UROLOGY SERVICES INQUIRY

USI Ref: Notice 99 of 2022
Date of Notice: 26 September 2022

Witness Statement of: Fiona Reddick

I, Fiona Reddick, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

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 or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

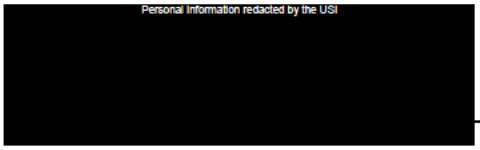
1.1 I was not aware of the extent of the matters falling within the scope of the Terms of this Inquiry. I have highlighted the scope of my role in my response to questions 4 and 5. I have indicated in my responses that I was responsible for ensuring that cancer access ministerial targets were adhered to and that any issues or delays were escalated as appropriate. This would have been carried out using the Trust's escalation process and completing breach reports which would have been shared locally and at Health and Social Care Board level. I had no managerial responsibility for the Urology Cancer Nurse Specialists. I have addressed my managerial responsibilities

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: 8th December 2022

16.3 The Regional Review recommended that there was an increase in staffing as follows:

a. Consultant Urologists should increase from 3 to 5 consultants - This proved problematic as, although the funding was available, it took some years to get 5 consultants in post and, even when the Trust was successful, some of the consultants only stayed for a short period of time.

   Documents attached namely:

   186. 2009-2022 – Consultants in post

   and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

b. Clinical Nurse Specialist to increase from 2 to 4 clinical nurse specialists. -

   i In 2009 there were two Clinical Nurse Specialists in post, Kate O'Neill and Jenny McMahon. The plan from the Review was to recruit a further 2 nurses who were to be aligned to cancer as per the review.

   ii It was also stated in the Review that this would be taken forward by NICAN during January – March 2011, which meant that the Trust couldn't move to recruit for these two posts until this had been finished.

   iii As Head of Service, I was not involved in this process and this was under the remit of Head of Cancer Services, Alison Porter and then Fiona Reddick, who both reported to Ronan Carroll, Assistant Director from 2009-2016, and then to Heather Trouton from 2016-2018, and then to Barry Conway from 2018-now. So, for this process I had no influence to 'speed it up' which, from a personal perspective, I felt did cause issues for the operational aspect of the service in that, whilst I operationally managed the Clinical Nurse Specialists, I had no influence over how and when they would be appointed.

   iv In October 2014, whilst still waiting on the decision on the Cancer Clinical Nurse Specialists, I prepared and presented a paper to Mrs Burns (Interim Director of Acute Services) in which I requested that we

would appoint 2 x Band 6 nurses so that we could start to train them up to become specialist nurses (there were no Band 6s qualified or with the experience to become Band 7s).

v The funding for this proposal was going to go 'at risk' but I presented that these were needed to assist in tackling the increasing waiting times **for** outpatient appointments. Mrs Burns agreed to go 'at risk' for these posts and we temporarily appointed 2 members of staff who were substantive Band 5s to these and then we backfilled their posts in the unit. To note, both of these Band 6s eventually have taken up permanent Band 7 Clinical Nurse Specialist roles (Leanne McCourt and Jason Young). Furthermore, in 2020 the Clinical Specialist Nurses have increased to 5 members of staff. However, the key issue here is that it took from 2009, when the recommendation was made, until 2020 when there were finally 5 Clinical Nurse Specialists in post.
Documents attached namely:
187. 20141002- paper re 6 and 7 urologist
188. 20141002- paper re 6 and 7 urologist a1
189. 20140915 costs for urology new model
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

16.4 Whilst there was no recommendation for an increase in non-Consultant grades (Trust Doctors/ GPs with Specialist Interest/ Lecturer in Urological Nursing), on-going vacancies and the inability to recruit to non-consultant grade has proved problematic for the Trust and has had a significant impact on capacity. The Trust had funding for 2 Trust Grade doctors which were vacant when I took up post in September 2009.

16.5 These non-consultant grades are of great benefit to the consultant body in that they are qualified to do flexible cystoscopies, prostrate biopsies, local anaesthetic day cases and some general anaesthetic day cases with supervision. They can do clinics on their own, will bolster up the out of hour rotas, and are senior enough to make decisions without having a consultant

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfil your role within urology had on patient care, governance or risk?**

17.1 I highlighted on many occasions at Cancer performance meetings the risks to patients who had a suspect cancer and who were delayed on getting an appointment to be seen and commenced on a first definitive treatment within 62 days. I worked with the Urology MDT in order to prepare and be Peer Reviewed in October 2017 - please see attachment 3. The serious concerns raised during this assessment were escalated by myself for including on the Acute Directorate Risk Register, please see attachment 4 and 5. I secured funding via Macmillan and HSCB Cancer Nurse Specialist workforce Expansion Plan for an additional Urology Nurse Specialist and there were delays in getting this appointed. Please see:

3. 20201229 Urology MDT Peer review External Verification 2017 Action plan

4. 20191216 email re Risk Assessment Form urology Peer Review Dec19

5. 20191216 email re Risk Assessment Form urology Peer Review Dec19 A

18. **Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.**

18.1 Communication from the service was not always forthcoming. I felt there could have been better communication with me when recruiting and appointing Cancer Nurse Specialists. There were delays in the appointments of nurses even though I had secured funding. Feedback from the regional Urology Professional Implementation Group (PIG) was limited.

36.1 Although my role was within Cancer and Clinical Services, any interactions I had with the Head of Service for Urology, ENT and Ophthalmology and the Cancer MDT Lead were amicable. I was unaware if there were any difficulties in working relationships between Urology staff and other Trust staff. Cancer related information and data would have been shared with Martina Corrigan on a regular basis by the cancer team. It was her responsibility to forward this to Consultants and team members within Urology service. Cancer Services sent escalations of delays for first appointments almost on a daily basis and it was the responsibility of Martina Corrigan to flag this. I had concerns about the delay in getting patients with a suspect cancer seen in a timely manner. This was flagged and escalated many times and was noted as a risk at each monthly Cancer Performance meeting both at local and HSCB level. At those Cancer Performance meetings, I had also highlighted to Martina Corrigan that Urology patients should have a keyworker Urology Cancer Nurse Specialist as part of a Key Performance Indicator (KPI). I would have highlighted this in other services whose patients required a CNS. I had been successful in securing additional funding via HSCB to appoint further Urology Nurse Specialists which was a regional requirement and stipulation, and was disappointed that this took so long to appoint indeed, I was surprised that I was not communicated with or involved in the recruitment of Cancer Nurse Specialists for Urology. This was kept within the Surgical Directorate. Communication with Cancer services was not always forthcoming.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1 I would not have been privy to this information within Urology services as referred to in Question 36.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any**

Carroll, Ronan

From: Carroll, Ronan
Sent: 10 May 2022 08:56
To: Carroll, Ronan
Subject: FW: Urology MDM

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
[redacted]

-----Original Message-----
From: Carroll, Ronan [redacted]
Sent: 28 January 2015 15:12
To: Clayton, Wendy [redacted]; Reddick, Fiona [redacted]
Cc: Graham, Vicki [redacted]
Subject: RE: Urology MDM

Tks – cannot afford for urology to slip back -0 so we all much keep focused

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

From: Clayton, Wendy
Sent: 28 January 2015 14:58
To: Carroll, Ronan; Reddick, Fiona
Cc: Graham, Vicki
Subject: Urology MDM

Hi

I have met with Vicki re urology escalations.

We are going to continue emailing the urology PTL's – twice weekly highlighting action required and risks.
Vicki is going to attend the beginning of the Urology MDM to ensure the Trackers are highlighting escalations / pts requiring dates for surgery.

Outstanding issues:
AOB issues with triage, however, Debbie has given Martina to the end of today to resolve – longest waiter 23 days.
DHH haematuria capacity/demand (I will forward separate email)

Vicki or I will continue to escalate individual risks to consultants/Martina. We will copy you in.

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Cc: Reddick, Fiona; Carroll, Ronan
Subject: RE: red flag triage

I will check this out for you Martina and get back to you shortly.

Kind regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: Corrigan, Martina
Sent: 01 February 2015 15:31
To: Clayton, Wendy
Cc: Reddick, Fiona; Carroll, Ronan
Subject: red flag triage
Importance: High

Hi Wendy

I am conscious we have had an issue with Mr O'Brien and the delay in returning his triage. I am aware that he is the only consultant that there is a delay in getting the triage returned.

