to the level expected and had not coped well with the intensity of the post. This had been spotted by several nursing colleagues initially and followed through by myself and Mr O'Brien. The Trust HR were involved via Zoe Parks. Personal Information redacted by the USI was taken off the on-call rota and only undertook outpatient clinics and flexible cystoscopies ***(relevant document located at S21 No 55 of 2022, 129. statement from Mr M Young 5 7 12 re*** Personal Information redacted by the ***).***

Personal Information redacted by the USI

57.3 I was requested to supply a letter to the GMC on Personal Information redacted by the USI in March 2014. This related to decision making and care pathway issues. I was supportive of Personal Information redacted by the USI at that stage with his management of our patients and the GMC letter predated the incident in our hospital. ***(Relevant document located at S21 No 55 of 2022, 130. Personal Information redacted by the reference 21 03 14).***

57.4 Personal Information redacted by the USI was employed as a locum Speciality Doctor. He was a competent doctor and well educated in urology for outpatient activity. He was offered a substantive post but had not signed up to the post due to a pay scale enquiry with the Trust. His temperament was noted by myself to be abrupt in his thought processing but he was an attentive Doctor to patients. An incident occurred in January 2013 when he failed to attend a pre-planned clinic which had been changed on the day in question by myself, in my role as Lead Clinician, to accommodate another clinic's activity. I was informed by the senior nurse at lunchtime that there may be a potential issue about Personal Information redacted by the USI not appearing for the afternoon clinic, which indeed was the case. On contacting Personal Information redacted by the USI when the clinic was due to start, I found that he had actually left the hospital and was at home. He did not give a reasonable answer as to why he was not at the clinic. Mr Clegg, HR manager, happened to be in my office discussing other issues, when I had phoned Personal Information redacted by the USI and Mr Clegg agreed with my approach that the conversation should be terminated at that point but it was arranged that Personal Information redacted by the USI would meet with myself in my office the following lunchtime. We found this behaviour bizarre. I contacted the consultant with whom Personal Information redacted by the USI was due to help in theatre the following day and asked that the consultant perform all the theatre duties including consenting of the patients for the afternoon list. The following day, Personal Information redacted by the USI contacted me by phone with an ultimatum. I told him to meet me in my office. Just prior to this meeting I had contacted Mrs M Corrigan, Head of Service, to enquire about his contract. On returning to my office, I found Personal Information redacted by the USI sitting in my office chair. I asked if this was his usual approach to being asked to meet at a consultant's office, to be sitting in the consultant's chair and he replied that it was 'on this occasion', he had taken 'the liberty'. At this stage, I informed him that his actions the previous day were unacceptable, had put patients at risk, that he had not informed me as his line manager and had not arranged cover. He did not offer an explanation. I regarded that I had no other option than to terminate his contract immediately, which he

accepted. The full transcript of this event is referenced in a letter ***(Relevant document located at S21 No 55 of 2022, 131. my ltr re*** Personal Information redacted by the USI ***26 01 13)***

Personal Information redacted by the USI

57.5 Personal Information redacted by the USI was appointed as a substantive Consultant Urologist in December 2013. In September 2015, there was a clinical incident relating to renal trauma mismanagement. There was a delay in the recognition of the condition and the therapeutic pathway to be taken. Mr O'Brien dealt with the case promptly when he identified the problem and raised concerns about the handling of the case at the time and subsequently at the Audit meeting ***(Relevant document located at S21 No 55 of 2022, 132. 20151022 urology departmental Governance Meeting 22102015 minutes).*** Mr O'Brien raised the issue with all the Consultants (MY MH AG JOD and MC) at the time. I spoke with Personal Information redacted by the USI in regards to his experience of handling renal trauma. As a unit we were aware that renal trauma was an entity that is challenging in view of its rarity and the complex surgical training and expertise required to treat. After a consult with Personal Information redacted by the USI it was clear his exposure to this form of surgery was deficient as such cases in his previous unit would have been transferred to another unit. As a collective unit we raised the issue of the surgical assessment of the situation and ability to follow through with the necessary intervention with the hospital management, firstly with Mrs M Corrigan Service Lead Administrator along with Mr Mackle AMD. A meeting with Mr Mackle and the urology Consultants was held to define the way forward. An action plan was put in place to have a second on-call consultant available for such cases and to mentor ward rounds for Personal Information redacted by the USI's week on-call. In addition to this, arrangements were made for Personal Information redacted by the USI to attend a surgical skills course focusing on this type of surgery.

57.6 The urologist held Meetings in December 2015 and March 2016 with Mr Mackle to discuss these arrangements. Mr Mackle and myself met with Personal Information redacted by the USI to outline the necessary expectations for progress and the Medical Director, Dr Wright, was informed by myself of the actions to be taken by our unit ***(Relevant documents located at S21 No 55 of 2022 133.*** Personal Information redacted by the USI ***cover 2016 and 120. 20151217 – confidential meeting*** Personal Inform ***).***

Personal Information redacted by the

57.7 Personal Information redacted by joined the unit as a Locum Consultant in Autumn 2020. Mr Haynes and myself had vetted his CV and application for the post. Although appearing to be an adequate candidate for the post, it became apparent within a short period of time that he was not of the standard required for a busy unit with a significant emergency workload. Early in his tenure it was evident his ureteroscopic skills were sub-standard. I had to return one evening to help him in theatre to stent a patient. I put this down to not fully knowing our equipment but had informed Mr Haynes of the issue. Mr Haynes took over a monitoring process from there on, which ultimately resulted in Personal Information redacted by being released from his post.

Personal Information redacted by the USI

57.8 Personal Information redacted by the USI, GP hospital practitioner with specialist interest, worked in the unit up to April 2013. He had periods of being off sick but under the care of the occupational health system in CAH. His condition was known to the urology outpatient staff but patients were not at risk in my opinion. Sister Kate O'Neill would keep myself as Lead Clinician and Martina Corrigan updated. ***(Relevant document located at S21 No 55 of 2022, 134.*** Personal Information redacted by the USI ***).***

(b) and (c) Patient Safety and Clinical Governance Issues

57.9 Inpatient safety at ward level had been noted over the years on several fronts. It was always regarded by the urology team that best care was provided by a dedicated urology ward where nurses trained in the finer points of urology care were located on a 24-hour basis. Although the 'Urology ward' had several locations within the hospital, there was a dismantling of the principle of specialist surgical wards by the Trust so as to accommodate General Medical patient admissions. This was a general bed pressure issue for the Trust, and in my opinion understandable, but was at the expense of the Urology service. The Urology team did put across our opinion at meetings with Mrs Trouton and Mr Gibson at the time. I believe this was around the time of the Regional Review in 2009. (Ref: Mrs Trouton and Mr Gibson would have Trust Documents on this issue ***(Relevant document located at S21 No 55 of 2022, 24. Ward reconfiguration with Heather Trouton 201109).*** After discussions, we had retrieved the Urology ward principle but this is an ongoing issue following the recent Covid period.

57.10 Individual Ward bed pressures intermittently occurred where the number of patients exceeded the official allocated number. This would have resulted in three beds in a twin room or patients in the corridor (although this was rare). These extra patients would have stretched the nursing staff to patient ratio. At times there were nursing vacancies again stretching the service. Although these issues were known to the Trust, I would have also informed the Head of Service Mrs M. Corrigan. These episodes were at times of high demand on the Emergency Department. The Trust was well aware and the hospital coped as well as possible under such strain. I did feel that nursing shortages impacted on patient safety but this question would be best answered by the nursing hierarchy. Insufficient beds was the issue and outside of the Trust capability to address properly, in my opinion. This is a Trust and DoH discussion.

57.11 Patient safety issues regarding equipment had been noted over my period of tenure. I had identified that the original theatre Electrohydraulic Stone Fragmentation Device had a higher risk of causing ureteric injury. I made a business case for our unit to purchase a Holmium Laser Lithotripter. The safety benefits of Holmium Laser were documented in correspondence to the Clinical Director, Mr Stirling, in 2004 ***(Relevant document located at S21 No 55 of 2022, 135. equipment 2-04 03 02 04).*** This is still in use currently albeit with an upgrade in the system. Due to the volume of stone surgery episodes being performed on the Trust sites, a case was made to increase the number of laser devices so that elective and emergency surgical episodes did not impinge on each other.

57.12 Other theatre equipment issues pertaining to safety related to percutaneous stone surgery and the device used for large renal stone fragmentation. The device was temperamental in working and efficiency. Via the THUG meeting process a case was made for the most up to date PCNL lithotripter device (Trilogy) to be purchased.

57.13 During my tenure, the endoscopic resectoscope system was found to be outdated and of poor quality that I had suggested that this form of surgery should be discontinued until new equipment was purchased (Ref: Trust correspondence to be supplied by Mrs M Corrigan). Also, the issue of the use of glycine in relation to endoscopic resection resulted in the move to saline for irrigation. The AMD, Dr

McAllister, and myself oversaw the implementation and monitoring of this change as noted elsewhere in this document (Q 41).

57.14 Patient safety issues from particularly long waiting times for outpatients and surgical procedures have been present throughout my 24-year tenure. This whole issue has been repeatedly raised with the Trust at all levels over the years. First, with Mr Templeton and this led to the McClinton report of 2004 with the result of the ASPEN independent surgical team's work on the waiting list along with the development of the ICATS service. The 2009 Regional Review was designed to address the same issues, as was the 2014 review of this process. The waiting list figures are repeatedly presented. The Trust and the Department of Health are clearly aware of this dilemma.

57.15 Systems exist to discuss this whole problem from our departmental meeting to regional meetings with the DoH. I am not party to the discussions the Trust has with the DoH. Unfortunately, the problem persists despite actions like waiting list initiatives, outsourcing of work, and increasing staffing. The hidden pathology of those patients not seen on time is a distinct concern and, of those with known conditions, the delay in their care pathways has caused them morbidity. This has been recorded with the Trust via M & M meetings, the Datix system and personal meetings with the Head of Service and Directors of Acute Services over the years. Apart from one meeting with the Senior Management Team with reference to the ESWL service, I am uncertain of the actions of the Trust with regards to these issues but would have hoped that the DoH would have been engaged. Addressing this issue is well above the level of my role as a Lead Clinician.

57.16 Unfilled medical posts both at senior and junior levels affected patient safety governance by contributing to the waiting lists by the fact that productivity was reduced by the diminished workforce.

57.17 A safety governance issue also arose relating to the consultant on-call rota having been recognised as onerous. It was planned as a full seven stretch of days and nights. As a team we felt that this should be split with having rest nights. Most of the team had a buddy system that they switched nights on call. The management of the Trust agreed with this principle.

57.18 The clinical governance of middle grade cover for the unit has been an issue. Vacant posts for elective sessions has impacted on outpatient activity. Other middle grade cover for inpatient on-call service was not adequately resourced and funded. This went back many years. For instance, we were hoping to have a second SHO post and a proposed job plan for both SHOs was submitted to Mr Mackle in 2005 for this to be discussed at the Royal College for approval, however, this never came to fruition ***(Relevant document located at S21 No 55 of 2022, 136. sho second post proposal).*** It is only in the past year that there has been consistency

57.19 The urology trainee registrars cover a 1:5 rota with the other nights being covered by a series of locum doctors. It is only in the past two years that this has been funded by the Trust properly with a permanent team in the unit covering day and night activity. This has offered a consistent hand-over of information on patients after each session.

57.20 The governance issue pertaining to the triage of referral letters has been an issue for many years. It was always my opinion that this was a Trust management issue and above my role as Lead Clinician.

57.21 I have been concerned about the role of the email service and its impact. Over the years its volume has increased. I have appreciated that it is eco-friendly and information transcription is faster. However, putting aside the time element needed to read and digest its content and the fact that the time taken is generally un-job-planned, it was the content held within an email with which I had concern. I was unsure of the Trust's position on the transfer of information/correspondence on patients, the recording of same as an official document and the responses of the receiver when email was being used. I had concerns that the Trust's logging system did not pick up and record referrals of this kind when solely sent via an email. If an email was not addressed, accidentally deleted or there was a slow response, then there is a delay or, worse still, a complete lack of enactment. **(*Relevant documents located at S21 No 55 of 2022, 116. email concerns***). I wrote to the Director of Acute Services, Mrs McClements, on the issue and was reassured that the Trust did have an email policy and a process of capturing this information. I had previously

spoken to Mrs Robinson, Manager of the Booking Office, on this point, so that she was aware of my concern.

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

(a) properly identified,

(b) their extent and impact assessed properly,

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

58.1 The mentoring and supervision of junior doctors has long been identified as an important part of training as well as identifying issues.

58.2 The staff grade doctor issues were identified early and addressed appropriately as recorded in Q57.

58.3 The consultant issues, when identified, were also addressed early with a corrective plan put in place as recorded in Q57.

58.4 With regards to the ward issues, these have been highlighted by the ward managers to nursing and the Head of Service. I understand that the Directors of Acute Services were fully aware of the situation and that, at times of significant stress on the service, a compromise was necessary. Protocols for nurse-to-patient ratios have been applied and, on occasions, beds have been closed. Other factors like infection control have been involved in the process. It has been endeavoured to have a defined urology ward, though this has been an intermittent situation.

58.5 Nursing vacancy was addressed by locum agency staff. This issue is a nursing hierarchy and management issue but it was understood that excessive reliance on locum agency nurses could impact on patient safety from the point of view of continuity of care and the appropriate level of nurse training in the specialty

58.6 Equipment issues were highlighted at surgical directorate and THUG meetings as also noted in Q57. In recent years, it has been appreciated that more than one laser has been required, as both emergency and elective work may be undertaken at the same time. Addressing the regional saline irrigation issue had been take on fully by the Trust (as noted in Q55) with the Anaesthetic AMD involvement. This saline irrigation report by the DoH prompted our department to go one step further to investigate a low pressure system which potentially had added safety features. A report to assess a fluid pump management system was compiled in 2014 after a visit to a Berlin Urology unit by myself, Dr Morrow ,Consultant Anaesthetist, and Sister England, Senior Urology Theatre Sister. This related to the patient safety issues around irrigation fluid use during endoscopic procedures. We had suggested that one dedicated nurse should be allocated to look after the fluid management system in totality, as highlighted in a recent audit carried out in the urology theatre and backed by our observation during the visit. (report infusion pump system urology)

58.7 The on-call stretch of a full week for the Seniors has been assessed within the team and, for several years, there has been a buddy system where a night or two is covered by a colleague if so desired. This had been highlighted as a potential issue as the consultant body had noted their presence in the hospital late at night had increased over time, especially since the urology registrars finished their shift at 11 pm. Having a night off was regarded by some as a break.

58.8 The middle grade deficiency was identified but, despite advertising, has only now managed to have been sorted. The impact of a full middle grade team is evident by the output in clinical activity they now perform in the Stone and prostate service.

58.9 The email issue I had raised has been taken under the wing of Mrs McClements, Director of Acute Services. The impact of this is under consideration.

58.10 The long waiting lists have been identified, known for some time, and their impact known to the Trust and especially the Department of Health, as noted in Q57. This is an ongoing issue.

58.11 The triage issue has now been identified and action taken to address issues surrounding this topic. Moving toward the e-triage model, where all the referrals are

logged electronically with a date, means letters are not ‘lost’ and therefore this model has a distinct governance advantage over the previous method.

58.12 In my view the medical staff issues were properly considered and the impact assessed with the propriate action taken.

58.13 The ward and nursing issues were escalated to the nursing and management hierarchy. I understand that there are protocols and the Trust has high bed occupancy rates, but I do believe a considered approach had been taken with patient safety being paramount. For instance, if there were staff shortages, then beds would be closed. I also understand there was care given to how many agency staff were working on each ward at any given time.

58.14 The administrative issues have been properly identified and assessed with actions planned.

59. 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. (Q73 will ask about any support provided to Mr. O’Brien).

59.1 Staffing issues for both medical and nursing have been a continuous issue for the Trust and the Department. Following the McClinton review in 2004 there was a modest increase in both medical and nursing staff. The same followed after the Regional 2009 Review, albeit taking time to recruit and fill the posts as noted in Q15 and 16. This process continues as further staff grade doctors have recently been employed, specifically to help at ward level. The recruitment of CNS is helping the oncology and wating list issue

59.2 Although nursing staff retention has been an issue, the Trust has accepted that reliance on locum nurses is required and vacant slots in the nursing system are quickly and easily filled, taking the pressure off the permanent staff.

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

60.1 The Trust helped with the one-stop clinic by funding extra nurses. This subsequently led to the Quality Award the unit gained, as mentioned previously.

60.2 Further funding came to aid the training of nursing staff to do nurse-led urodynamics, prostate biopsies and Botox bladder injections.

60.3 A major quality improvement initiative came with the Craigavon Research Hospital Grant. This, in combination with the NIMDTA sponsored ADEPT fellow, were the main reasons for being able to complete our studies on the stone treatment's care pathways, result assessments of our treatments, the introduction of our weekly stone meeting and fund the secretarial support. All of this has significantly improved the efficiency in processing safe care on a timely basis.

60.4 The enhanced provision to increase the number of Clinical Nurse Practitioners to the service has undoubtedly been a major advantage.

Mr. O'Brien

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

61.1 The Lead Clinician is a service post and, as such, I had no direct responsibility other than being a Consultant colleague. My main responsibility as Lead Clinician related to the recording and planning of the Rota Schedule for the monthly work activity of Mr O'Brien.

61.2 In the first fifteen years of my tenure when there were either two or three consultants, I probably would have had daily contact, and certainly three to four days a week contact, of some sort with Mr O'Brien. This may have been brief contact, for instance a conversation in the corridor or in the department, or longer contact when discussing informally our plans for the unit. Weekly contact for formal meetings such as departmental meetings would have been for an hour or so. During this period, a 'Grand Urology' ward round was undertaken on a weekly basis. This ward round involved all the consultants and junior staff on a Thursday morning round which would last for approximately two to three hours.

61.3 Monthly meetings would have filled a whole clinical session for Audit (now known as Patient Safety) and, on every fourth Friday afternoon, a Surgical Division meeting in the early part of my tenure. These meetings were collective with other consultants and staff being present.

61.4 Contact would also have been during a weekly one-hour long pathology meeting which was then changed to the MDT meeting, until I stopped attending the MDT.. The hour-long radiology meeting for the whole consultant and registrar team was first thing on a Thursday morning, followed by breakfast with the whole team.

61.5 During the setting up the ICATS service in 2005, meetings were held with the senior nursing team, administrator, Mr O'Brien and myself on a weekly basis, if not indeed 2-3 times a week, for an hour or two over a period of approximately 2 years.

61.6 With the introduction of the revised urology service following the 2009 Regional Review and the employment of additional consultants, the overall type of contact was similar but the daily contact would have been less. For instance, with more outreach clinics and activity in South Tyrone Hospital and the SWAH clinics, this resulted in less opportunity for contact. Emergency on-call was also less frequent which resulted in less contact time with the team in general. This would have resulted in informal conversations 2-3 times a week. Departmental meetings, albeit planned weekly, were variable. When there was a particular work initiative for the urology unit, this would have been weekly with the consultant team in general. An example would have been our 'Blue Sky' sessions after meeting with Dean Sullivan in 2013/14.

61.7 Other times of contact continued with the monthly Audit / Patient Safety meetings involving the whole team. Over the years, specific and ad hoc meetings with the management teams would have resulted in both Mr O'Brien and myself being present.

61.8 I also undertook Mr O'Brien's appraisals over a number of years – 2010 to 2015 – as detailed at Q34 above.

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

62.1 I was not responsible for, nor had I any role in, the formulation or agreement of Mr O'Brien's Job Plans. Job planning sign-off is the role of the Clinical Directors.

62.2 I did, however, engage with him both by informal conversation and more formally in appraisal sessions. Throughout my tenure, Mr O'Brien would have focused on the overall difficulty in the Trust's recognition of his total time spent performing most duties.

62.3 In 2004, I received a response from the BMA with regards the approach of the Trust to the Urology consultants' on-call commitment. This was on behalf of both Mr O'Brien and myself. (cover for spr pay 2004 bma letter). During the tenure of Dr I Orr as the Medical Director, he did review the Urology Consultants' Programmed Activity PA and had accepted the activity we had been performing was above the Trust's figures. **(Relevant document located at S21 No 55 of 2022, 115. Dr Orr urology increased PA 2006).**

62.4 It was appreciated that Mr O'Brien had issues with the definition of his Job Plan with specific reference to the time required for administration over the years as verbalized in conversations. However, his appraisal documents appear to note his Job Plans. For instance, his 2011 Appraisal clearly set out his Job Plan and was signed with the definition of his role and contribution to unit activity being established. His 2012 Appraisal document logs an 'actual job plan schedule' as opposed to an officially signed Job Plan, The appraisal document records going to facilitation in September

2011 and the Job Plan for 2011/12 remaining in place. The 2015 Appraisal notes that the Job Plan had been adjusted by the Clinical Director and needed signing. This was my involvement as an appraiser.

62.5 However, my role as Lead Clinician was to define the monthly team daily activities for all the medical members of the team. This was achieved by holding a team meeting monthly. This included Mr O'Brien's work placement activity for the month being discussed and he would have verified his ability to cover his allocated sessions. This monthly rota Schedule does not necessarily equate exactly to an individual's job plan. Sessional allocations often were moved so as to maximize the unit's clinical output. For instance, if someone was on leave, their theatre session would have been picked up by another consultant. Another example was being flexible with the date of monthly outreach clinics. Mr O'Brien, like the other consultants, would have freely participated in this approach for the unit's delivery of activity and indeed this was the reason for having such a meeting in the first place. If I sensed someone was committing to too much activity, I would point this out and did so on a few occasions with Mr O'Brien.

62.6 So, as such, I was not officially involved in Mr O'Brien's Job Plan, but my role implemented his personally agreed workplace activity sessions.

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

(i) What were those issues of concern,

(ii) When were they first raised with you?

(iii) Who raised them?

(iv) Do you now know how long these issues were in existence before coming to either your own, or anyone else's attention?

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

63.1 My first awareness that the Trust had issues of concern regarding Mr O'Brien was in 2009 when Mr O'Brien was admitting patients, who had a chronic history of urinary tract infections, on an elective basis for Intravenous antibiotics and fluids. (It should be noted that I also admitted patients for intravenous antibiotics but they either had infections present or were symptomatic). The Medical Director at the time, Dr Loughran, commissioned an external review of this practice. This resulted in the elective admission of these patients stopping, with a new Trust pathway being put in place. ***(Relevant documents located at***

Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/20090512_Ltr_AO'brien_PLtc

20090518_letter to AOB, 20090602_ltr_AO'brien_ptc, - Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/ 20090518_letter to AOB

20090717_ltr_AO'brien_urologypatients_PLlw, - Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/ 20090602_Ltr_AO'Brien_PLtc, 20090717_Ltr_AO'Brien_UrologyPatients_PLlw

20090804_meeting re urology clinical practice, supplied by Trust E.S) - Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence Patrick Loughran/ 20090804_Meeting re Urology Clinical Practice

63.2 An incident on a ward round related to the inappropriate disposal of a patient series of fluid balance charts. This was reported by the Ward Sister, Shirley Tedford, to the Head of Service, Mrs M Corrigan. This resulted in Mr R Brown, Clinical Director for Surgery and Urology at that time, meeting with Mr O'Brien to discuss the matter and an informal warning being given at the time. The discussions relating to this issue having been accepted, resolved. The warning had time expired by the time I had undertaken Mr O'Brien's 2011 appraisal in April 2013 ***(Relevant document located at Relevant to MDO/evidence uploaded December 2021/no 77appraisals/20110101 Appraisal A'OB).***

63.3 These two issues were defined by the Trust, both of which were brought to my attention at the same time they were raised.

63.4 However, I was also aware that the return of triage letters by Mr O'Brien was slow, as I was aware that completion of triage was a stipulation to allow him to go to the 2010 European Urology Meeting in Barcelona. He was able to complete this task in a short period of time and, as such, I assumed he was just behind and slow in what he was doing. It did raise the concern to me that the Trust took this action at the time and I interpreted this as evidence that they had regarded this as a more chronic issue. However, I was not fully appreciative of that fact at that time.

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

(a) Outline the nature of concerns you raised, and why 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?

64.1 Although aware of the episode in 2010, which appeared easily resolved by the prompt completion of Mr O'Brien's triage, it came to my notice when Mr O'Brien, as Lead Clinician for NICaN uro-oncology, was preparing the documentation for the clinical pathways and preparation for the Peer Review in Northern Ireland, that he was behind again on his triage. I had appreciated the significant amount of time preparing this documentation was likely to take. Because of being behind on his triage and knowing it was going to take time to complete the NICaN documentation, I offered to do his triage for a period of time and told him to focus on the NICaN work. I felt the work he was doing was important for both the Trust and Northern Ireland Urology. I think I did this in 2013 for approximately 6 months until his project was completed. Mrs M. Corrigan, Head of Service, was aware of these actions. There

was a second period in which I did his triage and I believe this may be the reference that Mrs Burns notes when Mr O'Brien had agreed not to triage new referrals from the end of February 2014**.** ***(Relevant document located at S21 No 55 of 2022, 137. 20140224- email yesterday).***

64.2 There was communication from Mrs Trouton at the end of 2013, recording ongoing issues with triage and requesting intervention from myself and the Clinical Director, Mr Brown. The email response records that I would speak to Mr O'Brien ***(Relevant document located at S21 No 55 of 2022, 119. 20131126- email missing triage).*** The correspondence of February 2014 would indicate that I did liaise with Mr O'Brien and plans had been in place for him to complete his triage and that I would do the rest, this being confirmed with the Director of Acute Service, Mrs Burns. ***(Relevant document located at S21 No 55 of 2022, 138. 20140218-email untriaged letters MY reply).***

64.3 It was brought to my attention again in January 2015 that there were delays in the return of referral letters to the booking office that were meant to have been triaged by Mr O'Brien as well as him having hospital charts at home, which were required for emergency and outpatient attendances. Mrs H Trouton, Assistant Director, had emailed myself noting that Mr O'Brien had been spoken to about this issue on a number of occasions but it appeared as a cyclical habit and could I find a way of asking Mr O'Brien to manage the process better. ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/20150122 email MY Confidential AOB chart).*** This was backed up the following day by correspondence from Mrs M. Corrigan, Head of Service, noting further charts being taken home by Mr O'Brien and noting that this was going to be escalated to Anita Carroll and Mrs Trouton, Assistant Directors, and potentially to Mrs Burns, Director of Acute Services. ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20150123 email MY Mr O'Briend charts at home).***

64.4 At the same time as recording this chart issue of January 2015, it was noted that there was a delay in returning referral letters which were due to be triaged. These particular letters appeared to have been oncology referrals as the return times should have been within 14 days as noted by Wendy Clayton, Operational Support

Lead Cancer & Clinical Services / ATICs Southern Trust, and Martina Corrigan, Head of Service. The correspondence from Mrs M. Corrigan indicates that she had spoken to me about this issue and was coming to my office to discuss further. Following this conversation, it appears I had spoken to Mr O'Brien the same day to be informed that he was arranging tests for these patients and that this administration would be completed within a day. I informed Mrs M. Corrigan of this point but had suggested that, if this was not the case, then the booking office should go ahead and book a clinic slot for the patients anyway ***(Relevant document can be located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20150128 email MY urology RFreferrals still missing from triage AOB).***

64.5 Correspondence from September 2015, backs Mr O'Brien's approach of arranging a CT urogram on receipt of the Red Flag referral. He also either phoned or wrote a letter to the patient in reference to this and to gain the associated necessary blood test. This was indeed part of the team's agreed 'advanced triage' protocol. Mr O'Brien, however, disagreed and did not adhere to the principle of booking the patient to the next available clinic, rather delaying till the CT urogram had been undertaken before offering an appointment. This would appear to have been a contributing factor for the delay in the return of referral letters. The principles of booking tests and the processes of the advanced triage were in accordance with several discussions the consultants had had at departmental meetings, as noted by Mr Suresh and Mr Haynes in this chain conversation. ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20150914 email MY urology triaging).*** This principle was again reiterated by Mr O'Brien in May 2016. **(*Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20160517 Uro Escalation).***

64.6 On the 30th November 2015, Mrs M Corrigan sent correspondence to myself requesting help to resolve the Mr O'Brien triage problem. She noted 277 untriaged letters, some dating back to 2014. The Booking Centre was to appoint to a clinic as per the referrer request and she was going to escalate to Mrs H. Trouton, Assistant Director. ***(Relevant document located at Relevant to Acute/Evidence after 4***

November Acute/Document No 77/Mr M Young/ 20151222 Personal Information redacted by the USI I cannot recall my action at that precise time (nor have I a record) but do note (as below) that in early 2016 triage was completed by team members.

64.7 In early January 2016, there were further untriaged red flag letters; this time the Red Flag appointment team reprinted them and between Mr Haynes and myself these were then triaged. **(*Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20160107 Uro Refs no back from triage).***

64.8 The same delayed triage was noted in February by Martina Corrigan, however, this did eventually get sorted out ***(Relevant documents located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20160219 email MY Urology referrals not back from triage and Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20160407 uro refs not back from triage).***

64.9 In the latter part of 2016 (precise date unknown), Mr O'Brien and myself had a conversation when he spoke about not being keen to take new patients on as he wanted to deal only with his waiting list. At this point Mr O'Brien had said something to me about a communication from the Trust about several issues. He did not elaborate. It appeared the communication from the Trust to which he referred related to a March 2016 discussion. I was not party to this meeting. In the latter part of 2016, he felt the oncology review was the most important issue and so he was concentrating on this point of care.

