Urology Services Inquiry

Oral Hearing

Day 68 – Tuesday, 7th November 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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THE INQUIRY RESUMED ON TUESDAY, 7TH DAY OF NOVEMBER, 2023 AS FOLLOWS:

CHAIR: Morning, everyone. Apologies for the delay. It is Tuesday, though, and we tend to have technical difficulties on a Tuesday! So, Ms. McMahon?

MS. McMAHON: Good morning. The witness this morning is Mr. Matthew Tyson and he is going to take the oath.

MR. MATTHEW TYSON, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON, AS FOLLOWS:

1 Q. MS. McMAHON: Mr. Tyson, thank you for coming along to give evidence to the Inquiry. You are a Consultant Urologist at Craigavon at the moment and you have provided us, helpfully, with a substantive Section 21 statement and also an addendum to that statement, and I just want to go to those, first of all, so you can adopt those as your evidence before we move on to the questions I need to ask you today.

The first statement is 63 of 2023, and it's found at WIT-42192. And we see your name at the top of that statement. Date of notice is 7th June 2022, and we'll find your signature at WIT-42226. And the date at the bottom of that, it's signed -- it's typed "Matthew Tyson", dated 12th August 2022, and do you recognise that as your statement?

A. Yes.

2 Q. And do you wish to adopt that as your evidence for the Inquiry?
A. Yes.
3 Q. The further addendum statement received by us at WIT-104212 -- and, again, date of notice 7th June 2022 and your name at the top. Your signature can be found at WIT-104214, and just typed signature, Matthew Tyson, dated 3rd November 2023, and do you recognise that as your addendum statement? 10:28
A. Yeah. 10:28
4 Q. And do you wish to adopt that as your evidence?
A. I do.
5 Q. I will come on to your addendum statement shortly, and we'll read out the relevant parts of that that you've provided some clarification on your substantive statement, and also some additional information, and we will come to that in due course. 10:28

But the context of your evidence is limited, really, to three distinct periods of time: You spent some time as a registrar in Craigavon Urology Department; you then went back as a consultant for a very short period, February to July 2019 -- and I think during that time you also had some annual leave, so it was roughly a four-month period, taking into account the annual leave as well; and then you returned as a consultant in October 2021. And you are currently in that post, although you have updated us to say that you have since handed in your notice and you will be moving on in 10:28 10:29

January 2024. But at current times, you are employed as a consultant urologist there.

So there is some limitations in scope in your evidence, but you have brought some information and it might be helpful for the Panel to hear that. We have heard a range of information about conditions and procedures and services and I just want to ask you both some specific questions, but also, generally, some issues arising from your experience as a consultant urologist. 10:29 10:30

I wonder if you could start your evidence by giving us a potted history of your training and your background and what you have done and what roles to take you to your current position? 10:30

A. Yeah, sure. So I went to medical school in Wales. I did my house jobs in Wales. I went to Australia for a year as an SHO. I returned to do core surgical training in Wales. I did a year of research and education fellow in Birmingham. 10:30

I then came to Northern Ireland as a urology trainee. I then got appointed as a consultant in February '19. I then went in July '19 to take a fellowship in, mainly, in complex stone management. I returned in October '21 to re-take up my position as a consultant. 10:30

6 Q. So your time as a registrar in 2012/2013 and then I think again in '15 and '16, what was the total time you spent as a registrar in urology in Craigavon?

A. Two years.

7 Q. Two years. Two separate periods of time?

A. Two separate periods of time, 2012 to '13, and '15 to '16.

8 Q. Now, in relation to the time as a registrar, you were under the supervision of some of the consultants there, Mr. Young and Mr. O'Brien? 10:31

A. In 2012 and '13, it would have been Mr. Young and Mr. O'Brien. In 2015, it would have been Mr. Young and -- they're all the consultants -- Mr. Glackin, Mr. O'Donoghue, Mr. Haynes, as well as Mr. O'Brien. 10:31

9 Q. So in terms of the learning curve during your time as a registrar, was it the case that you were working on an ad hoc basis with the consultants, or were you actually allocated on a daily basis to different consultants? Just give us a flavour of what that was like? 10:32

A. So it varied between the two different times. In '12 and '13, it would have been a mix between the consultants. You've got newly pointed, and Mr. Young and Mr. O'Brien. But myself and the other registrar would have been seen as Mr. Young's or Mr. O'Brien's registrar for a six-month period each. In the subsequent time in 2015, it was much more of a mix of going around all the consultants in the department and there were many more at that point. 10:32 10:32

10 Q. So due to the increased numbers, there was a greater possibility to spend time with other consultants as well?

A. There was, yes.

11 Q. And, as a registrar, were you always working under the supervision of a consultant, or was there autonomy in your own practice at that point?

A. So, the majority of the time, you are assigned to a consultant, either in their clinic or their theatre list. There was autonomy to some degree during on-call, but there was always a consultant on call supervising. And there were times doing flexible cystoscopy lists when you would be the operating surgeon, so to speak, but there would always be oversight, if required, if you needed to call upon someone. 10:33 10:33

12 Q. And during your time in 2012 and 2015, if I use those as shorthand for those two separate periods, did you feel as a registrar you were well supported? 10:33

A. Yes.

13 Q. The Inquiry has heard evidence from other witnesses of their different experiences and I just wanted to ask you did you have any concerns during your time as a registrar around any of the care or issues of patient risk that you might have seen? Anything arise for you? 10:33

A. The only thing I raised was the staffing issue, and that was the staffing issue upon the ward and also the middle grade rota. In 2012, there were mainly just two registrars and in a very busy unit. I can't remember how many there were in '15, but it hadn't really increased at all. And then by -- if we look at the period now, there are seven people for a middle grade 10:34

rota, so you can see that there is a staffing change from then to now.

And then the nursing issue I also had raised regarding that there were a lot of locum nurses to the wards and, 10:34
therefore, the ability to care for urology patients with substantive staff knowing the role and always being there I think was a limiting factor to what could be how you optimise the service. So you always look at how should things be. And so I raised that in a -- I 10:35
can't remember which meeting, but I would have raised that at an audit meeting.

14 Q. In your statement when you raise or draw attention to some of those concerns around staffing, and I will take the Panel to what you say around some of those issues, 10:35
it's within the context of the 2019 period of time when you came back as a consultant. And if we just draw a line at that at the moment and think about when you were a registrar -- because, in many respects, you have a bit of a unique perspective -- you were in and out of 10:35
the unit over a ten-year period and it would be interesting to get your view on what you thought had improved or not over the period of time when you came back and had a look and had a different experience at different grade as well. Just when you were 10:35
a registrar, did you operate with -- alongside Mr. Young, Mr. Glackin, Mr. O'Brien and the other consultants?

A. Yes.

15 Q. Did you have any concerns about any of the surgical functions that you saw being carried out or any of the operations?