I have had numerous conversations with some of the Urology Team and we are going to raise this at our meeting next Thursday. In order to present the problem I have been asked to have some information available for the meeting, in that they want to find out what the turnaround time is for all the consultants. This is so that we can show Mr O'Brien that he is the only problem. Can you provide me with this information even from the beginning of November which is when we moved to Consultant of the Week.

I am on leave until Wednesday but I need this for Thursday but if you need to discuss I am happy to do this on Wednesday AM

Many thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Carroll, Ronan

From: Corrigan, Martina
Sent: 09 May 2022 16:45
To: Carroll, Ronan
Subject: FW: Missing Urology RF referrals from triage

-----Original Message-----
From: Carroll, Ronan [redacted]
Sent: 20 November 2015 10:38
To: Corrigan, Martina [redacted]
Subject: FW: Missing Urology RF referrals from triage

Over to you

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

From: Clayton, Wendy
Sent: 20 November 2015 10:30
To: Carroll, Ronan; Reddick, Fiona
Cc: Graham, Vicki; Corrigan, Martina
Subject: RE: Missing Urology RF referrals from triage

Yes with AOB

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: [redacted]
Mob: [redacted]

From: Carroll, Ronan
Sent: 20 November 2015 10:19
To: Clayton, Wendy; Reddick, Fiona
Cc: Graham, Vicki; Corrigan, Martina
Subject: RE: Missing Urology RF referrals from triage

Are these referral with Mr O Brien

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

From: Clayton, Wendy

Sent: 19 November 2015 22:46
To: Carroll, Ronan; Reddick, Fiona
Cc: Graham, Vicki
Subject: Fw: Missing Urology RF referrals from triage
Importance: High

We will keep you updated

Regards

From: Graham, Vicki
Sent: Thursday, November 19, 2015 05:11 PM
To: Corrigan, Martina
Cc: Clayton, Wendy; Glenny, Sharon
Subject: FW: Missing Urology RF referrals from triage

Hi Martina,

Please see below list of patients whose referrals have still not been triaged. The date of these referrals date back to last Wednesday and Thursday.

Regards,

Vicki

Vicki Graham
Cancer Services Co-ordinator
Mandeville Unit
Personal Information redacted by USI
Email – Personal Information redacted by USI

From: rf.appointment
Sent: 19 November 2015 16:32
To: Graham, Vicki
Cc: rf.appointment
Subject: Missing Urology RF referrals from triage

Hi Vicki

We are still missing the below referrals from triage:

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

11-11-2015

62

25-11-2015

Carroll, Ronan

From: Corrigan, Martina
Sent: 09 May 2022 16:45
To: Carroll, Ronan
Subject: FW: *urgent action required*FW: urology referrals not back from triage

-----Original Message-----
From: Carroll, Ronan [redacted]
Sent: 06 January 2016 16:39
To: Corrigan, Martina [redacted]
Cc: Clayton, Wendy [redacted]
Subject: FW: *urgent action required*FW: urology referrals not back from triage

Martina
Can we leave with you to resolve pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

From: Clayton, Wendy
Sent: 06 January 2016 16:25
To: Muldrew, Angela
Cc: McGeough, Mary; Reddick, Fiona; Carroll, Ronan
Subject: RE: *urgent action required*FW: urology referrals not back from triage

Who is on to triage? If nothing back tomorrow, can you ask one of other consultants to triage please?

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: [redacted]
Mob: [redacted]

From: Muldrew, Angela
Sent: 06 January 2016 16:12
To: Corrigan, Martina
Cc: Clayton, Wendy; rf.appointment
Subject: *urgent action required*FW: urology referrals not back from triage
Importance: High

Hi

See below referrals that we have not received back from triage. Could you please chase these up for us?

Thanks

Improvement Lead. This role was to work with Specialities in order to improve patient experience. Transforming Cancer Follow Up was a large piece of work in conjunction with HSCB which was rolled out across different tumour sites – Breast, Haematology, Colorectal. In 2018 I gained support working in conjunction with the Quality Improvement Team to improve patient pathways for patients attending Oncology/Haematology Outpatient setting.

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1 Within Urology Services my understanding was that it was the responsibility of the Head of Service for that speciality in conjunction with their Assistant Director and ultimately reporting to the Director of Acute Services . From a Cancer Services perspective we held a Trust monthly Cancer performance meeting where all Specialities were invited and minutes, agenda and dashboard were shared. Martina Corrigan (Head Of Service for Urology) attended these meetings and would have always received the documents. The Urology MDT was also Peer Reviewed and the findings of this were shared with Martina Corrigan, Ronan Carroll, Heather Trouton and myself via the Trust Chief Executive and also to the HSCB.

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1 It was my understanding that the clinical governance arrangements of the Urology service sat within the Speciality managed by the Head of Service (Martina Corrigan) working closely with her Clinical Director and Associate Medical Director. As my role is not within the Urology Service I would not have been privy as to how this was done.

This would have been done within the Surgical Speciality.

Update on the concerns identified from the Urology MDT Peer review External Verification - October 2017

EV RAG rating – RED; % compliance 2017: 65%

Serious concerns	**Update May 2018**
1. No cover in place for the clinical oncologist and the consultant radiologist	Clinical Oncology representation (core & cover) – provided through the regional Oncology Centre when possible but is not the same person each time and is still not consistent Consultant radiology representation – no cover for the radiologist though an expression of interest is being developed to recruit an additional radiologist with urology interest/expertise
2. 11% quoracy due to low clinical oncology and radiology attendance	Quoracy has decreased from previous year (25% down to 11%). Only 5 meetings were quorate throughout 2016 and it is perceived that this has decreased even further. Therefore more patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision making processes and treatment.
3. Long waits for routine referrals	Due to increasing number of referrals, the service is concentrating resource on meeting red flags and urgent demand. Routine referrals waiting times have increased from 52 weeks to 128 weeks (present day). Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded.
4. Nephron sparing surgery undertaken locally	This issue was resolved at the time of the external validation as Mr Haynes was providing support to undertake nephron sparing surgery at Belfast City Hospital. The situation has

Hughes, NicoleX

From: Reddick, Fiona
Sent: 16 December 2019 13:14
To: Kerr, Vivienne
Cc: Conway, Barry
Subject: Risk Assessment Form urology Peer Review Dec19
Attachments: Risk Assessment Form urology Peer Review Dec19.doc

Hi Vivienne

Please find attached updated risk assessment for urology MDT to replace risk 3728. The other elements for skin and Head and neck came now be closed off

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head Of Cancer Services
Macmillan Building
Southern Health and Social Care Trust (SHSCT)
Personal Information redacted by USI or Personal Information redacted by USI

Aimee Crilly

From: Reddick, Fiona [redacted]
Sent: 06 January 2017 11:49
To: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: Urology MDT Peer Review
Attachments: EV-rpt_Craigavon__Urology_Local_MDT_Me__N14-2G-1_161125-163458.pdf

Dear all,

Please find attached the External Validation report from the recent validation process required for Urology Peer Review for circulation amongst all members of the Urology MDT.

This year Urology MDT were required to undertake a self- assessment which was then externally validated by the National Peer Review Team. We have been advised by HSCB that when MDTs are self -assessing that the feedback from National Peer Review team will be directly uploaded unto CQUINs rather than a formal feedback report coming into Trusts via Chief Executive.

As you can see the overall self- assessment score achieved 55% and this score of 55% was maintained by the external team.

The National Peer Review Team have indicated that the Urology MDT will have to undertake a self- assessment again in September 2017 and Mary Haughey will continue to work with the Urology MDT to prepare for this process.

I am conscious that at a Business meeting prior to Christmas leave that concerns were expressed by members re inadequate quoracy of the MDT particularly for Radiology and Oncology. I have escalated the concerns to Prof O'Sullivan Clinical Director – Cancer Centre and we are due to meet Tuesday 10th January to agree improved representation for Oncology input. Dr Gracey is aware of the concerns re Radiology.

We will continue to attend Urology Business meetings as requested.

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
[redacted]
[redacted]

Glackin, Anthony

From: Reddick, Fiona
Sent: 20 January 2017 17:13
To: Glackin, Anthony; Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: RE: Urology MDT Peer Review

Tony

Yes I understand that there have been and are ongoing challenges with quoracy at the Urology MDM. This has been escalated at HSCB level particularly from an Oncology perspective as the Lung and GU service is currently facing staffing issues. The North West Cancer Centre opened recently and recruitment of Oncologists there has depleted the service within Belfast Cancer Centre and there currently is not the same number of Oncology registrars available to provide cover within clinics.