64.10 It was only in late December 2016 that I became aware of the extent to which Mr O'Brien was behind again on doing triage. I was unaware of the scale of the issue and was not told by Mr O'Brien or anyone else that triage was not being done, just that there was a significant delay in it being done. I was informed in late December 2016 that there was approximately 700 letters dating back to June 2015 that had not been triaged and a substantial number of charts were at his home. It was at this point I understood that the Medical Director, Dr Wright, having been aware of this issue, intervened. As a Group of Consultants, myself, Mr Glackin, Mr Haynes and Mr O'Donoghue met with Mrs M Corrigan and Mr R Carroll, Assistant Director, to be informed of this whole picture. I recall seeing the bundle of referrals which were not

triaged in December 2016 and being particularly surprised by the volume**. *(Relevant document located at S21 No 55 of 2022, 118. 20170103E re informing consultants).***

64.11 Around the same time as the triage issue of November 2015, I was informed about a further issue related to the lack of follow up arrangements being defined after a clinic appointment for a patient in June 2015. Firstly, a dictated letter was not available on the ERC patient record and, secondly, it appeared that Mr O'Brien did not use the clinic outcome sheet ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20151203*** [redacted] ***).*** The outcome sheet was an integral part of the clinic process as it allowed a secretary to know in advance of doing the typing if there were important issues to address and who had actually attended the clinic. I was not aware that Mr O'Brien did not do this as it had been discussed before at departmental level. *This requires verification as other correspondence does record outcome sheets being available* ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20170113 Pts for review SWAH, 20170113 Pts for review SWAH A).*** There are further examples of delayed / undictated letters for greater than six months, which interrupted clinicians' understanding of the patient's planned care pathway in late 2015 and in August 2016 ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20151219 S*** [redacted] ***and Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20160824*** [redacted] ***).*** I was under the impression by August 2016 that the Clinical Director, Colin Weir, may have been planning a meeting with Mr O'Brien. Charts misplacement and undictated letters appears to have continued till October 2016 when I suggested the patient in question be put on to my clinic and direct correspondence sent to Mr O'Brien to return the chart promptly ***(Relevant Document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20161014*** [redacted] ***).***

64.12 Concerns about Mr O'Brien's performance, apart from my offer of help with the triage, were initiated by the Trust Management Team of Mrs M. Corrigan and Mrs

Trouton, this being passed to them, the delays having been noted by the Booking Office and Red Flag Team.

64.13 At the time, I was not aware of the meetings held by the Medical Director, Dr Wright, or Clinical Director, Mr Weir, with Mr O'Brien as mentioned in the subsequent correspondence of Mr Haynes. ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20181018 Return to Work AP).***

64.14 It was appreciated that Mr O'Brien was vocal about saying he had difficulty in completing triage as he did not have enough time. I know he wished to perform the 'advanced' triage in a detailed fashion and did not have enough time allocated to do this work. However, he had not indicated the extent to which he was behind in his triaging either in the number of referrals or the timespan they dated back, having had plenty of opportunity to do so in departmental meetings and in his appraisals with me from 2011 to 2016. From recollection, his voiced concerns on triage were from after the time of the introduction of the Urologist of the Week. He raised his concerns at our departmental meetings, whether the topic was scripted for discussion or on an ad hoc basis. The quantum of consultants and the Head of Service at each of these departmental meetings over the years (2014 -18) did vary, however, we all were aware of his comments. It was pointed out that we felt the detail and depth he was aspiring to attain was above the necessary level to complete the totality of the triage for the week. Booking an investigation was the arrangement we had discussed initially when setting up the Urologist of the Week system. ***(Relevant document located at S21 No 55 of 2022, 139. Urol depart autumn 2018).*** I was not aware of anyone else that he had conversed with on this issue nor any correspondence he has produced other than in 2018 for the 'Developmental day' meeting.

64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, to my knowledge, at the meeting in January 2017 as part of the lookback exercise and I am unaware of further meetings on same.

64.16 The more recent concerns in reference to the SAIs in relation to delayed referral on to oncology and the prescribing of Casodex / Bicalutamide, I only became aware of around the time of Mr O'Brien's retirement.

64.17 This Inquiry will have identified other issues with regards to Mr O'Brien's practice. These relate to the findings of SAI reports and the two Root Cause Analysis report that have resulted from these episodes. The first Root Cause Analysis report on the review of a Serious Adverse Incident covered the period January 2016 to September 2016 but was not signed off till 22 May 2020. This was five weeks before Mr O'Brien retired and the second Root Cause Analysis was in March 2021, nearly a year following his retirement. I was not party to these reports and certainly unaware of the first being commissioned. I was therefore unaware of the content of these reports and, in fact, had been preparing a leaving event for Mr O'Brien on his retirement in July 2020 ***(Relevant document located at S21 No 55 of 2022, 140 20200622 retirement of Mr Aidan O'Brien – consultant Urologist)*** with the expectation he would be returning part time.

65. 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.

65.1 I was involved in the discussions with Dr Loughran and Mr O'Brien in reference to the IV fluids and antibiotics. This defined the Trust's position on the topic but did result in a new care pathway for these more complex cases involving the microbiology team. (see Q63)

65.2 The issue relating to the inappropriate disposal of fluid charts from the medical records was discussed with Mr O'Brien at his 2011 appraisal. He recorded that he had a formal meeting with Mr Brown, Clinical Director, noting the errors and was regretful of the event (see Q63)

65.3 Discussions with regards to the triage issue are also covered in my response to Q64. Discussion with reference to Mr O'Brien and his triage or triage in general were predominantly at the departmental meeting. These were either raised as part of

the agenda or brought up independently on an ad hoc basis in the ‘Any Other Business’ section.(see Q64.14)

65.4 Triage discussed on a programmed agenda was mainly within the context of setting up the Urologist of the Week change in our working pattern in discussions during 2014. All the consultants had sensed the number of referral letters had increased and were more detailed. Mr O’Brien was not alone in this concern. Mr O’Brien was a great advocate for the principle of Advanced Triage, however, his concern was the depth of the added work involved rather than an emphasis on the number of referrals, which we all knew. The level of triage he was aspiring to achieve was difficult to attain possibly, some may comment that he was almost trying to do it in too much *detail, and as such the totality took too long. He* complained that others may not have done it properly. It was appreciated that triage was taxing but the other consultants felt that, if they were able to complete the task, then they could not understand why Mr O’Brien could not also do so. The nature of these discussions would note the detail of depth of triage as the arranging of first line investigations which were mainly to book a radiological test. This triage was not set to the level of a virtual clinic ***(Relevant document located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 Martina Corrigan/20180213-email departmental meetings).*** Time to perform triage was discussed and, although the duration was not fully defined, we had noted the current allocation in 2018 had been six hours. Further assessment was to be undertaken. ***(Relevant Document located at S21 No 55 of 2022, 139. 2018 urology departmental meeting Autumn 2018).***

65.5 Relevant discussions with the Management team are documented in Q64 above. This records the emails relating to triage and charts. At the same time as these emails were sent, there may have been conversations in their offices, to my recollection. I had a conversation with Mr Brown, Clinical Director, with regards to Mr O’Brien’s triage in late 2013 at the request of Mrs Trouton, Assistant Director. Mr Haynes and myself were involved in the triage of early 2016.(as noted in Q64)

65.6 After Christmas 2016 / early January 2017, my consultant colleagues Mr Glackin, Mr Haynes, Mr O’Donoghue and myself met with Mrs M Corrigan and Mr R

Carroll, Assistant Director, with regards to the Trust investigating the substantial number of untriaged letters and misplaced patient records that had been in Mr O'Brien's house. We were asked to partake in an exercise to triage these outstanding referrals and to review the medical records to identify if there were any patients that could be at risk. Of those referrals I triaged, several were upgraded to Red Flag and I asked a colleague to verify if he agreed with my decisions. Some were clearly Red Flag referrals. I am also aware my colleagues also upgraded some referrals. All un-triaged referrals had the potential for patients to come to harm. During the look back exercise, I didn't see any GP coded Red Flag referrals among the un-triaged referrals, i.e., it seems the Red Flag letters were triaged. Red Flag referrals are usually printed on yellow paper to make them stand out. The hard copy GP referrals are on their standard headed white paper. It was not clear to me if Mr O'Brien had screened the routine letters. This exercise took several weeks ***(Relevant document located at S21 No 55 of 2022, 118. 20170103 E re informing Consultants).***

65.7 Following Mr O'Brien's return to work, I was made aware by Mrs Corrigan, Head of Service, that a stipulation for this was that triage by Mr O'Brien was to be completed by the end of the Friday after being on-call and this would be monitored by herself for Mr Carroll, Assistant Director.

65.8 The issue pertaining to private patients were discussed in the lookback exercise of early 2017 (see Q64). I have had no other conversations on this point that I can recall.

65.9 The SAIs leading to the Root Cause Analysis have only been available following Mr O'Brien retirement. In addition to the comments made in response to Q64 on this issue, I did become aware of the insufficient prescription dosage of the prostate medication around the time of Mr O'Brien's actual retirement date following a conversation with Mr Haynes.

65.10 Soon after Mr O'Brien retired, Mr Haynes informed me that several other cases relating to the prescription of the Casodex / Biclalutamide had come to light in addition to the delay in MDT referrals to oncology. He said the Trust was informing the DoH.

66. 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.

66.1 There had been several reasons to move towards the Urologist of the Week. These were not only recorded as issues by Mr O'Brien but collectively by the department. We had several departmental meetings as part of what we called the 'Blue Sky' approach in 2014 – start with a clean sheet principle ***(Relevant document located at S21 No 55 of 2022, 141a. 20140818 Urology vision pathway 2014 and 141b. The Vision 1 Sept 14 presentation).*** Mr O'Brien was a keen participant in these meetings and with this collective agreement we made. Everyone bought into the process. This allowed more consultant-led decision making on patient care and without the elective activity interfering with triage (there had been thoughts on having elective activity in the afternoons but we all soon appreciated that this was not a good idea). This was an important step for the unit to enhance the service in all aspects including patient safety issues. Mr O'Brien appeared a strong advocate for these changes.

66.2 As noted previously, I appreciated Mr O'Brien had taken on extra work with the documentation relating to NICaN. I offered to help by doing his triage for several months in 2013 to allow him to complete the project. I also helped for a short time the following year with his triage.

66.3 The Booking Office duplicated all the paper referrals so as to have a second record of the referral in case the first was misplaced or not returned. The Booking Office also introduced a default mechanism of a preliminary triage grade as recorded by the person referring the letter but pending amendment to the consultant's assessment later, if necessary. I believe this was introduced in approximately 2014. This initial default triage for the letters assigned to all consultants, and especially Mr

O'Brien's, resulted in the red flag and urgent referrals being identified if the letters were not returned within the specified timeframe.

66.4 As previously noted, when the Trust requested the consultants in early 2017 to review the outstanding triage and charts, we engaged with this process promptly and the rationale was to identify if there were any patients at risk from a delay in the screening of letters or to identify if any patients required an early review consult. The follow-up of this process was led by the Trust Management system led by the Directors of Acute Services, Mrs Gishkori and then Mrs McClements. As clinicians, we were not involved in the decision-making process about Mr O'Brien's return to work **(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20181018 Return to work AP**. This I understand was via the Medical Director and Chief Executive's offices.

66.5 Monitoring of triaged letters and the return time specifically for Mr O'Brien was introduced after his return to work in 2017.

66.6 Monitoring of outstanding dictation for clinics and discharges has recently been introduced as a general policy but I suspect the issues with Mr O'Brien were an initiating factor.

67. As Clinical Lead, 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?

67.1 Triaging of Red Flag referrals should theoretically be processed on a daily basis as per Trust Guidelines. Such prompt triage, however, did not as such concern myself as the patients in general terms were not going to be seen that quickly and with the advanced triage system a scan was a likely test to have been completed in between referral and being seen. We often still meet our target times. The important point however was that the Red Flag patients were all identified. Red Flag letters sent by the GP were straightforward and easily identified by colour of the paper they were printed upon or the GP logged this at the top of the page.

67.2 We as a collective department agreed that triage was best performed by consultants. I personally regarded this as important for the reason that it was the screening of the 'Urgent' and especially the 'Routine' GP category referrals as being the most important. This was to ensure that what was defined as 'Routine' by the GP was in fact correct or whether, instead, there was some indication that needed upgrading to a Red Flag.

67.3 So concern existed if the 'Routine' and Urgent' letters had not been screened. This is part of the reason for asking for the letters to be returned following triage so that the Trust's Booking Office can process appropriately. Albeit only after Mr O'Brien's return to work I had a conversation with him on this precise point noting the importance of the 'Routine' referral. He agreed. My role as Lead Clinician did not extend to risk assessment. Once these issues were raised then the medical and administrative management structure were the team to complete this assessment. However, as a group we were involved in the risk assessment when asked to address the un-triaged letters in early 2017.

67.4 Undictated correspondence following a clinic appointment is a risk from the perspective that other clinicians may not know the outcome of a consultation. This would be the case for a GP as they would not have access to the chart. Hospital team would have the benefit of seeing the written commentary but not any other thoughts. Without the return of 'Outcome Sheet', the secretary would also not know how to process the patient when the letter is undictated. I believe Mr O'Brien had liked to dictate after the completion of the patient journey. This, however, missed opportunities for other clinicians to be kept informed in-between times. At several unspecified and un-minuted Departmental meetings, this had been raised with and without Mr

O'Brien's presence. The secretarial management would have been aware of these points.

67.5 The lack of availability of viewing a chart opens the possibility of a patient not giving a clinician the full medical history necessary. This is not so much an issue now as most, if not all, of the medical history is on the ECR system. I understand that the administrative management teams would have directly contacted Mr O'Brien if a chart was missing.

67.6 The more recent issues of late referral onwards to oncology, I was not aware of until Mr O'Brien retired. However, this is an obvious example of a patient safety issue.

67.7 So, in summary, I believe that potential risk to patient care and safety was recognised. For example, the risks associated with untriaged or undictated letters may impact on patient care and safety, especially if the result was delay in diagnosis of a condition that has a time dependant treatment pathway. It is appreciated that issues were brought to my attention by the management structure, however, assessing risk and determining remedial actions were not within my domain, albeit that my colleagues and myself were involved in implementing some of the necessary remedial actions (e.g., working through untriaged referrals in early 2017 – see Q66). It was recognised that this was an issue for the higher management structure, rather than the Lead Clinician role, to sort out.

68. 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.

68.1 As noted previously, I helped with periods of doing his triage.

68.2 Other areas of help included the fine-tuning of the monthly schedule. The SWAH urology clinic was monthly and was an all-day clinic. Reasonable travel time was involved for the clinicians, namely Mr O'Brien and myself, to attend and return from this clinic. It was always a Monday. Mr O'Brien liked to have time set specifically aside the day after the clinic to do all the administration associated with

this clinic. This was a request that was built into the schedule. I am unsure of the precise time when this was commenced but certainly was in place for a few years before his return to work in 2017. This schedule continued until this clinic ceased. It was customary for the surgeon to collect the set of charts for this clinic on the Friday before and bring them when travelling to the clinic. This, in fact, gave an opportunity to prepare for the clinic, if wished. The clinician would bring the charts home again that evening after the clinic. In my circumstance, I brought the charts back to the hospital on the Tuesday morning before going to my theatre list. For Mr O'Brien, as noted above, the clinical session on the Tuesday morning following the SWAH clinics was left unfilled so he could complete the dictation and administration and with this to return the outcome sheet with the notes on return for his Tuesday afternoon Craigavon clinic.

68.3 Following his return to work in 2017, Mr O'Brien would take the Friday after his on-call week off as leave or he was not scheduled for work sessions. This was to allow him to complete any untriaged letters that he was not able to do during his on-call week. Often, letters arrive in the 'in-tray' late and therefore can roll over into the scheduled elective care sessions. Also, if it had been a particularly busy on-call week, then finding the time to complete triaging could have been difficult. In my opinion, it was a reasonable request for him to have leave but an unfilled schedule was the plan so as to allow him time to complete triage as this was a stipulation for his return to work. Triage was to be completed by the end of the Friday after the week on-call. It appeared that this time allocation was sufficient as I was unaware of him asking for more time.

69. 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.

69.1 My role as Lead Clinician did not cover the monitoring process of Mr O'Brien's practice, either before or after the definition of these issues.

69.2 As indicated in my response to Q68, I do know, however, for Mr O'Brien that a timeframe for return of triaged referrals had been set for the evening of the Friday after completing a week on call (I needed to know this as it was relevant to setting rotas). On-Call was a Thursday to the following Thursday morning. Monitoring for this new arrangement was via the Head of Services for Urology, Mrs M Corrigan, who would report to the Assistant Director, Mr R Carroll.

69.3 This process differed from before as such monitoring by the Head of Service was not part of her role specifically but she would have been informed by the Booking Office if there had been outstanding triage.

69.4 This process also differed from before by the fact that, although there were guidelines for triage return timeframes, pre-2017 I believe that Mr O'Brien's triage return timeframes were variable and as such difficult to entirely monitor and enforce.

69.5 I understand that there was meant to be a report generated on the completeness of Mr O'Brien's triage after his on-call week.

69.6 Monitoring of chart location and outstanding dictation was more vigorous with interval records of these figures being distributed. ***(Relevant document located at S21 No 55 of 2022, 142. email 20181017 return to work action plan clayton to Carroll and Corrigan).***

69.7 The Trust Management Team would be in a better position to comment on the metrics, and provide details about who defined and oversaw the process.

70. 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?

70.1 The monitoring of Mr O'Brien's triage was a management responsibility issue outside of my remit as Lead Clinician.

70.2 However, I can confirm that documents were produced recording other metrics regularly. They were straightforward, in recording the number of charts on level 2, undictated discharges and clinic letters, and those waiting to be typed. These metrics reports were sent to all the consultants and their secretaries for their information. The process of this recording appeared effective, and was taken as a prompt if you were behind or a note if someone was off on leave and, as such, someone else needed to pick something up.

71. 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?

71.1 I understand that the monitoring process put in place did remedy the triage issue as the Head of Service kept a check on this weekly and daily if required. I understand a report was kept and Mr Carroll, Assistant Director, informed (if further information on this is required, the Head of Service Mrs M Corrigan can supply it).

71.2 Although not within my remit as Lead Clinician, I was verbally informed that the process was working well for over a year.

71.3 However, the Head of Service had a spell of leave that was longer than expected. It came to light later, via correspondence from the Assistant Director Mr Carroll, that the monitoring process had slipped during this time.

71.1 Further commentary on this would best be given by Mr Carroll, Assistant Director (***Relevant document located at Relevant to Acute/Evidence after 4***

November Acute/Document No 77/Mr M Young/ 20181018 Return to work AP). However, it was reported that the monitoring process, when in action, was productive.

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

72.1 Mr O'Brien has raised concerns about patient care, safety, risk governance and administrative issues over many years. He has been focused on the importance of inpatient care over his whole tenure. The McClinton report (2004, discussed above) was based on our concern over the volume of emergency cases and not being able to deal with elective cases. This was addressed by the McClinton report in which Mr O'Brien was involved

72.2 He was particularly concerned about the loss of radical pelvic surgery in the Trust and its impact on other pelvic surgery provision. This being raised at the beginning of the Regional review in 2009 with the committee and Mr Fordham, the clinical urology lead for the Review. This was considered but regional centralization for this surgery was the agenda.

72.3 The dismantling of the urology ward in 2009 was felt to be a backward step. This issue was raised at our departmental and specially arranged meetings with the Trust Management. This was not just Mr O'Brien's concerns but department's as well. Mrs Trouton and Mr Gibson, Assistant Directors, as well as Mr Mackle AMD, were involved in these meetings. Eventually, we regained the principle of patients being cared for on a urology ward.

72.4 Time for performing administration had been an issue for Mr O'Brien throughout his tenure. I understood it may have been one of the main reasons he had difficulty signing off his Job Plans over the years. This discussion would have been with the Clinical Directors during his tenure. Although there was a sense of agreement amongst the clinical staff that administrative time was not generally adequate, I understand that Mr O'Brien would have known that his allocation of time was the same as others.

72.6 Mr O'Brien had contributed to discussions when we had met Dean Sullivan from the DoH in 2014, when our departmental team held meetings to discuss our response to the Regional Urology Review. He was concerned about all the waiting list. Triage, he felt, should have been separate to the on-call activity. The initial plan for the On-call week had incorporated clinical activity in the afternoon but we all agreed that on-call emergency and ward activity, in combination with the advanced triage system, would be the activities performed during the on-call week. Mr O'Brien was in agreement with this plan.

72.7 In preparation for our Developmental Day in September 2018, Mr O'Brien had written a document in relation to his main concerns. These included Urologist of the Week, triage, and waiting times for outpatient and elective surgery.

72.8 Mr O'Brien, in this document, when discussing the concept of the Urologist of the Week principle during our 'Blue sky –Vision' departmental meetings and with Mr Sullivan in the summer of 2014, felt that when on-call then no other activity should be undertaken. He did however subsequently acknowledge triage would be part of that week's work.

72.9 With regards to triage, he had found it impossible to complete triage while Urologist of the Week and still did so at the time of this Developmental day meeting in 2018. He noted he would do a detailed triage during the weekend after being on-call, noting that this was equivalent to several virtual clinic sessions and using up his administrative time. He stated that the Red Flag referrals were straightforward but stated that the urgent and routine were the issue, particularly in the context of the waiting times for the first consultation. He noted that these patients often needed an investigation in the meantime.

72.10 Not only did Mr O'Brien comment on time spent on triage during this 2018 meeting as being an issue but there was a plan for this to be assessed further.

72.11 He was concerned that the registrars, when called about cases elsewhere, were not passing this on to the consultant for their input. I understand that the training registrars, as part of their induction to the unit, are now informed about this feature by the programme director.

72.12 He expressed concern that a daily ward round was not being done by all consultants during their week on call. He also considered that any activity other than the primacy of inpatient management should not be undertaken, 'never mind triage'. He was concerned that inpatient outcomes had been compromised.

72.13 He expressed concern that, when patients were an inpatient, they should have had their investigation completed before discharge.

72.14 A further concern he had raised in 2018 was in relation to the quality of nursing care on the ward. He expressed issues about the level of stability in the nursing staff as there appeared to be a high turn-over and this was aided by the winter pressures often seen. ***(Relevant document located at S21 No 55 of 2022, 92. Urology departmental meetings autumn 2017).***

72.15 I remember Mr O'Brien raising the issue of predictable and unpredictable on-call commitments in recent years. This related to the planned activity of weekend ward rounds and whether this should be specifically recorded in Job Plans for both Saturday and Sunday mornings. This was to be assessed when discussing subsequent job plans.

72.16 He had requested the Trust's Policy and Procedure on Triage but had not received a response and, in January 2017, had advised the Director of Acute Services that the issue of triage and its relationship to the UOW be addressed. He requested a clear written understanding of the obligations to triage.

72.17 He was concerned about the inter-specialty disparity in waiting times, he felt the Trust Board were unaware of this point, and logs that the long waiting list has resulted in morbidity for his patients**. *(Relevant document can be located at S21 No 55, 86. 20180924 urology service development meeting).***

72.18 Addressing the concerns with regards assessing triaging time and definition of predictable work during on-call, was not within my remit as Lead Clinician but lay with the higher level of medical management. It was, however, recognized as 'work in progress' when discussed at departmental meetings.

72.19 The nursing issues were a topic to be addressed between the Head of Service, Ward Sisters and the nursing management teams.

72.20 In relation to triage, all the other consultants at departmental meetings over the years did record their frustration with the volume of work required to complete the task but were still able to complete their allocated triage list within the on-call week timeframe, though sometimes it did run over if there was a busy week. When explaining the depth in which Mr O'Brien performed his advanced triage, we would point out this level of commitment and time taken was not necessary and it was not designed to be a virtual clinic activity.

72.21 The commitment to the preparation of cases for the Oncology MDT meeting was noted to be substantial by Mr O'Brien and the rest of the team and it is understood that time allocation in the Job Plans of those consultants that commit to chairing the panel, is now recognised.

73. 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.

73.1 As discussed above, when triage was identified as an issue to me, I offered help in doing his triage when he was preparing the urology regional uro-oncology and Peer review documentation.

73.2 As also discussed above, rostering of the Friday clinical sessions post on-call weeks were either left free or taken as leave. It was regarded as a productive and supportive way forward.

73.3 I understand that time within the job plan had been allocated to allow for MDT preparation.

73.4 As described above, rostering of the Tuesday morning after attending the SWAH clinic was left free.

73.5 I understand that an assessment of time spent for predictable and unpredictable work during the on-call week was to be undertaken. This assessment was also to include time spent triaging.

73.6 Ward issues were to be addressed with the registrars by the Programme Director and Educational Supervisors.

74. 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.

74.1 In the course of responding to this Inquiry, I have now seen documents that I have requested. Urology issues have been recorded in Corporate, Acute and Divisional Risk Registers. Equipment issues were reported in 2008 **(relevant document located at S21 No 55 of 2022,108.** ***acute directorate risk register 2008-2021),*** Urology cancer pathway delays in 2011, urology access waiting times in 2012 and 2013, and review backlogs in 2015 ***(relevant documents located at located at S21 No 55 of 2022, 100. 20120911 CRR , 101. 20130910 CRR 104. 20150908 CRR).*** Theatre staff deficiency is also noted ***(Relevant document located at S21 No 55 of 2022, 143. Divisional SEC 2008-2022),*** as is the ward overcrowding issue in 2017.

74.2 Whilst it is recognized that some of the departmental meetings are poorly minuted, the more major meetings (such as in 2014 with the DoH representatives for

the Blue-sky Vision way forward project and the Developmental day in September 2018) do reflect concerns raised by Mr O'Brien.

74.3 The Trust Management team may have additional information.

Learning

75. 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.

75.1 As part of this Inquiry, I requested information pertaining to any other Root Cause Analysis other than the one published after the Health Minister made his announcement. I have been supplied with the Root Cause Analysis report on the review of a Serious Adverse Incident covering the period January to September 2016. This was only signed off on the 22nd May 2020***. (Relevant document located at S21 No 55 of 2022, 144. 20200522 final report).*** This report was assessing the issue of Mr O'Brien's triaging. The executive summary notes the causal factors as the GP not assigning the clinical priority accurately and that the referral letters had not been triaged. One of the recommendations did suggest the Trust should re-examine or be reassured that it is feasible for the Consultant of the Week on-call to triage both non-red flag and be on-call. It suggested the Trust produce a written policy and guidelines for clinicians on the expectations and requirements of the triage process. It recommended that there be a monthly audit report for each consultant's compliance with triage and, if a persistent issue existed, that this would be escalated to the Medical Director and Chief Executive. The report recommended that the Consultant in question needed to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his colleagues, thus ensuring all patients are triaged in a timely manner. He was to review and rationalize his obligation to prompt triage along with his other duties.

75.2 The report comments that the consultant under review 'was the most persistent' of the consultants not triaging and 'there were multiple attempts to tackle the issue'. The report logs the triage issue to extend back to 1996. This was

addressed but ‘would slip back’. In 2007 there appeared to be a ‘cleaning up’ exercise of a 10-year waiting list. In 2010, the Director of Acute Services and the Associated Medical Director were aware of the triage issue again and in the report it comments that the Director of Acute Services painted a picture of many issues with the consultant in question. The Head of Service commented on ‘inheriting the problem,…. that it was a long running issue, going back perhaps 25 year, … had the longest backlog and took longest to triage,…and when asked to triage, didn’t do it …. This ‘came to a head in 2010 and again in 2014’.

75.3 The report comments on the Index case review from 2016, published in March 2017, that ‘a significant number of letters within urology are not being triaged by the minority of the Team’. This panel also concluded that triage of the GP referral letters remained a key element in validating and ensuring patient safety, with the opportunity for early intervention for patients at risk of malignant disease. A letter highlighting several concerns was sent to the Lead for Acute Governance for Acute Services in December 2016. It pointed out that the existing processes did not have a clear escalation plan to include the individual consultant and had not been effective in addressing triage non-compliance. It also recorded that, from July 2015 to October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting. In January 2017 this was escalated to the Director of Acute Services, the Assistant Director of Anaesthetic and Surgery, Medical Director, and the Chief Executive.

75.4 This report also records that the Assistant Medical Director had written to Mr O’Brien in March 2016 to address governance and safety in regards to the untriaged letters going back over two years. The report records that Mr O’Brien had responded to the chairperson of this index case study as to the fact he did not have time to perform on-call duties and triage non-red flag referrals.

75.5 The look-back exercise identified 700 letters in Mr O’Brien’s filing cabinet which were then reviewed by the other consultants (this refers to January 2017).

75.6 The review team for this Root Cause Analysis report interviewed past and present Directors, an Assistant Director, Head of Service, an AMD, and Mr O’Brien. The importance of triage was recognised by all and Mr O’Brien had commented

'number one ranking in overall scheme of things'. This report noted the upgrade of letters from GPs was recognised in the 2009 Regional Review as significant in number.

75.7 The Panel for this Root Cause Analysis interviewed Mr O'Brien, noting his lead in the NICaN process and him agreeing that triage was very important . He still stated that he would not triage non-red flag referral letters. He had felt that triage was too time consuming and rendered inpatient care unsafe. The panel regarded that Mr O'Brien's method of triage was beyond what was required and was equivalent to a virtual clinic. He was offering a higher standard of care to some and not others. The panel noted that the other members of the team were able to perform the Consultant of the Week duties and triage, offering patients similar outcomes to what Mr O'Brien's way of 'advanced triage' had done.