A. No.

16 Q. What was your view of the professional standards of the consultants that you worked with in surgery, with staff -- did you have any experience of any concerns at all? 10:36

A. No, I had no concerns.

17 Q. We will come on to look at an issue around Bicalutamide 50 in a moment and the prescribing of that while you were a registrar, but I want to just now go to your statement and look at some of the issues that you have raised or some of the matters that you address in your statement that may be of relevance. 10:36

10:36

One of them, as you say, was an issue around staffing and, if we go to your statement at WIT-42201 and if you go to paragraph 12.1, I will just read the question to put it in context. And we have asked:

10:37

"Do you think the Urology Services generally were adequately staffed and properly resourced throughout your tenure? If not, can you please expand, noting the deficiencies as you saw them? Did you ever complain about inadequate staffing? If so, to whom? What did you say and what, if anything, was done?" 10:37

And in paragraphs 12.1 to 12.4, you say this:

"I make these observations regarding the time in question for the time 24th February 2019 to 16th July 2019 as a urology consultant in the Trust, and times preceding as a urology trainee rotating through the Trust.

Urology Services were/are not adequately staffed given the long waiting list to be seen in clinic or receive an operation from a consultant's perspective. The Urology Ward was at times under-staffed from the perspective of skilled urology nurses, or relying on agency nurses, and urology patients were often placed on other non-urology wards, making ward rounds longer.

I remember voicing my concerns regarding the above at a Urology team meeting with the urology consultants and urology manager present some time between March 2019 and June 2019. I do not recall the answers given, but understood/was informed these concerns were known and management were working on the issues." 10:38

Now, as you say, that's an example of something you have raised around nursing staff and the Inquiry and the Panel have heard evidence of the difficulty both recruiting and retaining staff and the reliance on agency staff. Was it your experience at all at any point of any of your varying tenures at Craigavon that the difficulty with reliance on agency nurses or the absence of either qualified -- properly

urology-qualified nurses or nurses generally, did you think that posed a risk to patient care?

A. Inevitably, it does, and it's looking at what is the ideal situation to be in. If you are a patient, you want to go to a ward where you have staff who are very aware of the protocols in place and management of patients as regards what goes on in a unit. You want staff who are trained in a way that they are always there in a service, and that's why you have staff in a set job. 10:39 10:40

So having people who are very good come in from certain locum agencies -- and a lot of them are very good, but you have to feel for them at times because it was not their permanent role and they were turning up to fulfil a job in a role, and they had to learn and work out, "Right, how do things work in this department?". 10:40

So, if you look at an ideal, the ideal is permanent staff who are there on a regular basis, who understand the roles and responsibilities of that job in order to fulfil the best requirements for those patients. 10:40

18 Q. And did you get a sense -- by the sense of your statement, it seems that it wasn't the first time that the urology consultants and urology manager had heard of this issue; it was something, did you feel, that was ongoing and trying to be addressed? 10:40

A. Yes, it was an ongoing issue.

19 Q. Was there ever an opportunity to -- for you or any

other medic to feed into a risk assessment about the potential harm that that scenario may have been causing? So, for example, to actually in some way provide data that might have fortified the position that there was a patient risk, rather than it just being on an ad hoc basis?

A. From a viewpoint of standing back and when you go on to the ward to see what the situation is like, that's why I raised those points. Any potential issue that could occur on a ward, you can fill out a Datix form and you can once again raise it through the chain of management. For the very brief time I was there, there was no incident for me to raise specifically, but it was -- it's about noting that there can be an issue and there could be an issue if things continue in the way they were. So that's why it was very important to raise because it's the foresight to saying "Hang on, something will happen." 10:41 10:41 10:41

20 Q. So rather than wait until it does, "Here are my concerns"? 10:42

A. Yeah.

21 Q. Were you aware of any other consultant or medic raising a Datix specifically around staffing? Just in your own experience, were you aware of that?

A. Not that I was aware of, no. 10:42

22 Q. I wonder if we could go to your statement at WIT-42205, paragraphs 24.1 and 24.2? Again, you have mentioned the staffing issue and I just want to close that point. So we have asked you about working relationships at

Question 24:

"What was your view of the working relationships between nursing and medical staff generally? If you had any concerns, did you speak to anyone and, if so, what was done?". 10:42

And you say:

"There was a good working relationship for the time period I was there. There was recognition that staffing levels could be low at times, as discussed above needing agency nurses, but a determination to do the best for each patient and maximise what we did have. 10:42 10:43

I had no concerns beyond low staffing levels at times, which management were aware of, and beyond raising the issue as stated in answer to Question 12..." 10:43

-- which we have just looked at. In relation to working relationships, did you have any -- I know you said you had no concerns generally, and we will look at the issue around the CNS nurse and the use of the CNS, but did you have any sense of any fractured relationships that might have impacted on patient care or patient risk at all during any of your times at Craigavon? 10:43

A. Not during the time when I was there. Coming back and

reading through all the things that occurred when I was not there, or not privy to, obviously there appears to have been some strained relationships, it would appear. But for the times I was there as a registrar, the unit appeared a very happy and cohesive place. For the four months I was there as a consultant, I was mainly there at those four months doing complex stone management. So I was mainly involved with Mr. Young and Mr. O'Donoghue and, certainly from that perspective, that part of the team, it was very happy and cohesive, and I didn't foresee or hear of anything in the wider team at that point. 10:44 10:44

23 Q. And at what point did you hear of the wider issues that are now the subject of the Inquiry?

A. Only through and from -- subsequently, from this Inquiry. 10:44

24 Q. So from documents you received from the Inquiry and from your own knowledge in relation to what you read, rather than what you knew?

A. Yes. Yes. 10:44

25 Q. And given that, given the time period that you'd been in urology at Craigavon, what was your view when you became aware of the extent of the issues or the breadth or depth of the issues that seemed to have been ongoing during your time there? 10:45

A. I guess the only way to put is obviously "upsetting", in a way, and from what appeared and what is at present a very cohesive team, joining the unit was because the team was very cohesive and supportive, but to then

read, obviously, there's other potential goings-on is obviously a bit upsetting in that perspective, I would say.

26 Q. Well, if I can take one of the examples that has been well ventilated before the Inquiry, the issue of triage, was that something that you were involved in as a registrar? 10:45

A. No.

27 Q. And, in 2019, when you came back as a consultant, did you have any -- you obviously were involved in triage at that point? 10:46

A. Yes.

28 Q. What was your view of how effective that was in 2019, the process that you were undertaking as a consultant?

A. So, in 2019, we undertook what's known as advanced triage. So during your consultant on call week, you would triage the electronic referrals, as well as the paper referrals in a timely manner, which meant that by the end of the week you had a clean ship and everything was done. And anyone who you thought was going to come to immediate harm, you brought them in there and then or to a Hot Clinic so you could see them during your week on call. And it was important to have the triage done for two reasons: One was for patient safety and governance, but also so that your colleague coming on, you don't leave them with a back foot before they're about to start an on-call week. 10:46 10:46

29 Q. If I could just take you to your statement at WIT-42199 at paragraph 9.2 -- so we're asking about triage:

"Upon commencing work as a consultant for the Trust in 24th February 2019, I was informed by Mr. Young and Mr. Haynes and Urology Manager, Martina Corrigan, on how to undertake triage of GP referrals, online ECR and paper referrals, and code to appropriate time to be seen.

In relation to listing patients for theatre, I was informed on what categories each operation type needed to receive in order to be addressed in the appropriate manner."

Now, I just want to ask you so that I'm clear on the sentence "code to appropriate time to be seen", is that a referral to the traffic light system of triage or was it explained to you in a different way at all?