Rory and I attended a meeting last week with colleagues from Belfast Trust and commissioners to explore options to address the current difficulties. I have highlighted that there is a risk that the Urology MDM here in SHSCT is at a point where full quoracy is making it extremely difficult to function. We are due to meet again next Friday and hope to have potential solutions agreed by then.

I am happy to meet with you in the meantime to discuss further.

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
Personal Information redacted by USI
Personal Information redacted by USI

From: Glackin, Anthony
Sent: 16 January 2017 10:32
To: Reddick, Fiona; Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: RE: Urology MDT Peer Review

Dear Fiona,
can I meet with you to discuss ongoing problems with quoracy at the Urology cancer MDM. The Urologists are coming to the view that this meeting is no longer sustainable in view of the pressures on our single handed Radiologist and the infrequent oncology attendance.

Kind regards

Tony

Directorate of Acute Services

Notes of a meeting held on Monday 4th of January 2021 to discuss the Complaint regarding Mr O'Brien

Present: Patricia Kingsnorth
Fiona Reddick
Patricia Thompson
Hugh Gilbert
Dermot Hughes

In Attendance: Peter Rodgers

Meeting Began with Introductions as usual,

Mr Hugh Gilbert Clarifies he has most recent reports done and he shall forward them onto Mrs Patricia Kingsnorth. PK agrees that once she receives most recent data she shall collate data and then return them to HG for a final draft of applicable data.

PK acknowledges that Mr O'Brein's solicitor has requested the specific questions that will be asked during their meeting.

Mr Dermot Hughes Advises that questions should be specific and to the point, to ensure clarity of answer requested.

Patient 2

Team Begin to Discuss Mr Patient 2 s Case,

Questions Raised:- why was Patient 2 not referred on as per the MDM 25/07/2019 and recommended he was referred onto oncology and seen on 23rd of august

MDM said Patient 2 should have been referred a month prior however the referral did not happen until 25 September and discussed on the 26th

Review team question, why was there an absence of a key worker/ specialist nurse, was Mr O'Brien intentionally excluding key workers in his practice and why this happened.

Review team then acknowledge that throughout all nine cases there are no mention of key workers.

Patient 8

Team Discuss Patient 8 's Case and timeline

Understand that Patient 8 s Cancer was a coincidental find, however no follow up investigation provided. Regarding Mr O'Briens knowledge of the patients result he failed to inform the patient, Team curious again whether this was due to lack of a key worker.

Team discussed was this possibly due to Covid, as well as a lack of safety net for pathology to go on to MDT.

PK & DH iterate that guidelines that Mr O'Brien was to follow are not current guidelines and to consult those during further investigation.

HG raised question regarding all cases as to why Mr O'Brien did not use the opportunity to consult those who may have had more exposure or expertise in the cases he was dealing with

FR Voices how it is imperative to have good communication amongst MDT which Mr O'Brien neglected.

Team voice their concerns as to the standard that had been stated and standard that SHSCT had signed up for as opposed to the standard of care Mr O'Brien provided to his patients.

DH, PK curious as to why no key worker had not been noted in previous SAI this was thought to be because it was not a solely cancer SAI.

HG voiced concern regarding how a MDT may feel compromised in "raising their hand" if something is out of guidelines due to a senior member of staff as well as the MDM condoning treatment.

HG also clarifies he is in the midst of chasing more information regarding hormone therapy with a man who has more expertise in the field this data will then be shared with PK.

Another meeting arranged for 18/01/2021 at 0930

70.2 Each of these five service areas had major challenges at this time. For example, in Maternity Services there were a number of clinical incidents including a [redacted]. This meant that I had to allocate more of my time to this part of my portfolio, which meant I had less time to focus on the other areas including Cancer Services. I believe this is an important point by way of context – i.e. at any time, I was dealing with many complex issues across the Division.

70.3 The Integrated Maternity and Women's Health Division was a standalone Division from April 2007 up to March 2016, when the Acute Directorate was re-structured by the Director of Acute Services at that time, Mrs Esther Gishkori and then Integrated Maternity and Women's Health was coupled with Cancer and Clinical Services in April 2016, creating the large Division that I took over from 1 June 2018. Early in 2021, I escalated work pressures to the Director Acute Services (Mrs Melanie McClements) and she agreed with me that the Division needed split in two. Mrs McClements was supportive and she secured approval from the Chief Executive (Mr Shane Devlin) to adjust the structure and from 1 June 2021, Integrated Maternity and Women's Health reverted to being a standalone Division, with Cancer and Clinical Services Division becoming a smaller but still a busy Division.

70.4 In my view, the decision taken by Mrs Esther Gishkori in April 2016 to couple Cancer and Clinical Services with Integrated Maternity and Women's Health as a large acute Division was a mistake.

70.5 During my tenure as Assistant Director for Cancer and Clinical Services, I worked with the Head of Service for Cancer Services (Mrs Fiona Reddick) to support her in managing these services. As detailed in my response to question 7 above, the Head of Cancer Services focussed on four broadareas as follows:

a. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
b. Providing the Cancer Tracking function and multi-disciplinary team (MDT) meeting co-ordinator support to Cancer Multidisciplinary Teams Meetings.
c. Supporting the Peer Review process
d. Delivery of local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust

70.6 During my tenure as Assistant Director for Cancer Services, my primary focus was on performance against the 14, 31 and 62 Day targets. I had a clear line of sight to performance information through monthly reports and the monthly Cancer Performance meetings. With regards to the Cancer MDTs however, I did not have a clear line of sight, as I did not receive the Annual Reports from the Cancer MDTs and there was no monthly reports to show me how the Cancer MDTs were working. The absence of monthly reports from the Cancer MDTs was not a mistake as such, as the processes in place were the same as they were since the establishments of the Cancer MDTs in 2007.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 93 of 2022

Date of Notice: 27 September 2022

Witness Statement of: Marc Williams

I, Marc Williams, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

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 or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 I am a consultant radiologist with a specialist interest in uroradiology. I commenced working for the Trust in 2009 and this is the only post I have had. I report radiological examinations, in particular uroradiological studies. I am the lead radiologist to the Urology MDT which I attend weekly and have done since the inception of the MDT. There have been 1-2 radiologists attending the urology MDT (I do not know any further detail in regards to the dates) and there have been significant periods of time where I was the sole radiologist. I provide opinions on urological studies to this meeting. I have not had any input into the investigations within the department of urology nor

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: __ Personal Information redacted by the USI _____

Date: ___6 October 2022_____

improve the service to patients. Core membership is complete with named cover in place. The MDT has a designated lead clinician and has then opted to rotate the chairing of the MDT meetings between the surgeons and this works well. Dedicated preview time for the MDT chair has been agreed so that there is good preparation for the MDT meeting to ensure smooth running.

The Trust has been successful in recruiting additional urology surgeons over the last 18 months so that they have increased from three to six which has enabled the surgeons to sub specialise. Two of the surgeons undertake only limited cancer procedures such as Transurethral Resection of Bladder Tumours and both attend the MDT when their patients are being discussed. The MDT also has input from a senior general surgeon with a special interest in urology and he undertakes very limited number of procedures and links into the MDT each week.

Histopathology is well represented at the MDT meetings and the core member participates in appropriate specialist External Quality Assurance programmes.

Oncology attendance continues to improve with the appointment of a medical oncologist based at the Trust and there is a good video link into the specialist MDT at Belfast for clinical oncology support.

Radiology attendance is problematic and more so due to long term absence which now leaves a single handed radiologist to provide the clinical services as well as MDT meeting cover. The MDT recognises this is a problem and is in discussions with the senior management team on how to resolve this problem.

There are two Clinical Nurse Specialists (CNSs) in post and their attendance at the MDT meetings is excellent. Specialist nursing services have developed with the CNSs undertaking flexible cystoscopy and Trans Rectal Ultrasound (TRUS) biopsy which is commendable. However, there are clear deficiencies in the completion of holistic needs assessments (HNA) for all patients and the identification of key workers and this needs to be addressed.

The surgeons' and CNSs' individual attendance is good with all achieving the 67% required. There was only one meeting recorded as having no histopathology attendance. In the reported year only six meetings had no radiologist but the review team is concerned that this has deteriorated since January 2015 with only a singlehanded radiologist in place. The medical oncologist only attended 58% of meetings but it was reported that this has improved and the clinical oncologist who links in from Belfast was only recorded as present at 31% of the meetings. Therefore, there were 16 meetings with neither oncologist present including a gap of 5 weeks and this needs to be addressed.

Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment.

The MDT meets on a Thursday afternoon starting at 2.15pm with a planned finish at 5pm. To ensure this, the number of patients to be discussed is capped at 40 to facilitate a full and robust discussion takes place for each patient. 48 meetings took place in the reported year.
The MDT chair has dedicated time to preview and quality assure the clinical summaries provided for each patient prior to the MDT meeting. This ensures that the multiple referral

NHS

EXTERNAL VERIFICATION REPORT

(MULTI-DISCIPLINARY TEAM)

Network	NICaN
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (N14-2G-1) - 2016
Compliance	
UROLOGY LOCAL MDT MEASURES	**Self Assessment** 55.0% (11/20)
Zonal Statement	
Completed By	Clare Langslow
Job Title	Quality Manager
Date Completed	13 October 2016
Agreed By (Clinical Lead/Quality Director)	Sally Edwards
Date Agreed	15 November 2016
NPRP Team Comment	
Key Indicator	
Structure and Function	

SA Agreed with exception

Assessment

Core membership complete but there is no listed cover for the radiologist or the clinical oncologist so therefore attendance and quoracy remain an issue. Only 42 MDT meetings were held in 2015 with a four week gap in December. 43% meetings had no radiologist present and 19% no oncologist. Overall quoracy was only 48%.

Key Indicator
Co-ordination of Care/Patient Pathways

incredibly complex and difficult for people the first time. That's the standard of care that you offer to your patients.

I mean, we spent years fighting for resources and we spent a long time. We still don't have enough resources but thankfully we have a lot more Clinical Nurse Specialists. By any metric, if you look at what people say and what the evidence is, people get much better and much safer cancer care with Clinical Nurse Specialists. 14:46 14:46

CHAIR: Just coming back to some of the things about this, the operation of this and the quoracy issue, for example. I mean, it's really striking that in 2019, not one meeting was quorate. One of the issues you were saying was that the radiologist, the cancer radiologist, had another MDT at the same time. Surely it is not beyond the reams of possibility for somebody to pick that up and say, well, let's change the day. 14:47

DR. HUGHES: I think what it was, they did the urology service, which was a very, very large service, and they did the lung cancer service in the afternoon, which is very large and very complex as well, and they simply didn't have time. As well as that, it was staffed by rotating locums, so there was no continuity. Even though it may have been quorate one or two times, it may not have been the same professional. In essence you didn't have embedded oncology within the team on a stable basis. 14:47

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 The uroradiological aspects of my job would be discussed with individual urologists (in person or by email) or at the Urology MDT. I have no formal meetings with the urologists other than the MDT. These meetings are weekly (on a Thursday afternoon) and patients are listed for discussion by urologists. I attend when I am not on leave. When I am on leave, another radiologist now attends, unless that person is also on leave.

20.2 If there are issues to raise in regard to uroradiological practice then these will be discussed with the urologists in person or by email. Such issues would relate to overall and not individual practice, for example how a service could be improved. An example would be the multiplicity of examinations to answer the same clinical question, for example general practitioners requesting ultrasound and a urologist requesting a CT scan.

20.3 When only a single radiologist (me) attended the MDT and that radiologist was on leave, there would not be a radiologist present. The issue with a lack of attendance by a radiologist was an issue for a prolonged period of time (I do not know the interval) and this was mentioned at the MDT on a number of occasions (I do not recall when, by whom specifically (although most likely Mr O'Brien and Mr Glackin) or how often) but this was not solvable in the absence of an appointment of an additional radiologist, which was the Trust's responsibility and I cannot comment as to how much effort the trust made to achieve this but I am of the opinion that the Trust did not do all it could to appoint an additional radiologist by making an attractive job, particularly when in competition with other Trusts both within Northern Ireland and the UK. I think, but I cannot be sure, that the MDT chair (both Mr O'Brien and Mr Glackin) have raised the issue of radiology cover with the relevant

Stinson, Emma M

From: Trouton, Heather [redacted]
Sent: 28 November 2017 13:57
To: James, Barry; Gracey, David
Subject: RE: Urology reproting

Barry , our current main deficits are Nuclear medicine, Cardiology and Urology. Gynae was also a single handed service with Ann but Ciara has specialised in Gynae so that is much better now.

David , are there any others?

Heather

From: James, Barry
Sent: 25 November 2017 22:48
To: Williams, Marc
Cc: Trouton, Heather
Subject: RE: Urology reproting

Not sure how the Surgical directorate can occupy nearly an entire day of one radiologists time, without paying our directorate for your services!

Baby steps Marc – first this should be offered to the whole consultant body in the interests of fairness.
Whoever it is would first learn how to read the images. This will take time on it's own. As part of the teaching you can feedback or supply the minutes of the meeting (I presume they exist) to allow integration of the clinical component if he/she cannot attend due to current job plan.
Future MDTs can be tailored to cluster the prostate cases if required, or separate the prostate component into a separate meeting all together – all viable options that can be explored down the road once the initial training is complete. Who knows, he/she may fall in love with GU imaging and fulfil your every desire!
Just start and let it develop organically. We will never know unless we try. Don't scare people off before they even start.
Recruitment of a full blown GU radiologist in NI is unlikely as I think the role does not exist – do you know anyone else that has a similar job to you? Most who report GU also report all forms of body MRI (Arthur, Peter Blair/Ball, Andrew, Myles, Scott etc).
So Marc – if we get a volunteer at the weeking meeting and there is appropriate provision in your job plan would you at least start the process? Hell I might even sign up if the terms are favourable!

Heather to progress this you need to secure time limited funding for training for both parties and additional study leave/budget to facilitate – eg ARRS course is $400 and you can do from home.

Out of interest Heather – do we have any other 'at risk' areas? Is cardiac CT one of them? SPRs in their later stages of training have asked and I have always said GU, nuclear and chest – that right?

Barry

From: Williams, Marc
Sent: 25 November 2017 10:17
To: Porter, Simon
Cc: Trouton, Heather; James, Barry
Subject: Urology reproting

Simon

I hear on the grapevine that you may be interested in reporting prostate MRI? I wanted to let you know what this will involve.

The European Society of Uroradiology recommend that anyone reporting prostate MRI attends a urology MDT and this should be regarded as compulsory. Patient management is decided based on the imaging and perceived clinical risk and there are for example some patients with terrible disease with comparatively normal MRIs. It is imperative to have knowledge of all this i.e. the role of MRI in prostate cancer and the potential management of patients. Fortunately there are a number of documents that I have collated over the years that will help and PIRADS v2 is very useful.

The ESUR recommends that any individual reporting prostate MRI reports a minimum of 50 cases per year. The future of the service involves TRUS/US fusion ie targeting lesions that have been identified on MRI with real time US and MRI image fusion. We currently do this cognitively and have been prohibited taking this any further given the quality of the outsourced reports and their inability to provide any meaningful information on where lesions are (urologists need images marking up). Outsourcing also has resulted in patient harm due to significant discrepancies but the trust seems very keen on taking the cheapest reporting option rather than for example weighting cases appropriately so that they can be reported as WLI.

The urology MDT is on a Thursday afternoon and lasts 3-4 hours. I find the preparation arduous and it can take over 4 hours. There are often 40 patients on the meeting, spanning 30 pages of A4. If you wished to partake in contributing to the MDT rather than just reporting prostate MRI we deal with all sorts of cases including what to do with indeterminate renal lesions and renal MRI plus various other pathologies (bladder, upper tract TCC etc). Like at other MDTs, a second review of the imaging can identify additional findings or change interpretations. This happens fairly frequently (the difference between a nephrectomy or a nephroutetercomy in a renal tumour for example or the a report of a locally advanced prostate tumour in fact being an anatomical variant or seminal vesicular haemorrhage – all recent examples). Indeterminate renal lesions and complex cysts are a significant workload.

What we really need in the trust is the recruitment of a radiologist with an interest in GU. Someone that can partake in the GU service and attend and take the MDT. The only way to achieve this is to make a real attempt to recruit by putting out interesting job plans that offer more than the bare minimum. Mentions of flexibility, off site SPA, more than 1.5 SPAs, recruitment and retention premia etc. I remain unclear why the trust does exactly the opposite and how it expects to recruit in the circumstances, which leaves me as a sole practitioner which is not safe and not recommended by the college.