75.8 The Review team panel noted Mr O'Brien had consistently not returned triage information for many years, possibly decades. This was recognized by Directors of Acute Services, AMD, and Head of Service. Periods of compliance were followed by non-compliance.

75.9 The panel noted that the 2014 Informal Default Triage system would still miss those patients who would have been upgraded to Red Flag. The review team assessment of escalation to the Medical Director and above only occurred around the time of the lookback exercise and only put into place a process to monitor in 2017. The panel note that Mr O'Brien had highlighted his views on time pressure of COW and triage at the same time.

75.10 This Root Cause Analysis, which was signed off in May 2020, has been particularly informative for me. It was a shame that, although covering the period of 2016, it had taken a further 4 years to be signed off. This report has highlighted the duration of the triage difficulties with Mr O'Brien that had been known to the higher management for many years but the significance of the amount not known to his colleagues until a few years prior to the '2017 look back exercise'. Probably the most important comment, however, is that Mr O'Brien stated to the panel that he would not triage non-Red Flag referrals. This should have triggered an earlier disclosure as,

despite Mr O'Brien's recognition of the importance of these, he still did not give the required commitment.

75.11 The second Root Cause Analysis has only just been signed off in March 2021. This had identified delayed oncology referrals and was only commissioned at the time of Mr O'Brien's retirement.

75.12 This highlighted two issues, firstly the drug prescription and secondly a delay in prompt onward referral. I am unsure about the drug prescription but if there was a mechanism to confirm the outcomes of MDT had been actioned, this would have identified this issue. I do not believe I was in a position to have recognised this shortfall in Mr O'Brien's practice. I was not an integral part of the system setting up the uro-oncology service and there was the expectation that a clinician followed the MDM outcome.

75.13 All referrals should be passed on to the Booking Centre. This also includes email referrals. I have mentioned this to Mrs Robinson (Booking Office Manager), who reassured me that the secretaries know to forward these on. However, if these are not passed on by the doctor to the secretary, then there is scope for missing this referral process.

75.14 Delay in employment of the CNS has affected the referral system to oncology. This would have been a further checking mechanism - they would have picked up on the delay.

75.15 A summary of a patient's care plan is noted on the clinic 'Outcome Sheet'. This lets secretaries know the plan for a patient while awaiting the dictation. If the dictation was delayed, the secretary could still have had the opportunity to identify any issues.

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

76.1 It should not be forgotten that the Urology service in the Southern Trust has a lot of positive attributes over the three decades of its existence. It has, however,

been an uphill struggle and any changes were slow and underfunded. From the start, with the initial review, one CNS was recommended but I insisted on two senior nurses. It has always been difficult for a clinician-initiated project to get off the ground, whereas DoH or Trust initiatives seem to pass easily in my opinion.

76.2 The triage issue relating to Mr O'Brien should have been clearly sorted out at an earlier stage by the medical management structure.

76.3 The Trust wanted triage performed so as to know the quantum for each category of patient urgency. Post-triage was a Trust problem to sort, not the clinicans' problem.

76.4 The referral letters when recorded on the ECR system are clearly dated and have an assigned clinician. The paper version, however, has been the issue throughout and its tracking timetable not enforced by the booking system. A regular report on the Trust's triage status for all to see would have highlighted who was behind. The Booking Centre probably did have a tracking system but I did not see it as visible.

76.5 The long waiting lists for outpatients and surgery created a backlog and this backlog never cleared, it just added to the work that was still coming into the unit. These long waiting lists resulted in the inability to offer timely therapies, with patients often presenting in extremis to the Emergency Department.

76.6 The delays and difficulties in filling all the medical and nursing posts significantly impinged on progress and compounded all the issues noted before. The delay in having a full complement of Clinical Nurse Specialists was an important feature for the uro-oncology service. It is only now with a full presence that consultants, with the Nurse, consult with the patient and the Nurses can also follow up on the administrative aspects of onward referral, having attended the MDT meeting.

76.7 Radiology and medical oncology presence at MDT over the years had been a problem from a deficiency in their numbers being able to attend. (Associated point on this issue is best supplied by the Chair of MDT)

76.8 Onward referral to the oncology service has been identified as an issue. When the Urology NICaN documentation was being defined originally, it was my understanding that the principle of onward referral being made at the MDT meeting was to be performed electronically at the meeting so there would not have been any delays while awaiting the correspondence letter from the consultant urologist. The MDT process and the letter were therefore defined as two separate entities. This does not appear to be the current approach but may well have prevented the most recently defined issue of delayed referral. Also, the cancer tracking system had focused on the initial referral pathways but a more advanced system would have covered the complete journey.

77. 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?

77.1 I consider the learning, in summary, to be as follows:

a. Listen to the clinicians and work with them - All of the projects suggested by the urology team in CAH (e.g., urology outpatient specific area like Thorndale) have had a major advantage for the quality and quantity of the service, which others have tried to replicate. We were first to commence what was to become the ICATS service, the one-stop clinic, and the achievement of gaining a regional service for a therapy outside of Belfast, namely ESWL.

b. Monitor processes that have been installed, with regular reviews, followed by formal presentation - If issues are defined, then ensure action is taken. This would have identified the triage issue and put in action a pathway to correct it. This principle of confirming an action had been performed would also have covered the onward referral for oncology if a copy of the letter had been sent to the Cancer Tracking Service, for instance.

c. When an issue with 'a doctor in difficulty' is identified, then a formal regular review performed in a sympathetic context should be regularly put in the calendar and follow the recommended pathways - Regular review with a one

to one with a senior clinician could have offered the opportunity for both Mr O'Brien and the Trust to discuss progress.

78. 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.

78.1 As mentioned previously, there has always been a sense of an uphill struggle in trying to introduce urology systems. The issue of long waiting lists for surgery and outpatients has never been sorted. A clean slate was never achieved. The principle of catch-up always existed. The DoH, although knowing the issue and providing some short-term and incomplete help by financing activity such as waiting list initiatives, was not addressing the bigger picture of long term infrastructural needs.

78.2 The triage issue has been known at the top level of the Trust for years according to the Root Cause Analysis completed in 2020. This was not just one person but a system issue.

79. 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?

79.1 The team providing the service is not, in my view, at fault.

79.2 I would have expected Mr O'Brien to have come to me and alerted me about the referrals not being triaged. I hadn't spotted that it had been such an issue. I'm not in charge of his practice but I thought he would have afforded me the opportunity to

speak to him on a personal level. There was no reason why he couldn't approach me. I had helped him in the past. We have always had a good relationship and speak openly about a wide variety of things. The departmental meetings were an opportunity to discuss and be frank. We all listened to Mr O'Brien and did appreciate the time he spent when he did triage, but we also pointed out that the original reason of moving to Consultant of the Week was to now allow us to do timely triage within the on-call week. This was meant to be an improvement from the previous arrangement when triage was performed when on-call and still doing elective work at the same time. The advanced triage was set up to book a test and certainly was not designed to be like a virtual clinic, which Mr O'Brien comments upon. He would have known this from our comments. It is interesting to note that the subsequent Root Cause Analysis of 2020 made the same comment. Maybe I should have been more insistent at our meetings that he follow our pathway on the triage method.

79.3 The handling of the untriaged letters is both an issue for Mr O'Brien and the Trust system. He should have been more open about the numbers of letters he had not addressed. He could have handed them back. The Trust did have the correct process available but didn't implement it adequately.

80. 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?

80.1 I do believe the governance arrangements were fit for purpose but, like most services that are evolving, updating needs to follow. There is no doubt the Trust has learnt from this experience and has already put into place measures while awaiting this Inquiry's outcome.

81. 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?

81.1 I have two points to raise:

a. In mid-November 2018, I received two phone calls from Mr O'Brien's family. The first was from Mrs O'Brien, noting her anxiety that none of her husband's colleagues had rang to ask how he had been. She had referred to an 'outcome' but I had said I had not been informed of any event so could not comment and, in fact, since I had not heard anything for eighteen months I had presumed all was fine. She then raised the issue of private patients' pathway. I said I was unable to comment as it had all been two years previously. I took the conversation as that of a distraught wife and listened. However, two days later, Mr Michael O'Brien rang asking more pointed questions about the process of triage and how the system worked for putting patients on waiting lists and theatre lists. The conversation progressed but with what I felt to be an air of intimidation as he said words to the effect that, 'it would be a very messy process for all', which I took to be a reference to myself, Mr Glackin and Mr Haynes.

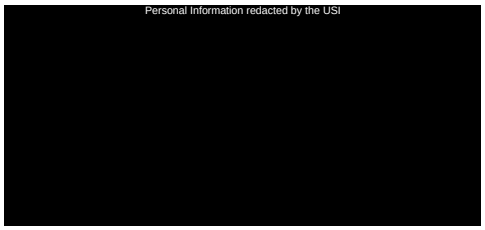
b. The second point I wish to record is simply my involvement in the charitable organization C.U.R.E. (Craigavon Urology Research and Education). This is an external organization to the hospital. Its focus is as per its title. It was set up to support medical and nursing staff progress their education to benefit the urological patient. Research in the past has been academic with laboratory work with the intention of gaining a medical thesis or an academic journal paper. It has supported nursing and medical staff attending academic meetings. In recent years it has been supportive of the national Journal of Urological Nursing under the wing of BAUN (British Association of Urological Nursing). Funding has been mainly via patient donations. My involvement in the charity is as a Director along with three other members, one of whom is Mr A O'Brien.

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: 22nd August 2022

S21 Notice Number 55 of 2022

Witness Statement: Michael Young

Table of Attachments

Attachment	File Name
1	ACTUAL ROUTINE WORK ACTIVITY Word doc 2002
2	ACTUAL ROUTINE WORK ACTIVITY 2005-2006 x
3	ACTUAL ROUTINE WORK ACTIVITY 2007-09 x
4	ACTUAL ROUTINE WORK ACTIVITY 2010 x
5	job plan autumn 2006
6	medical structures consultation 18 May 07
7	letter terry mcm interview 2007
8	Policy re doctors in difficulty (VERSION 2)-August 2008
9	Ensuring PMETB Standards are met - Educational Tariff
10	urology review letter to McNicholl 01 12 08
11	final SHSSB Tier 2 urology update 250406.ppt
12	CAH6 feb 07 Aldrina.ppt
13	urology meeting 22 10 09
14	re proposed changes to current ICATS clinics 24/8/2010
15	HM700 - ltr to Trust Dir Acute re Uology Review Implementation
16	Team South Implementation Plan v0.1
17	urology new model requirement).
18	urology day care unit space requirements 2011 all
19	urology daycare space requirements oct 12 overview 3
20	proposal job plan 2012 final draft 1
21	new urology service model
22	urology outpt Gillian Rankin sept 10
23	dr rankin 27 10 10 letter
24	Ward reconfiguration Heather Trouton 20 11 09
25	To Chief Executive Office
26	urology review recommendations for stocktake April 2014v1
27	team South response to urology review 2014
28	Staffing issues secretaries
29	cons-reg cover admin letter
30	calvinspence BMA 0604
31	cover for spr pay 0704 bma
32	holiday cover request 05
33	urology-consultant SHSSB 221204
34	urology trends D2
35	templeton sept03
36	Activity on general wards – urology 1 revised
37	business analysis template urology oncology 04
38	Defining the problem
39	McClinton urology report 2004
40	MY response to external review 0904
41	proposal for the appointment of a locum urologist 10 04
42	proposal for the establishment of an inpatient endoscopy session 290304
43	Proposal for the development of urology nurse specialist
44	letter to JT re reopening may 05

45	urology day care unit 2012
46	non-consultant grades in post 2009-2022
47	urology ICATS Implementation document v0.6 final version 031106
48	urology ICATS implementation Document draft v0.5
49	report infusion pump system urology
50	audio typist paddy Loughran 01 12 08
50b	outstanding administration report
51	Q23 stc administration
52	proposal for urology nurse specialists 060505
54	Job Plan 2008
55	s21q29.17 KS
56	s21 q29.17
57	Line Management
58	2011 appraisal E Mackle 280113
59	2012 appraisal mr e mackle 060613
60	2013 appraisal mr e mackle 311214
61	2014 appraisal dr michael young (dr e mackle)221215
62	2015 appraisal mr m young(mt e mackle) 28-07-16
63	2016 appraisal dr michael young (dr e mackle) 241017
64	2018 appraisal dr m young (dr T McNaboe) 191219
65	2019 appraisal dr m young(dr s Murphy) 220321
66	2020 appraisal dr M young (dr ej holmes) 041121
67	appraisal dated 27.10.10 received 8.11.10 (e mackle),
68	dr m young(dr e Mcnaboe) 2017 appraisal 300418
69	assessment of kidney and ureteric stone clearance
70	a.e referral STC
71	ESWL referral form mar 21
72	guidelines a+e
73	nurse led clinic flow chart Jul 2021
74	pathway and proforma for nurse led stone clinic
75	ADEPT PROJECT STONE presentation finance meeting – long version
76	Retrospective review of audit patients treated by eswl
77	Ref: stone treatment centre 2018-19 MY 'changes 1
78	stone Treatment centre 2021-22 IPT – MY views
79	HSJ Value awards submission
80	Proposed stent removal service Craigavon area hospital
81	20100603 – urology benchmarking
82	suprapubic catheterization guideline 2017 draft and 2014 updated
83	hyponatriaema report 20 12 13
84	hyponataemia report 5 2
85	irrigation fluid response document 06 03 15
86	20180924 urology service development meeting
87	DEPARTMENTAL MEETINGS SUMMARY OF ACTIONS FOR SUMMER 2008
88	MINUTES OF UROLOGY DEPARTMENTAL MEETING - 18 4 13
89	MINUTES UROLOGY DEPARTMENTAL MEETING 6.6
90	MINUTES FROM UROLOGY DEPARTMENTAL GOVERNANCE MEETING 19th AUGUST 2015
91	Urology dept meeting 9.11
92	Urology departmental meetings autumn 2017
93	20161027-Dept Meeting Minutes

94	20160922 - mins urology departmental meeting
95	20160922 - mins urology departmental meeting
96	2016- Dept topics autumn - M Young Hard Copy
97	Urology Departmental Meetings Spring 2018
98	Urol Depart Autumn 2018
100	20120911 CRR
101	20130910 CRR
102	20140909 CRR a
103	20140909 CRR c
104	20150908 CRR
105	20151208 CRR
106	20160204 CRR
107	20160908 CRR
108	acute directorate risk register 2008 to 2021
109	divisional CCS 2008 to 2022
111	step by step guide to job planning
112	profroma mYoung-requiring 10+Pas
113	prospective job plan initial 04
114	new contract JT letter march06
115a	let to Stephen hall re 08 job 11 12 07
115b	20200309 1119 [redacted] in confidence
115c	Dr Orr urology increased PA 2006
116	email concerns
117	response to email concerns MMcC
118	20170103 E re informing Consultants
119	20131126- email missing triage
120	20151217 – confidential meeting [redacted]
121	20130513 email attachment of mins of uro dept meeting 18 4 13
122-124	20170803 new complaint for investigation - [redacted] A1, A2
125	[redacted] sept 17
126	response to Joshua complaint 09 06
127	response to complaint by [redacted] 24 04
128	[redacted] AS185
129	statement from Mr M Young 5 7 12 re [redacted]
130	[redacted] reference 21 03 14
131	my ltr re [redacted] 26 01 13
132	20151022 urology departmental Governance Meeting 22102015 minutes
133	[redacted] cover 2016
134	[redacted]
135	Ref: equipment 2-04
136	sho second post proposal
137	20140224- email yesterday
138	20140218-email untriaged letters MY reply
139	Urol depart autumn 2018
140	20200622 retirement of Mr Aidan O'Brien – consultant Urologist
141a	20140818 Urology vision pathway 2014
141b	The Vision 1 Sept 14 presentation
142	20181017 return to work action plan clayton to Carroll and Corrigan
143	Divisional SEC 2008-2022 Risk Register
144	20200522 final report

ACTUAL ROUTINE WORK ACTIVITY 2002-03

M. YOUNG M.D. F.R.C.S.(Urol)

Monday	Tuesday	Wednesday	Thursday	Friday
Ward Round ESWL STC clinic	Theatre (third wk DPU)	ESWL Ward Round	X-ray Conference Grand Round SpR Teaching	- Admin - SpR Teaching Sessions - Audit meetings
Histopath Conference Urodynamic Reviews Admin. Ward Round	Theatre	Admin / free session	Third & Fourth Out rech Clinics Banbridge or Armagh Ad hoc Waiting list init. Cystoscopy list STH	CAH outpatients (Third - surgical Directorate) Ward Round

This is daily activity performed and excludes emergencies, referrals and week-end rotas. Start and finishing times are variable.

ACTUAL ROUTINE WORK ACTIVITY 2005-06

M. YOUNG M.D. F.R.C.S.(Urol)

Monday	Tuesday	Wednesday	Thursday	Friday
Ward Round ESWL STC clinic	Theatre (third wk DPU)	ESWL Ward Round	X-ray Conference Grand Round SpR Teaching	- Admin - SpR Teaching Sessions - Programme director activity
Histopath Conference Urodynamic Reviews Admin. Ward Round	Theatre	Admin / free session	Third & Fourth Out rech Clinics Banbridge or Armagh Ad hoc Waiting list/ Urology Service restructuring action plan	CAH outpatients (Three out of four) Ward Round

This is daily activity performed and excludes emergencies, referrals and week-end rotas. Start and finishing times are variable.

ACTUAL ROUTINE WORK ACTIVITY 2007-09

M. YOUNG M.D. F.R.C.S.(Urol)

Monday	Tuesday	Wednesday	Thursday	Friday
Ward Round ESWL (cover) Admin STC clinic	Theatre (third wk DPU)	ESWL (cover) Ward Round	X-ray Conference Grand Round SpR Teaching Lead clinican activity	- Admin - SpR Teaching Sessions - Programme director activity
Histopath Conference Urodynamic Reviews Admin. Ward Round	Theatre	Admin / free session	Third & Fourth Out rech Clinics Banbridge or Armagh Ad hoc Waiting list/ Urology Service Lead clinican activity.	CAH outpatients (Three out of four) Ward Round

This is daily activity performed and excludes emergencies, referrals and week-end rotas. Start and finishing times are variable.

ACTUAL ROUTINE WORK ACTIVITY 2010

M. YOUNG M.D. F.R.C.S.(Urol)

Monday	Tuesday	Wednesday	Thursday	Friday
1.Ward Round 2.ESWL (cover) 3. Admin 4. STC clinic 5. Banbridge / Armagh outreach clinics 3rd and 4th	Theatre (third wk DPU)	ESWL (cover) Ward Round	X-ray Conference Grand Round Lead clinican + Dept meeting activity	1.Admin 2. SpR Teaching Sessions 3. ad hoc extra theatre list
1.Thorndale Consultant clinic and Urodynamic 2.Ward Round 3. lead Clinican activity	Theatre	Admin / free session	Uro-oncology MDT	CAH outpatients (Three out of four) Ward Round

This is daily activity performed and excludes emergencies, referrals and week-end rotas. Start and finishing times are variable.

JOB PLAN
M YOUNG
Consultant Urologist
Autumn 2006

Monday am	8.30/9	Ward Round
	10	STC availability / STC session / Admin / Urodynamic consultation
	12	STC Clinic (over lunchtime 12 – 1.45)
Monday pm	2 - 3	Histopath. MDT
	3	Urodynamic consultation (scheduled weeks)
	3	New Prostate clinic consultation (variable)
	5 – 6/6.30	Pre op ward round
Tuesday am	8.30	Pre op ward round
	9 - 5/6	Theatre (Day Surgery 3rd week in month)
	end 6/6.30	Post op ward round
Wedsnesday am	9	Ward round STC session / availability Admin
Wednesday pm	2	Free / Private Patient
Thursday am	8.15	X-ray MDT
	10	Grand Round
Thursday pm	12.30	Urology Team meeting (Development planning) (variable length 12.30 – 4pm)
	till 5	Otherwise Admin
	3rd and 4th week – Outreach clinic Banbridge / Armagh (Currently for an interim time, covered by Locum Consultant because of other activity Thursday pm)	
Friday am	8.30/ 9	Programme Director Admin/Teaching/Admin
Friday pm	2	Outpatients Clinic CAH
	(3rd week – surgical directorate meeting / Admin)	
	5-6	Ward round activities

M Young
Job Plan

Additional Activity / Ad hoc

- Please note that the term 'Admin' refers to general patient administration to run my practise and hence includes paperwork as well as patient and their relatives' consultation. It also covers all aspects of my role as Lead Clinician in Urology. There is therefore no set times for these activities and are fitted in and around clinical activity where possible and may be performed at weekends.

- Work at home also occurs on Lead Clinician activities.

- Private patient surgery at UIC is performed every 1-2 months for equivalent of one session (and this could be at weekends or leave periods).

- Programme Director activity also occurs at home.
It also involves sessional activity for meetings and interviews. Increased time allocation has been noted on this and relates to recent changes in the program of 'Modernizing Medical Careers'.

- Third Year Surgical Examiner - twice yearly

- Medicolegal examinations - several in the year (50/50 split personal/hospital requests) - no attendances at court last year.

Southern Health and Social Care Trust

Medical Directorate Structures – Draft for Consideration

Southern Health & Social Care Trust – Version 1.3

[redacted]

Medical Directorate Structures – Draft for Consideration

Southern Health and Social Care Trust

1 Introduction

The Southern Health and Social Care Trust [Southern Trust] came into operation on April 1st 2007, employing over 11,000 staff and with an annual budget of approximately £400 million.

The Southern Trust directorate structures are based around programmes of care and therefore have a focus on patient groups or populations rather than institutions or professionals. The organizational structures have been designed to:

- Place patients at the centre
- Promote multi-disciplinary team working
- Ensure effective partnership working by developing interfaces with other agencies and promoting the development of inter-agency team working
- Promote better integration by bringing together services in such a way as to simplify care pathways for clients, patients, carers and families.
- Ensure the development of both professional and managerial leadership for all disciplines
- Ensure effective integrated governance and patient and client safety
- Promote the development of high quality, modern and effective services
- Ensure resources are used efficiently and effectively
- Provide clear lines of accountability

The Southern Health and Social Care Trust is committed to the advancement of Medical leadership and the development of a Clinical Directorate Model.

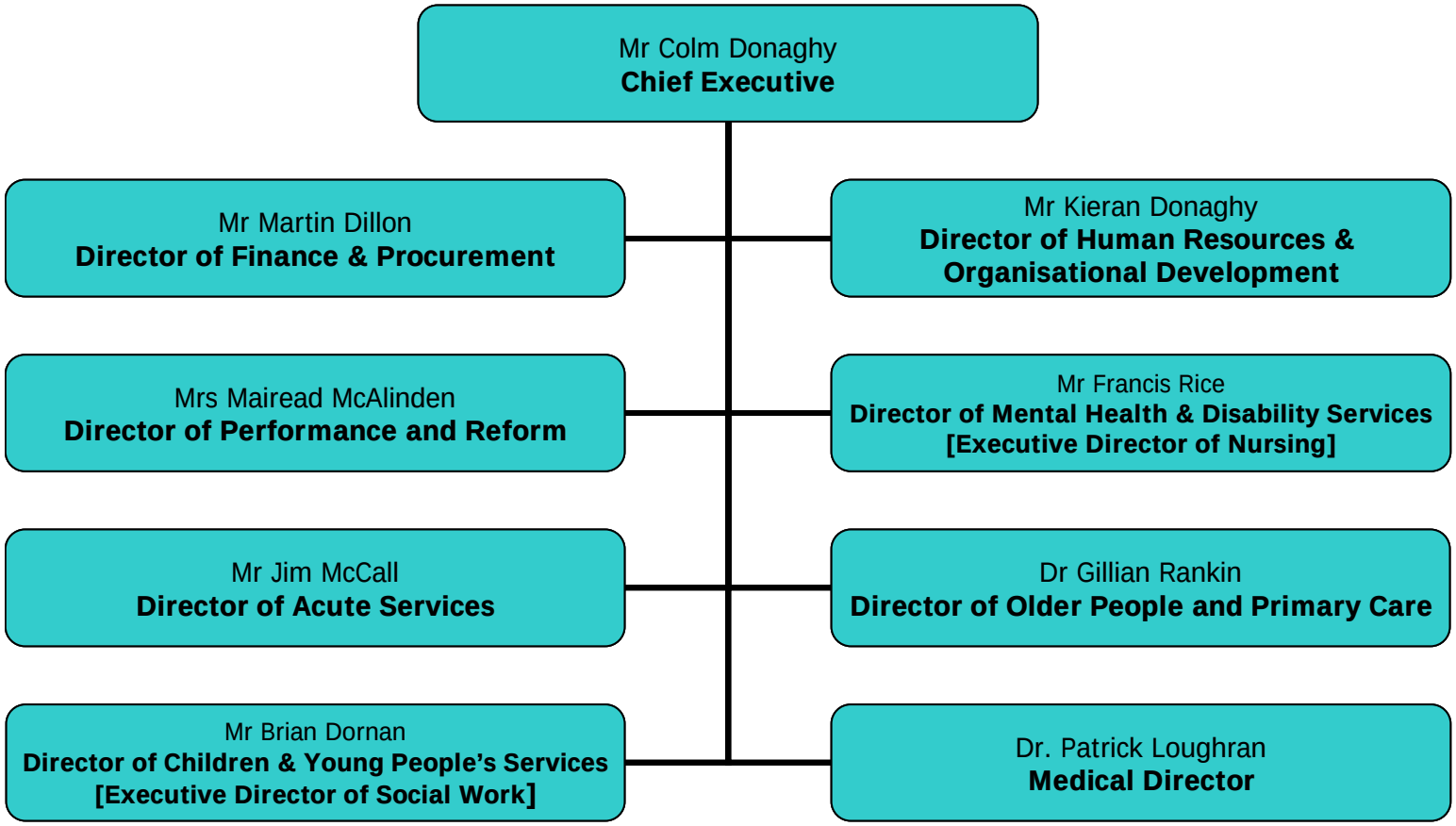
This paper sets out the principles and draft structure of the Medical Directorate supporting the service directorates and at this time excludes other Medical Support functions, further consideration will be given to these over the coming weeks.

All comments are welcome to:

Email: patrick.loughran[redacted]

Tel: [redacted] [Laura White – PA to Dr. Loughran]

2 Southern Trust Structure



3 Clinical Directorates in Legacy Trusts

Legacy Trust	Title	Post Holder
Newry & Mourne[1]	Medical Director	Dr. Loughran
6.5 PA's	Clinical Director Surgery & Anaesthetics	Mr. R. Brown
	Clinical Director Medicine & Radiology	Dr. O'Brien
	Clinical Director Obstetrics & Gynaecology	Dr. B. Alijarad
	Clinical Director Mental Health	Dr. J. Simpson
Craigavon Area Hospital	Medical Director	Dr. S. Hall
15 PA's	Clinical Director – Surgery	Mr. E. Mackle
	Clinical Director – Medicine	Dr. P. Murphy
	Clinical Director – Radio diagnosis & Imaging	Dr. S. Hall
	Clinical Director – Anaesthesia & Theatres	Dr. D. Orr
	Clinical Director – Obstetrics & Gynaecology	Mr. I Hunter
Armagh & Dungannon[2]	Medical Director	Dr. C. Cassidy
3 PA's		
Craigavon & Banbridge	Medical Director	Dr. S. Best
2 PA's		

[1] 2 Consultants X 0.25 PA each

[2] 1 PA allocated for Education and Training

4 Key Principles of Trust Medical Management Structures

4.1 Introduction

This paper sets out the key principles and proposed structure for medical management in the Southern Health and Social Care Trust. It is proposed that within this structure Medical Management posts will be one of four types and will follow a clinical directorate model:

- Medical Director
- Associate Medical Director
- Clinical Director
- Specialty Lead

4.2 Clinical Directorate Model

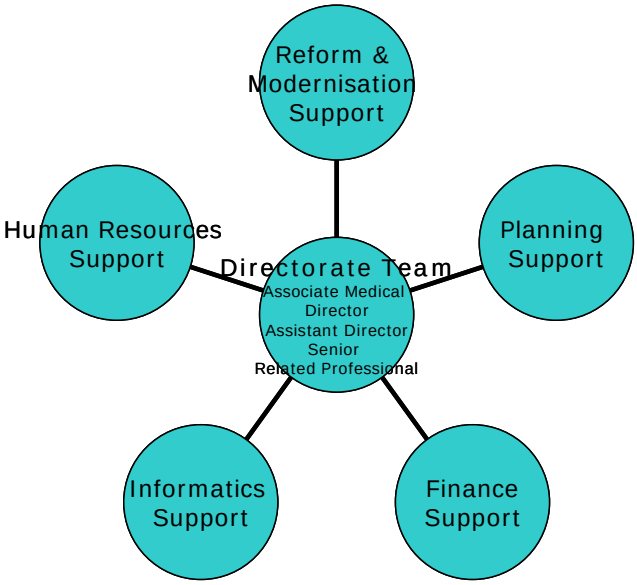
The clinical directorate model originates from Johns Hopkins Hospital in the US (Heyssel, et al., 1984).