A. In relation to routine, urgent and red flag.

Q. And did you have any control over the actual period of time in which a patient might be seen, or was it just within those three categories?

A. No, there was other controls. So if you thought a patient was going to come to immediate harm or they were at immediate risk, you could bring them in as a hot patient to a Hot Patient Clinic during your on-call week. So there is the ability to find that if you think someone is in immediate danger, to bring them in. But, beyond that, no, routine, urgent and red flag would be seen within those time periods, unless you

clearly state that you feel that maybe there is someone who needs to come in within a certain period of time for whatever reason. But you have to then justify that above all these other patients as well, because there's lots of patients who are being triaged. And so it's about appropriately triaging that patient to the right category. 10:49

31 Q. And so that was something that was before a red flag, someone who actually needed to be seen quicker than a red-flag referral? 10:49

A. Yes.

32 Q. Yes. And when you say you had to justify that, are you saying as a clinician you had to make sure that you were maintaining a priority, given that everyone -- the other red flag people weren't in that hot seat, as it were? 10:49

A. Yes.

33 Q. Or did you have actually justify that to management in any way?

A. Not to management directly. But it's relating to equity of access to a system for the people who are referred to the service. But it's the ability as a clinician to say if someone is going to come to immediate harm or danger, that you bring them in straightaway. So if you have someone who is referred to you in -- they may have an issue that needs to be seen directly there and then, even perhaps the same day, and you bring them in as an on-call patient, well, that happens, and it's about reading the information 10:49 10:50

you have been given from the GP to make a decision upon that patient upon what you've been given.

34 Q. And the ability to do that, to front-load even before a red flag, is that something that has always been in existence or was it something that in 2019 was a relatively new approach? 10:50

A. I don't know what time they brought it in as regards the Hot Patient Clinic, but it was there in '19. I don't know what year they brought it in by.

35 Q. And was it something that was regularly used by other consultants as well? Was it something that was manifestly needed by the simple fact that there was a Hot Clinic and there were people who needed to be there? 10:50

A. I don't know the data for the other consultants of who brought patients in. I can tell you that I utilised the facility and I continue to utilise that form of being able to see a patient sooner, if required. 10:51

36 Q. And is the Hot Clinic, is that something that's already facilitated within job plans and it's already time-tabled? There's no extra work involved in that, it's something that has been built into the system? 10:51

A. It forms part of the consultant on call week.

37 Q. In the second part of that sentence, in relation to operations, you said, the second sentence: 10:51

"In relation to listing patients for theatre, I was informed on what categories each operation type needed to receive in order to be addressed in the appropriate

manner."

Is that another type of triage? I just want to understand what that sentence means so that we are sure what this system is. 10:52

A. It means listing a patient either as the routine and urgent or a red flag.

38 Q. Does that refer to the waiting list for admission or the waiting list for operations?

A. Waiting list for an operation. 10:52

39 Q. So the category of priority is attributed to the patient, rather than the operation -- is there a distinction in your mind?

A. No, it's related to the patient and what the patient requires. 10:52

40 Q. Thank you. Now, you mention about administrative support at WIT-42203, at paragraph 17.1 and 17.2. And you refer to the service provided at 17.1:

"The service provided secretary support to each consultant. Audiotypists helped for large volume of letters dictated, along with administrative staff to record referrals received. 10:53

In relation to 24th February 2019 and 16th July 2019, I received secretarial support from Teresa Loughran for typing of letters, to book operating lists, to ensure results were followed up and to allow access for communication from other specialties, GPs and patients. 10:53

There were no issues related to this arrangement. There were also audiotypists to aid the secretarial workload on typing patients' letters due to the large volume."

10:53

Now, there has been evidence before the Inquiry of administrative delays on some issues. The triage, we've discussed. You didn't do that as a registrar and, as I understand it, you have no problems with the triage system as a consultant since you've come back as well, either in 2019 or currently? 10:54

A. Well, I have no issue in undertaking it and doing it, no!

41 Q. There's no backlog, from your perspective?

A. No. 10:54

42 Q. Do you understand if there's a backlog at all in triage in the unit at the moment?

A. No, not for me or the consultants I currently work with I'm aware of any backlog. Certainly when I take over from whoever has been on the prior week, the triage is done and, before I hand over to the next one, the triage is done. 10:54

43 Q. In relation to dictation from you as a consultant when you're dictating your letters after clinics, for example, is that something that you have always done right away? 10:54

A. Yes.

44 Q. Immediately after seeing your patient or at the end of the clinic?

A. Immediately after seeing a patient in clinic in the room, I would dictate a letter. And I have a system on the outcome sheet that I then tick next to the box of the patient's addressograph to know I've done it.

45 Q. And that's done electronically now with the tapes? 10:55

A. Yes.

46 Q. And in relation to review follow-ups, when you were back in 2019 did you experience any backlog on reviews or delays in patients coming back?

A. I noted that when I then took a consultant job, that 10:55 the Trust had a long backlog of operating and reviews to be seen. It was not something you are overly aware of as a registrar -- you're there to train and you're there to undertake your service requirement for that point. It became a different appreciation of a service 10:55 as a consultant and so in the very -- I was only there for a brief time in '19, but, noting a backlog, I undertook a number of extra clinics to help the backlog to try and alleviate the pressure on the lists.

47 Q. And, as a registrar, you said you wouldn't have been 10:55 aware of that particular administrative burden, but when you came back as a consultant were you surprised by the extent of the backlog, or was it something that just seemed to be accepted as being there?

A. I was -- it's -- in starting a consultant job, it's not 10:56 something you overly want in a way, because you want to be able to see patients in a timely manner. So it was something which I was slightly taken aback by the actual depth of the waiting list, yes. But, in

hindsight, I suspect looking over the period of time which I've been there as the registrar -- from then, almost ten years prior, it's clearly something that has accrued over a period of time. And then certainly coming back in 2021, I came back at the tail-end of Covid and, yes, the backlog was considerable at that point and certainly a bit of a shock. 10:56

48 Q. And given that you have been there in 2012 and then back in 2021, what was your general view of the department and the service overall? Did you think that certain areas had got better/certain areas had got worse? What was your general feeling when you went back in almost ten years later? 10:57

A. Well, in 2019 when I saw the waiting lists, I didn't see it as a insurmountable issue to get over; it was a resource issue and could we over-work to get rid of the backlog, and then could we implement any strategies to try and prevent that from happening again? So I saw that in '19 as a challenge, which I think I foresaw we could achieve and turn around. 10:57

Coming to a end of Covid, a 2021 period, where clearly what had happened during Covid had tipped the whole system over the edge for Urology, that was a different ball game completely. 10:58

49 Q. And when you say it wasn't insurmountable in 2019 and you've provided some examples of how that might have been -- things might have been, perhaps, caught up with at that point, were they discussions that were ongoing

in the unit? Were you speaking to others about this? Were other people saying the same thing as you?