If you wish to input into the GU service I would be happy to help discuss how this may work in practice as it will be a significant commitment to us both with time required in job plans and other considerations.

Marc

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 02 May 2016 20:55
To: Williams, Marc
Subject: Re: Urology MDM

You have no booked patients for the below dates and times. Please displace work to attend.

As per my prior email reply your job plan has been escalated to AMD. I am meeting with the MD on Wednesday and the Urology MDM will be discussed due to issues raised by both Radiology and Urology. I will let you know the outcomes of both in person.

David

Sent from my iPad

On 2 May 2016, at 15:19, Williams, Marc [redacted] wrote:

> I am not available at any of these times as I have clinical commitments. I am also unsure as to the value of discussion unless this is to address my job plan or the trusts efforts to recruit and it's presumably not. Meeting to discuss MDT add ons is not a good use of time.
>
> I will, from now on, be working to my job plan: I have 2 hours of prep time per week in the job plan. The first hour is supposed to be for the urology Thursday morning meeting. This leaves approximately 1 hour of prep for the MDT (for a meeting that lasts upto 3 hours). Once this hour ends, I won't be spending any more time preparing nor providing radiology input into cases that I have not prepared for. I will ensure that the MDT chair knows which cases won't have any input that week.
>
> I have been asking for extra preparation time for the urology MDT but there is no indication whatsoever that this will be provided and I have been asking for perhaps 9 months. An email I sent last week was unanswered which is most unfortunate.
>
> A new GU job has been advertised which has 2 hours of prep time for the MDT in it. I don't get this.
>
> I remain unclear and confused as to why I should have to fight to get time to do the job I am asked to. I have been trying, by giving up my free time, to provide radiology input to the whole of the MDT but as I have said, this will not continue indefinitely.
>
> I have also started looking for alternative employment and am considering taking locum work to bridge the gap.
>
> Marc

From: Muldrew, Angela
Sent: 29 April 2016 14:32
To: Gracey, David; Williams, Marc; Haynes, Mark
Cc: Graham, Vicki; McVeigh, Shauna
Subject: Urology MDM

Hi

Cc: Carroll, Ronan; Reddick, Fiona; Haughey, Mary; Young, Michael; Glackin, Anthony; Haynes, Mark; Suresh, Ram; ODonoghue, JohnP; Convery, Rory
Subject: Radiological Presence at Urology MDM

Dear David,

I take this opportunity of writing to you regarding the presence of a radiologist at Urology MDM.
Radiological input into any MDM is not only crucial to the multidisciplinary discussion of each patient, but it is compulsory.
We have had a properly constituted Urology MDM since April 2010.
During the earlier years, the greater problem had been to have the input of an oncologist at each MDM.
That has been resolved in that we have had a clinical oncologist video-link from Belfast, and a medical oncologist present on site, these past two years.
However, the issue of radiological input remains unresolved.

Having considered this issue at length, and having experienced and participated in repeated attempts over the years to have the issue resolved, I believe that the core issue is that the Department of Radiology has never acknowledged or accepted that radiological membership of MDT and presence at MDM are both compulsory.
This is in marked contrast to the Department of Pathology which has ensured that a pathologist is present at almost all MDMs.
We urologists have had to suspend all other elective activities to accommodate MDM.

I wish to emphasise that we greatly value the expertise and experience of the only radiologist who does attend MDM.
However, we find the lack of commitment to ensure attendance at the majority of meetings unacceptable.
If not resolved with immediacy, this issue poses an existential threat to our MDM which we may be forced to terminate.

I do appreciate how difficult it can be to resolve some longstanding issues.
However, having participated in Peer Review here and elsewhere, the issue here is as I have found it elsewhere.
That is, each and every MDM must have a radiologist present!

I intend to discuss this issue with the Medical Director when I meet with him on Friday 01 April 2016.
It would be helpful if this issue could be satisfactorily addressed by then.

I attach the Quoracy Spreadsheet 2014 and the Peer Review Report 2015, as requested,

Thank you,

Aidan.

Angela Kerr

From: Williams, Marc [redacted]
Sent: 09 May 2016 11:42
To: O'Brien, Aidan
Subject: RE: Radiological Presence at Urology MDM

Aidan
We had a half hour meeting. Discussed job plan and it seems David is making some progress. I am being given an extra hour.
We discussed various other points. Mark has made some notes and I am sure he will be happy to discuss with you what we talked about or I can whenever you like.
Thanks again
Marc

From: O'Brien, Aidan
Sent: 09 May 2016 10:48
To: Williams, Marc
Subject: FW: Radiological Presence at Urology MDM

Marc,

FYI,

Aidan.

From: O'Brien, Aidan
Sent: 09 May 2016 10:47
To: Gracey, David
Cc: 'ANGELA.muldrew [redacted] Graham, Vicki; McVeigh, Shauna; Haynes, Mark
Subject: FW: Radiological Presence at Urology MDM

David,

I am concerned to learn that a meeting is scheduled for 11 am today to discuss the above, without my having been advised or invited to attend, and whilst still awaiting a response to my email of 20 March 2016.
I am about to operate and will probably not be able to attend.
I am fully supportive of Marc Williams in this regard.
To have two hours allocated in a Job Plan to prepare for two uroradiological meetings per week, one of which is MDM, is woefully inadequate.
To have two hours allocated in a Job Plan to prepare for up to 50 cases per week is no derisory as to not require any further comment.
I do believe that the failure to allocate adequate time to enable a radiologist to prepare adequately for MDM when such preparation is mandatory, has now resulted in an existential threat to Southern Trust Urological MDT.
I do believe that this needs to be addressed in a positive manner to facilitate and bolster MDM rather than undermine it.
These are my thoughts which essentially remain unchanged from previously,

Aidan.

From: O'Brien, Aidan
Sent: 20 March 2016 09:03
To: Gracey, David

Aimee Crilly

From: Williams, Marc [redacted]
Sent: 25 September 2017 17:21
To: O'Brien, Aidan; Graham, Vicki; ODonoghue, JohnP; Glenny, Sharon; Gracey, David
Cc: Haynes, Mark
Subject: RE: [redacted]

Dear Aidan

Thanks.
I think we could have done better in radiology and I am in part to blame as my review of the case for MDT was not complete enough and I think this is unusual for me. At least the relatives were accepting of things after your conversation.
As a slight aside, despite having 3 hours of prep time for the MDT, I find I am having to rush and work at a speed I am not comfortable with just to get through the cases in this time. I will be keeping this under review.

Marc

From: O'Brien, Aidan
Sent: 25 September 2017 17:06
To: Williams, Marc; Graham, Vicki; ODonoghue, JohnP; Glenny, Sharon; Gracey, David
Cc: Haynes, Mark
Subject: RE: [redacted]

Dear All,

Mark Haynes advised me of the apparently conflicting diagnoses on Friday evening, asking me to explore, to ensure that patient's current state and management was appropriate.
I reviewed NIECR and PACS, coming to the conclusion that it was virtually impossible for the patient to me dying of prostatic carcinoma.
I thought that it was possible, but unlikely, that he could have a bladder carcinoma, and even more unlikely that he have metastatic bladder carcinoma.
I reviewed the imaging with Barry James yesterday, Sunday, concluding that the patient probably had metastatic lung carcinoma, and of which he may well have been dying at that time.
I then contacted his home, speaking with his wife and daughter, who were of the belief that they had been advised that the patient was dying of prostatic or bladder carcinoma, with liver and bone metastases.
However, and importantly, on explaining all of the relative probabilities, our diagnostic conclusion of metastatic lung carcinoma rhymed with their own suspicions.
They had no difficulty is accepting and agreeing with that conclusion.
They were appreciative of the discussion,

Aidan.

From: Williams, Marc
Sent: 25 September 2017 14:57
To: Graham, Vicki; O'Brien, Aidan; ODonoghue, JohnP; Glenny, Sharon; Gracey, David
Subject: RE: [redacted]

Trust (11 PAs) to be eligible to undertake WLIs. This was rectified in July 2016 with a condensed job plan to accommodate his wishes. In January 2017 an audit put WLI reporting at risk.

Please see the following supporting emails:

42.-44. 28.6.16 - Dr Williams unable to undertake WL as not on 11PAs as required by the trust
45. 3.7.16 - Dr Williams 11PA condensed job plan agreed to facilitate WL
46. 6.1.17 - Dr Williams proposing to resign if WLI sessions stopped

17.8 In 2017 an Independent Sector provider [Irrelevant information redacted by USI] provided a reporting service for subspecialty uroradiology studies, but they withdrew their services following criticism of some of the reports by Dr Williams, with a subsequent impact on report turn around times.