In such a model, a hospital is divided into a number of clinical divisions or directorates, each grouping one or more similar specialties together. Each clinical directorate/division is managed by a management team headed by a doctor, and typically consisted of a nurse director and an administrator (Harrison and Pollitt, 1994).

An essential component of the application of this system in the Southern Trust is that each Associate Medical Director will work with an Assistant Director together with a related professional. Nevertheless, the team which includes the Assistant Director, the related professional and the Associate Medical Director will be responsible for the work of the directorate.

The Associate Medical Directors are central to the management process and are directly accountable to the respective Director [with professional accountability to the Medical Director.]

Within the Southern Trust structures it is envisaged that the Associate Medical Director would lead the medical members of the directorate team. Appropriate professional support for the directorate will be provided from the service directorates of Finance, Human Resources and Organisational Development and Planning & Reform.



Given the scale of many of directorates within the Southern Trust it is envisaged that the Associate Medical Directors and Directorate Team would require sub structure support in the form of Clinical Directors and Specialty leads.

5 General Description of Posts

5.1 Overview

The characteristics of these posts will be as follows:

- Job descriptions and personal specifications will be made available
- Appointment by Interview [Associate Medical Directors/Clinicial Directors]
- Duration of appointment: 3 years initially, with an opportunity to apply for a further period of employment

The Trust recognizes that some doctors who may be keen to become involved in medical management/leadership may have concerns about loss of a clinical base and dilution of practical skills. The Trust will adopt a flexible approach and work with individuals to ensure maintenance of a high quality service.

Full support will be provided to those doctors who wish to remain/get involved to a greater degree in management/leadership.

Where necessary, the Trust will guarantee that the clinician will be afforded time and training to become fully re-engaged with the original clinical team at the end of their term of employment

5.2 Specialty Lead

5.2.1 Nature & Scope:

Specialty Lead posts are required to bolster medical management capacity and ensure co-ordination within a specialty.

5.2.2 Accountability

Specialty Leads will account managerially and professionally to the Clinical Director of their division.

5.2.3 Career Progression:

Usually, the post of Specialty Lead is a 'taster' role for those who want to try medical management out. The post may become a stepping stone to a wider management role, or may prove to be as much as the post holder wishes to take on for a longer period. Many will wish to progress to the post of Clinical Director.

5.2.4 Personal Development:

The amount of management-related personal development needed in this role will be influenced by the career intentions of the post holders. Those wishing to proceed into a more substantial medical management role can undertake a 'full' management development programme – as determined by coaching, assessment and feedback. Those not wanting to progress a career in medical management will need fewer development inputs.

5.3 Clinical Director

5.3.1 Nature

Clinical Director posts are required to ensure the smooth-running of services. They are needed to contribute both strategically and operationally, to both the management and professional agendas of their division.

5.3.2 Scope

This is a significantly wider role than that of Specialty Lead. Clinical Directors will be responsible for ensuring that the highest standard of clinical care is delivered and that all targets and objectives are met in line with national and local standards,

Clinical Directors, by agreement with their senior manager, have powers of delegation and will usually manage those to whom they delegate responsibility and authority (most frequently, Specialty Leads).

5.3.3 Accountability

Clinical Directors normally account managerially to the Associate Medical Director for everything; including how they have managed the 'professional agenda' (this is in parallel to the Medical Director's accountability to the Chief Executive). In-keeping with all other medical posts, Clinical Directors are accountable for their own professional behaviour, to the Medical Director.

5.3.4 Career Progression:

Experience as a Specialty Lead is desirable but not essential prior to appointment as a Clinical Director. Once in post, the majority of Clinical Directors may not wish to be career managers. The Trust will support as many as possible in the pursuit of a career in medical management.

From the post of Clinical Directors, there are many 'onward' routes in medical management, including Associate Medical Directors, as these become available.

5.3.5 Personal Development:

Clinical Directors will need to take their management-related professional development seriously. Personal development planning will take place systematically, and in a way that is linked to their management appraisal.

5.3.6 Time Commitment and Remuneration

To be agreed and will be commensurate with the responsibility and time commitment. Where the Trust asks for a significant time commitment from a doctor it is recognized that that doctors will need medical support in the form of formal backfill arrangements.

5.4 Associate Medical Director

5.4.1 Nature

The Associate Medical Director roles support the Trust Medical Director and Service Directors in delivering the operational and professional medical agenda of the Trust.

5.4.2 Scope

There are a number of areas that Southern Trust would like to bring into particular focus for Associate Medical Directors. These are:

- Leading the medical team
- Strategy development
- Performance management
- Implementing clinical governance

- Patient safety
- Audit & clinical effectiveness
- Appraisal and revalidation
- Job planning & pay progression
- Managing poor clinical performance and difficult colleagues
- Medical manpower issues – including junior doctors hours
- Medical education and research

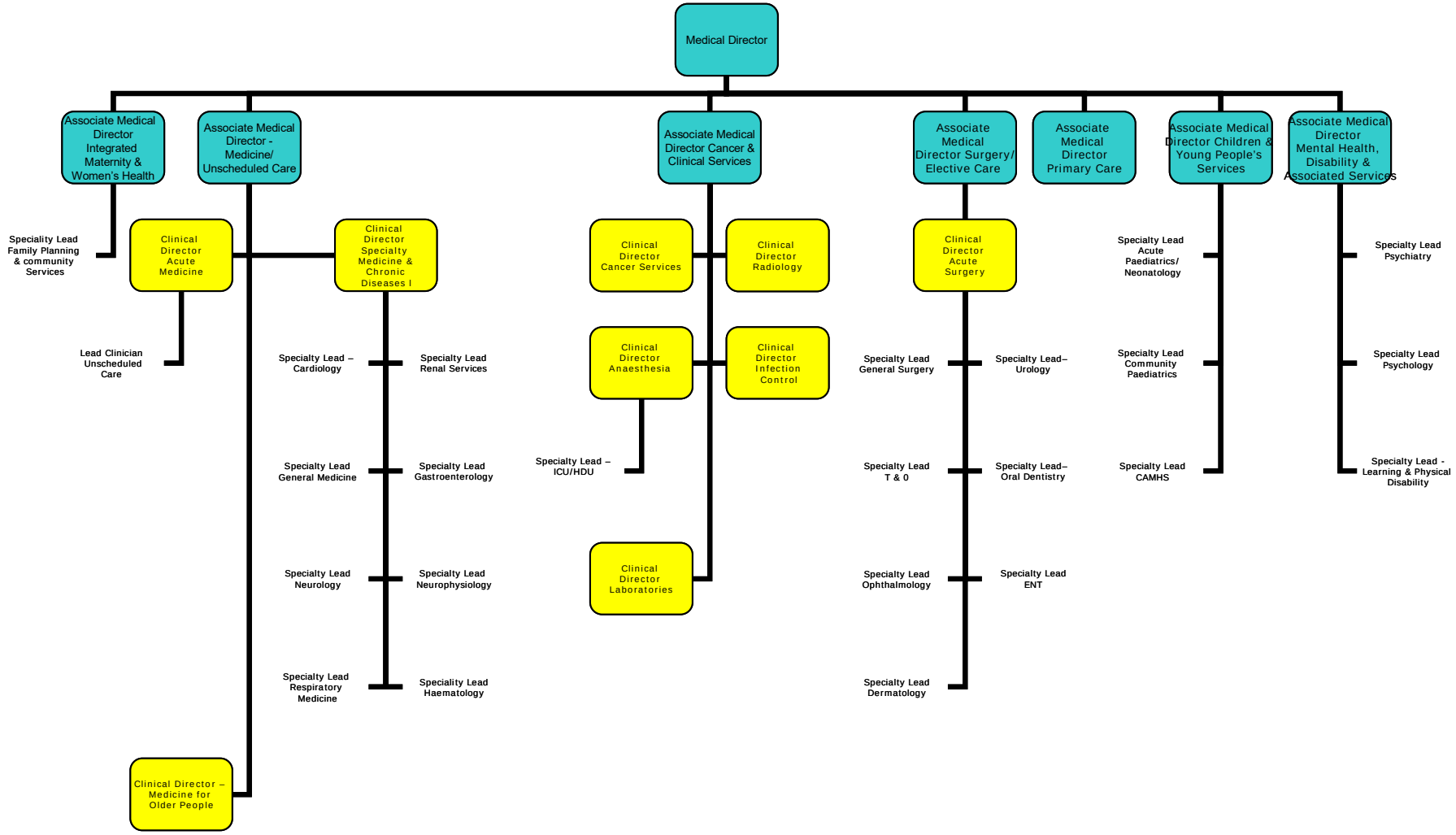
5.4.3 Accountability:

Associate Medical Directors will account managerially to their respective Director and professionally to the Medical Directors

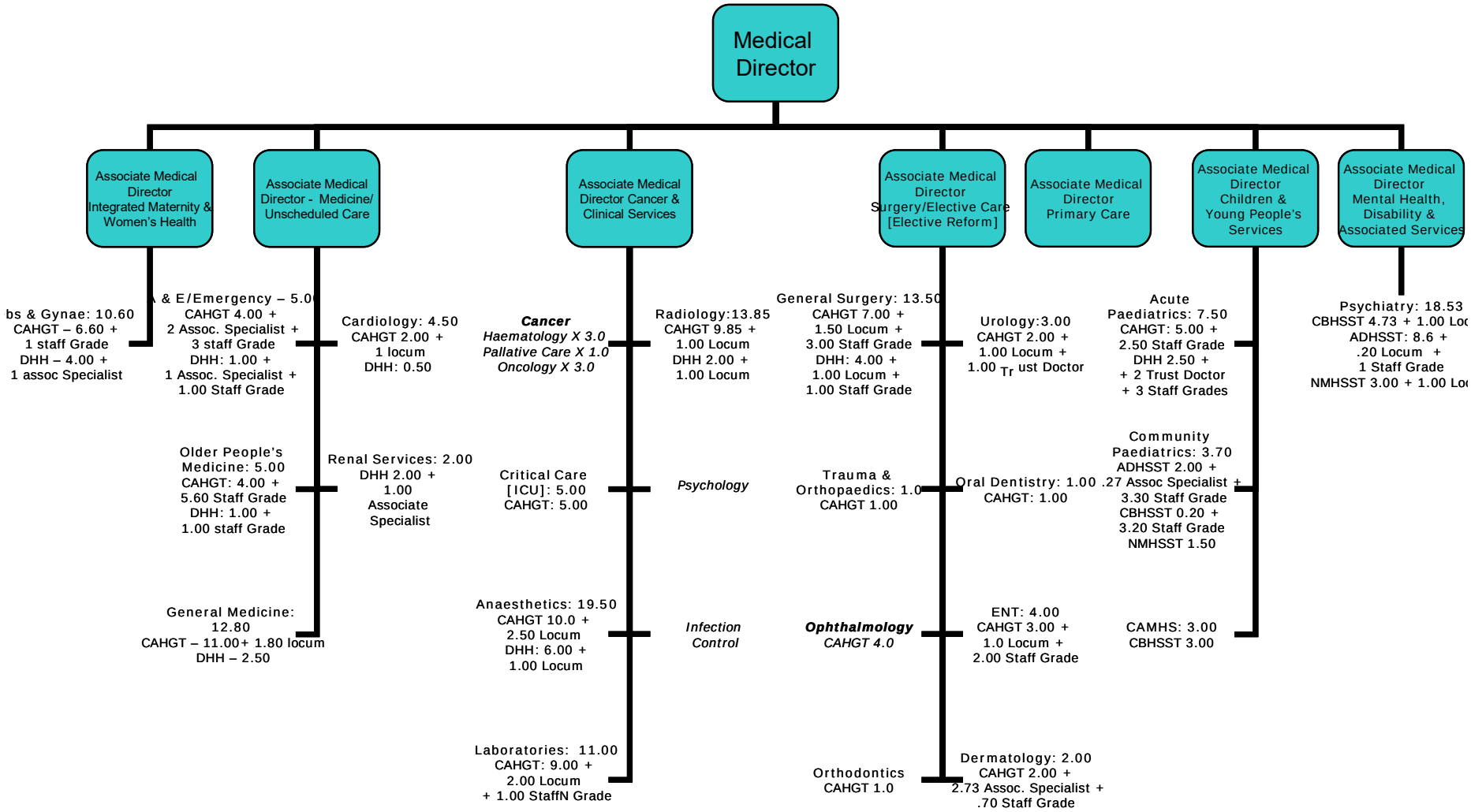
5.4.4 Time Commitment and Remuneration

To be agreed and will be commensurate with the responsibility and time commitment. Where the Trust asks for a significant time commitment from a doctor it is recognized that doctors will need medical support in the form of formal backfill arrangements.

6 Proposed Draft Structure



Appendix 1: Draft Medical Directorate Structures – Staffing Complement



Appendix 2: Span of Responsibility

	No Consultants	Craigavon Area	Daisy Hill	South Tyrone	Lurgan	St. Lukes/Armagh Community Hospital	Banbridge Polyclinic
Integrated Maternity & Women's Health	10.60	Maternity and Gynae Outpatients Parentcraft Admissions & Assessment Unit Delivery Suite Midwifery Led Unit 1 East Ante Natal 1 West Postnatal 2 West Gynaecology	Maternity Floor Gynae/Obs Outpatients Delivery Suite Community M/W services GU Clinic				
Medicine/ Unscheduled Care	31.30	Medical Admissions Unit Accident & Emergency Discharge Lounge 1 South Medical 1 North Cardiology 2 South Medical 2 North Medical 2 North Haematology Ward 1 & 2 Medical Cath Lab	Accident & Emergency 4th Floor 5th Floor 6th Floor Coronary Care Unit Renal Unit Chest Pain Clinic	Minor Injuries Unit A Floor Medical Day Hospital Loane House	Day Hospital Stroke Unit Ward 4 Ward 5 Dermatology Ward 6 Ward 7/8	Minor Injuries Unit Mullinure Hospital Day Hospital	
Cancer & Clinical Services	63.0	Radiology Laboratory	Radiology Laboratory	Radiology Day Surgery		Radiology – Armagh Community Hospital	

	No Consultants	Craigavon Area	Daisy Hill	South Tyrone	Lurgan	St. Lukes/Armagh Community Hospital	Banbridge Polyclinic
		Anaesthetics ICU Pain Management Mandeville Unit Glennane Unit Lung Cancer Specialist Nursing Breast Care Specialist Nursing Colorectcal Specialist Nursing Theatres Day Surgery Psychology	Anaesthetics Theatres HDU Pain Management DPU/Endoscopy Colorectcal Breast Stoma				
Surgery/Elective Care [Elective Reform]	26.50	4 North Surgery 4 South Surgery 3 South Surgery 2 South Urology 3 South ENT	Level 3 Surgical Asssesment Unit Discharge Lounge/Pre-Op Assessment Unit				
Primary Care		GP Out of Hours	GP Out of Hours	GP Out of Hours		GP Out of Hours	
Children & Young People's Services	10.20	3 North Children's Neonatal ICU	Ambulatory Paeds Paediatric Ward SCBU	Ambulatory Paediatrics'			
Mental Health & Disability Services	21.53	Psychiatric Unit	Day Hospital			Longstone Hospital Orchard House St. Luke's Hospital	

Appendix 3: Associate Medical Directors PFA Responsibilities

			Possible Divisions	PFA Target	
Associate Medical Director of Integrated Maternity & Women's Health	10.60		Maternity Gynaecology Parentcraft	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. From April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient being declared medically fit, rising to 100% by March 2008. From April 2007, all other discharges should take place within 12 hours, reducing to six hours by March 2008. By March 2008, Boards and Trusts should reduce by 10% the rate of births to mothers under 17 years of age (the Northern Board achieving a rate of 2.8 births per 1,000 females, the Southern 2.2, the Eastern 3.4 and the Western 2.1).	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports. By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies

			Possible Divisions	PFA Target	
				By March 2008, Boards and Trusts should ensure all patients assessed as clinically urgent are able to access specialist Genito-Urinary Medicine/Sexual Health services within two working days. By December 2007, Trusts should have systems in place for the post-discharge surveillance of surgical site infections following Caesarean Section.	Framework and the Emergency Planning Functions Directions. By September 2007, Trusts should have arrangements in place to learn from at least three major interventions which, based on international evidence, are known to save lives.
Associate Medical Director of Medicine/ Unscheduled Care			**Acute Medicine:** Accident & Emergency Medical Assessment Unit Medicine for Older People	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. From April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient being declared medically fit, rising to 100% by March 2008. From April 2007, all other discharges should take place within 12 hours, reducing to six hours by March 2008. From April 2007, no patient should wait longer than 12 hours in A&E and, by March 2008, 95% of patients who attend A&E should be either treated and discharged home, or admitted within four hours of their arrival in the department. Boards and Trusts should ensure that, from April 2007, any patients waiting in an emergency care department for more than 12 hours are classified as Serious Adverse Incidents and reported to the Department.	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports. By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies Framework and the Emergency Planning Functions Directions. By September 2007, Trusts should have arrangements in place to learn from at least three major interventions

			Possible Divisions	PFA Target	
				By March 2008, older people with continuing care needs should wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.	which, based on international evidence, are known to save lives.
			Specialty Medicine & Chronic Diseases: Gastroenterology Cardiology Haematology Renal Medicine Rheumatology Neurophysiology Neurology Respiratory Medicine	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. From April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient being declared medically fit, rising to 100% by March 2008. From April 2007, all other discharges should take place within 12 hours, reducing to six hours by March 2008. By March 2008, Boards and Trusts should ensure no patient with MS, who has been assessed as eligible for disease modifying treatment under the ABN guidelines, should wait more than 13 weeks to start treatment. By March 2008 Boards and Trusts should ensure all patients with severe inflammatory arthritis who, at 31 March 2006, were on the waiting list for treatment with biologic therapies, have commenced their treatment. Boards and Trusts should ensure patients have timely access to renal dialysis services, three times weekly, with overall capacity (haemodialysis and peritoneal dialysis) being increased by 10% year on year to March 2008, in line with the expected growth in demand as outlined in the Renal Services Review 2002.	
Associate Medical Director of	63.0		**Cancer Services:** Mandeville & Glenanne	By March 2008, at least 98% of patients diagnosed with cancer should commence treatment within 31 days of the decision to treat, and at least 75% of	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports.

			Possible Divisions	PFA Target	
Cancer & Clinical Services			Unit Palliative Care Lung Cancer Specialist Nursing Breast Care Specialist Nursing Colorectcal Specialist Nursing	patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days (increasing to 95% by March 2009). From April 2007, Trusts should see all breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer within 14 days of the receipt of the GP referral.	By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies Framework and the Emergency Planning Functions Directions. By September 2007, Trusts should have arrangements in place to learn from at least three major interventions which, based on international evidence, are known to save lives.
			Imaging: Radiology	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.	
			Anaesthesia: Anaesthetics ICU Pain Management Theatres Day Surgery	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.	
			Laboratory/ Biochemistry Haematology Histopathology Microbiology	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.	
			Infection Control:	By May 2007, Trusts must submit to the Department, for approval and monitoring, Infection Reduction Plans that include Trust-specific targets for prevention and control of health care associated infection. Progress in meeting these targets must be robustly monitored and reported monthly by the Infection Prevention and Control lead to the Trust Board. By September 2007, Trusts should have arrangements in place to learn from at least three	

			Possible Divisions	PFA Target	
				major interventions which, based on international evidence, are known to save lives. By December 2007, Trusts should have systems in place for the post-discharge surveillance of surgical site infections following Caesarean Section.	
			Pharmacy	As part of this, throughout 2007-08 Boards and Trusts are required to implement the agreed action plan (including support arrangements) to meet the targets set in the Pharmaceutical Services Improvement Programme.	
Associate Medical Director of Surgery/Elective Care [Elective Reform]	26.50		**Acute Surgery** General Surgery Urology Vascular Surgery ENT Ophthalmology Orthondontics Trauma Orthopedics Dermatology	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. From April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient being declared medically fit, rising to 100% by March 2008. From April 2007, all other discharges should take place within 12 hours, reducing to six hours by March 2008.	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports. By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies Framework and the Emergency Planning Functions Directions. By September 2007, Trusts should have arrangements in place to learn from at least three major interventions which, based on international evidence, are known to save lives.

			Possible Divisions	PFA Target	
Associate Medical Director of Primary Care			GP Out of Hours	Boards and Trusts should begin rolling out a diabetic retinopathy screening programme from April 2007, with full coverage being achieved across Northern Ireland by March 2008. By July 2007, with a view to improving regional access to mental health services on foot of the Bamford Review, Boards and Trusts should submit to the Department, for approval and monitoring, proposed targets and associated reform plans for improving the response to, and support for, people with mental health problems presenting at primary care level.	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports. By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies Framework and the Emergency Planning Functions Directions. By September 2007, Trusts should have arrangements in place to learn from at least three major interventions which, based on international evidence, are known to save lives.

			Possible Divisions	PFA Target	
Associate Medical Director of Children & Young People's Services	10.20	**7.5**	**Acute Paediatrics:** Paediatric Medicine Neonatal SCBU Ambulatory Paediatrics	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. From April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient being declared medically fit, rising to 100% by March 2008. From April 2007, all other discharges should take place within 12 hours, reducing to six hours by March 2008. .	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports. By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies Framework and the Emergency Planning Functions Directions. Boards and Trusts should ensure that, from April 2007, any patients waiting in an emergency care department for more than 12 hours are classified as Serious Adverse Incidents and reported to the Department.
		3.70	**Community Paediatrics**	By March 2008, Boards and Trusts should ensure all relevant recommendations of the Child Protection Overview Report have been implemented Boards and Trusts should ensure services for people with autism continue to be developed reflecting, in due course, the recommendations of the review of autism services to be completed by September 2007 By March 2008, Boards and Trusts should ensure all relevant recommendations of the Child Protection Overview Report have been implemented	
		3.00	**Child & Adolescent Mental Health Services**	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. Boards and Trusts should ensure services for people with autism continue to be developed reflecting, in due course, the recommendations of the review of autism services to be completed by September 2007. By March 2008, Boards and Trusts should ensure specialist eating disorder posts are created in each	

			Possible Divisions	PFA Target	
				Board area (a regional total of 12), to facilitate early detection and intervention for children and young people and so prevent cases becoming more severe in adult life. By March 2008, Boards and Trusts should ensure all relevant recommendations of the Child Protection Overview Report have been implemented	
Associate Medical Director Mental Health, Disability & Associated Services	18.53	**18.53**	**Psychiatry:** Mental Health Learning Disability Physical and Sensory Disability	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment. By March 2008, Boards and Trusts should ensure a further 50 people should be resettled from mental health and learning disability hospitals – while long stay facilities should be reconfigured to better reflect patients' care needs. By July 2007, with a view to improving regional access to mental health services on foot of the Bamford Review, Boards and Trusts should submit to the Department, for approval and monitoring, proposed targets and associated reform plans for improving the response to, and support for, people with mental health problems presenting at primary care level. By March 2008, Boards and Trusts should ensure community mental health and learning disability services are further developed, augmenting existing community teams (including an additional 25 staff for crisis response, home treatment and assertive outreach teams and 25 community learning disability staff), to provide appropriate, responsive services, promote access to round-the-clock support, and reduce waiting times. By March 2008, Boards and Trusts should ensure specialist eating disorder posts are created in each	By September 2007, Trusts should have an action plan in place to address the recommendations from the forthcoming RQIA governance reports. By December 2007, Boards and Trusts to fully implement the Department's Safety First framework action plan and include safer, high quality, care as a standing agenda item for board meetings. By March 2008, Boards and Trusts should have fully implemented the relevant recommendations in *Improving Patient Safety, Building Public Confidence* (the NI response to Shipman). By March 2008, Boards and Trusts should have completed self assessments against the emergency planning controls assurance standard and attained moderate compliance with both the Civil Contingencies Framework and the Emergency Planning Functions Directions.

			Possible Divisions	PFA Target	
				Board area (a regional total of 12), to facilitate early detection and intervention for children and young people and so prevent cases becoming more severe in adult life.	
		?	**Psychology:** Acute Community	By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.	

21/12/07

Dear Terry

I was grateful that you were present to preside over the recent trainers meeting for urology. It was an interesting meeting. It is a pity all were not present - nothing new there - some only turn up with a vested interest.
Over the past few months I have thought about the whole process of employment of juniors during the past year as well as how urological training is progressing. It has been a difficult time for all 'on both sides of the fence'. It should be logged that there was extreme problems producing an interview panel for both of the urology interview sessions last year - it should be noted that if the same points of contest were raised this year there would be no problem as the application appears to be C.V. based. Since I found it extremely difficult to define an adequate panel, I thought it important to steer a central course and from this to have a perceived 'well above board result' to suit all. This appeared the case at the time.
The second issue, which to you maybe an unknown quantity, is the recent changes in urological training. I will address this in separate correspondence.
There are a few points I wish to put across.
1/ First and foremost, the correct process should be maintained and followed no matter what is said.
2/ The interview produced a Reserve List for the two available posts - ie if either of the two people offered the post turned it down it would be offered to the next in line.
3/ Offers were based on acceptance of the post which were time based and often dependant on other interviews - a different process to our usual.
4/ This is not necessarily the same as a waiting list to run for virtually nine months from interview.
5/ If it is to be accepted that there is a Waiting List to extend for six months - is this from the time of interview (ie the time of an offer to extend for six months) or from commencment of the post (which equates to virtually nine or so months from interview)?
6/ There is unminuted urology communication on this issue stating that any job that comes up during the year will be put into the pool for advertisement for the following year. The premise for this is to get a spread of urology trainees.
7/ This has been borne out by the request, on my behalf, that an advertisement be place in the Press for a LAT post ie that last year recruitment related to last year’s selection process.
8/ It should be noted that explicit notice in all previous urological interviews logged a precise waiting list time. This particular point was not defined by the most recent panel and by inference a different process to before.
9/ Of importance to this issue, does a default mechanism fall into place whether a point was raised or not? Default mechanism relating to European law or if not explicitly recorded as usual in past interviews.
10/ I am completely uncomfortable with the notion that a committee can discuss the decisions of an interview panel well after the events. This is like viewing application forms before setting the criterion for short listing. There are members of the committee who are not eligible to be on the interview panel and would in theory be then voting. I am in complete agreement that the training committee can set the agenda for any interview, but it is the sole responsibility of the interview panel to decide the ranking etc.
11/ As Chairperson of the last interview panel, I found this a difficult task. The prime commitment I had was to preside over a fair process. I have not voted in the selection process for some time now except during the last interview (this being necessary to make a fair assessment).

I would like to document that I personally scored the next in line 'reserve listed' person extremely highly and am completely satisfied with their ability to take up a post as a urology trainee.
12/ The point in question is I want as foremost in portrayal, is the perceive appearance that 'Due Process' has been followed, in a time when those that have been disadvantaged for one reason other another, have been cared for by our system.
13/ If NIMDTA regard that no matter what is said or not said and that a reserve list is the same as waiting list as well as it lasting for six months from the date of the job starting (not interview) then I am satisfied with the process and hence there will be no repercussions from the same for any of us.

I summary I am content that the next person in line be offered the post. He is an excellent trainee and would undoubtedly have gained a training post next year. My prime concern is that we are perceived in this difficult time to be doing the correct think. My extreme concern at the meeting was the notion that the goal posts can be moved after the event by people who were not even on the panel.

Michael Young

Urology Programme Director

Version 2 (August 2008)

Northern Ireland mdta Medical & Dental Training Agency

GUIDANCE IN RELATION TO THE MANAGEMENT OF DOCTORS AND DENTISTS IN DIFFICULTY

1. Introduction

The policy has been written with a view to defining the procedures for dealing with doctors and dentists in the training grades who are experiencing difficulties within the Northern Ireland Deanery. The aims of the policy are to promote early identification of trainees in difficulty and provide a clear structure for identifying addressing these difficulties. It is based upon the principle of acting fairly, supportively and confidentially when dealing with problem situations that arise and draws and should be read in conjunction with the publication from the Department of Health, Social Services and Public Safety on '*Maintaining High Professional Standards in the Modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS (DHSSPS 2005).'* This guidance provides the disciplinary framework for doctors and dentists in Health and Social Care and requires all HSC bodies to have procedures in place for handling serious concerns about an individual's conduct and capability that reflect this framework. The guidance covers restriction of practice and exclusion from work; conduct hearings and disciplinary matters and procedures for dealing with issues of capability.

It is the duty of all doctors to protect patients where it is believed that a doctor's conduct, performance or ill health constitutes a threat to patients. It is therefore the responsibility of the team with whom a trainee is working to highlight concerns before they become too severe and to enable the trainee to access the right help.

2. Roles and Responsibilities

A trainee has a contractual relationship with his or her employer and is subject to the policies established by the employing body. The employer has responsibility to ensure that employment issues, including performance, health and sickness issues and disciplinary matters are dealt with appropriately to facilitate the trainee's satisfactory performance.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) has responsibility for commissioning education and training whilst the Trusts and other training providers have responsibility for delivering education. Training providers have a responsibility to ensure that mechanisms are in place to support trainees and enable problems to be addressed at an early stage.

The educational supervisor is the most likely person to be involved initially when a trainee is in difficulty although the Director of Medical Education, Clinical Tutor, Clinical Director, Medical Director, GP trainer, Dental trainer and NIMDTA may also need to be informed depending on the nature and seriousness of individual circumstances. The roles and responsibilities of the various educators all of whom have a responsibility for dealing with doctors and dentists in difficulty are summarised in Appendix 1.