A. As a team, I had the opinion that we were working together to have strategies to reduce how many patients went on to clinic lists, how we prevented follow-up -- and that's the whole idea behind advanced triage, virtual work. So patients, instead of always coming back to clinic with results, if they didn't need to come back and a letter would suffice, it's that sort of way of working, of what other strategies could you implement. 10:58 10:59

Another thing we implemented was a virtual sort of stone meeting, which predates the current GIRFT report. That is now part of the GIRFT report -- not because of what we did, but we just pre-empted the direction of travel at that point. So we instigated a stone meeting and that meant instead of all the stone patients having to all come to a clinic, they would be seen in a stone meeting each week. This is currently ongoing. We see between 30 to 50 patients on a Tuesday afternoon in that meeting. Traditionally, those patients would have all gone to a clinic, which meant your backlog would have been in months to years. If you now present as a stone patient, you will be seen from that meeting within the week or the following week. So you've turned around from months to years, to the same week or the following week. And the team were a runner-up for the Quality Improvement Awards in Manchester for that 10:59 10:59 10:59

work. So, going back to the question of did I foresee a turnaround by instigating these sort of strategies, yes, I did.

50 Q. You've given me a lot of information, so I will try and unpick some of the -- 11:00

A. Sorry!

51 Q. That's okay, it's all very relevant. But we'll just start at the end and you've mentioned about the award and the model, I think, the stone meeting model, if we can call it that. That seems to have been very 11:00 effective in reducing turn around times. Is that a model that can be read across other treatments?

A. Yes, definitely.

52 Q. And do you know if it has been sought to be adopted across other treatments by the Trust, either this Trust 11:00 or any trust?

A. Maybe not in -- not currently in this Trust or other Trusts that I'm aware of, but it's a model that I suspect is probably used by other specialties. But it's the wider picture of Northern Ireland of how we 11:01 could restructure, knowing we have five Trusts and should we narrow down to one.

53 Q. Well, just on the more micro level of the actual meeting and the way in which that seems to have been very effective in reducing waiting times, was it 11:01 a costly model to introduce or a labour-intensive model, or is there something about it that would perhaps make managers pause before seeking to roll it out more broadly?

A. Well, one of the reasons we were a runner-up for the Quality Improvement Awards was because we demonstrated a significant cost saving in undertaking this method of working, and also patients from -- were more satisfied in having direct communication very soon after presenting with their stone disease. So, from a patient perspective, from a cost perspective, from an efficiency, from a safety, compared to waiting on a long list to be seen in clinic, it's a bit of a no-brainer. And lots of departments now in the UK do work in this manner for stone meetings, and it's a model which we developed in part from visiting the Scottish stone centre and recognising the virtual ways that they worked, and then implementing some of their strategies in order to aid the people for the Southern Trust, but also looking at the bigger picture for equity in the whole of the region. 11:01 11:02 11:02

54 Q. I may be struggling to find a downside that may not exist, but I suppose the broader question is: Given its success and cost-effective patient risk reduction, better outcomes for patients, less revolving door, I presume, for patients being re-admitted, which is a big factor, did managers sit down with you and others and say "This model works -- how can we adopt this for other specialties and other parts of urology itself?"? 11:02 11:03

A. Not that conversation, no.

55 Q. When you talk about 2019 and saying, just to go back slightly, the waiting list not insurmountable, you have come in at that time, I suppose, with fresh eyes.

Other consultants were already in post. Did you think that your opinion that it was not insurmountable was informed by the fact that you were coming and knew again, or did you just simply walk in and these conversations were already ongoing of "This is not insurmountable, we can catch up"?

A. It's hard to think back to say whether the conversation was already ongoing. I suspect they may -- I honestly couldn't reliably comment on were they already ongoing.

56 Q. Well, some of the suggestions that you've made about what could have been done about resource and allocation, for example, were they conversations that were happening when you arrived or did you introduce some of these ideas as potential remedies? 11:03

A. Well, certainly the stone conversation, I had had prior with Mr. Young and he also helped oversee it. Mr. Haynes was very helpful in that, in helping out in how we redevelop this as well. But beyond the rest of it, other parts beyond my control, no. I mean, I'm very much, I'm a complex stone surgeon, so, from my aspect of the service, I can comment reliably on that part, but I would struggle at this point to comment reliably on those other parts in 2019. 11:04

57 Q. I suppose, the question is aimed more at whether there was a collective discussion among consultants around a strategy to try and address what, at that point, were already perhaps high and rising waiting lists; was there a sense that people were chatting about this, whatever their specialty, and saying "We can get on top 11:04

of this if we do X, Y and Z" -- do you have any recollection of those conversations?

A. Only as regards the advanced triage perspective and how we don't bring all patients back to follow-up reviews. Mr. Haynes was a big champion upon making sure that patients who could have their follow-up virtually as regards their results or their ongoing follow-up for any particular reason, that we did that in a virtual way. So, from that perspective, I can remember from that department... 11:05

58 Q. Now, you have mentioned that you felt very -- felt supported during your time in Craigavon at WIT-42214. And this is when you went back as -- and you have already said as a registrar you felt supported, but this is when you went back as a consultant, 46.1. We have asked you about support, and you said: 11:05

"I did feel supported. Mr. Young was an excellent mentor and, starting as a new consultant in February 24th 2019, he was also either at hand or a telephone away for how any part of the service functioned or any questions a new consultant may have. Martina Corrigan, as Head of Service, had an open door policy, making the team feel supported, and I believe was championing the need to reduce the Trust waiting times, especially for routine urology services." 11:06 11:06

So when you came back as a consultant, you felt that there was a safety net, as such, for you in this new

post?

A. Yes, it's one of the reasons I decided to take the job. It's the people, if you look, who you're going to work with -- will they see how you want to develop as a surgeon and will they support your strategy or the way you wish to move forward, and that's one of the reasons why I took the job in the Trust. 11:06

59 Q. I had referred earlier on to the cancer nurses and I don't think you were particularly involved in that role; the CNS wasn't something that you had particular involvement with? 11:07

A. So, the CNS I had particular involvement with from October 2021, and that was only from a period of time when I came back -- because of the low consultant numbers, I was involved in the MDM up until July 2023 to help out. So, from that perspective, I then did see cancer patients and the CNS then is a vital role, who I always insisted to be present at the clinic appointments, as they are the point of contact for those patients. 11:07 11:08

60 Q. And did you always find that the capacity to have a CNS available for you was met? Were the numbers good?

A. There were only a couple of times when there was no CNS present, and that was either because they were away doing another role, potentially, or one time someone was unwell. So, at that point, it's very important that I copy them into the correspondence of the letter from the appointment, and also provided the patient with their contact details and I asked the CNS to 11:08

contact that patient following the appointment.

61 Q. You've mentioned MDMs as well. It wasn't something that was routinely part -- I think you had the stone meeting, rather than MDM on a weekly basis?

A. Yes. 11:08

62 Q. But you did attend some MDMs. What was the time period again for --

A. From the end, say, October 2021 until July 2023.

63 Q. And what was your view of, when you were attending MDMs, what was your view of the issue around attendance 11:08 of both consultant urologists and other specialties?

A. The majority of the time, very good, but there were times when a meeting would have to be potentially cancelled if there was not enough consultant urologists present. Or, at times, if there was no Radiology 11:09 support, then any decisions for Radiology or scans to be reviewed, we then had to roll those patients over -- and in incredibly rare instance if there was no pathologist or oncologist present. But the times I was there, I would say it wasn't the majority of the time; 11:09 it was very much the minority, but it still did occur.