Please see the following supporting emails:

47. 16.2.17 - delay in MRI prostate reporting, no IS availability
48. 20.2.17 - MRI prostate reporting delays, IS services withdrawn
49. 25.5.17 - meeting proposed to feed back to Dr Williams regarding [Irrelevant information redacted by USI] *and offer of change of job plan*
50.-52. 5.6.17 [Irrelevant information redacted by USI] *discrepancies, prior to* [Irrelevant information redacted by USI] *reporting there was only a single reporter with no peer review*
53. 6.6.17 - IS discrepancies being addressed
54. 17.10.17 - Dr Williams disagreeing with [Irrelevant information redacted by USI] *report*
55. 22.11.2017 - Dr Williams and [Irrelevant information redacted by USI] *responses to discrepancies*

17.9 Urology MDM radiology cover was problematic throughout my tenure. Dr Williams was the sole Consultant Radiologist appointed to the MDM, as he was the only one with uroradiology expertise. He found the number of cases at the meeting and the length of the MDM notes arduous. His MDM

preparation time was increased to facilitate the meeting (May 2016). Initial clashes with other acute clinical duties, conflicting either with preparation time or the actual meeting, were addressed to optimize attendance (September 2017). Dr Williams leave also frequently coincided with the MDM. It was not possible to move the MDM, or discuss individual cases, at another day or time, to accommodate Dr Williams and facilitate patient flow, and Dr Williams was similarly not able to move his preparation time.

Please see the following supporting emails:

56. 14.5.15 - could Urology MDM day be moved, Dr Williams time protected
57. 15.5.15 - request to consider moving Urology meeting to better accommodate Dr Williams declined, MDM to proceed if radiology cases do not need discussed
58. 27.4.16 - Dr Williams resigning from Urology MDM, senior input requested
59. 27.4.16 - request to AMD for assistance with Dr Williams job plan and urology MDT attendance
59a.
60. 28.4.16 - Dr Williams complaining about the length of the urology MDM notes
61. 2.5.16 - proposed meeting regarding urology MDM
62. 2.5.16 - Dr Williams asked to prioritise meeting regarding urology MDM, job plan escalated to AMD.
63. 9.5.16 - urology MDM meeting, Dr O'Brien supports further time for Dr Williams to prepare.
64. 23.9.16 - patient deferred from urology MDM because no radiologist present
65.-66. 16.1.17 - Urology MDM minutes, concern regarding quoracy
67. 26.1.17 - Dr Williams unable to attend Urology MDM for several weeks because of leave and other commitments
68. 26.1.17 - Dr Williams unable for several MDTS due to annual leave, acute CT cover changed to enable meeting attendance

Stinson, Emma M

From: Gracey, David [redacted]
Sent: 22 November 2017 12:35
To: Trouton, Heather; Tariq, S; Wright, Richard
Subject: FW: [redacted] prostate MRI (another discrepancy)

Dear All,

For your consideration, [redacted] may feel it is in their best interests to withdraw their service if I pass this on. Would involvement from urology (Mr Mark Haynes)be appropriate as withdrawal may place this portion of their service at risk?

Regards

David

From: Williams, Marc
Sent: 22 November 2017 11:37
To: Gracey, David
Cc: Trouton, Heather; Tariq, S
Subject: RE: [redacted] prostate MRI (another discrepancy)

David
Thanks.
See my comments in red.
Please feedback to [redacted] if you want.
We should be in NO doubt that the outsourcing of these examinations has caused significant quality issues and prevents the further improvement of our service to the best it can be. We are already ahead of any trust in NI and we could have done better. I worked hard to get us to this position and I can do nothing more now.
Ask any urologist if they are happy with the service.
Managers need to rethink what is happening here. The trust could always try and recruit?

From: Gracey, David
Sent: 22 November 2017 11:08
To: Williams, Marc
Cc: Trouton, Heather; Tariq, S
Subject: FW: [redacted] prostate MRI (another discrepancy)

Marc

[redacted] esponses to the recently raised discrepancies

Regards

David

From: [redacted]
Sent: 21 November 2017 13:57
To: Gracey, David
Cc: Trouton, Heather; Tariq, S; Clinical Governance; Daniel Rose
Subject: RE: [redacted] prostate MRI (another discrepancy)

ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

17.1 I felt and do feel fully able to support the urological service in my role as a radiologist. I did not raise any issues in this regard.

18. **Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.**

18.1 I felt and do feel fully supported by my urological colleagues. If any issues were raised in regard to uroradiological practice, I felt these were taken seriously. An example of this would be the outsourcing of patient care with imaging performed suboptimally on external scanners, which was raised by me. Such scanners are often not technically capable of producing optimal images. When raised, it was agreed not to send out prostate MRI although this has happened again recently as part of the [redacted] contract.

Irrelevant information redacted by USI

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 As stated, I report examinations requested by urologists to guide them in the management of their patients. As a radiologist. I have no other input into the operation, governance or clinical aspects of urology as such. The reports of radiological examinations are used for patient management by urologists.

Royal College of Radiologists expects radiological departments to have a discrepancy meeting in place primarily for learning. This is not a Trust requirement but the Trust ensures that this happens on a monthly basis. I follow up some of my reports by saving such examinations for reference to future imaging studies, clinical information, or reference to histology. A radiologist would not have time to follow up all their reports and I only do so for interesting cases and to ensure that my reporting is accurate. I save cases on the Trust's PACS system.

14. **Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.**

14.1 I have not been offered any support for quality improvement.

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1 I understand that the quality of services in urology would be the responsibility of individual consultants who are then responsible to the clinical director of urology. I do not know who the head of service or clinical director are or previously were for urology.

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1 I have no knowledge of the governance arrangements in urology as I do not work in that department.

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you**

email. If I had issues with urology, I would raise them with the urology clinical director or another urologist. I do not know who the current clinical director of urology is.

26. **Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.**

26.1 I did not have any concerns in regard to any of the issues set out in paragraph 24 and I have not raised any issues. To clarify, the issue in regard to radiological attendance at the Urology MDT was not a concern I personally held but one I simply noted. This was an issue for the MDT chairman and the Trust. The lack of radiology cover (by a radiologist with a subspecialist interest in uroradiology) at the MDT was an issue in some individual cases as radiology reports made by non specialist radiologists were not reviewed (by a radiologist at the MDT with an interest in uroradiology) and in some instances resulted in inappropriate outcomes, for example the follow up of abnormalities that did not require any (I recall a case of an incidental testicular lesion for which follow up was suggested and none was required) and a patient who had a nephrectomy for a benign lesion. In regard to the latter, the case was re-discussed at the Urology MDT (with histology) where I reviewed the kidney lesion for which the nephrectomy was performed and I considered it unlikely to be malignant.

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

Stinson, Emma M

From: Gracey, David <Personal Information redacted by the USI
Sent: 23 September 2016 13:41
To: Glenny, Sharon
Cc: Trouton, Heather; Robinson, Jeanette
Subject: RE: Urology escalation - Patient 113 Personal Information redacted by the USI

Discuss with radiology outside of the meeting

From: Glenny, Sharon
Sent: 23 September 2016 13:34
To: Gracey, David
Cc: Trouton, Heather; Robinson, Jeanette
Subject: FW: Urology escalation - Patient 113 Personal Information redacted by the USI

Hi David

Please see urology escalation below – same situation as previous patient, patient deferred x 3 from MDM discussion due to requirement for radiology opinion. Any suggestions?

Sharon

From: McVeigh, Shauna
Sent: 23 September 2016 12:42
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: Urology escalation - Patient 113 Personal Information redacted by the USI

Hi,

Please see escalation of patient that is currently on day 49 of her pathway and remains a suspect cancer patient. She had a CT performed which is suspicious for renal cancer. She has been discussed at MDM and was listed for virtual MDM 15.09.16, no outcome could be made – deferred for radiology. Was listed for MDM 22.09.16 no outcome was made as need radiology opinion. She has been deferred until 06.10.16 – day 62 as we done have a radiology present until then.

She most likely will require a date for surgery following this.