It is the responsibility of the training provider to investigate and manage concerns. Training providers must keep NIMDTA informed of all significant concerns and should inform the Postgraduate Dean in writing of any disciplinary action being taken against a trainee. The flow chart attached at Appendix 2 provides guidance on action which a training provider should take when problems arise.

If through investigation it appears that the problem relates to the trainer or the training post then the Postgraduate Dean must be informed in order that appropriate action may be taken and where necessary the training post inspected.

3. Identifying trainees in difficulty

All possible steps should be taken to identify and act on early signs and symptons of difficulty. The majority of these are behavioural but also include signs of clinical incompetence, for example poor record-keeping; poor clinical decision making and judgement, inappropriate referrals etc.

Successful remediation or support for doctors and dentists in difficulty requires an understanding of the underlying problems. A checklist (Appendix 3) has been developed to help educational supervisors and others to diagnose and manage the early signs of a doctor in difficulty.

Concerns about a trainee's conduct or capability may come to light through:

- an untoward incident
- a complaint or litigation
- appraisal
- assessment
- performance data or clinical outcomes
- clinical audit

Clear evidence should be sought and concerns raised with the trainee at an early stage in order to obtain his or her perspective. The trainer should consult with colleagues to explore the nature and seriousness of the problem. As soon as it is clear that there is a problem with the trainee's conduct or performance action should be taken.

Managing potential risk to patients is the first priority and should be managed by the trainee and trainer/educational supervisor agreeing what the trainee can do safely and ensuring support and supervision from the whole clinical team to allow the trainee to practise safely in areas where he or she is underperforming.

Once the underlying cause of the trainee's difficulties is identified a realistic learning plan should be provided that will motivate and engage the trainee. If it is not possible

to deliver this in the trainee's current placement the trainee will need to be moved to a placement which will deliver the learning plan. The learning plan should be regularly reviewed throughout the course of its delivery to ensure that it continues to meet the trainee's needs. If the trainee continues to have difficulty, in spite of remedial action, advice should be sought from NIMDTA.

As a general principle good communication should be maintained at every stage with NIMDTA being informed as appropriate and as early as possible. The educational processes need to work closely with Trust internal procedures and close communication between the appropriate individuals within NIMDTA and those responsible at Trust level is crucial.

4. The Problems

These can be divided into four main areas as follows:

- Personal conduct
- Professional conduct
- Competence and performance issues
- Health and sickness issues

Personal Conduct Issues

Examples include intoxication, drug abuse, falsification of records, theft, fraud, serious acts of insubordination, sexual, racial or sectarian harassment, unlawful discrimination or victimisation on the grounds of age or sexual orientation. The employing authority will take the lead under its disciplinary procedures and will inform the Postgraduate Dean in writing at an early stage.

NIMDTA will not be involved in such a disciplinary panel but will need assurance of the following:

- The employing authority will follow its agreed disciplinary procedure
- The trainee has been advised that they may be represented at any stage of the disciplinary procedure by the BMA/BDA, or work colleague
- Guidelines applicable to Northern Ireland are followed if a trainee is to be suspended
- Pastoral support is provided if required

On occasions it may be necessary for the Trust/Postgraduate Dean to advise the General Medical Council/General Dental Council of any action taken against a trainee.

Professional Conduct Issues

Examples include research misconduct, failure to obtain consent properly, prescribing issues, improper relationships with patients, improper certification issues (eg the signing of cremation forms, sickness certification) and breach of confidentiality. The Trust or other employer will take the lead under its disciplinary procedures and will inform the Postgraduate Dean in writing at an early stage. An agent of NIMDTA eg Head of School, GP Trainer, Programme Director or Dental Adviser will provide input

into such a disciplinary process. Any decision to involve the GMC/GDC will be taken jointly by the employing authority and NIMDTA. NIMDTA will need to be assured that:

- The employing authority will follow an agreed disciplinary procedure
- The trainee has been advised that he/she may be represented in the process by a companion who may be:
    - another employee of the HSS body;
    - an official of the BMA, BDA or defence organisation;
    - work or professional colleague
- National guidelines are followed if a trainee is to be suspended
- Pastoral support is provided if required

Competence and Performance Issues

Examples include a single serious mistake, poor results clinically (possibly found as a result of audit), poor communication skills, poor consultation skills and repeated failure to attend educational events.

Trainees with such problems will need to be referred by the educational supervisor to the Programme Director and Head of School in the first instance although the Trust or other employer may need to take a lead in some of these problems if there has been a complaint from patients or relatives and the possibility of legal action.

In the event of an isolated serious mistake the Postgraduate Dean must be informed in writing and at each stage in any process that results from such a mistake. Pastoral support must be offered and the doctor/dentist advised to seek legal representation.

If the doctor's/dentist's performance is consistently poor, despite educational measures such as remedial or targeted training, then it may be necessary to inform the GMC/GDC. Any decision taken will be agreed jointly by the employing authority/employer and NIMDTA.

It is accepted that Trusts and other employers have an over-riding duty to protect patients and NHS staff, and exceptionally an employer may need to invoke its policies and procedures to expedite a critical situation. NIMDTA should be kept informed of any such action.

Health and Sickness Issues

Every doctor/dentist must be encouraged to register with a local general medical practitioner and consult with their doctor in the first instance when ill.

'If you know that you have a serious condition that you could pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness or its treatment, you must take and follow advice from a consultant in occupational medicine or other suitably qualified colleague on whether and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients'.

Ill health and sickness absence should be managed through the employer's sickness absence policies. Where sickness absence gives cause for concern the trainee should be referred to the Occupational Health service and information shared with the educational supervisor, the Director of Medical Education/Clinical Tutor, Medical and HR Directors on a confidential basis, with the consent of the individual concerned. NIMDTA should also be informed in writing of such cases and where the trainee's fitness to practise is called into question the employing authority should make a referral to the GMC or GDC as appropriate. Advice from either body may be sought in advance of referral.

Periods of grace due to sickness absence before training may be affected are as follows:

- Foundation 1 doctor – 4 weeks in the year
- Foundation 2 doctor – 4 weeks in the year
- GP Trainee – 2 weeks in a 12 month post
- Specialty Registrar – 3 months in the training programme before CCT date affected

6. Keeping Records

Documentation should commence as soon as a performance concern comes to light and copies given to the trainee. Whilst only a small minority of performance difficulties escalate into a disciplinary situation, records should nevertheless be kept from the earliest stage to help ensure continuity (e.g. a trainee who changes educational supervisor) and to avoid duplication of effort. Good documentation is an essential part of educational governance.

Should a problem with a doctor become more serious or repetitious, it may be advisable to seek guidance from the local HR Manager or Director who can advise on any further specific documentation.

Trainees need to have confidence that this documentation is intended to support and help them to address their difficulties rather than as a punitive or legalistic activity. Transparency is paramount to retain the doctor's trust and cooperation. The following will help to ensure openness as well as rigour:

- Educators should avoid recording and keeping information about discussions with doctors without their knowledge or consent.
- Records of conversations should be held confidentially, with the doctor's knowledge and consent, by the person who has conducted the assessment of the problem with the doctor in difficulty.
- The doctor should be given a copy of any documentation concerning his or her performance and encouraged to keep such copies in his or her portfolio for discussion at appraisals.
- Should the doctor move to a different job, or in the event that the problem escalates or others become involved, it may become necessary to pass the record to other parties, again with the consent of the doctor where possible.

Transfer of information about trainee doctors' progress from post to post should become standard procedure including areas of concern.

- All documentation must comply with the requirements of the Data Protection Act and the Freedom of Information Act (FOIA).

5. Transfer of information to Future Training Providers

The educational supervisor in the next placement must be informed of problems arising in the previous placement to ensure that any remedial action that has been taken continues and assessment of successful progress is made. In Dental postgraduate training the relevant Dental Advisers should ensure the transfer of information from one post to another is complete.

In instances where disciplinary issues or serious competence issues are involved a written statement must be given to the Postgraduate Dean to pass on to the new employing authority, on a need to know basis, with the knowledge of the doctor/dentist concerned. The doctor/dentist will have the right to see such a statement and challenge its accuracy, but not to prevent it being transferred to the new employing authority.

Information should be accurately recorded with a clear account of the issue, the action taken and the date when any disciplinary action is considered to be spent.

Details of special educational needs are best transferred via the Postgraduate Dean to the receiving educational supervisor.

Where a doctor/dentist becomes ill during the training it is important that consistent support is provided which can be transferred across training placements. There should be one source of referral to Occupational Health for doctors and dentists appointed to training programmes/posts. Unless there are ethical barriers to doing so, information should be shared by the Postgraduate Dean across employers, on a need to know basis.

6. Assessment and Appraisal

Regular appraisal and assessments are essential to provide feedback on performance and continuing progress and identify educational and development needs. It is important that Deanery standards are adhered to. Appraisals and assessments must be documented and copies retained.

APPENDIX 1: Roles and Responsibilities of Educators

1) Clinical Supervisors
2) Educational Supervisors
- Lead Educators

Specialty
3) College Tutor
4) Programme Director
5) Head of School
6) Regional Adviser

Trust
7) DME/Clinical Tutor
8) FP Director

9) Associate Postgraduate Dean
10) Postgraduate Dean
11) Director of GP Education
12) Postgraduate Dental Dean

1) Clinical Supervisor

Consultant with whom the doctor works clinically, and who assesses whether that doctor is safe to carry out the clinical work he/she is expected to do within the department, and that he/she progresses within the particular training post/module. This will include direct input to workplace-based assessment.

Responsibility for Doctors in Difficulty

This direct contact with the doctor puts the clinical supervisor in an ideal position

- to detect problems with regard to clinical knowledge and skills, team working, communication, attitude, time keeping, etc.
- Any problems observed should be documented, discussed with the trainee and brought to the attention of their educational supervisor.
- Trust policies and procedures should be followed as appropriate.

2) Educational Supervisor

Responsible for ensuring overall progress of the doctor through training. Includes responsibility for regular appraisals, collation of workplace-based assessment outcomes and the provision of career advice and support as required.

Responsibility for Doctors in Difficulty

- Should be made aware of and gather evidence about concerns from other team members.
- Should discuss these concerns with the doctor during regular appraisals and consider ways of addressing them, with the help of the multi-disciplinary team.
- If problems cannot be resolved within educational supervision context, or in current post, Educational Supervisor needs to access help from either within the Trust (Foundation Programme Director or Clinical Tutor) or within the Specialty (College Tutor or Programme Director), depending on the grade of the doctor and the nature of the problem (i.e. health, capability or conduct).
- Careful documentation is crucial at all stages.

3) College Tutor

Appointed by Specialty College but based in theTrust and responsible for advising and supporting doctors within a particular specialty in a Trust.

Mostly responsible for ensuring that trainees and supervisors adhere to College standards with regard to local educational programmes, regular appraisals and assessment, logbooks/portfolios in that particular specialty.

Responsibility for Doctors in Difficulty

- Career advice about their specialty
- Advice on exam procedure and requirements e.g. for doctors repeatedly failing exams
- Advice on specialty-specific issues
- Support for Educational Supervisors

4) Programme Director

Appointed by Deanery to manage specialty training programmes at Deanery level within a given specialty.

Responsible for allocation of specialty trainees to posts, supervision of individual training programmes, regular formal assessment including RITA/ARCP process, problem solving and feedback on progress.

Responsibility for Doctors in Difficulty

- Support trainees within their programme and deal with individual issues
- Support Educational Supervisors within their programme and provide advice on issues with individual doctors
- Identify issues at annual RITA/ARCP review
- Ensure that Doctors in Difficulty Strategy is implemented

- Resolve issues within programme (e.g. by moving individual doctor to different post/supervisor) wherever possible
- Bring more serious problems to attention of Trust (e.g. if patient safety at risk) or Deanery (e.g. if implications for training programme and additional resources required)

5) Head of Specialty School

Oversees, on behalf of the Deanery the activity and proper functioning of the Specialty School; liaises with the relevant College, Faculty or SAC; and supports the Programme Directors.

Responsibility for Doctors in Difficulty

No direct responsibility but can act as general source of advice for specialty and may decide to bring a particular problem to the attention of the Specialty School, to raise awareness and learn from the case.

6) Regional/Specialty Adviser

Appointed by College in consultation with Deanery/Institute; provides link between College and Deanery on education and training in the specialty.

Responsibility for Doctors in Difficulty

General support to doctors in difficulty and those who have to deal with them, particularly when advice is required on mandatory requirements of training.

7) Clinical Tutor/Director of Medical Education

Appointed by Postgraduate Dean together with Trust; manages the educational contract between Deanery and Trust and provides main link between the Postgraduate Dean and individual Trust with regard to training and education of doctors in all grades within a particular Trust.

Responsibility for Doctors in Difficulty

- Should be made aware of all issues with individual doctors in training in the Trust
- Should provide advice and guidance to trainees, clinical and educational supervisors on matters relating to health, capability and conduct
- Should monitor and inform the Deanery on progress of doctors in difficulty
- Should work closely with Human Resources Department on issues regarding doctors in difficulty, especially where patient safety may be compromised
- Should refer to Deanery those problems that cannot be resolved within the Trust
- Should involve Human Resources Department and invoke Trust procedures as required

8) Foundation Programme Director

As above but with particular responsibility for Foundation trainees. Needs to work closely with the Clinical Tutor/Director of Medical Education and Associate Dean for Foundation Training on all issues regarding Foundation trainees.

9) Associate Postgraduate Dean (Career and Personal Development)

Associate Dean with specific responsibility for doctors in difficulty provides strategic lead and direct support to educators on matters concerning doctors in difficulty, on behalf of the Postgraduate Dean.

Responsibility for Doctors in Difficulty

- Develop, manage and inform on framework for dealing with doctors in difficulty
- Ensure that resources are available to support the framework including remedial training, referral to NCAS, etc.
- Ensure that those dealing with doctors in difficulty are appropriately trained and supported
- Provide advice to educators on individual doctors in difficulty
- Assess and support those doctors in difficulty who require specialist input at Deanery level

10) Postgraduate Dean

Overall responsibility for postgraduate training and education within a geographical area.

Responsibility for Doctors in Difficulty

- Support and advice to Associate Dean dealing with doctors in difficulty
- Provide direct input to those cases where training may need to be terminated, or where appeals procedures need to be invoked

11) Director of GP Education

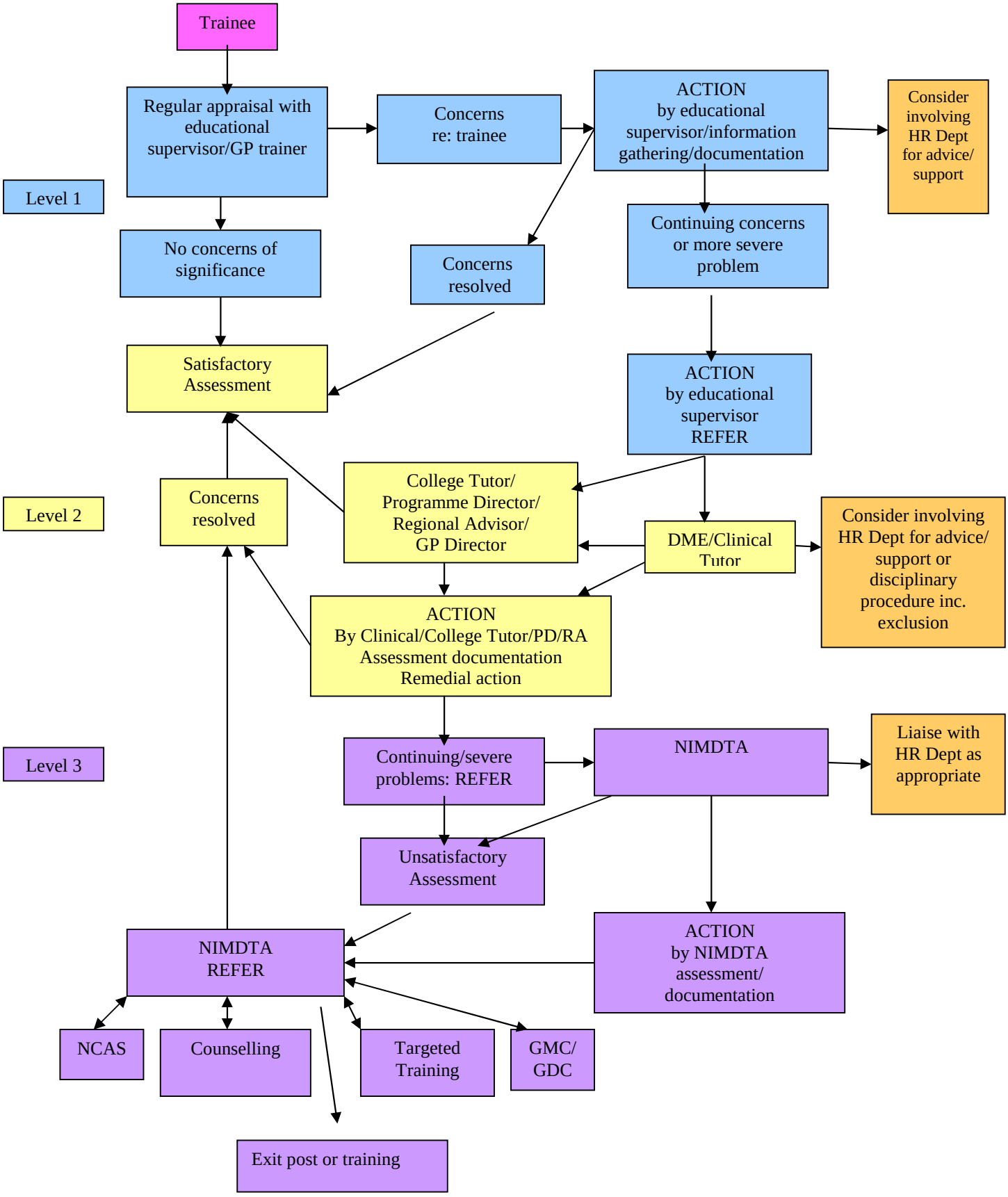
As for Associate Dean/Postgraduate Dean but with sole responsibility for trainees in General Practice.

12) Postgraduate Dental Dean

As for Associate Dean/Postgraduate Dean but with sole responsibility for trainees in Dentistry.

APPENDIX 2

Trainees in difficulty – Process Flowchart



Level 1

The aim of Level 1 is to identify trainees in difficulty as early as possible in order to avoid difficult situations where problems have developed to such an extent that their solution requires major intervention. Regular appraisal and assessment of a trainee's performance by educational supervisors is an important opportunity to identify and deal with the majority of problems within the trainee's current educational setting.

Where concerns are identified by a supervisor these should be discussed openly with the trainee and further information gathered from other members of the team.

Level 2

In certain situations e.g. major clinical incident the most appropriate course of action will be to follow the disciplinary procedures of the trust (in accordance with the 'Maintaining High Professional Standards' framework). However the Director of Medical Education/Clinical Tutor and NIMDTA should be informed that such an action has been undertaken.

More commonly the next step would be to involve the clinical tutor (see Appendix 1). Depending on local circumstances or whether the problems may have implications for progress in training for that trainee it may also be appropriate to seek the advice of the college tutor, specialty training programme director and /or regional advisor. For General Practice trainees the most appropriate contact may be the Director of GP Education and for Dental trainees the Postgraduate Dental Dean.

Many problems will be resolved by local intervention by the Director of Medical Education or Clinical Tutor, with the support of the college tutor etc. This will include assessment of need, further documentation and where appropriate remedial action with the support of the local consultant(s)/educational supervisor(s) and their team(s).

Level 3

This level of intervention will be required for a minority of trainees in difficulty who have been identified by DMEs/Clinical Tutors and or training programme directors as having difficulties which either have not been resolved by local intervention, or which require further input which is not available locally.

All trainees fulfilling these criteria should be referred to NIMDTA who will undertake further assessment of the needs of the particular trainee.

Where appropriate the trainee can be referred for support and counselling and/or arrangements can be made for targeted training with a selected educational supervisor.

Such interventions will have resource implications. Not all trainees will wish to move through this formal process and individual solutions to trainees' problems at local level may and should still be encouraged.

All attempts at targeted training will need to be recorded and monitored with clear indications of how progress has been assessed. Such systems as are agreed and planned for implementation may need to be discussed with Chief Executives, Medical Directors and Clinical Tutors. This is not just a matter of courtesy but to ensure that the systems link into Trust based systems for clinical risk management and clinical governance.

Where a concern about a doctor's or dentist's performance arises and the employer feels it needs help, the GMC (or GDC) and NCAS may be approached.

- If the concern, whether of performance, health or conduct, is so serious as to call into question the doctor or dentist's licence to practice, then the regulator's (**GMC/GDC**) advice should be taken. This approach will therefore only be used in the most serious circumstances.

- In all other circumstances, such as immediate concerns that might require exclusion or suspension, general concern about a practitioner's performance, conduct or competence, and in any situation where the local organisation is unsure how to proceed, **NCAS** should be contacted

APPENDIX 3

Checklist for educational supervisors: how to diagnose and manage a trainee in difficulty

Symptoms and Signs

Is your trainee demonstrating any of the following?

Anger; rigidity/obsessive behaviour; emotionality; absenteeism; failure to answer bleeps; poor time keeping or personal organisation; poor record-keeping; change of physical appearance; lack of insight; lack of judgement; clinical mistakes; failing exams; discussing a career change; communication problems with patients, relatives, colleagues or staff?

Have there been complaints from patients or staff about any of the following?

Bullying; arrogance; rudeness; lack of team working (e.g. isolation; unwilling to cover for colleagues; undermining other colleagues; criticising or arguing in public/in front of patients); defensive reactions to feedback; verbal or physical aggression; erratic or volatile behaviour

Underlying reasons/explanations

Can you identify any reasons for the above signs and symptoms – for example?

Poor approach to studying; lack of knowledge; lack of skills; lack of confidence; deficient interpersonal skills; language barrier; attitudinal /personality problem; stress due to life events; stress due to work (e.g. dysfunction in the team; problems with trainer/supervisor or the training process; a specific critical incident affecting confidence); poor motivation; health problems; drug or alcohol abuse; physical illness; psychiatric illness; workload; sleep deprivation.

Is the problem due to any of the following factors within the individual?

Capacity – a fundamental limitation that will prevent them from being able to do their job (e.g. mental or physical impairment) even with all reasonable adjustments in place.

Learning – a skills deficit through lack of training or education. In these cases, skills-based education is likely to be appropriate, provided it is tailored as closely as possible to the individual learning style of the doctor and is realistic within exiting resources.

Motivation – a drop in motivation through being stressed, bored, bullied or overloaded – or conversely being over-motivated, unable to say no, anxious to please, etc. In these cases some form of mentoring, counselling or other form of support may be appropriate and /or addressing organisational issues like workload, team dysfunction or other environmental difficulties that may be affecting motivation.

Distraction – something happening outside work to distract the doctor; or a distraction within the work environment (noise or disruption; team dysfunction). The doctor may need to be encouraged to seek outside professional help if the problem is outside work.

Health – an acute or chronic health problem which may in turn affect capacity, learning or motivation. Occupational health may have a role here; or the doctor may need to be encouraged to visit his or her GP.

Alienation – a complete loss of any motivation, interest of commitment to medicine or the organisation, leading to passive or active hostility, “sabotage” etc. This cannot generally be rectified and damage can be caused to others (patients and colleagues) and to the organisation if allowed to continue for too long. The doctor should be moved out of the organisation, with whatever support or disciplinary measures may be deemed appropriate.

Investigation

Have you talked to the trainee to gain their perspective?

Have you talked to staff/colleagues confidentially to verify your findings?

Is there any documentary evidence?

Can you talk to other professionals concerned with the trainee’s welfare e.g. GP (with their permission)?

Management

Have you clearly documented any information or evidence you have discovered?

Have you discussed the purpose of this documentation with the trainee?

Does the trainee understand that the appraisal process is confidential but that some documentation of problems is necessary for regulatory purposes and can you agree on this?

Can and should the trainee remain at work?

Is this a case for a trust disciplinary procedure or referral to the GMC?

Management Plan

Have you developed and agreed a suitable learning plan with the trainee?

Can you organise and commit to increased and regular supervision?

When will re-appraisal and reassessment take place?

If problems are not or cannot be resolved should this be referred on to the clinical or college tutor /training programme director?

Further guidance about how and when to act on these concerns is provided below in the Process Flowchart (Appendix 2).

Ensuring PMETB Standards are met – Guidance for trainers within Northern Ireland

This document outlines the roles and responsibilities of those delivering postgraduate medical education within Northern Ireland. It provides a framework to ensure that the statutory PMETB standards for trainers are met. This includes setting out the competences that the trainers should have in the different educational roles described below and the process of accreditation.

Following the publication of standards for trainers by the postgraduate medical education and training board (PMETB) NIMDTA has developed a strategy to ensure that trainers have access to the appropriate development opportunities that will enable them to meet the standards.

Many trainers have considerable experience in the provision of postgraduate education and a process to enable this to be recognised is an important component of the strategy (APL, APEL).

The purpose of this document is to outline the roles, responsibilities and training requirements of Clinical (CS), Educational (ES) Supervisors, and others working in postgraduate medical education in the Deanery in relation to Foundation and Specialty Training.

This guidance will also support Trusts and other Local Educational Providers (LEPs) in their quality control as they educationally support, manage, audit and resource the educational role of CS & ES.

This guidance is mapped to the Gold Guide to Specialty Training [June, 2008]; Postgraduate Medical and Education Training Board [PMETB] Generic Standards for Training; PMETB Standards for Trainers [PMETB Jan 2008] and the Foundation Programme.

The PMETB Standards for Trainers (Jan 2008) [SFT]

Standard 1: Trainers must provide a level of supervision appropriate to the competence of the trainee.

Standard 2: Trainers must be involved in and contribute to a learning culture in which patient care occurs.

Standard 3: Trainers must be supported in their role by a postgraduate education team and have a suitable job plan with an appropriate work load and time to develop trainees.

Standard 4: Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees.

Definitions

Trainer:
The term trainer will encompass a variety of consultants, and other experienced practitioners, who train on ward rounds, OP clinics, operative lists etc.

Clinical Supervisor:
Each trainee should have a named clinical supervisor for each placement. A clinical supervisor is trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement. The roles of Clinical and Educational Supervisor may then be merged.

Educational Supervisor:
An educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee's Educational Agreement.

ES's will require a higher level of educational development for their role which will usually be significantly more demanding.

In many instances the same person may undertake both CS and ES roles for a given trainee. However, in specialty training (including GP trainees in secondary care attachments) some doctors may act as ES for more than one trainee and receive feedback on trainee performance from multiple CS. Some doctors may act as CS only.

Roles and responsibilities

The clinical supervisor: **Role and responsibilities:**

- Enables trainees to learn by taking responsibility for patient management within the context of clinical governance and patient safety
- Ensures that clinical care is valued for its learning opportunities; learning and teaching must be integrated into service provision
- Undertakes clinical supervision of a trainee, giving regular, appropriate feedback according to the stage and level of training, experience and expected competence of the trainee
- Undertakes assessment of trainees (or delegates as appropriate), has been trained in assessment and understands the generic relationship between learning and assessment
- Liaises with the appropriate Educational Supervisor over trainee progression
- Must ensure that all doctors and non medical staff involved in training and assessment understand the requirements of the curriculum (foundation, specialty or GP) as it relates to a particular trainee

The Educational Supervisor:

This is a complex role which spans the areas of clinical supervision as well as educational management, educational supervision and feedback, an understanding of the role of assessment in learning, the use of portfolios as a learning and assessment tool, an understanding of how to identify, support and manage a trainee in difficulty, and of supporting trainee career decision making. They must ensure that the appropriate learning opportunities are available so that the trainee can meet the curriculum requirements.

A key responsibility of the educational supervisor is to carry out both educational and workplace appraisals with the trainee and generate the structured report for the ARCP.

Educational supervisors are responsible for overseeing training to ensure that trainees are making the necessary clinical and educational progress.

Competence Framework

This framework sets out the competences against which the trainer will be assessed for accreditation. The document will then go on to outline how this might be achieved through training courses or their equivalent. (See also the Accreditation for Prior [Experiential] Learning process)

<u>Level One</u>

Clinical Supervisors

Competences

These have been drawn from the PMETB standards and fall into 4 areas:

1) Teaching Skills

- Able to demonstrate a level and range of practical teaching skills as defined by the PMETB standards
- Sharing of good practice to ensure a consistent approach

2) Understanding of the Specialty Curriculum and the PMETB regulatory framework

- Able to demonstrate an understanding of the training requirements as set out in the specialty curriculum including: how the training objectives are to be delivered and what the assessment process is
- Having an understanding of the PMETB regulatory framework

3) Assessment and Appraisal

- Experience of giving feedback to trainees about their performance
- Able to demonstrate an understanding of assessment as a developmental tool as well as a summative process
- Experience of the use appraisal with trainees
- Experience of supporting a trainee with managing the requirements of the programme, meet the learning objectives, and develop a learning portfolio
- Able to demonstrate an understanding of how to proceed when a trainee fails to progress

4) Supervision

- Experience of supervising trainees in both clinical and non clinical skills
- Experience of giving trainees appropriate career guidance and support

Level 2

Educational Supervisors

Competencies

- be adequately prepared for the role and have an understanding of educational theory and practical educational techniques e.g. have undertaken formal facilitated training or an on-line training programme or participate in relevant training the trainers programmes
- be trained to offer educational supervision and undertake educational appraisal and feedback
- deliver workplace appraisal in line with regional policy
- undertake training in competence assessment for specialty training
- provide regular appraisal opportunities which should take place at the beginning, middle and end of a placement
- develop a learning agreement and educational objectives with the trainee which is mutually agreed and is the point of reference for future appraisal
- be responsible for ensuring that trainees whom they supervise maintain and develop their specialty learning portfolio and participate in the specialty assessment process
- provide regular feedback to the trainee on their progress
- ensure that the structured report which is a detailed review and synopsis of the trainee's learning portfolio is returned within the necessary timescales
- be able to advise the trainee about access to career management

An educational supervisor should have the skills and competencies identified at level one. The following skills should be demonstrated to be accredited at level two: -

- Appraisal skills should include: –
- Able to carry out the placement reviews
- Development of personal development plans for the trainee
- Development of the learning contract with the trainee
- Ability to undertake competence assessments.
- Have an understanding of the portfolio, how it relate to the curriculum and be able to support the trainee with the development of their portfolio
- Have an understanding of educational theory and techniques
- Be able to deliver the training objectives in the workplace
- Manage those trainees who are not meeting the required progress

Level 3

Educational Leads

Educational leads include Directors of Medical Education (DME), College/Specialty Tutors, Programme Directors, Heads and Deputy Heads of Schools.