64 Q. And when you say roll patients over, was that the delay to the next meeting for discussion?

A. That was delay to the next meeting, yes.

65 Q. And they were usually picked up at that meeting -- 11:09 would that have been your experience, that there wasn't a further delay by the absence of quoracy over a longer period?

A. No.

66 Q. I wonder if we could scroll down to paragraph 68.1? Sorry, I don't have the correct reference. We have asked you at paragraph -- Question 68:

"What do you consider the learning to have been from a governance perspective regarding the issues of concern within Urology Services?"

And you have already told us you had no concerns around any of the consultants, but this is your answer to that -- you say: 11:10

"Learning as to the administrative and governance processes, I note these have been looked into and the process made more robust in relation to a referral and recording of cancer MDM. I note a new role has been created for cancer MDT administrator to focus on audit of MDT outcomes, which should identify any deviation from agreed actions for patients." 11:11

Now, just in relation to that issue about deviation from agreed actions following MDMs, was it ever your experience that that was something that happened, that there was a deviation?

A. No, not until I have read the Urology Inquiry documentation. 11:11

67 Q. And in your experience of MDM attendance both during that particular period -- I know it's late on in our time, in our timeline, but what was the process or what

did you understand to be the process or proper procedure, if there was to be a deviation from a previously agreed MDM proposed plan?

A. Well, it's paramount that if anyone deviates from a plan that's been discussed amongst a large group of experts, that that should be represented. You can't single-mindedly go off on a deviation from it. And so I would expect anyone who had then subsequently seen a patient who then the plan could potentially change, to represent that patient. 11:12

68 Q. So, for example, if an agreed plan was a certain form of treatment and the clinician then subsequently performed some tests and they came back that may have changed his view as to the appropriateness of that treatment, rather than just then make that decision, is it the expectation currently, or has it always been in your mind, that that should come back to the MDM for discussion? 11:12

A. It should have come back to the MDM for discussion and that's the way I would view it from an obvious standpoint of you've gone to a meeting to make a plan, you've gone away, something's changed -- well, you bring it back. 11:12

69 Q. And within that context, is it your view that the MDM plan is a proposed one, based on what is presented at the meeting at that point, but that it should always come back for collective endorsement? 11:13

A. If the plan is going to change beyond the proposed treatment or plan to something completely different,

then it has to be re-presented.

70 Q. Is there any -- is there another perspective on that, that the MDM is a recommendation that the clinician then discusses with the patient and, together, they then decide what the best outcome is, given the patient's views? 11:13

A. Completely. So it's patient-centred care and we can only do recommendations to patients. But if a patient or a clinician then decide to go along a completely different path, it needs to be brought back because the reason being is if the patient decides on a different route, is there an alternative option which may even be better or enhanced, even if they don't want to go a recommendation. So it's not about just accepting "Okay, that's fine, go that way" -- it's about bringing back and going "Well, they want to do this -- what does everyone think? They want to do it, fine, but can we recommend anything else as well?". So it's the ability to bring back to discuss for the benefit of that patient. But, fundamentally, it's the patient's decision. 11:14 11:14

71 Q. So it's drawing on the expertise of the other members of the MDM. So, for example, if a patient doesn't want a proposed form of treatment because of side effects and that's brought back, an oncologist may say "Well, actually, here's another option -- if that's the worry for the patient, this may negate that worry" -- is that an example of what you're saying would be the benefit? 11:14

A. Completely.

72 Q. If a patient refuses all treatment that is being offered or suggested or recommended by the MDM, would that be something that you would anticipate being brought back for discussion or is that something the clinician can give consent about at the appointment with the patient and leave that as it is? 11:15

A. It would vary upon a case-by-case basis, potentially, but the majority of the examples would probably be that you should bring the patient back to document for the meeting that the patient has decided upon this form so everyone is aware. And, again, it's: Does that patient require further consult, even with a different specialty? So once again, if they wish to decline and go along that route, I personally would still bring them back to notify in case anyone else would be of benefit in seeing that patient -- because it may not just be a urologist; it may be an oncologist, it may be somebody else. 11:15

73 Q. So the MDM presents a potential for an ongoing conversation about patient care? 11:16

A. Yeah, and which direction that patient, who may have decided to do something else, may wish to go into. So it may be to bring you back to present to the radiologists, the clinical oncologists, the medical oncologists, the palliative team. 11:16

74 Q. I had asked you about CNS nurses and I know your experience of that is very limited, and I think your knowledge of any concerns around that is from what you have read about the Inquiry, rather than any of your

own experience, is that right?

A. That's right, yes, yes.

75 Q. There is an e-mail where you've asked for one of the nurses to take on more responsibility. It's non-contentious, but it's an example of you seeking to 11:16
expand the capacity and the, I suppose, turnover for other members of staff. And if we look at that at WIT-33371 -- and the nurse in question is Jason Young. This is an e-mail from you to Wendy Clayton at 4th May 2022, so fairly recently, and you have copied in -- and 11:17
I just want to use this as an example of you suggesting a way in which very highly qualified nurses, which seemed to have been the case for urology nurses in Craigavon, may be utilised in another way where you have made a suggestion, and I just want to explore 11:17
where that may have ended up. You say:

"Hi,

I have spoken to Jason, who is keen to increase his 11:17
role in the stone side of the team. I would propose he does a session each morning and we will set up a pathway re:

1. Ureteric stones for the conservative management 11:17
route. This would allow us to be more towards the NICE and EAU Guidelines, in having patients' renal function checked, as well as calcium and urine as already done, as well as we could book the follow-up imaging and

discharge if suitable and stone passed along with prevention advice for suitable patients.

2. To include the follow-up at present to ensure ureteric stents taken out at home by patients. In the long run, this should be a more automated approach. 11:18

3. Follow-up of long-term not highest risk patients, they should come to me - cystine spinal single kidneys, abnormal or altered anatomy etc - and short-term with view of discharge if stable stone formers, including small, unchanged stones, discharged with advice. 11:18

Would be great if Jason had an ECR account to book this high volume of work under that myself, or myself or John, in our name, that we could provide oversight to that is separate from all our other results so I don't end up doing the work for Jason when I sign all the results off. I would like to make a website pathway for the regional ESWL referral only from Urology teams in the region for direct booking onto the service and then managed by the Radiology team. 11:18 11:19

The ESWL service, I am very keen to have day-to-day running by Radiology and, given our regional service, a Band 8 for the centre would be suitable, given it would be the Northern Irish ESWL centre at this point. 11:19

This would then also include the ED teams in the region

for referral to stone MDM as per Girft report pathway, and then a more robust pathway, as the paper form means some are not filled out fully. A meeting with IT would be great.

Thanks,
Matt."

There's a lot of detail in that, but I wanted to bring that to the Panel's attention as an indication of could I call that proactive, pre-emptive management of workload? 11:19

A. Yes.

76 Q. And appropriately focused delegation, perhaps, to allow you to focus on the patients that need your attention and allow both the clinical and administrative issues around other patients to be dealt with by, in this case, Mr. Young, Jason young? 11:20

A. Jason Young.

77 Q. Yeah. Now, it seems that this is a very focused e-mail to streamline both the service and the use of staff more appropriately, and we will see the reply of Wendy Clayton just above at the blue text at the top. She then on 4th May 2022, after this e-mail, sends to Mark Haynes: 11:20

"Mark,

Can we discuss at our next one-to-one meeting please?"