Patient 113 Personal Information redacted by the USI
CAHE Personal Information redacted by the

Day	Date	Event
5	20/06/2016	First Seen at Craigavon
9	24/06/2016	Await clinic outcome from 20.06.16 - CTU reports - Bozniak type 4 cyst in relation to the lower pole of the left kidney highly suspicious of neoplasia. Report fast tracked to GP
9	24/06/2016	Renal DMSA has been appointed for 28.06.16.
28	13/07/2016	Patient for MDM discussion 21.07.16 - clinical summary provided by Mr O'Brien.
36	21/07/2016	MDM Action : Discussed at Urology MDM 21.07.16. This lady has been found to have a left renal cystic tumour. For review by Mr O'Brien to discuss management options, either active surveillance or laparoscopic left radical nephrectomy pending the outcome of more recent cardiac assessment.
37	02/08/2016	Patient's review has been booked for 22.08.16 - it was patients choice to be reviewed in SWAH so can add an adjustment to reflect this. Management options to be discussed at review.
39	23/08/2016	Patient attended review 22.08.16 - await clinic letter.

6.0 FINDINGS

for initial biopsy.

- The patient's care was through a Multidisciplinary Team process but unfortunately they did not benefit from it. The Multidisciplinary Meeting failed in its primary purpose to ensure patients received best care as defined by Regional and National Guidelines.
- The Urology MDM was under resourced and frequently non quorate due to lack of professionals. The MDM had quorate rates of 11% in 2017, 22% in 2018 0% in 2019 and 5% in 2020. This was usually due to lack of clinical oncology and medical oncology. Radiology had only one Urology Cancer Specialist Radiologist impacting on attendance but critically meaning there was no independent Quality Assurance of images by a second radiologist prior to MDM.
- The Urology MDM was under resourced for appropriate patient pathway tracking. The Review Team found that patient tracking related only to diagnosis and first treatment (that is 31 and 62 day targets). It did not function as a whole system and whole pathway tacking process. This resulted in preventable delays and deficits in care.
- Safe cancer patient care and pathway tracking is usually delivered by a three pronged approach of MDT tracking, Consultants and their Secretaries and Urology Specialist Nurses, in a Key Worker role. The Review found that these 9 patients were not referred to Specialist Nurses and contact telephone numbers were not given. Therefore the CNS were not given the opportunity to provide support and discharge duties to the 9 patients who suffered as as consequence. The MDM tracking system was limited. The consultant / secretary led process was variable and resulted in deficits. The weakness of the latter component was known from previous review.
- As patients were not re-discussed at MDM and Urology Cancer Nurse Specialist were not involved in care, non implementation of these MDM recommendations was unknown to others in the MDM. One patient D presented as an emergency and his care was changed to the MDM recommendation by another consultant.

Multidisciplinary working and referral

- The review team noted repeated failure to appropriately refer patients
- Service User A should have been referred to oncology initially and then to palliative care as his disease progressed.
- Service User B should have had an earlier diagnosis and referral to oncology.
- Service User D should have been referred to oncology and palliative care.
- Service User E should have been referred to oncology for time critical care.
- Service User F should have been referred to oncology.
- Service User G should have been referred to the Small Renal Mass Team.
- Patient H should have been referred to the Regional / Supra-Regional Penile Cancer Network according to NICAN Urology cancer guidelines 2016 but a

9.0 RECOMMENDATIONS AND ACTION PLANNING

This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.

Timescale - Immediate and ongoing

Assurance - Comprehensive Cancer Pathway audit and Patient experience.

Recommendation 3.

TheSHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely.

This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collatorative and equal culture. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight monthly agenda. There must be action on issues escalated.

Timescale – Immediate and ongoing

Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, numbers of issues outstanding.

Recommendation 4.

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.

This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans.This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).

Timescale - 3 months and ongoing

Assurance - Quorate meetings, sufficient radiology input to facilitate pre MDM QA of images - Cancer Patient pathway Audit - Audit of Recurrent MDM discussion - Onward referral audit of patients to Oncology / Palliative Care etc.

Recommendation 5.

The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed.

This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by a safety mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers. A report should

5.0 DESCRIPTION OF INCIDENT/CASE

Service User B

Service User B was diagnosed clinically and biochemically with prostate cancer, and was commenced on bicalutamide 50mgs. Bicalutamide (50mg) is currently only indicated as a preliminary anti-flare agent (or in combination with a LHRH analogue) and is only prescribed before definitive hormonal (LHRH analogue) treatment. The review team note that this treatment was not in adherence with the Northern Ireland Cancer Network (NICAN) Urology Cancer Guidelines (2016), which was signed off by the Southern Health and Social Care Trust (SHSCT) Urology Multi-disciplinary Meeting, as their protocols for Cancer Peer Review (2017). This guidance was issued when Doctor 1 was the chair of this group and had full knowledge of its contents. The review team note that, following discussion with Service User B, he was unaware that his care given was at variance with regionally recommended best practice. There was no evidence of informed consent to this alternative care pathway.

A biopsy result taken at the time of transurethral resection of prostate (TURP) showed benign disease (low volume sample 2g from central area of prostate). There were no further investigations to explore the clinical suspicion of prostate cancer.

The possibility of localised prostate cancer was considered from the time of presentation because the PSA was elevated; however, there was no record in the medical notes of any digital rectal examination (DRE) findings. During the operation further signs might have been elicited and appropriate biopsies could have been performed. TURP is not an adequate way to biopsy the prostate gland for suspected prostate cancer. The Review Team conclude that sufficient evidence of localised prostate cancer was apparent from the time of presentation. A correct course of action would have been to arrange appropriate staging scans and biopsies. Service User B should have undergone investigation with a MRI scan of the prostate and pelvis and a bone scan should have been considered. A transrectal biopsy performed either at the time of the TURP or separately, would have secured the diagnosis.

Arrangement could then have been made to start conventional Androgen Deprivation Therapy (a LHRH analogue) with referral on to an oncologist for consideration of external beam radiotherapy (EBRT) potentially with radical intent. However, the patient was apparently lost to follow up after his appointment in July 2019.

Service User C

Service User C was referred to urology service following a visit to ED in December 2018. He was reviewed promptly by Dr 1 in January 2019. Investigations were arranged and a diagnosis of a large right-sided renal carcinoma was made. He was counselled regarding the risks and benefits of surgical intervention and chose to proceed with the high-risk surgery.

On 6 March 2019 Service User C was admitted for an elective radical nephrectomy. The procedure was undertaken as planned and he was transferred to the intensive care unit (ICU) to support his blood pressure. He was later transferred to the ward. He developed a bacteraemia (infection) which was successfully managed with the advice of the microbiology team. Follow up CT scans were performed in June with a planned follow up in July 2019. This did not happen. Service User C was admitted to Ward 3 North following an ED admission. He was reviewed again via telephone in November

5.0 DESCRIPTION OF INCIDENT/CASE

2019 by Dr 1 who arranged for a repeat CT scan to be performed on 17 December 2019 with a plan for review in January 2020. This did not happen.

The CT scan report was available on 11 January 2020 which showed a possible sclerotic metastasis in a vertebral body which had not been present on the previous CT scans. This report was not actioned until July 2020 when a new consultant reviewed the care. Service User C was subsequently diagnosed with prostate cancer.

The Review Team find that the treatment and care in relation to management of the renal tumour was of a high standard. High-risk surgery was performed successfully following informed consent as to the risks and benefits of the surgery. A urology review was planned for July 2019 following the CT scan report in June but this didn't happen. Service User C appeared to be lost to review. The scan performed in December 2019 with a plan to review in January was not actioned and the plan for review did not happen. This resulted in a delay of 6 months in diagnosis of a prostate cancer from the scan result. This would be approximately a delay of 18 months from his first presentation in ED in November 2018.

Service User D

Service User D attended ED on 24 December 2018 with retention of urine. A urinary catheter was inserted, and a urology consultant review was planned to coincide with a trial removal of catheter with a specialist nurse. Service User D was placed on the waiting list for a TURP. A normal PSA result (2.79 ng/l) was noted.

On 19 June 2019 Service User D underwent a TURP. The procedure notes describe the prostate tissue as having "endoscopic appearances of prostatic carcinoma". Histology confirmed adenocarcinoma (Gleason score 5+5) in 90% of the resected tissue. His case was discussed at MDM on 25 July 2019 who noted there was no evidence of metastases on a CT abdomen and pelvis. It recommended a CT scan of chest and a bone scan to check for spread outside the prostate. Further, a LHRH agonist as ADT should be commenced. In August 2019 a bone scan and CT scan were requested together with an ultrasound scan of the urinary tract to assess bladder emptying. Doctor 1 prescribed Bicalutamide (50mgs once daily), in order to 'assess its tolerability in a generally frail man' and in the 'light of the low presenting PSA'.