It would be expected that senior lead educators would have undertaken a formal qualification. Possible qualifications would include, the 'Doctors as Educators' qualification from the RCP, a Certificate, Diploma or Masters in Medical Education.

Currently, formal qualifications may be considered aspirational but as the accreditation process develops it is expected that this will be an expectation rather than an aspiration.

Training Requirements

CS (level 1) and ES (level 2) will need to demonstrate that they have received training in the following:

Equality, diversity and cultural awareness. (This will need to be repeated every 3 years)
Recruitment and Selection

Level 1 (Clinical Supervisor training):

Workplace Based Assessments / Foundation Competency Assessments
Giving feedback to trainees (of all abilities)
Learning agreements / educational needs
Assessment and appraisal
Principles of ARCP's / RITA's
Relevant specialty portfolios / e-portfolios including Foundation
Understands PMETB requirements of CS

Level 2 (Educational supervisor training):

Essential:
Completed level 1 training
Adult learning principles (styles, reflection, education cycle, structured teaching, environment, role modeling)
Workplace based ('on the job') teaching

Careers support
Managing the trainee in difficulty
Monitoring / Quality control - Deanery and PMETB standards

Optional:
Group teaching skills
Presentation skills / visual aids
PBL
Evaluation of teaching
Coaching, mentoring and pastoral care

All clinical and educational supervisors will be required to undergo annual appraisal which must include an element of educational appraisal.

Level 3 (Educational Leads)

Those undertaking a lead educator role would be expected to have a formal qualification or equivalent.

Accreditation of Prior Learning (APL)

APL refers to the situation when a trainer, CS or ES has attended relevant organised prior-learning which has been assessed by a learning provider, and for which certificates are awarded on completion.

Such individuals can request that this APL be accredited by the Local Educational Provider and the Deanery. Such courses can include;

- Teaching the Teachers, provided locally or by relevant colleges
- Instructor Training for Accredited Resuscitation Courses
- Masters , certificates, diplomas in Education;

The above list is not exhaustive and any trainer who provides evidence of curricular content of a relevant course will be considered.

Accreditation of Prior Experiential Learning (APEL)

APEL generally refers to incidental prior learning which is un-assessed. Such learning may be gained through unstructured experiences and work. It also includes un-assessed formal training courses. Certificates may or may not be available as evidence that the learning has taken place.

AP(E)L process focuses on and gives credit for their attainments, skills and knowledge – in other words, their 'competences'.

These individuals, if they so wish, should have the opportunity to submit a portfolio of evidence to their Trust DME (or designated deputy) to ascertain if they meet the new standards and what, if any, top up training they require.

All clinical and educational supervisors will be expected to demonstrate that they continue to meet the standards outlined through annual appraisal. It is anticipated that this will form part of the 5 yearly revalidation and re-certification process.

Under PMETB's quality assurance proposals it is the LEP's responsibility to ensure that all clinical and educational supervisors are adequately trained and this will form part of the annual QC report to the Deanery. Corroboratory evidence will be sought at the Deanery QM visits.

Requirements on Trusts and other Local Education Providers

From January 2010, all educational supervisors must be selected and accredited for their role against the NIMDTA Framework areas on a regular three-yearly cycle of review.

There is no 'one size fits all' but the outcomes of local processes are expected to be that:

- A database of all nominated clinical and educational supervisors is established and maintained by the Trust or local education provider. This must include a record of training undertaken, accreditation date and recommendations made with regard to future development.
- A process of portfolio-based accreditation for educational supervisors is established with a rolling three-yearly cycle of review.
- The accreditation/reaccreditation process is carried out against the GMC's common domains
- The process must be linked to a review of results from the PMETB trainee survey.
- The process must be developmental i.e. it must incorporate identification of needs for further development as an educator in the form of a personal development plan.
- The review will also result in a formal statement of accreditation from the Director of Medical Education (or nominated deputy) including a recommendation in relation to the supervisor's educational workload in accordance with NIMDTA's educational tariff. This recommendation should be in the form that it can be carried forward as a basis for negotiation in the annual consultant job planning process.

- A clear and transparent selection process is established for all new clinical and educational supervisors. Educational supervisors would normally be expected to submit an evidenced portfolio to the Director of Medical Education (or nominated deputy) before taking on their role.
- In the roll out phase in 2009, existing supervisors may initially be accredited for up to three years on the basis of their past experience and job role. This time-limited grandfather clause is subject to the supervisors concerned undertaking to participate in the cycle of three-yearly review when called. This pragmatic measure will enable the reaccreditation load for Trusts to be spread over a three-year period i.e. not all reviews falling in the same year.
- Trust and other local education providers must provide an ongoing programme of faculty development in accordance with the identified development needs of all educators within the Trust or provider.
- Provided the above outcomes are achieved, Trusts may develop their own administrative processes.
- Trusts and other local education providers will be required to demonstrate that they are meeting the requirements of the professional development framework for Supervisors as an integral part of NIMDTA's routine quality management processes.
- Rolling programmes of faculty development must be provided within each Trust to enable clinical and educational supervisors to meet the mandatory training requirements described above. Faculty development though should be an iterative process, enabling clinical teachers to reflect and to receive feedback on their teaching and supervision. It is not a one-off 'sheep dip' exercise. Local faculty development programmes should facilitate support and development through, for example the provision of advanced programmes for experienced educators, mentoring and supervision support, and the additional content of local faculty development programmes should meet the training needs of supervisors identified through the three-yearly cycle of review.
- Supervisors who wish to pursue their educational development in more depth are advised to consider enrolling on a university-accredited course such as the Postgraduate Certificate/Diploma or Masters in Clinical Education at the Queen's University Belfast or equivalent accredited courses.

Educational Tariff Guidance

This guidance should be read in conjunction with the definitions provided above.

Postgraduate medical education has changed dramatically in the last few years and in line with increasing accountability found across the public sector, there are greater expectations than ever on consultant trainers. From 2010 the Postgraduate Medical Education and Training Board, requires that 'trainers must have a suitable job plan with an appropriate workload and time to develop trainees'. It is therefore now an expectation, as laid out in the educational contract with Trusts that appropriate time for training is allocated within an individual consultant's job plan. This will be monitored as part of the Deanery's routine quality and contract monitoring processes.

Educational Supervisor - 1 PA per week per 16 trainees

Comment

This would usually be planned as part of supporting programmed activity (SPA) time. However, a consultant's workload might be such that additional programmed activities (PAs) are required or time is found within clinical activities. Trainers with an educational supervision role will be expected to demonstrate their competence through participation in the three yearly cycle of educational review described in the 'Requirements on Trusts' section of this document.

In the interests of clarity, the Director of Medical Education (or nominated deputy) within each Trust will make a formal recommendation for consultants to take forward to the job planning process based on the tariff below. This will be subject to, and an outcome of successful participation in the educational review process. Please note that this is not a guarantee that additional PAs will be made available – ultimately this is a matter for negotiation between employee and employer – but it is NIMDTA's view that these are reasonable expectations that meet national requirements.

Clinical supervisor - 0.25 PA per week (maximum) independent of number of trainees

Comment

Clinical supervision entails no longitudinal relationship with trainees, and as such is already a requirement of consultants under Good Medical Practice. Participation in the three-yearly review process is optional but to be encouraged. The Professional Development Framework should be used to guide faculty development programmes for this group of trainers.

Training Programme Director - 1 PA per week (minimum) per 40 trainees

Comment

The role of the training programme director is defined in the 'Gold Guide' (Department of Health 2008) paragraphs 4.12–4.14. PMETB requires that training programmes are led by programme directors who have responsibility for the management of both trainees and their programmes. Funding for training programme directors is sent directly to Trusts from NIMDTA. Programme directors overseeing certain groups of trainees may attract a higher rate of remuneration.

Foundation Programme Director - 1 PA per week (minimum) per 40 trainees

Comment

The foundation training programme director is responsible for the overall management and quality control of a Foundation Programme that consists of 20-40 placements designed for foundation training across the local health economy. Funding for the support of foundation training is sent directly to Trusts from the NIMDTA on a per trainee basis and may be used flexibly by Trusts.

College or Specialty Tutor

Comment

NIMDTA does not hold a view on the job planning requirements of College or specialty tutors as their role and level of involvement in local education varies from Trust to Trust and across specialties. Increasingly though, tutors may find themselves playing an important part in the selection and reaccreditation of educational supervisors and will normally be accountable to the Director of Medical Education.

Director of Medical Education - 3–5 PAs per week

Comment

Directors of medical education will work to a Trust job description and time allocated within the job plan. Historically, clinical tutors and directors of medical education have been dually funded by Trusts and the Deanery. These important posts, and associate positions are being increasingly developed and supported and in large Trusts the sessional commitment may rise to as much as full time.

Other educational tasks

Comment

From time to time consultants will be required to participate in other educational activity such as attendance at specialty training or School committee meetings, Deanery meetings, participation in recruitment episodes and other Trust-based educational activity such as teaching or facilitation in simulation centres. It is not possible to provide blanket guidance around these many and diverse educational responsibilities and these elements of an individual's role should be allocated time in the job plan by individual negotiation.

The Appraisal Process and the ARCP

Educational Meetings: initial

The Educational Supervisor arranges to meet trainees at the beginning of each attachment to:

- Check that the trainee has received a local induction
- Ensure that competency check lists have been completed
- Ensure that the trainee has relevant handbooks; speciality, faculty etc.
- Discuss trainee learning needs, how these will be developed and which assessment methods will be used to evaluate whether the trainee is meeting required competencies (i.e. complete a learning agreement)
- Record all meetings, outcomes of meetings as required and communicate these to trainee, Faculty Group, Training Programme director as appropriate.
- Discuss the range of evidence which might contribute to the building of a portfolio of training progression
- Review the trainee's portfolio at each meeting and adapt/monitor learning needs in relation to curricular requirements (Foundation, Specialty or GP)

Education Meetings: mid point

The Educational Supervisor arranges to meet the trainee at the mid point of each attachment to:

- Discuss and review progress to date. If necessary amend learning outcomes
- Discuss taster opportunities if appropriate and ensure that these are relevant and appropriate to career intentions
- Review learning portfolio and support trainee development of evidence of competency
- Ensure that the trainee is appropriately engaging in the assessment process, learning from this, and achieving the expected competencies for the stage and level of training.
- Negotiate remedial efforts if required.

Education Meetings: end point of rotation

The Educational Supervisor arranges to meet the trainee at the end of each attachment to:

- Review progress to date in relation to the requirements of the curriculum
- Ensure that all appropriate assessments have been completed, review with the trainee, which competencies have been met, and amend professional development plan as appropriate, noting what needs to be carried forward to the next rotation and forward plan future trainee learning needs
- Ensure that all relevant documentation has been completed

Annual Review of Competence Progression [ARCP], appraisal, and annual planning

The Educational Supervisor is responsible for bringing together the structured report which looks at evidence of progress in training and submitting this together with other documentation as required to the ARCP process. In the Foundation Programme the Educational Supervisor signs off the FACD, which is then countersigned by the Associate Dean /Training Programme Director

The ES will also carry out a workplace based appraisal for each trainee annually as appropriate using the regional Appraisal Documentation.

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr MRA Young, Consultant Urologist
SECRETARY: Miss Paulette Dignam
TELEPHONE: Personal Information redacted by the USI
FAX: Personal Information redacted by the USI
E-MAIL: Personal Information redacted by the USI

01st December 2008

CATHERINE MCNICHOLL
CHAIR OF THE UROLOGY STEERING GROUP

Dear Catherine,

I am writing to you as chair of the Urology Steering Group to express my concern about the proposed alteration in how the urology services are going to be changed. I, like I suspect others, feel that the Department of Health has not fully grasped the potential consequences of this action. My interpretation is that the Department is endeavouring to downgrade the scope of urological service provision in all facilities outside of one unit in Belfast. It is appreciated that the Department of Health has focused on pelvic cancer work as defined by IOG guidelines. Others may quote that there is no strong evidence to back this approach. We are all encouraged to perform audit but this appears to be disregarded for this particular project.

I however would like to take a different angle on this point. Urological Surgeons provide a service to their own patients as well as being part of a larger team to help with urological emergencies and difficulties that our General Surgical and Gynaecological colleagues may have. Training and competencies in this field take time to accumulate and to be maintained. There is a significant crossover of surgical technique that is applicable, however if pelvic surgery is to be removed from the current Cancer Units there will be a significant knock on effect.

This dogmatic approach to a population base has not been taken in other areas within the UK where unit size of four to five hundred thousand still has a viable oncology approach. With the uncertainty of population boundaries for Health Service provision I feel that it is unwise to take the "all eggs in one basket" approach. I would regard that there is the capabilities of having three significant urology units to cover the vast majority of the urological spectrum with the rare and low volume workload being provided in a central unit or indeed if at such a low quantity may have to be on a supra regional basis. I do not regard pelvic oncology as falling into this spectrum.

Unit manpower and size is critical to cover the population's total need. Eventually there will be a loss of experience and this will lead to a further shift in the expected patient pathway. Recent review by your Department has obviously defined the need for three units in Northern Ireland for Trauma and Orthopaedics. Their needs are probably not far from our own.

If however the Department is going to instigate IOG guidelines then there are indeed certain conditions which even our local regional centre will not be able to provide and such cases will have to be transferred to the mainland for their therapy. I appreciate that some may say that close links can be taken in such instances however if the IOG guidelines are to be implemented, this you will have to regard as insufficient. If the Department however does instigate a complete centralisation of services then I would suggest that there are four subsidiary peripheral units, as I regard that the principles of treatment closer to home is important. I would urge that IOG guidelines, although focused on one precise area for this review will have immense detrimental knock-on effects that they should be taken with significant regard.

Yours sincerely,

Mr M RA Young, MD FRCS (Urol)
Consultant Urologist
/pd

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Tier 2 Urology Services for Southern Area Population

- **LUTS**
- **Prostate Diagnostic Service**
- **Haematuria**
- **Stone Service**
- **Female Urology**
- **Oncology Review**
- **Andrology**

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Caring Through Commitment

Format of Today's Presentation

- Update on operational aspects of Tier 2 services
- Estimate of number of clinics required for the SHSSB and resources required to implement, based on the following assumptions:
    - 2050 new urology referrals p.a. from SHSSB residents
    - Results of audit of new referrals during Jan, Feb & March 2006 – providing an indication of potential demand for Tier 2 services and numbers of new clinics required
    - Estimates of numbers of patients requiring review at Tier 2 clinics and numbers of review clinics required

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Costing Assumptions

- Marginal cost per case extracted from 2004/05 specialty costs uplifted by 2.5% inflation for 2005/06, and by 2.5% for 2006/07
- Payroll is costed at mid-point using 2006/07 pay rates (excluding the impact of Agenda for Change)
- Service costs are based on estimates of requirements which require final review and sign-off by project team.
- Service costs figures have been rounded for ease of presentation.

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Results of Prospective Data Collection Exercise

Analysis of Referrals	%
Direct Urgent Admissions	5%
Return to GP	3%
Routine Consultant OPD	19%
Urgent Consultant OPD	10%
Erectile Dysfunction	1%
Scrotal Swellings	3%
Female Urology	11%
Haematuria	18%
Male LUTS	13%
Prostate Diagnostic	11%
Stone Service	7%
	100%

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Craigavon Urology Services

Guiding Principles:

- **Quality** of urological care is at least the same or improved compared with current provision
- Improved **response** to service demands
- Improved two-way **communication** between primary and secondary care providers
- Improved **communication** with the patient
- Improved focus on the **patient's experience** of the urology service
- **Team** approach to care

Implementing Tier 2

- We fully appreciate that the objective of Tier 2 services is to have the maximum number of patients investigated and managed in the primary care/community setting
- Tier 2 services will require time to develop the experience and qualifications, competence and confidence to achieve this objective.

  ⇒ Need funded **time** for case discussion between Tier 2 team members and Consultant Urologists

  ⇒ Additional **resources** - e.g. Urology Administration Co-ordinator, Systems Manager, MDT Resources

  ⇒ Dedicated clinical **space**

CRAIGAVON AREA HOSPITAL GROUP TRUST
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Tier 2 Urology Services for Southern Area Population

- **LUTS**
- **Prostate Diagnostic Service**
- **Haematuria**
- **Stone Service**
- **Female Urology**
- **Oncology Review**
- **Andrology**

Update – Tier 2 LUTS

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	Managed by nurse specialist	OCT O5	NOV 05	DEC 05	JAN 06	FEB 06	MAR 06	Total	%
Patients appointed		29	18	33	61	37	27	205	-
Patients assessed	√	**21**	**16**	**33**	**57**	**34**	**24**	**185**	**90%**
DNAs / CNAs		7	2	0	3	3	5	20	10%
Ongoing LUTS review	√	**11**	**6**	**15**	**20**	**17**	**12**	**81**	**44%**
Referred for investigation	√	**3** 1 CU 1 CU/UDS 1	**5** 2 CU 2 UDS 1 USS/CU	**5** 2 CU 1 U/UDS 1 USS 1 CU/ Bx	**12** 4 CU 3 UDS 2 CU/UDS 2 USS 1 TRUS Bx	**5** 4CU 1CT	**4** 2 TRUS 1 CU/USS 1UDS	**34**	**18%**
Review by Consultant		**2**	**3**	**3**	**4**	**1**	**2**	**15**	**8%**
Straight to surgery	√	**0**	**0**	**3** 3 TURP	**5** 4 TURP 1 epid cyst	**5** 3TURP 2CU/IVU	**1** litholopaxy	**14**	**7%**
Discharged	√	**5**	**2**	**7**	**12**	**6**	**4**	**36**	**19%**

Tier 2 LUTS – Estimate of Demand

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Estimate of number of clinics required

NEW PATIENTS

Estimated % of SHSSB referrals suitable for service	13%
Number of referrals p.a. suitable for service	267
Number of patients per clinic	4
Number of clinics required per annum	**67**

REVIEW PATIENTS

Number of referrals p.a. suitable for service	267
% that will need to be reviewed at Tier 2 clinic	44%
Number that will need to be reviewed at Tier 2 clinic	117
Average number of reviews per annum	3
Estimate of total reviews per annum	352
Number of patients per clinic	8
Number of clinics required per annum	**44**

Tier 2 LUTS – Estimated Cost of Service

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Estimated Cost of Service - £55K per annum

New Clinics	**£510 per clinic**
Review Clinics	**£480 per clinic**

Key Resource Requirements:

- **Nursing**
- **Radiographer**

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Tier 2 Urology Services for Southern Area Population

- LUTS
- Prostate Diagnostic Service
- Haematuria
- Stone Service
- Female Urology
- Oncology Review
- Andrology

Tier 2 Prostate Diagnostic – Estimate of Demand

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimate of number of clinics required

NEW PATIENTS - 'Day 1' Assessment clinic		
Estimated % of SHSSB referrals suitable for service	11%	
Number of referrals p.a. suitable for service	226	
Number of patients per clinic	4	
Number of clinics required per annum	**56**	
NEW PATIENTS - 'Day 2' TRUS Biopsy		
Number of referrals p.a. suitable for service	226	potentially 100% needing biopsy.
Number of patients per clinic	4	
Number of clinics required per annum	**56**	
NEW PATIENTS - 'Day 3' TRUS Biopsy Review		
Number of referrals p.a. suitable for service	226	
Number of patients per clinic	4	
Number of clinics required per annum	**56**	

REVIEW PATIENTS

Diagnostics/Oncology Review/Consultant clinic

PSA monitoring clinic/service required??

Tier 2 Prostate Diagnostic – Estimated Cost of Service

CRAIGAVON AREA HOSPITAL GROUP TRUST
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Estimated Cost of Service - £129K per annum

'Day 1' Assessment clinic	£420 per clinic
'Day 2' TRUS Biopsy	£960 per clinic
'Day 3' TRUS Biopsy Review	£930 per clinic

Key Resource Requirements:

- Nursing
- Consultant Radiologist
- Radiographer
- GPwSI

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Tier 2 Urology Services for Southern Area Population

- LUTS
- Prostate Diagnostic Service
- Haematuria
- Stone Service
- Female Urology
- Oncology Review
- Andrology

Proposed Tier 2 Haematuria Service

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	Who? - Now	Who?-New Service
Review of letter	Consultant	Consultant
X-ray card completed	Consultant	Nurse
Patients booked to session	Consultant Secretary	Consultant Secretary
Haematuria Clinic		
Patient comes to assessment unit	Nurse	Nurse
Patient taken to x-ray	Nurse	Nurse
Patient taken for cystoscopy	Nurse	Nurse
Cystoscopy performed *	Registrar	Nurse

AM

~~PM~~

**** Results of cystoscopy managed within protocols***

Proposed Tier 2 Haematuria Service

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Outcomes for the patient

- Further investigations and treatment
- Referred back to GP for treatment and review
- Future review appointment(s) at CAHGT
  - Review Clinic (Consultant)
  - Review Clinic (Nurse) *

* **Protocol driven**

Tier 2 Haematuria Service – Estimate of Demand

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimate of number of clinics required

NEW PATIENTS

Estimated % of SHSSB referrals suitable for service	18%
Number of referrals p.a. suitable for service	369
Number of patients per clinic	4
Number of clinics required per annum	**92**

REVIEW PATIENTS

Number of referrals p.a. suitable for service	369
% that will need to be reviewed at Tier 2 clinic	75%
Number that will need to be reviewed at Tier 2 clinic	277
Average number of reviews per annum	1
Estimate of total reviews per annum	277
Number of patients per clinic	4
Number of clinics required per annum	**69**

Most of the review requirement will be provided via the one new/review clinic proposed for CAH.

Tier 2 Haematuria – Estimated Cost of Service

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Estimated Cost of Service - £167K per annum

£1,810 per clinic

Key Resource Requirements:

- **Nursing**
- **Consultant Radiologist**
- **Radiographer**

Resources currently funded at CAH and DHH to be confirmed

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Tier 2 Urology Services for Southern Area Population

- LUTS
- Prostate Diagnostic Service
- Haematuria
- Stone Service
- Female Urology
- Oncology Review
- Andrology

CRAIGAVON AREA HOSPITAL GROUP TRUST
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Proposed Tier 2 Stone Service

Source of Referral

GP | Other Hospital | A&E | Other CAHGT Department | Ward

	Who? - Now	Who? - New Service
Review of letter	Consultant	Consultant
Diagnostics	Consultant	Nurse
Consultant Clinic / STC Clinic / Direct Access ESWL / Direct Access to Ward (not ESWL)		
Patient Consultation	Consultant	Consultant
Booking arranged for ESWL	Consultant	Nurse / Co-ordinator
ESWL procedure performed	Consultant/Radiographer /Nurse	Radiographer /Nurse *
Post ESWL review	Consultant	Consultant
Ongoing review		

Review Clinic (Consultant) ↔ Review Clinic (Nurse) #

** Access to Consultant*

 # Protocol driven, metabolic screening & possibly some follow-up by telephone as appropriate

Proposed Tier 2 Stone Service

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A&E - Renal Colic

OR

Dedicated Clinic Time (9am-10am), possibly daily

- Patient treated in A&E, sent home and advised to return to clinic the next day
- Clinic operated by Nurse
- Nurse collation of data and investigations
- Access to Consultant as required (managed within protocols) *
- Avoiding hospital admissions where possible

Consultant

- A&E Staff can refer to Consultant Urologist if this would be more appropriate for the patient

** STC Service/Consultant of the week*

Tier 2 Stone Service – Estimate of Demand

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimate of number of clinics required

ELECTIVE PROVEN STONES

Estimated % of SHSSB referrals suitable for service	7%
Number of referrals p.a.	140

NURSE PROVIDED SERVICE

Arranging Diagnostics
Telephone follow-up clinic
Metabolic screening clinic
Review post stent removal

Time to perform above. No. of sessions to be determined.

A&E RENAL COLIC CLINIC

To be run as a daily clinic

Nurse time	1 hour approx per day.
Funding of diagnostic radiology	Average 1 patient per day.

Tier 2 Stone Service – Estimated Cost of Service

Estimate of Funding Required:

To be determined

Key Resource Requirements:

- **Additional resources will be sought for:**
  - **Nursing input to organise initial diagnostics**
  - **Nurse-led review clinic**
- **Funding will also be sought for the daily A&E Renal Colic service**

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Tier 2 Urology Services for Southern Area Population

- LUTS
- Prostate Diagnostic Service
- Haematuria
- Stone Service
- **Female Urology**
- Oncology Review
- Andrology

Proposed Tier 2 Female Urology

- CAHGT have determined that Female Urology will include:
  - Female LUTS
  - Incontinence
  - UTIs

- GPs will choose to refer their patients to either:
  - Hospital based Urology Service
  - Hospital based Gynaecology Service
  - Community based Continence Advisor

- The pathway overleaf describes the journey for patients referred by their GP to the Hospital based Urology Service

Proposed Tier 2 Female Urology

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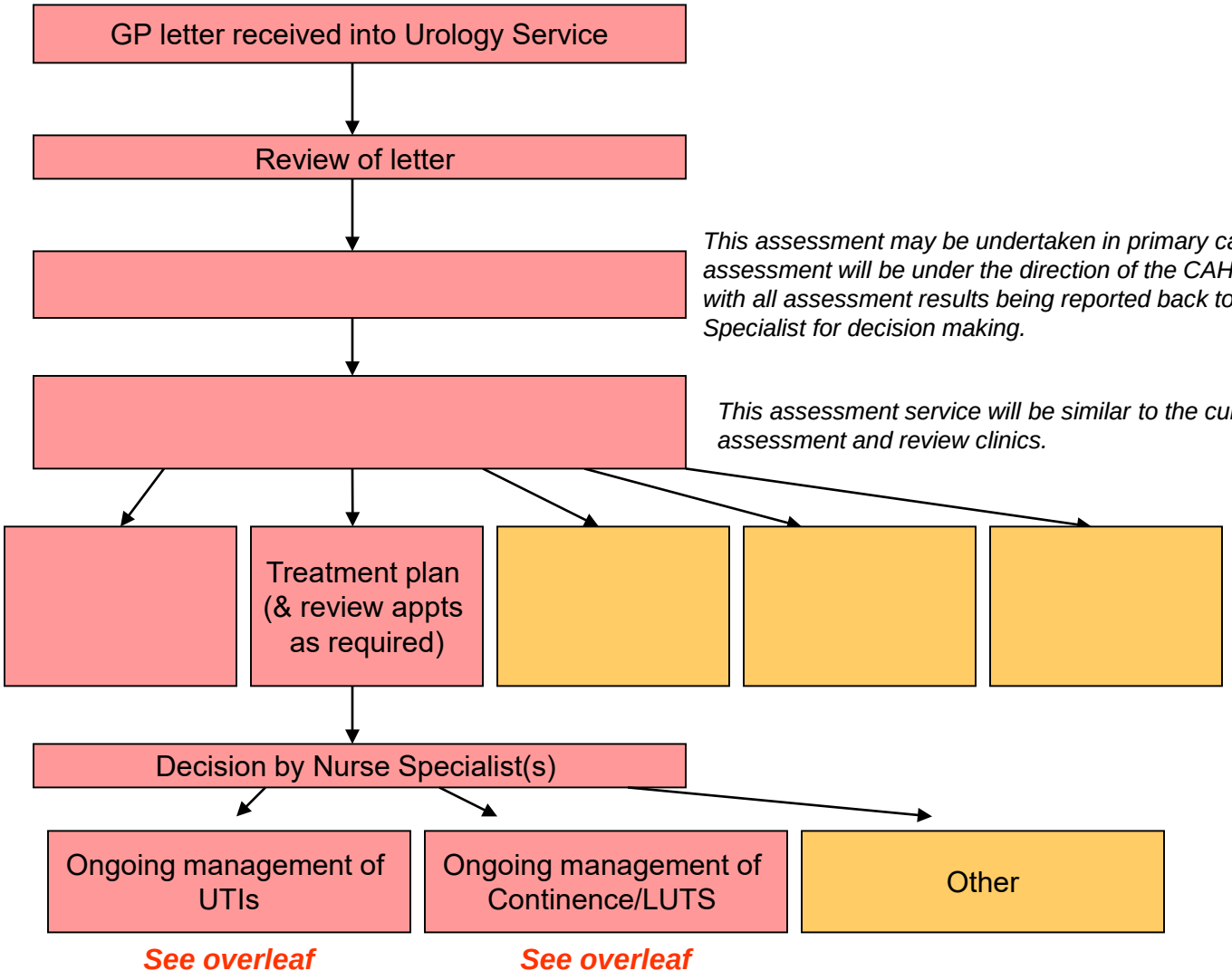

This assessment may be undertaken in primary care, The assessment will be under the direction of the CAHGT Urology Service with all assessment results being reported back to the CAHGT Nurse Specialist for decision making.