I am just wondering if there was an update on that, if there was any outcome of those suggestions or what happened next?

A. Okay, it's probably best if I take them one by one then because there's a lot in the e-mail. So the first one regarding Jason Young -- so, it's the ability of a service to divide care to the most suitable clinician. So Jason Young, as a nurse specialist, his role, part of his role for a stone team is the conservative management of the low risk ureteric stones to ensure those patients have their imaging organised at the right point. 11:21 11:21

But the main point of this was renal functions and that's why I refer to the guidelines -- is if you have a ureteric stone, you should have a periodic renal function checked to ensure it's not declining when you're in a conservative route. So that then was actioned and Jason took up that role. So the outcome of that was Jason took up that role. 11:21 11:22

Number 2, "To include follow-up at present to ensure ureteric stents are taken out at home." So I am an advocate of not putting in stents unless really required and, if they are put in, can these be taken out by the patient at home with a stent on a string? So for the majority of times when I was doing ureteroscopy in laser cases in, say, Daisy Hill or 11:22

Lagan Valley, if suitable, which is the majority of patients, if they required a stent, it goes on a string and an information leaflet to patients to say how you take that stent out at home. And then the follow-up of that is Jason Young -- also his role would telephone the patient to ensure that stent has been removed -- from a perspective to document, it's been removed, so we don't end up with stents in for long periods of time. There should be a more automated approach. It's can we develop -- we're in 2023 -- is there a better way to show that a patient has removed the stent? Could they take a picture and send it on an app to say "This is my stent, I've taken it out", rather than Jason Young phoning them up. It's saying we need to move and look towards the fact we're in 2023. That's still a project in development, because we don't have the resources to undertake that technology move, which would free up Jason from having to call someone.

11:22
11:23
11:23

Number 3, "Follow-Up of long-term..." -- so this is once again me saying, as a complex stone surgeon, you want me to see the toughest cases, the patients who are going to come to harm from recurrent stones, and it's trying to show that in splitting the work into the right silo to see the right person, I can concentrate on making sure that the highest risk people, I see, and my time then is looking at the real complex cases. And this then develops into what's then known as a complex stone unit and that's how, in Northern Ireland, we're

11:23
11:23

moving to a complex stone unit model where there will be in the Southern Trust -- and hopefully from the start of some time in 2024 we will move to that model. And that's in negotiation with the Civil Service, with David McCormack from the regional meetings each month, that we have developed that model. So that's looking to the future to say: How do we as an entire region have equity for Northern Ireland? So that's number 3. 11:24

The next paragraph then is the Jason to take responsibility for the work he does -- so to make sure he signs off to say "I've signed off those renal function tests -- they're abnormal", or to say "Hang on a minute, they're abnormal, I'd better bring it to the attention of the consultant." 11:24 11:25

The following paragraph then is regional ESWL. So Northern Ireland now has a regional ESWL centre, which started a few months ago, and that's, once again, me looking at how is the day-to-day management of a regional service best delivered. Yes, I have oversight and I have helped to develop the actual centre and I'm available, but the day-to-day running has to be the up-skilling of the staff who will provide those treatments -- in this case, it's the radiographers -- and up-skilling of them and them having oversight to a service which they are predominantly delivering the treatment, whereas urology obviously books to the ESWL service and we have 11:25 11:25

oversight of it and we do run it, but it's in combination with Radiology as well, with the radiographers. So that's me stating that we need a proper remuneration to a radiographer to run a regional service, so it works. 11:26

78 Q. And was it a mixed success in some of the suggestions or was -- what was the outcome of your suggestions?

A. So to run through them again -- number 1, I still have advocated there needs to be at least two nurse specialists for stones to successfully run the volume of patients that come through it. We currently don't have a full-time nurse specialist for that role. Jason's time is also split into the lower urinary tract symptom clinic as well. So for the model which I would propose for the safety and the efficacy and the governance and the best model for patients, you need two stone nurses for that service. So that's something which I've advocated and I think the service needs, but we don't have two at present. 11:26 11:27

To number 2, I know my colleagues have all moved more towards putting stents on strings. The automated approach is something which, until we can be provided with the correct technology to achieve that or resources to undertake that, that won't happen. 11:27 11:27

Number 3, my clinics are mainly made up of the highest risk patients, but that's based on also the fact that I need to see the highest risk patients because they

are more likely to come to harm.

And then the regional centre, as I said, is now a regional centre and it's probably also important to note, because the team worked hard on that, that they -- that we have been awarded, for the quality improvement and the process we've put in place, an award from the Civil Service for -- and the Department of Health for setting up the regional centre and the model which we created. 11:28

79 Q. So, in general terms, it's a mixed bag of results. Some of the things you've suggested are pragmatic and practical and achievable in the short term. Some are more long-term and some are visionary in some respects of what, hopefully, will happen in the long-term? 11:28

A. Yeah, but I will say the staffing issue is achievable. You just have to staff the unit properly. You need two nurse specialists. We don't have two nurse specialists.

80 Q. And did anyone meet with you after this e-mail? Did Mark Haynes come and speak to you or Wendy Clayton or was there a follow-up meeting about some of the suggestions? What does the suggestions around improved governance actually look like at your level? What happens after this e-mail? 11:28 11:29

A. So following on from this e-mail, I met regularly with Mark Haynes and Wendy. Mark Haynes and Wendy Clayton have been very big advocates and supporters of this model, and it's -- without their help and without their

knowing who the stakeholders are in order for this to be achieved, without them then it would me be having conversations with myself.

MS. McMAHON: Chair, I wonder if that would be a convenient time to take a break? 11:29

CHAIR: It's now half past eleven. We will come back at quarter to 12.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED, AS FOLLOWS: 11:36

CHAIR: Thank you, everyone.

81 Q. MS. McMAHON: Mr. Tyson, I just want to go back to your addendum statement. I said I would come back to it and I just want to go into it at this point and read some of it into the record. It's at WIT-104212. And I just want to read the first five paragraphs. You start at paragraph 1: 11:47

"I commenced my employment as a consultant with the Southern Trust on Monday, 25th February 2019, and not Sunday, 24th February 2019." 11:47

And then you give us a list of paragraphs that require amendments. At paragraph 2, you say: 11:48

"At paragraph 14.2, WIT-42202, I have stated 'Low staffing, however, from a nursing and doctor perspective leads to a tied and stressed workforce and increases the probability of things going wrong from

a clinical perspective'..."

-- and you've told us that there's just an error in typo -- it should be "tired". At paragraph 3, you say:

11:48

"At paragraph 66.3, at WIT-42222, I have stated 'I have been made aware that there was administrative issues of triage not being returned in a timely manner and that the administration team now ensures that they have accounted for all referrals and that the triaging doctor returns the outcomes in a timely manner.'
This should state 'I have been made aware that there were administrative issues of triage not being returned in a timely manner not related to myself and that the administration team now ensures they have accounted for all referrals and that the triaging doctor returns the outcomes in a timely manner.'"