The Review Team could not locate any record in the medical notes of a digital rectal examination being performed at any point during this patient's medical treatment. This may well have provided evidence to support the malignant nature of the prostate gland prompting a swifter biopsy.

The patient was discussed at MDM on 25 July 2019 when the recommendation for ADT (a LHRH analogue) was made. He should have been started on this hormonal therapy to achieve "castration testosterone levels" as soon as the diagnosis of poorly differentiated prostate cancer was made. Instead he was started on an inadequate dose of a drug (bicalutamide) which was not licensed for the treatment of prostate cancer and was contrary to the recommendations at MDM. This therapy was not in adherence with the Northern Ireland Cancer Network (NICAN) Urology Cancer Clinical Guidelines (2016) which were signed off by the Southern Health and Social Care Trust (SHSCT) Urology Multi-disciplinary Team, as their standard of care for Cancer Peer Review (2017). This guidance was issued when Dr 1 was the regional

Clinical History of Service User C / Patient 5

Service User C (SUC) was [redacted] old when he presented to the Emergency Department at Craigavon Area Hospital on 12 December 2018 following the onset of visible haematuria earlier that day. The haematuria was described as dark red flecks of blood in his urine. The haematuria was accompanied by right flank pain and dysuria. He did not report having any significant lower urinary tract symptoms previously. He reported that he had smoked for about three years in his twenties. He did not have any history of occupational exposure to substances associated with an increased risk of bladder cancer. It was noted that he took warfarin for atrial fibrillation.

He was found to have a pulse rate of 76/minute. He was normotensive and afebrile. He had normal heart sounds. His chest was clear on auscultation and his abdomen was soft. There was no record of any abdominal mass palpable and there was no abdominal tenderness. He was found to have a smooth prostate gland on rectal examination. There was some consideration as to whether the right lateral lobe was larger than the left lateral lobe. There was no clinical suspicion of prostatic malignancy.

His serum C Reactive Protein level was 5 mg/L. His Haemoglobin level was normal at 136 G/L and he had a mild leucocytosis of 12,800. His renal function was impaired with an estimated glomerular filtration rate (GFR) of 57ml/min. His INR was 1.7. A specimen of urine was evidently haematuric and was submitted for culture. He was considered fit for discharge from the Emergency Department to await an appointment to attend the Haematuria Clinic. He was prescribed Trimethoprim 200 mg twice daily and a referral was sent to the Office of Cancer Services at Craigavon Area Hospital. The referral was received on 13 December 2018. It was triaged by Mr Glackin, Consultant Urologist, on 13 December 2018. He allocated Red Flag status to the referral on triage. He requested that an appointment be arranged for SUC to attend as an outpatient for ultrasound scanning of his urinary tract and for flexible cystoscopy. He did not arrange any imaging in advance of his attendance.

SUC's daughter subsequently contacted [redacted] to request a private consultation for her father with me. I contacted her by telephone to advise that there was no need, as instead I would request a CT Urogram followed by a review of her father as an outpatient at my clinic at the hospital.

SUC was found to have a large right renal tumour on CT Urography performed on 04 January 2019. It was reported to have a craniocaudal diameter of 15cm. The right

Protocol for the Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings

This protocol has been written to clarify the method of reporting and communicating critical, urgent and significant unexpected radiological findings.

Patient safety incidents may be caused by a failure to acknowledge and act on radiological imaging reports. Guidelines for the communication of urgent reports have been published by The Royal College of Radiologists.

The need for a cohesive policy for the reporting of critical, urgent or significant unexpected radiological findings became apparent with the amalgamation of the hospitals within the Southern Trust.

The National Patient Safety Agency (NPSA), in its safety notice 16 'Early Identification of Failure to Act on Radiological Imaging Reports' draws attention to the number of serious patient incidents that have occurred due to a failure in communicating results, some of which resulted in fatalities or long term adverse harm. The document highlights the changes healthcare organisations need to make to ensure that radiology imaging results are communicated and acted on appropriately. The document covers information for referrers, radiology departments and managers (NPSA, 2007).

Safety Notice 16 highlights the need for referrers to complete request forms clearly including name of referrer, job title and work area with contact details. It also incorporates recommendations for referrers to ensure that systems are in place to provide assurance that requested images are performed and the results of these are viewed, acted upon accordingly and recorded. It is the referring registered health professional responsibility to ensure this is followed.

The Royal College of Radiologists outlines the following definitions.

- *Critical findings* Where emergency action is required as soon as possible
- *Urgent findings* Where medical evaluation is required within 24 hours
- *Significant Unexpected findings*
  - Cases where the reporting radiologist has concerns that the findings are significant for the patient and will be unexpected.

What constitutes a significant unexpected finding will often be subjective, and whilst the need for direct communication of a report is largely down to the judgement of the reporting radiologist, conditions which would be considered significant and unexpected would be: an initial finding of possible cancer in a non-cancer referral, incidental pulmonary embolus.

Purpose

- To outline the procedure for informing the referrer of urgent, critical or significant unexpected findings on imaging thus expediting the patient investigation and treatment
- To inform the patient cancer tracker team if necessary
- To escalate any further imaging required
- To document all communicated results within the RIS (Radiology Information System)

Scope

- The Head of Diagnostics will be responsible for disseminating the policy to the Imaging Clinical Director and all Radiology Site Leads
- The Clinical Director and Radiology Site Leads will be responsible for disseminating the policy to all radiologists and reporting radiographers.

Communicating Life-Threatening Urgent Or Cancer Findings To The Referrer Or Cancer Tracker

This policy outlines the method of informing referrers of radiology findings that require immediate/urgent attention.

This methodology should be used for the following radiological findings:

1. Critical results (life threatening)
2. Urgent results
3. Significant unexpected findings

Aim

To provide a method of informing the referrer and/or cancer tracker of a report that needs acted upon immediately.

Participants

Those involved in the completion of this task include:

- Radiologists
- Registrars
- Reporting radiographers
- Clerical and admin staff based within radiology

For Critical (life threatening) results – the reporter is responsible for contacting the referrer immediately, by telephone, to inform them of the diagnosis.

For Urgent & Significant Unexpected Findings – the reporter will put a flag on the examination, which will place the examination in a dynamic work list which the clerical team will review three times daily.

Once the referrer or cancer tracker has been notified by email, the clerical member of the team will remove the. When the cancer tracker is notified, they will immediately add the patient to CaPPS and show the report to the relevant Consultant for further action on the cancer pathway.

Methodology

For Reporting Personnel

1. The report is saved on the system by the reporting personnel
2. Prior to the authorisation of the examination, go to the dynamic work list and right click on the patients' examination.

Angela Kerr

From: Williams, Marc [redacted]
Sent: 04 August 2016 10:16
To: O'Brien, Aidan
Subject: Private patients at MDT

Aidan
Please can you discuss the issue of private patients being discussed at the urology MDT.
I understand that the trust does not indemnify us for discussing these cases so if an error is made, we are personally liable. This is not withstanding the fact that private patients should be paying for the services of all staff at the MDT.
I have asked for clarification from the medical director and am awaiting discussion. I will not be providing any radiology input into these cases until I receive clarification.
Can I suggest that this is discussed at the MDT AGM or such like.
Thanks

Marc

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1 In my view, I do not think that management take concerns seriously within the Trust and often fail to act or do not communicate that they have done so. Issues I have previously raised, for example in regard to the duplicity of investigations I have outlined above, are not acted on. When one raises an issue, usually a response is not received.

35.2 Many issues I raise in regard to radiological practice, to the radiology clinical director and the radiology service manager, which are not specifically urological, are not addressed by managers and opportunities for the improvement of patient care and efficiency are lost. Examples would include SPA entitlement for service improvement and teaching. Such issues are raised infrequently as I do not think time spent raising them is well spent.

35.3 There is certainly scope for improvement in radiological practice. Managers need to acknowledge each and every issue raised to them and state how best the issue could be dealt with, rather than appearing not to engage at all. I regularly feel that I am not listened to by management (the CD, AMD, AD, service manager). Radiology consultants should be given areas of responsibility and time in their job plans for this role. Areas for improvement should be discussed with clinical and non-clinical managers and a plan made to make improvements to the service.

Staff

36. **As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good**