This assessment service will be similar to the current Male LUTS assessment and review clinics.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Proposed Tier 2 Female Urology (Cont'd)

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Ongoing management of UTIs

- Further specific targeted investigations including IVP, cystoscopy
- Review appointments at Tier 2 clinic or other service as required.

Ongoing management of Continence/LUTS

- Further specific targeted investigations including uro-dynamics
- Review appointments at Tier 2 clinic or other service as required.

Tier 2 Female Urology – Estimate of Demand

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimate of number of clinics required

NEW PATIENTS

Assessment

Estimated % of SHSSB referrals suitable for service	11%	
Number of referrals p.a. suitable for service	226	

Nurse Specialist clinic

% that will need to be discussed with nurse specialist	100%	
Number that will need to be discussed with nurse specialist	226	
% that will potentially need to attend nurse specialist clinic	100%	*Initially*
Number that will potentially need to attend nurse specialist clinic	226	
Number of patients per clinic	4	
Number of clinics required per annum	**56**	

More specialised diagnostics clinic

% that will need to attend more specialised diagnostics clinic	75%	~
Number of patients that will attend more specialised diagnostics clinic	169	
Number of patients per clinic	4	
Number of clinics required per annum	**42**	

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Tier 2 Female Urology – Estimate of Demand (cont'd)

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

REVIEW PATIENTS

Number of referrals p.a. suitable for service	226
% that will need to be reviewed at Tier 2 clinic	25%
Number that will need to be reviewed at Tier 2 clinic	56
Average number of reviews per annum	3
Estimate of total reviews per annum	169
Number of patients per clinic	8
Number of clinics required per annum	**21**

Tier 2 Female Urology – Estimated Cost of Service

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimated Cost of Service - £83K per annum

£11K p.a. for assessment

Nurse Specialist clinic	**£510 per clinic**
More Specialised Diagnostics clinic	**£800 per clinic**
Review clinic	**£470 per clinic**

Key Resource Requirements:

- **Nursing**
- **Consultant Radiologist**
- **Radiographer**
- **Physiotherapy**

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Tier 2 Urology Services for Southern Area Population

- LUTS
- Prostate Diagnostic Service
- Haematuria
- Stone Service
- Female Urology
- Oncology Review
- Andrology

Proposed Tier 2 Oncology Review Service

- Nurse-led review service to provide a review for oncology patients
- Clinic will take reviews from Urology Consultants and Junior Staff who may have seen the patient in the general urology outpatient clinic/ward and also the Nurse-led Prostatic Assessment Clinic
- Clinics will cater for 8 patients (initially stable prostate cancers)
- Patients will be reviewed on a 6-monthly basis, unless their need changes or their doctor requests a variable review date
- Patients will be given a contact number for urology nurses, should they require communications between the allocated review times
- Patients will be allocated a 20-minute consultation
- The urology nurse will be able to refer to other disciplines, e.g. AHPs

Tier 2 Oncology Review – Estimate of Demand

CRAIGAVON AREA HOSPITAL GROUP TRUST
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Per original proposal:

	No. of clinics per week	No. patients per week	Total patients per annum
Nurse Led Uro-Oncology Review	1	8	368

Estimate of number of clinics required

REVIEW PATIENTS

Estimated % of SHSSB referrals suitable for service		
Number of referrals p.a. suitable for service	145	No. of men in SHSSB diagnosed during 2003
% that will need to be reviewed at Tier 2 clinic	75%	
Number that will need to be reviewed at Tier 2 clinic	109	
Average number of reviews per annum	2	
Estimate of total reviews per annum	218	
Number of patients per clinic	8	
Number of clinics required per annum	**27**	

Tier 2 Oncology Review – Estimated Cost of Service

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimated Cost of Service - £13K per annum

Review clinic **£470 per clinic**

Key Resource Requirements:

- **Nursing**

CRAIGAVON AREA HOSPITAL GROUP TRUST
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Tier 2 Urology Services for Southern Area Population

- LUTS
- Prostate Diagnostic Service
- Haematuria
- Stone Service
- Female Urology
- Oncology Review
- Andrology

Proposed Tier 2 Andrology Service

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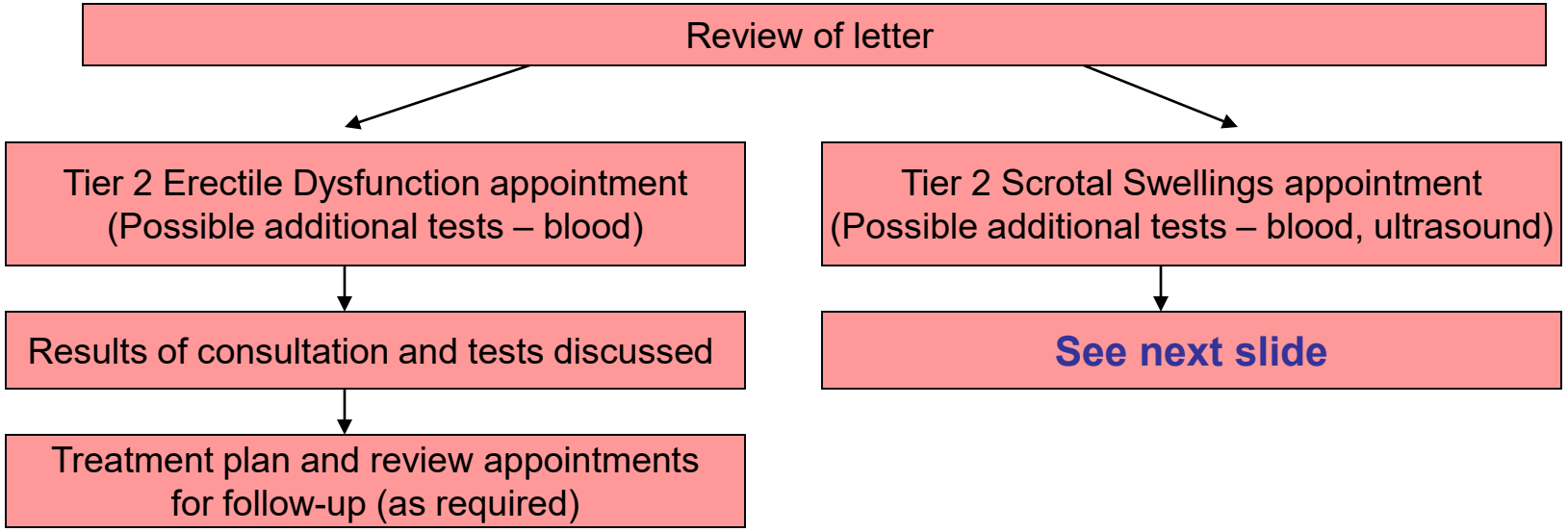
- No dedicated service currently exists
- It is proposed to introduce a Nurse-led service, focusing on the following:
  - Erectile Dysfunction
  - Scrotal Swellings

  Initial Priorities
  - Sub-fertility
  - Penile problems

Proposed Tier 2 Andrology Service

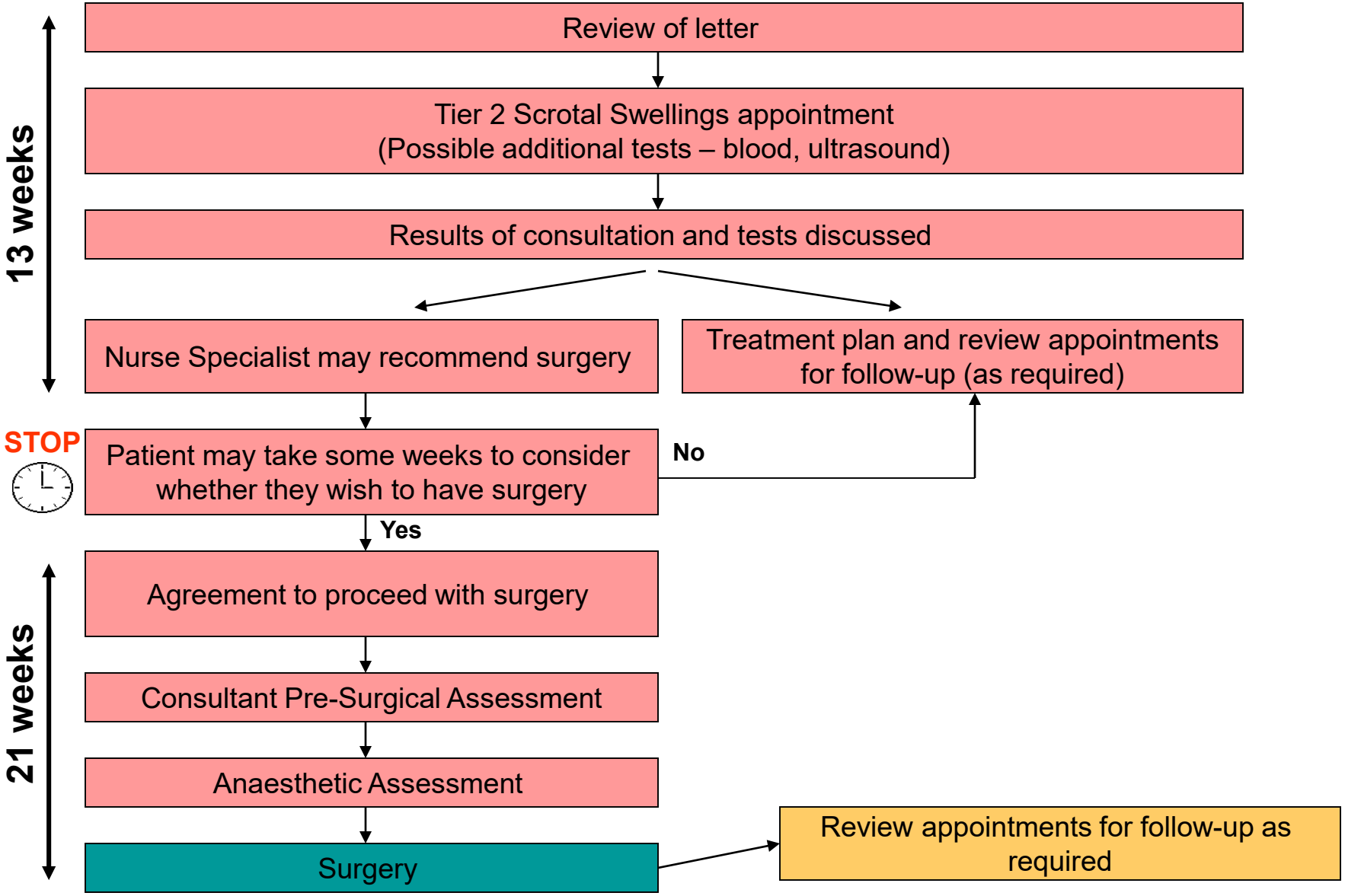


Proposed clinics:

- **Erectile Dysfunction clinic (4 patients per clinic)**
- **Scrotal Swellings clinics (4 patients per clinic)**
- **Review clinic (8 patients per clinic)**

Proposed Tier 2 Andrology Service – Scrotal Swellings

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment



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Tier 2 Andrology – Estimate of Demand

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Estimate of number of clinics required

NEW PATIENTS		
ERECTILE DYSFUNCTION		
Estimated % of SHSSB referrals suitable for service	1%	
Number of referrals p.a. suitable for service	84	*Includes cross-referral from LUTS*
Number of patients per clinic	4	
Number of clinics required per annum	**21**	
NEW PATIENTS		
SCROTAL SWELLINGS		
Estimated % of SHSSB referrals suitable for service	3%	
Number of referrals p.a. suitable for service	62	
Number of patients per clinic	4	
Number of clinics required per annum	**15**	
REVIEW PATIENTS		
Number of referrals p.a. suitable for service	146	
% that will need to be reviewed at Tier 2 clinic	60%	
Number that will need to be reviewed at Tier 2 clinic	87	
Average number of reviews per annum	3	
Estimate of total reviews per annum	262	
Number of patients per clinic	8	
Number of clinics required per annum	**33**	

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Tier 2 Andrology – Estimated Cost of Service

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Estimated Cost of Service - £17K per annum

Erectile Dysfunction clinic	£180 per clinic
Scrotal Swellings clinic	£400 per clinic
Review clinic	£220 per clinic

Key Resource Requirements:

- Consultant Radiologist
- Radiographer – back-fill for Stone Treatment sessions to free existing resources for Andrology service
- Radiology support
- GPwSI

Summary of Service Costs

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Indicative Service Cost = Cost per clinic X Estimated number of clinics required

	Indicative Service Cost (Per Annum) £K
LUTS	55
Prostate Diagnostic Service	129
Haematuria	167
Stone Service	To be confirmed
Female Urology	83
Oncology Review	13
Andrology	17
TOTAL	**464**

Current levels of funding to be confirmed.

Thus additional funding required to be determined.

Summary – Key Considerations

- **Availability of Funding**
- **Resources (Clinical Resources – Nursing / GPwSI, Urology Administration Co-ordinator, Systems Manager, MDT Resources)**
- **Need funded time for case discussion between Tier 2 team members and Consultant Urologists**
- **Training Needs**
- **Need for dedicated clinical space**
- **Timescales for implementation**

Integrated Clinical Assessment and Treatment Services (ICATS)

Aldrina Magwood
SHSSB ICATS Programme Manager
15 February 2007

Modernising Elective Care

- No one waiting more than 12 months for in-patient or day case treatment by March 2006

  Minister's Announcement on 3rd April 06– this target has been achieved.

- No one waiting more than 6 months for outpatient appointment, an in-patient or day case treatment by **March 2007**

- No one waiting more than 13 weeks from referral to a resolution of the referral e.g. decision to treat, by **March 2008**

Where are we going ?

Still to be agreed but further reductions to patient journey expected:

What are ICATS?

- Theatre and Bed Capacity
- Hospital Outpatients
- Primary Care/ GP
- Self Care/ Community Care

What are ICATS?

Theatre and Bed Capacity

Hospital Outpatients

ICATS

Primary Care/ GP

Self Care/ Community Care

What are ICATS ?

- services at the interface between primary and secondary care
- a way of providing more options when a GP seeks specialist advice/care
- a means to manage a referral and keep the patient and GP informed and involved in a timely way
- multidisciplinary services that can identify and provide the most appropriate response to a referral
- Services that can be provided in primary, community or hospital settings

Rationale

- **Length of waiting times**
- Morbidity rates higher than they should be
- Impact on quality of life
- Impact on primary care

- **Need for more options**
- Referrals all heading into one limited outlet = consultant OP appointment
- conversion from OP to surgery in some specialties low (e.g. orthopaedics – approx 30/40%)therefore seeing a consultant is not always the best option
- Ability to have diagnostic tests done before a decision is made about the most appropriate treatment options

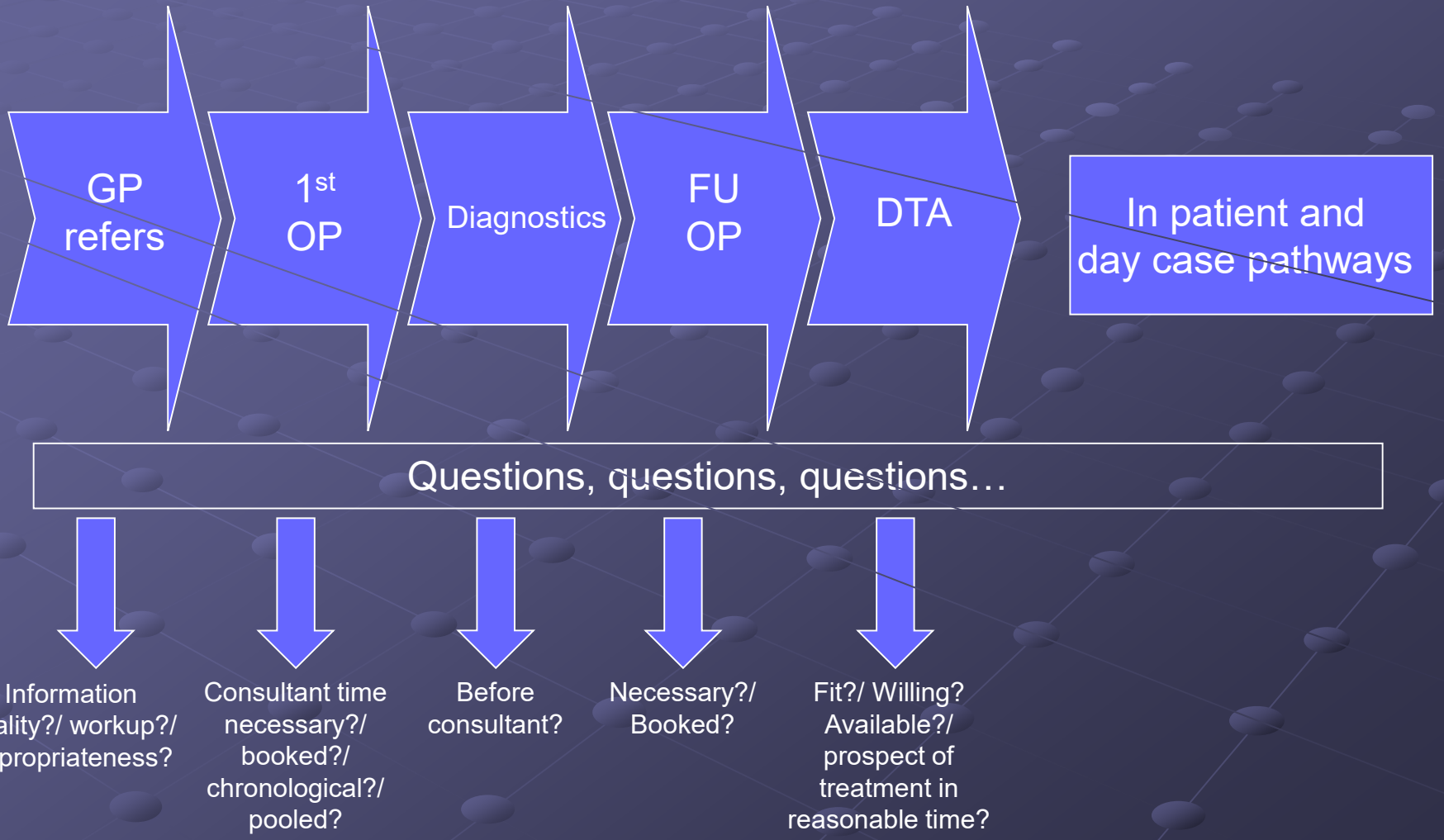
- **To align capacity and demand of patient flow to enable greater patient choice, and support prevailing access targets.**

- **Belief that 'more of the same' (waiting list initiatives) will never be able to tackle the underlying issue of matching demand to the most appropriate capacity**

- **To provide accessible, timely and appropriate treatment for tier 2 services in the community by shifting the balance of services back to primary care**

- **To make better use of specialist expertise hence enabling secondary care to focus on urgent and more complex cases.**

Traditional model



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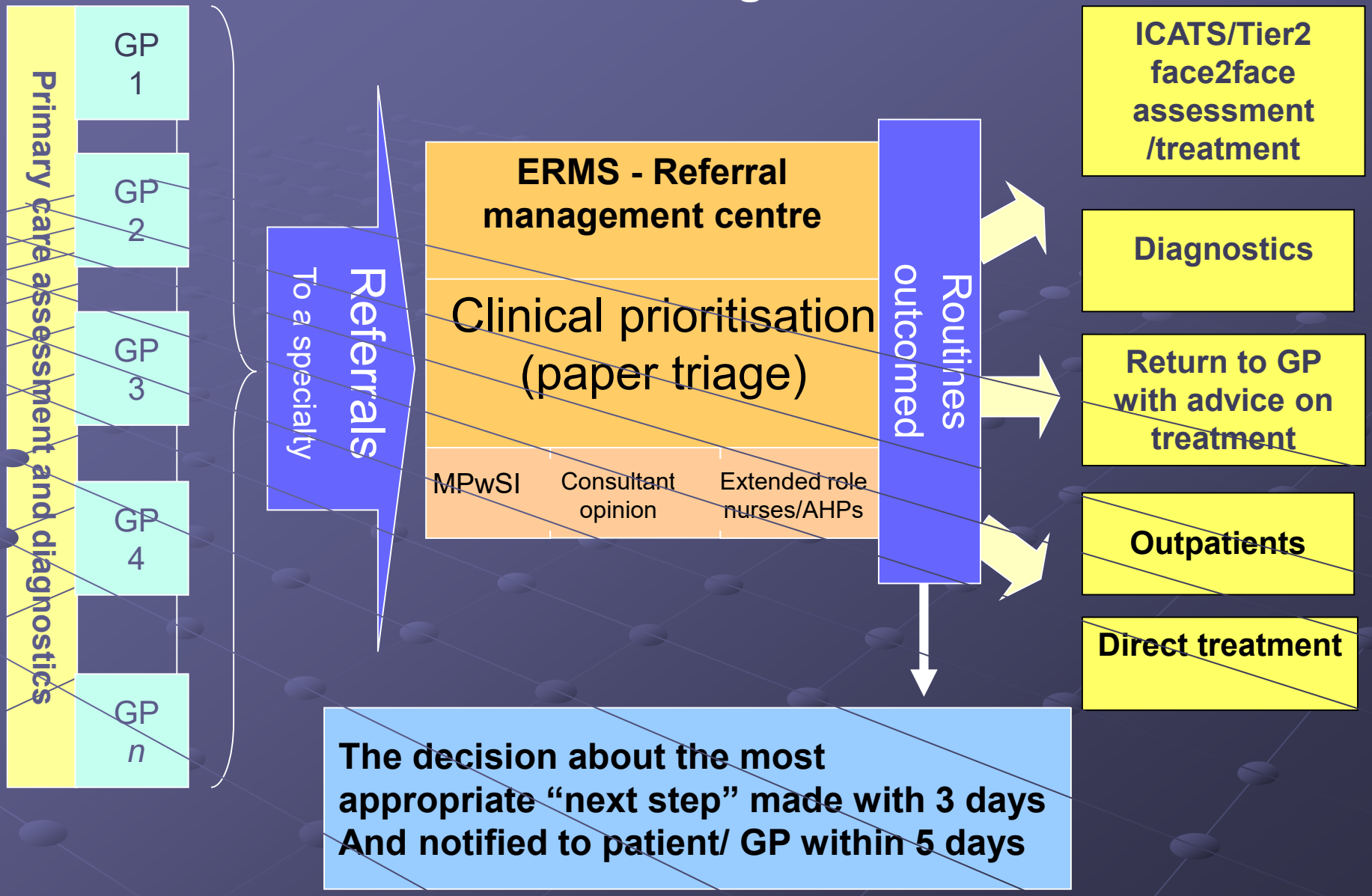
ICATS – Clinical Management Process

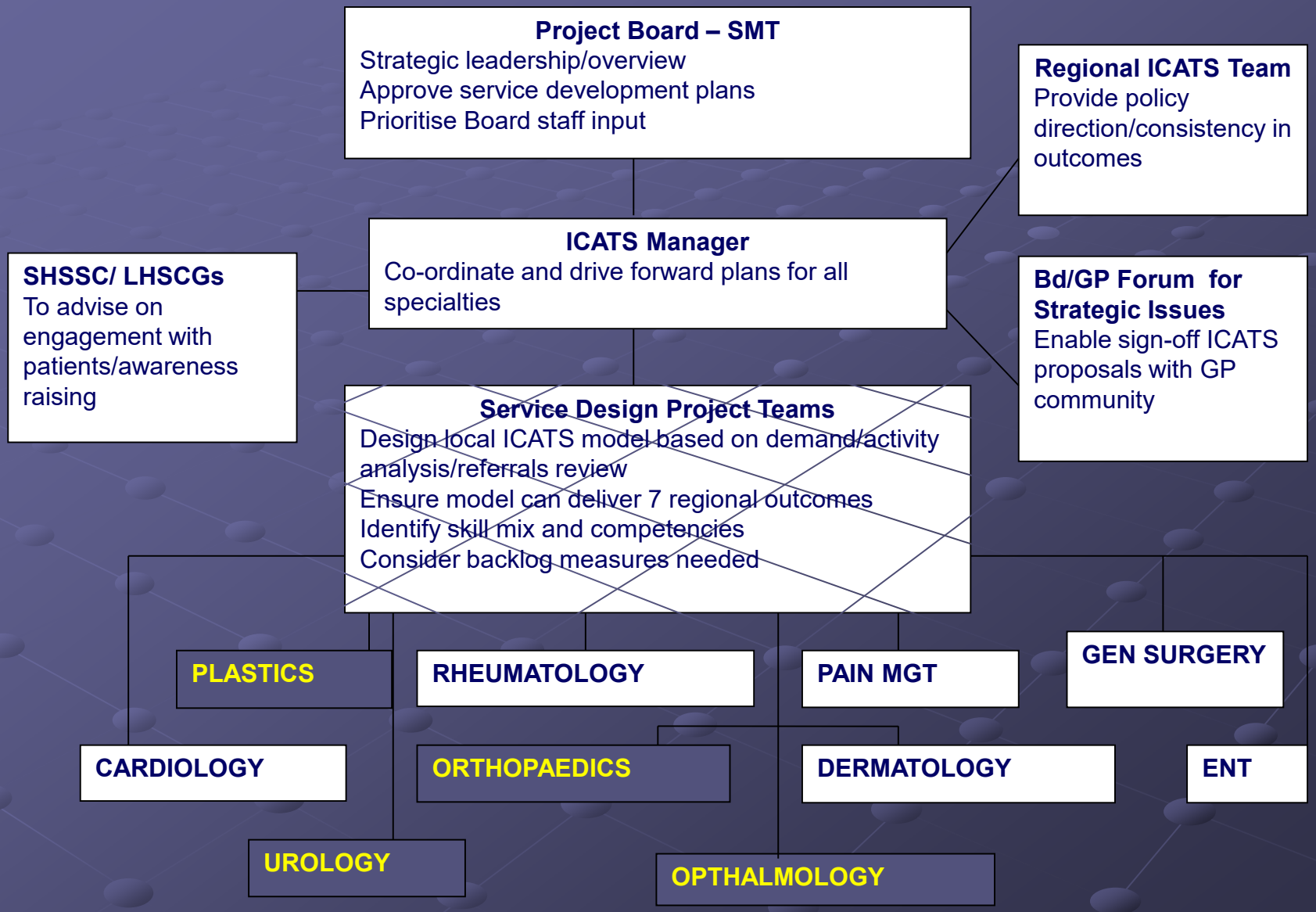


The decision about the most appropriate "next step" made with 3 days And notified to patient/ GP within 5 days

ERMS UPDATE

- Initial tender unsuccessful in appointing system supplier.
- 'Go live' date – April/May 07
- Original proposal for regional Service Centre at Everton Complex, Belfast will not be going forward
- Locality based service centres reflecting new RPA trust structures
- 'Process Workshops' being led by SDU at end of January to review – Tier 2 PAS/ patient contact letter, hospital registration office, assessment/ treatment clinic, diagnostics, triage and discharge/ return to GP.

SHSSB Structure



What are we implementing?

By Winter 2006/07

Orthopaedics

- A range of MPwSI, physio and podiatry services to assess 5600 referrals p.a.
- Clinics commenced 4th December across five localities

Urology

- MPwSI and Nurse Specialists providing e.g. LUTS, prostate diagnostic , haematuria, urodynamic clinics for approximately 2500 referrals p.a.
- Recruitment July-Oct 05, Nurse-led services April 06

Ophthalmology

- Initially building up triage and assessment services through Optometrists, Nurse Specialists and GPSI's of approximately 7000 referrals p.a.
- Recruitment to commence through host Trust January 07.