11:48

11:49

You've given evidence on that as well.

You say at paragraph 4:

11:49

"Upon review of my witness disclosure bundle, I have noted at WIT-13114 that Mr. Carroll has stated that I was the Standards and Guidelines lead. In relation to this reference by Ronan Carroll, I would say as follows: I was the Standards and Guidelines lead for benign urology. The cancer-related guidelines were incorporated into the roles of Mr. Glackin and

11:49

Mr. Haynes for their specialist roles with Cancer Services and the cancer MDM. I undertook my role from 24th October 2021 until July 2023. The role was for mainly urology stone-related guidelines, to help transform the stone pathways for the SHSCT and development of regional ESWL stone service." 11:50

Just stopping there, in relation to that role, Standards and Guidelines, you've mentioned that in your e-mail about NICE and the EAU Guidelines as well, and you are clarifying at this paragraph that it was for non-cancer in relation to your development of the stone service? 11:50

A. Yes.

82 Q. At paragraph 5, you say: 11:50

"Upon review of my attendance record for MDMs from January 2022 until May 2022, WIT-24251, I would make the following comment: Attendance at MDM was affected by annual leave, birth of my son, occasional elective theatre lists, and a possible virtual attendance episode not recorded. I am no longer part of the cancer MDM due to my subspecialist role and development of regional stone services." 11:50

11:51

Now, before we move on to paragraph 6, I just want to take the Panel to two pieces of documentation, to give them context for this. The first one could be found at PAT-001698. And for the purposes of the cipher list,

it refers to Patient 82. This is an operation note. We'll see the hospital, Craigavon, and the operation performed. Is that your writing?

A. No.

83 Q. No. You didn't fill in the operation note? 11:51

A. No.

84 Q. Who fills that in?

A. Well, this is a -- I am a registrar here, as a first year registrar -- this is Aidan O'Brien doing the operation note. He is my supervisor, I am the trainee. 11:52 I am performing this procedure, which is injection of botulinum toxin into a patient's bladder who has urodynamic proven detrusor overactivity.

85 Q. Thank you for filling that background in -- it saves me trying to struggle with the pronunciation and the 11:52 writing! But the date on this is 29/5/2013, so it's during your registrar time. The surgeon is down as Matthew Tyson, as you've said you've performed that. And if we just go to the bottom of the operation note, we will see the -- Mr. O'Brien has signed as a surgeon. 11:52 Is that because of the supervisory nature? Is that the process? Just so we understand the process, you were doing this under supervision?

A. So, on the top left-hand side of the page, it's my name is the operating surgeon. Aidan O'Brien has signed it 11:52 as the signature of writing the operation note.

86 Q. And just for completeness, the other piece of documentation that's going to be referred to when I read out the section of Mr. Tyson's addendum

statement is at PAT-001769. And if we go to PAT-001769, so this is a discharge letter. Consultant Urologist at the top, Mr. O'Brien, and the GP's name. All of the information has been redacted. We can see it's Patient 82. The date of admission was 29th May 2013, which we saw on the previous letter. And the procedure, which you've just explained, is marked in the table of details. So the body of the letter says: 11:54

"Patient 82 11:54

Above operation was undertaken in the day surgery unit and he was discharged home the same day. I know the gentleman has a background history of detrusor muscle overactivity, as well as prostatic carcinoma. I know 11:54
the gentleman is on an antigen blockade and I believe he currently takes bicalutamide 50 mg once a day and tamoxifen 10 mg daily. I note his latest PSA is 0.14 ng/ml on 1st March 2013. He appears to have this well-controlled since 2011. 11:54

Many thanks.
Yours sincerely..."

-- and then your name is typed in as "Mr. Matthew Tyson, Urology Registrar to Mr. Aidan O'Brien, Consultant Urologist." 11:55 And if we just move down again, please, and we'll see the date that's dictated is 23rd June 2013, and typed two days later on 25th June, just

a month since the date of the procedure which was carried out on 29th May 2013.

Now, they are the operation notes and the discharge letter as background, and then I will read paragraph 6 of your addendum statement -- and we have provided you with this information, and you say at paragraph 6: 11:55

"Upon review of Patient 82's notes and records and specifically the discharge letter at PAT..." -- 11:55

CHAIR: Sorry to interrupt, but can we just have that up on the screen then again, please?

MS. McMAHON: My apologies. It's WIT-104213.

CHAIR: Thank you. 11:56

87 Q. MS. McMAHON: Apologies, Chair. Paragraph 6. So, you say:

"Upon review of Patient 82's notes and records and specifically the discharge letter at PAT-001769, 11:56
I would like to make the following comments:

I was involved in this case from the perspective of a first year urology trainee in 2013, undertaking a supervised injection of intravesical botox into the 11:56
bladder for treatment of bladder storage symptoms under Mr. O'Brien. I note a written discharge from Mr. O'Brien was provided to the patient and GP upon discharge from the procedure.

A further dictated discharge was provided by myself for the procedure as a typed letter. My typed letter states 'I note the patient to be on 50 mgs of bicalutamide and tamoxifen', which will be from reading the paper discharge summary. My role was to provide a discharge summary for the procedure of intravesical botox to the bladder undertaken as a first year urology trainee. The perceived delay in dictation may relate to the time it took the notes to arrive to Mr. O'Brien's secretary's office for dictation, possible annual leave, on call commitment, or the date dictated recorded on the letter may also be inaccurate. This was done at the time on a tape-recorded dictaphone and it was the role of the registrar to provide dictated discharge letters for inpatient activity, both acute and elective admissions. 11:57 11:57

Current practice is for a dictated discharge to be undertaken immediately following operation, most commonly by the Consultant Urologist via digital dictation software. Further inpatient discharge is generated by the foundation doctor, but with oversight of the Urology team." 11:57 11:58

And I will just finish the extract from your addendum -- your final paragraph says:

"Finally, I would like to state that I handed in my notice on 25th October 2023 due to my wife needing to relocate for work and, thus, for family reasons, I will be leaving my employment at the Southern Trust on 18th January 2023." 11:58

So if we just go back to the Patient 82, the reference to that, just generally in relation to Bicalutamide 50, which is, as you know, the reason for bringing you to these documents, is that something that you prescribe as a clinician? 11:58

A. No.

88 Q. Have you ever --

A. Not as a monotherapy.

89 Q. Have you prescribed it in other forms? 11:58

A. To prevent a tumour flare, I would prescribe it in instigating an LHRH agonist for 28 days.

90 Q. So as a combined therapy?

A. As a combined therapy, for a short duration of time.

91 Q. And do you prescribe Bicalutamide 150 as part of your practice at all? 11:59

A. Not in my practice, no.

92 Q. Are there any circumstances in which you would prescribe Bicalutamide 50 as a monotherapy?

A. No. 11:59

93 Q. Just generally in relation to the prescription of medication in a way that is not as per the licence purpose for both the dose and the drug, have you ever had to step off licence in your own practice in order

to accommodate the certain presentation of a patient and prescribe something that's not strictly on licence?