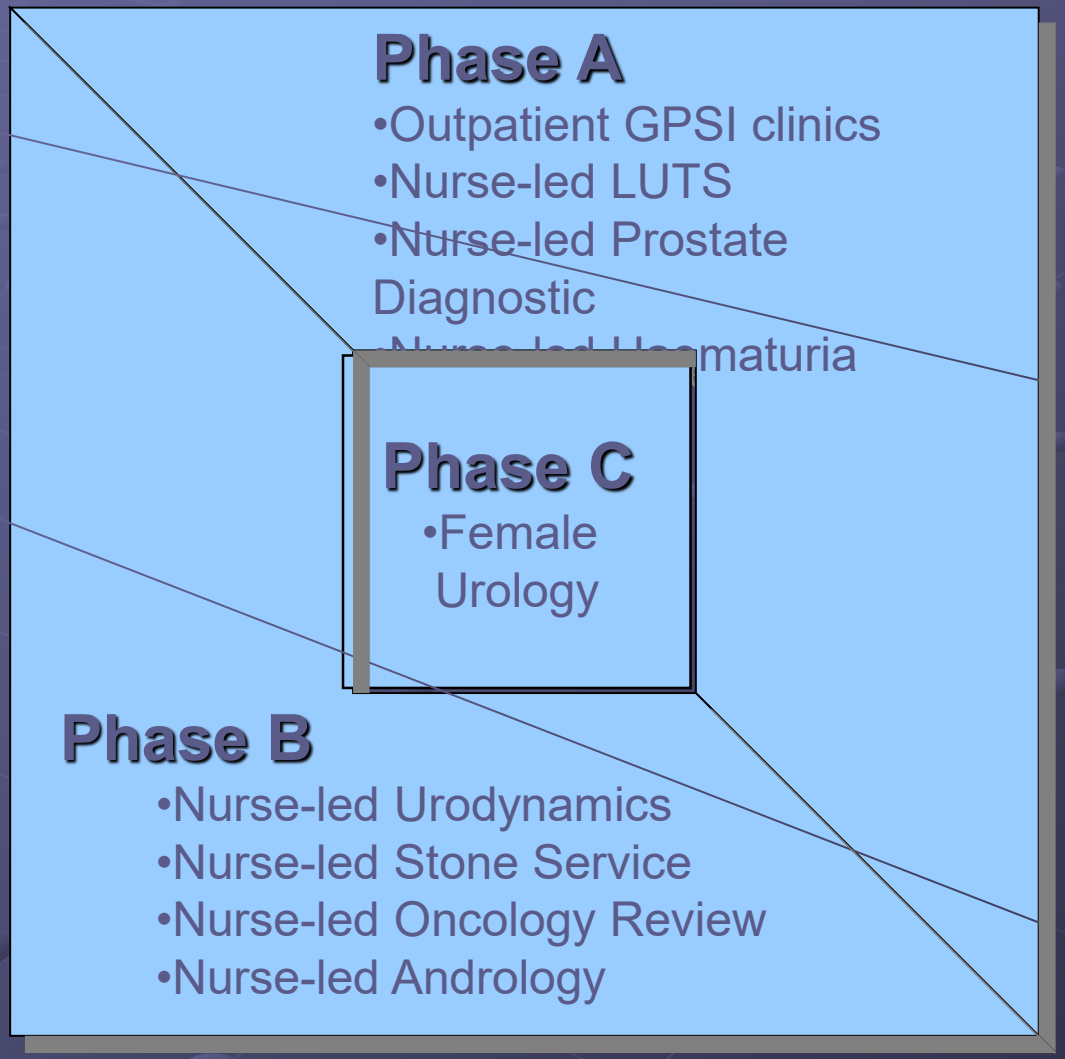
ENT

- **Service Design Models agreed at Regional ICATS meeting on 20 December.**

Orthopaedic ICATS

- Recruitment complete. Service includes GPSI, physio, podiatry and admin staff.
- Carn Resource Centre – base of Southern area ICATS service with weekly outreach to Armagh, Newry, Dungannon and Banbridge
- Clinics Commenced on 4th December. Will be seeing approximately 500 patients up to end of January from GPK backlog.
- To date approximately 10% on to consultant, 22% discharged.

Urology ICATS Service Design Model



April 06-December 06

December 06-March 07

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Southern Board residents waiting for a Urology Appointment

March 2005

- 1329 waiting for consultant opd appointment
- 1120 waiting at CAHGT
  - 67% waiting >9mos
  - 38% waiting >18mos
  - 27% waiting >24 months

March 2006

- 883 waiting for consultant opd appointment
- 643 waiting at CAHGT
  - 24% waiting >9mos
  - 13% waiting >18mos
  - 6% waiting >24 months

October 2006

- 363 waiting for consultant opd appointment
- 233 waiting at CAHGT
  - 0.5% (2 people) waiting 9-11 months with provider outside SHSSB

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Next Phases

December 06- March 07

Implementation of Core Models Recruitment, Training and Premises and work on the O/P backlog

January 07

Following regional approval, progress plans for implementation of ophthalmology and ENT

January 07- March 07

Complete service designs for dermatology, pain mgmt, cardiology, general surgery, rheumatology.

ICATS Investment

- 2006/07
  - In- year capitation share of £2m (£4m FYE)
  - Non-recurrent investment for start-up project management and backlog costs, training
  - Recurrent investment in orthopaedics, and urology (including training, g&s, diagnostic and other support costs)
  - Capital Investment (via CIU)–
    - Urology – 450K CAHGT – equipment and accommodation
    - Orthopaedics – 450K CAHGT – diagnostics and accommodation
    - Orthopaedics – 140 K C&BCT –equipment and accommodation
- 2007/08 - £8m (awaiting DHSSPS confirmation). This will take total ICATS allocation to £12m regionally Southern Board Capitation share is £2,220,000.

? Questions

Contact Details:

Aldrina Magwood
ICATS Manager
email: Personal Information redacted by the USI

ISSUE	ACTIONS	WORKGROUP	TIMESCALE
EQUIPMENT Broken Equipment – letters to management over 1.5 years with virtually no response. 2 working rectoscopes by pulling all the instrumentation from two trays they could another two sets. Equipment too old, not on a service contract, pieces are vulnerable with a piece falling off intraop (Clinical incident completed – no response back) Same equipment, different suppliers STORZ and WOLF sets Can't tell the exact	Ownership of the problem Who actually owns the problem and who will take it forward? Service contract?? Guidelines on safety – does management agree with this Incident Reports – how are these brought back to the team. Does anything happen? Has there been any raised for this problem Baseline Audit required. Last one 4 – 5 years ago for urology initiative. Harvested the higher standard of equipment and investment made at that time for new equipment. Require a further audit Standardise equipment? Location of procedures – what site will procedures be carried out – what equipment needed for each site Service contracts for equipment Following eg 50 uses, should these be	Ronan Carroll Mary McGeough Martina Corrigan Mr Young Mr O'Brien Mr Akhtar Beatrice Moonan Theatre sister Sandra McLoughlin	Initial Meeting to take place by week ending 6 November. Audits etc to be completed by week ending 20 November Report back by end of end of November.

numbers of forceps for stents. Utererscopes – only have two – one is broken so only one available for procedures. Flexible uteroscope – only one 'old' scope. There should be 3-4 flexible and 4-6 rigid to meet urology service needs	serviced Decontamination of equipment and affects on equipment New technology for the future.		
WARD RECONFIGURATION	Where is the 3 month review What was to be gained from fragmenting the service between emergencies, longstay and shortstay? Would it have been better for urology to share as a specialty on one ward to bring the same number of bed reductions? Affects to patient care with patients have to move between wards so many times. Quality?? What do the urology team and nursing	Heather Trouton Martina Corrigan Noleen O'Donnell Catriona McGoldrick Nursing Staff Mr Young Mr O'Brien Mr Akhtar Sharon Glenny	3 Monthly review meeting organized for November 2009 Report of findings to Urologists by end of November

	staff see as the better “system” for caring for patients. Safety for patients Expectations on nursing staff, eg, emergency care ward and the movements of patients/patient flow. Are management aware of the concerns from clinical and nursing staff? Do they see the problem first hand? Emergency ward should be 100% emergency, not a mixture of elective and emergency. Patients could be moving 3 – 4 times during the course of their stay. Patients may only be staying on one ward for 6 hours! All wards should be equipped to deal with all types of patients, depending on where they will be staying. Was cutting beds to save money the most effective? What about clinical teams having to move around to see patients. Loss to patient care and quality of care		

	What is best for urology department? Need clear ideas and deadlines Having now sampled existing model		
Clinical Day Care Centre *IV Fluids and Antibiotics*	Business case to staff CDCC unit regularly for patients for IV fluids and antibiotics as admission avoidance to wards ??having junior anaesthetist to get peripheral venous access. Management keen for this to go ahead. Need to know which patients are suitable for this unit and how often they require treatment. Most days have access to beds and 2 side rooms. Side rooms used for intravesical chemotherapy. ??urology ambulatory day case	Shirley Tedford Martina Corrigan Sheila Mulligan In Liaison with three Urologists	Mid-December
Intravesical chemo	Janice has now moved across Cost centre required Supplies being order through 4 north	Shirley Tedford Martina Corrigan Janice	Mid- December
Trial Removal of	When in 2 south had bed capacity – now	Shirley Tedford	Mid-December

Catheter	don't Some done in the community if appropriate. Those that need brought back to CAH go to CDSW. Catheters removed, scanned, regs contacted and discharged home. Would like to move to ambulatory day area. Staff there qualified to do catheterization, bladder scans, etc. Patient who are going on end of urodynamics sessions for TRC/change of catheter could go to ambulatory area. Protocols to be written for this. Cant depend as much on community staff as have done in past. When patients attend A&E and sent out to community, this area will give a base to be referred on to.	Martina Corrigan Mairead Leonard Nicola McClenaghan In liaison with three Urologists	
Clean intermittent catheterization	There are some patients who need to come into hospital Propose that they come into ambulatory area rather than beds.	Shirley Tedford Martina Corrigan Martina (Community-based) Wendy(Community-based)	Mid-December

	Over 4 month period was a saving of 166 bed days Martina and Wendy need to be involved in this from community perspective CDCC – how much floor space will they have to actually cope with this demand? Shift from in-patient to day case to ambulatory care Pathway construction Is there enough resources to take this forward? Need to set out what the requirements are to make this work Need to establish what consultants happy to send to this area. Need to calculate the nursing hours to make it work and build a case around that.	Jerome Marley	
Urodynamic service	Asked to take this out of 2 south Medicine moving in this week. Cannot move into Thorndale until	Shirley Tedford Jenny McMahon Mr Young Mr O'Brien Mr Akhtar	Mid-December

	agreement from where slots into timetable for consultant support. What about in-patient urodynamics? Children after procedure? ??treatment room in 3 south for this? Need to know how many in-patients are affected. ??CDCC for this and arrangement made for these patients there – 2 medical ??STC – if room for equipment. Available Tuesday, Wednesday PM, Thursday and Friday ??Does urodynamics have to be carried out in Thorndale or is this an opportunity to look at changing location for the service entirely.	Martina Corrigan	
REVIEW BACKLOG	Consultant Review Backlog is: MY – CAH = 889 - ACH = 172 - BBH = 116 Total = 1177 AOB – CAH = 508 - ACH = 165	Sharon Glenny Martina Corrigan	End November for plan to be submitted.

	- BBH = 129 Total = 802 MA – CAH = 128 A lot of effort has been put in already from MA to reduce his backlog of reviews. Philip Rogers sessions now increased to have two dedicated sessions for review backlog work. Tues pm for AOB Fri pm for MY MY sessions already in place AOB sessions still to commence. Review backlog case submitted to SDU and allocation of funding given and this can only be drawn down as clinics happen. Options were discussed and Sharon will meet individually to agree a way forward in relation to backlog		
THORNDALE	Location – short on OP consulting rooms, 2 large procedure rooms which are excellent.	Martina Corrigan Sharon Glenny Judith Anderson	

	Emergency access difficult – traditionally 999 call. Now link corridor in place. No disabled parking. Staff now using car parks since paying car parks in place. Swing doors on unit, could do with automatic doors. Air conditioning for unit – Colin Spiers to carry out assessment Fax and photocopier – multifunctional devices – Siobhan Hanna Smell out of toilets – Health and Well being – Director of Estates Waiting Room Area – not enough space for all the patients and their families when attending clinic. Staff – more reception cover now. Need to think about what their duties actually are. Need constant support. No cover over lunch time. – Judith Medical support – not sufficient to cover all the clinics – Mr Young Thorndale staff – isolated. Access to	I	

	senior staff difficult. Need built into timetable. ICATS – set up pre-targets. WLI not sustainable long-term. Harder to continue with week on week. With lack of registrars will be hit harder than ever. LUTS – 1:2 reviews – chronicity of patients would lead to think that these are being seen more often. TRUS – demand from red flags is high, but should all patients be red flag for this service? Always requires additional clinics D4 never set up in the original SDM. Needs this for the patient journey Needs looked at under the guidelines of NICAN and need to conform to these. Biopsy infection rates – nothing done yet regarding this. Antibiotics have changed and there may be an increase in admission rates. Decontamination of probes has	LUTS (Workstream) Jenny McMahon Sharon Glenny Judith Anderson TRUS (Workstream) Martina Corrigan Sharon Glenny Kate O'Neill Alison Porter Judith Anderson Information Team	

	commenced in accordance with decontamination policy. Haematuria – need to think about what is red flag. Current waiting list is 7 weeks. Service needs overhauled. Do all patients need all of the investigations. There is regional and global variations. Need to think about what we want for our service. Link corridor – will this improve service. Who is the best person to do the cystoscopy? What about the decontamination of scopes? Where will this be done? Minimal data set for referral letters is not being met, but referral letters is not being returned. One member of Thorndale staff moves with the patients to have the 4 procedures carried out in DSU on Friday afternoon 1. Quantity required each week – actual referral letters received. Diagnosed by day 31 and treatment in 62 days. If need treatment in Belfast need diagnosed and staged by day 28. 2. Process to get done on one day	Haematuria (Workstream) Martina Corrigan Mary McGeough Alison Porter Jenny McMahon Sharon Glenny	

	Upper tract imaging for NICAN. Doesn't go down to level of detail to say IVP Andrology – ED, scrotal swellings and lumps Ideally split into purely ED clinic. Takes a few clinics before get to end point. At least 2 – 3 reviews for each. Lack of time for patients. Jerome more frustrated with his role. Need to look at what Jerome can do/able to do at the clinic. Is he covered to do the things he is or could do? If Jerome stand alone would double the amount of patients seen, but then space becomes a problem. Jerome doing bloods and injection therapies. From clinical governance can he do more? Non-ED patients – USS access, eg testes. Would be more ideal to have this at the time of clinic. Could be facilitated if split by referral criteria. 1. clarify the patient types attending the clinic 2. consequences to the clinic accommodation if this happens 3. what if the patient requires surgery – can Philip consent 4. Need protocols to drive the way forward	Andrology (Workstream) Mr Young Mr O'Brien Mr Akhtar Jerome Marley Philip Rogers Alexis Davidson Martina Corrigan Sharon Glenny	

	GPwSI – 10 patients was too many. Now reduced to 8 . Uro-Oncology clinic – should only be used for patients with stable prostate disease. Opportunity for patients on consultants review backlog to be referred into this clinic. Walk-ins/Virtual clinics – Not actually being recorded anyway, but an amount of time is being spent each day/time to deal with these patients. Patient advice line lost with ward reconfiguration – may have had an affect on the Thorndale staff. Patient Choice – offered where possible, however, on instances this can not be accommodated, eg, gentleman attending 2 types of clinic on one day. Future needs : MDM Regional Review – satellite clinics Female Urology – never got off the ground Day 4 TRUS – need to find a way to see these patients in the Thorndale Unit, regardless of funding	Philip Rogers Sharon Glenny Future Needs (Workstream) Mr Young Mr O'Brien Mr Akhtar Jenny McMahon Kate O'Neill Jerome Marley Philip Rogers	

		Martina Corrigan Sharon Glenny	
ONCOLOGY	MDT – CAPPS Thursday PM MDT meeting. Letter from H Mullen mid June requesting that Trusts move to Thurs PM MDT meeting. Start date 01.01.10 using link to Belfast or going to Belfast. Involves the whole urology team – all cons, radiologist, pathologist, nurse specialists, Jerome, Philip. Team approach to delivery all integrating to discuss cancer cases. All complex pathology will be discussed by video link with Belfast. Clinical Governance and quality/standards. Number of cases will require the whole afternoon. Each consultant would like to present their own cases. Will not detract from the Thurs morning x-ray meeting. May require 1.5 – 2 sessions per week for preparatory work and subsequent action Affects to out-reach clinics needs to be quantified and consideration given to locations of these in the future. In a 5 cons model, only 3 may still continue with oncology work – therefore outreach clinics still continue with	Resolution to accommodation and backfill to be found Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter Paula Tally	Meeting on 12th November

	remaining consultants. Each consultant must attend 66% of meetings in order to retain presenting rights. Existing Thurs PM sessions need to be reallocated to other clinical sessions if available? Or How do the existing sessions get covered, eg, locum? Or 2 consultants present to discuss on behalf all 3, and so that we continue with the outreach clinics		
CAPPS	Presence in theatre 2, ICATS room, DSU, STH, consultant rooms in all clinics is required. Hardware required to run the software. If not available through own IT department, could this be included in Regional review?	Let Martina know where equipment required and then raise with IT/Alison. For outreach can be raised with Connie Connolly. Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter Paula Tally	
Nurse Specialists	5 being made available across 3 areas for	Mr Young	

	oncology	Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter Paula Tally Sandra Wadell Bid required from SHSCT	
RED FLAGS	1. Carry on as normal 2. Establish how many urgent cases need to be assessed (as opposed to non-cancer cases) Do you run the risk of swamping the system with "red flags". Need to have the capacity to deal with these, therefore need true figure. Any patient triaged as TRUSA or HAEM should automatically become a red flag patient? – not current practice. Only if GPs marked as RF or if consultant upgrades as RF do they form path of the cancer pathway.	Consensus that the patients who are triaged for TRUS and HAEM should be regarded as requiring an urgent appointment/RF. Quantum analysis is required. Further discussion on 12th November 2009. Also at departmental meeting. Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Alison Porter	

TEAM JOB PLAN	Implement the recommendations of the Regional Urology review. Looking at demand into service and how can meet the demand. – this would require an additional cons urologist. Devoted to the consultant led service only. 3 urological centres with one at SHSCT, includes Southern Region of Western Trust. Overview: 20 per week after ROTT, 1040 per year. Conversion to review Chronicity Open registrations on PAS from 05 Consultant Initiated referral 52 week model 27 new and 95 review per week DTA from Opts, other sources, eg, A&E, private work, consultant referrals 42% in-patients 58% day cases 23 in-patients per week 22 day cases per week	Mr Young Mr O'Brien Mr Akhtar Sharon Glenny Martina Corrigan Heather Trouton Paula Tally	

	Looked at what would then be acceptable across a 5 consultant model – MY provided info. 9 ins and 4 day sessions per week 6 – 7 out-patient sessions per week 5 day case sessions per week (per MY model) Depends on how many junior doctors are available and location of clinics.		

From: O'Neill, Kate
Sent: 11 August 2010 15:21
To: Corrigan, Martina
Cc: Young, Michael Mr; McMahon, Jenny
Subject: RE: Proposed changes to current ICATS clinics

Martina,

Please see below amendments & comments as agreed with Mr Young:

Monday:

ICSNURSA – Day 1 prostate assessment. These clinics traditionally started at 9:30am as Thorndale Unit did not exist then and equipment had to be brought to whatever area we could borrow for the clinic to take place. As there is Registrar support at this clinic the number of patients can be increased to 5 by adding a patient at 9am.

ICSNULUT – LUTS review clinic. We have agreed that this clinic is at its maximum, though please commence clinic at 9am and remove the last slot.

ICSNULUP – New LUTS patients. This clinic is at the level agreed by the Southern Board. It can only ever be increased if junior doctor support can be secured. Please make no alterations at this time.

ICSNURSH – Prostate histology. Template needs amended to show that there are now 6 half hour slots commencing at 2pm. (previously 3pm owing to pathology meeting). We have been seeing 5-6 patients for months now and this has not been captured. We also phone out patients who are asymptomatic with a negative biopsy result.

Consultant clinic template also to go on for Mr Young to see his variety of patients (Day 3/ Day 4/ complex cases/ Urodynamics)

Tuesday:

ICSNURSB – Prostate biopsy. Amend template to recognise that 5 patients are having biopsy not 4. 9am x2, 9:20am x 2 and 9:40am x1. This activity has not been captured properly for several years. Dr McClure supports this clinic and also oversees the reporting of all ultrasonographer scanning within the unit. We may need to discuss with him again re the availability of USS of testes to support the andrology clinic running along side this one.

ICGPUNDA – AM CLINIC. This clinic has developed over the last year. It is not offering a one stop for testicular lumps and bumps as we haven't confirmed radiology support for this (which I think may have been negotiated & agreed in the original plan). This means that patients have to come back for

review following scan. The template should be changed to read 6x new patients commencing at 9am with 20minute slots followed by 6 review patients at 10 min slots.

PM CLINIC – This is a review clinic and currently sees 5 patients. This can be increased to 8 patients at 15min slots commencing at 2pm.

Wednesday:

CUROHW – This ward histology clinic commences at 10am as the doctor first completes the ward round and consents patients for theatre. 8 patients are seen here and therefore no alterations to be made.

Additional prostate biopsy with Mr Akhtar also takes place usually two Wednesday mornings per month agreed at scheduling each month.

ICGPUPR2 – This general urology clinic with Dr Rogers currently sees 4x new and 4x review patients. Please keep as it is no alterations to be made.

Thursday:

ICSNURSA – Prostate assessment & takes place alternate weeks. Supported by Dr Rogers & please continue at 4 patients as another clinic runs along side it.

ICGPUNDA - This is an andrology clinic which takes place alternate weeks. Currently 3x new and 5x review. Please amend to read 5xnew and 5x review commencing at 9am.

ICGPUR2 – This is alternate Thursdays. Keep at 4xgeneral urology review but commence at 9am to allow Dr Rogers to be free to see the prostate assessment patients which is a separate clinic running along side this. Mr Young said to show that this is a 2hour clinic, followed by link into the other clinic if possible.

Thursday afternoon MDM

Friday:

ICSNULUP – New LUTS patients. This clinic is at the level agreed by the Southern Board. It can only ever be increased if junior doctor support can be secured. Please make no alterations at this time other than moving the slots forward to commence at 9am.

ICGPURO5- Stable prostate cancer clinic. This clinic was in development and is fed from the consultant clinic. It can now be increased to 6 patients with a commencement time of 9am and 20min slots. This will free up more slots within the Consultant OPD.

ICSNURHEA – Haematuria service. This clinic is very "fluid" in nature as it takes place to fit with skill mix and USS support. The template at the moment only shows that 2 patients attend per week however it is 4 and this should be amended immediately as this has been the case for months now. The day on which the clinic takes place is planned on a monthly basis through Jenny & Jeanette in USS and booked accordingly through Leanne Hanvey. We wish to move towards a one stop with this service if junior doctor support can be secured for either a Wednesday or Thursday morning to do 4x flexible cystoscopies. This in turn would create 4 surveillance Haematuria slots for the DPU lists each Friday which are so badly needed.

Please note we have not discussed Urodynamics as yet in this work.

Hope this is useful, if anything else needed please give us a shout.

Thanks,

Kate

Health and Social Care Board

Performance Management and Service Improvement Directorate

HSC Board Headquarters
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Trust Directors of Acute Services

Our Ref: HM670
Date: 27 April 2010

Dear Colleagues

REGIONAL UROLOGY REVIEW

As you are aware, the Trust was represented on the Regional Urology Review which was completed in March 2009. The final report was presented to the Department in April 2009 and was endorsed by the Minister on 31 March 2010. I am aware an initial meeting of team East was held on 22 March and team North on the 1 April 2010 and team South is planned for the 13 May 2010.

Now that the Minister has endorsed the recommendations from the Review, it is imperative that the Trusts with lead responsibility for the development of the Business Case/Implementation Plan move quickly to develop the team model and agree the activity to be provided from the additional investment.

The Teams should base their implementation plan on each of the relevant Review recommendations; a full list of the recommendations is included in Appendix 1. I am aware that each of the teams has established project management arrangements to develop and agree the implementation plan for each team. It is also anticipated that these teams will agree the patient pathways, complete a baseline assessment of the current service, their current location and the activity available from the existing service model. The teams should aim to have completed the first draft of the Implementation Plan and submit this to the Board by Friday 11 June 2010.

It is planned that an overarching Implementation Project Board will be established comprising the Chair and Clinical Advisor from each of these project Teams, and key HSCB staff; to oversee the implementation of the Review. The first meeting of the Urology Project Implementation Board will be held on Thursday 1 July 2010 at 2.00pm in the Conference Room, Templeton House. The Project Team chair should send the team nominated representatives to Personal Information redacted by the USI by Friday 7 May 2010. I have asked Beth Malloy, Assistant Director, Scheduled Services, Performance Management and Service Improvement, to chair the Project Implementation Board.

The Review estimated the cost of implementing the recommendations to be £3.5m, of this £637k has already been allocated to Belfast Trust, and the remaining balance of £2.9m is

available. Please see Appendix 2 which has notionally allocated this budget to each of the teams, and it is on this basis the Teams should work collectively across Trusts to develop the Implementation Plans. The plan should also include a proposal for the use of the non-recurrent 'slippage' funding available from the teams share of the recurring £2.9m, this should include what additional in-house sessions will be provide to maintain the waiting times as at 31 March 2010 and to deal with any backlog of patients waiting for urological diagnostic investigations or outpatient review.

As per the details outlined in the Review, the initial assumption regarding the activity associated with each of the additional Consultant appointments is included in Appendix 3. To assist the teams in the further discussion, the figures outlined in the Urology Review have been updated and are attached in Appendix 4.

The Implementation plan, proposed patient pathways and the non-recurrent funding proposal should be sent to Beth Malloy Personal Information redacted by the USI by Friday 11 June 2010.

Yours sincerely

Personal Information redacted by the USI

HUGH MULLEN
Director of Performance Management and Service Improvement

Enc

cc Trust Directors of Performance
John Compton
Paul Cummings
Beth Malloy
Michael Bloomfield
Iain Deboys
Lyn Donnelly
Paul Cavanagh
Paul Turley
Bride Harkin

Appendix 1

1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Appendix 2

Estimated Team Costs for the Implementation of Adult Urology Review Recommendations.

	Team South	Team North	Team East	Total	No	Unit Cost	Total
Staffing Costs							
Consultant Urologist – additional wte team allocation	2 wte	1 wte	3 wte	6	6		
Consultant Urologists wte	£208,000	£104,000	£312,000	£624,000		£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	£124,800	£62,400	£187,200	£374,400	3.6	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	£62,400	£31,200	£93,600	£187,200	1.8	£104,000	£187,200
Band 5 Radiographer @ 6 per wte Con Radiologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 3 Nursing @ 0.46 wte per Con. Urologist	£17,870	£8,935	£26,805	£53,610	2.7	£19,856	£53,611
Band 7 Specialist Nursing *1	£103,605	£0	£103,605	£207,210	5	£41,442	£207,210
Band 5 Nursing @ 0.64 wte (day surgery)	£5,972	£2,986	£8,958	£17,916	0.64	£27,995	£17,917
Band 4 Personal Secretary @ 0.5 wte per consultant urologists	£23,265	£11,633	£34,897	£69,795	3	£23,265	£69,795

Band 3 Admin support to radiologists at 0.5 wte per Radiologist	6,618	3,309	9,927	£19,854	1	£19,856	£19,856
Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2	£31,438	£0	£28,129	£59,567	3	£19,856	£59,568
Band 4 Medical Records support 0.5 per unit *3	£11,632	£23,265	£23,265	£58,162	2.5	£23,265	£58,162
Band 7 MLSO – Bio-medical Science *4			£41,442	£41,442	1	£41,442	£41,442
Staffing Costs Sub Total	**£797,164**	**£348,510**	**£1,172,174**	**£2,317,848**			**£2,317,853**
Support Costs							
Surgical G&S @ £94,500 per Con. Urologist	189,000	94,500	283,500	£567,000	X 6	£94,500	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	100,000	50,000	150,000	£300,000	X 6	£50,000	£300,000
Radiology G&S per Con. Urologist	5,000	2,500	7,500	£15,000	X 6	£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	64,000	32,000	96,000	£192,000	X 6	£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	40,000	20,000	60,000	£120,000	X 12	£10,000	£120,000
Support Costs Sub Total	**£398,000**	**£199,000**	**£597,000**	**£1,194,000**			
Sub Total	**£1,195,164**	**£547,510**	**£1,769,174**	**£3,511,848**			**£3,511,853**
Less funding in 2008/09			**£637,076**	**£637,076**			**-£637,076**
FINAL TOTAL	**£1,195,164**	**£547,510**	**£1,132,098**	**£2,874,772**			**£2,874,777**

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

	Existing Establishment	Number of consultants with a sub-specialty interest	Additional CNS
Team South	0	2	2
Team North	2	2	0.5
Team East	2	4	2.5

*2 – 0.5 allocated to each Team as per the Specialist Nurse

*3 – 0.5 allocated to each Trust Unit within each Team

*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

Appendix 3

The exact details of the additional activity associate with the additional Consultant appointments will require agreement with the Board Commissioning teams. As outlined in the Review, it is assumed that the additional activity will be as follows:

Ref: Review Page 40-41
Outpatients: 1176 – 1680 per Consultant
Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post
Outpatients 19,992 to 28,560
IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments
Outpatients 7,056 to 10,080
IP/DC FCEs – 6,000 to 7,500

Regional Total
Outpatients 27,048 to 38,640
IP/DC FCEs – 23,000 to 28,750

Please note:
This analysis does not take into account the improvements expected from the introduction and full implementation of the ICATS for urology, as outlined on page 19 of the Review. The additional activity from the CNS has still to be quantified. In addition, the quantification of the service improvements, to be gained from the implementation of the Review recommendations, still to be agreed with the each Trust (for each of the team) and the Board are not included.

Regional Review of Urology Services

Team South Implementation Plan

Document History	
Document Name:	Team South Implementation Plan
Status:	Draft v0.1
Version and Date:	V0.1 14 Jun 10
Origin:	Acute Planning SHSCT

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Appendices

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

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

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a Trust Grade Doctor from August 2010),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

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

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1
LUTS	3
Haematuria	2
Andrology	2.5
General Urology	2.5
	13.5

Main Theatres (CAH)	Weekly	
	6	3 all day lists

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

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