A. Well, strictly speaking, tamsulosin does not have a licence for stone-related -- for ureteric stones. And in urology practice, we have moved away from everyone having a prescription potentially of tamsulosin for ureteric stone. It's not a licensed indication per se. It is recognised in the literature that there are certain events, such as distal ureteric stones or post ESWEL, that may be of benefit, so from that relation we have at times prescribed tamsulosin. As part of the stone meeting, though, we do not prescribe tamsulosin, as we are not seeing the patient face-to-face and, therefore, we do not prescribe it. 12:00

94 Q. So, if you are seeing the patient face-to-face and they fit the profile by which an off licence or a literature-supported prescription may be appropriate, what's the procedure with the patient? How do you manage that? Do you explain to them or what way do you get consent -- how does that operate in practice? 12:00 12:01

A. You would explain that the drug itself is not a licensed indication, but for stones it's -- I, personally, don't use it at present, but you should inform the patient that it's not a licensed indication and you should explain the side effect profile; you should explain the evidence behind why you're using that drug and you offer it to the patient -- and it's an offering the patient the drug, not -- it's always offering a patient a drug, it's not saying "You must be 12:01

on this." It's the pros and cons to say why you may have put a patient on that medication for a short period of time and not a lifelong indication.

95 Q. And would you record that in the patient notes or somewhere else? 12:02

A. We would record why we have put that patient on tamsulosin and had the discussion with them.

96 Q. And would that be information that you would provide to -- in the GP's letter or discharge letter or review letter? Would you go into that sort of detail or would 12:02 that not be a normal practice?

A. It would be normal practice if someone is being discharged on tamsulosin for a stone-related event to be on their discharge, yes.

97 Q. And the explanation for that prescription on the 12:02 discharge letter or not?

A. Well, the tamsulosin should be defined for a short period of time. So if you are passing a stone, traditionally people put patients on tamsulosin for a four-week period, so it will be a short prescription. 12:02

98 Q. Now, the Panel have seen and we will just go back to the discharge letter, PAT-00176 -- PAT-00176. Is that right? 1769, sorry. The Panel will have seen that the discharge letter mentions Bicalutamide 50 mg. Now, you have said in your addendum statement that you would 12:03 have taken this information from the patient's file, and that would have been information that was recorded by the consultant -- in this case, Mr. O'Brien. Just so we understand the procedure by which the registrar

does the discharge letter, in your own practice at the moment, do registrars do your discharge letters?

A. Not per se discharge letters, so -- it's probably easier just to explain from start to finish. So the patient comes in for an elective or emergency operation -- every patient who is operated on, either by myself or by the registrar on call or someone who I am training, everyone has a dictated letter, and that forms part of their discharge, and that has to be undertaken immediately following the procedure -- and that's why we have digital dictation software and I am insistent upon those letters being done. My backup for that is my secretary, who, when patients who have been operated on and discharged in our name, they will tell me if someone hasn't had a letter done -- and there have been a few rare instances where a letter hasn't been done and so I have then chased up the fact that a letter has not been dictated. 12:04 12:04 12:04

From the perspective of then the patient who is then on a ward, they then have a letter which is a digital -- not a digital dictation letter, but a digital discharge summary which is provided by and typed by the FY1. But the information which the FY1 gets is from the team seeing the patient and explaining "This is what the discharge plan will be." 12:05 12:05

If the case requires and if I am on call or there is a case of certain complexity that requires then

a further letter, I will also dictate a letter so that I'm very clear that this has been undertaken in the right manner, or especially if there is a referral to another specialty, or certainly another region.

99 Q. Would it ever be the case that a registrar would question the details on the patient's notes that were to find their way into a discharge letter? Has it ever been the case either you as a registrar or having registrars would say " Can I query this with you? I am not sure about the detail I am putting in here."? 12:05 12:06

A. Yes, so, if the registrar is unsure what the discharge follow-up plan is, they ask me and I inform them what I say -- what I think it should be. And I also, if I come across a discharge plan that has been typed wrongly, I send it to the doctor who has typed that to have it amended. 12:06

100 Q. The Inquiry has heard from a relative from Patient 82 in evidence and, if we go to TRA-01869, and this is just an extract from that in relation to this letter. Now, the Chair has asked the question at line 21 about the individual circumstances of the patient and the patient's relative refers to bicalutamide. It's artificial reading from a transcript to give you the sense, but the point is in the next paragraph -- this is just the preceding paragraph: 12:07 12:07

"In terms of the Bicalutamide, you know, somebody has mentioned a -- just to I get all this terminology -- a pathway, a clinical -- a standard for clinical

practice."

And the Chair says:

"Sorry, you are reading from a document there?" 12:07

And she said:

"No, it's my own words."

12:07

And she then says:

"It refers to standard clinical practice for Daddy's management, so I presume that's something that's written down that doctors are meant to follow. I would 12:07 have expected..."

-- and she mentions another doctor and you.

"...and Mr. O'Brien to have known that. Yet, 12:07 [the other doctor] and Mr. Tyson seen Daddy's medication and never queried why he was on a low dose of Bicalutamide."

And this is the letter that she's referring to. 12:08

Now, whenever you were a registrar, were you aware of the use of Bicalutamide 50 at all or in certain circumstances?

A. No. But I clearly have done a discharge documenting it!

101 Q. Yes, yes, and it's really just to unpick the procedure around that. The Inquiry is looking at governance and perhaps how things get repeated or where there may be 12:08
fault lines that could inform any of their recommendations. So it's just to see the way in which the procedure operated for the family we have raised this as an issue as well, obviously, and we just want to just understand. So from what you've said so far, 12:08
you look at the patient's notes and you dictate the discharge letter based on the notes and is it the case that, in your position as a registrar and your knowledge at the time, that there was nothing to trigger a query from you around Bicalutamide 50 being 12:09
prescribed as it was in this letter?

A. There was nothing at the time, as a first year registrar, for me to suddenly go "There's a pattern, there's something going on." It's a first year registrar doing a discharge for someone who has come in 12:09
to have intravesical botox to the bladder, reading the paper, discharge summary of medication, and then also then moving on to the next summary of discharge, because our role at that point was to discharge -- to do dictated letters on all the inpatient activity. So 12:09
I am sat there with lots of notes, going "Right, next one...". so I'm now looking at the function of that interaction, which was to come in and have botox in the bladder, and noting they are on medication and

follow-up with Mr. O'Brien.

102 Q. And we noted that the dates of the letter, the dictation and the date of the procedure was roughly a month apart. Was that normal procedure, that there could be a delay? I know in your statement you've, if I can say, you've made some guesses as to why there may have been delay but there's no other evidence to support any of that. And I know that you were on annual leave for a week and study leave for a week in June and it may have just been sitting there -- we don't know the background. But just as a general question, did you think that there was an issue around delay and dictation? Was it something you noticed? It does seem, at this remove, to be quite a long time after the procedure. 12:10

A. Without reviewing all -- without reviewing the year and looking to see what the average time of dictation was for in the procedure, I wouldn't be able to give you a reliable answer to that. But what I would say is -- I'd say two things -- I'd say the first thing is all patients had a discharge upon leaving hospital, which was the paper discharge, and there is a paper discharge which Aidan O'Brien has undertaken for this patient from that inpatient episode. The second thing is at the time, there were two registrars, myself and one other person, and it was a very, very busy job, and our time to do discharges, we mainly did these when we were on call. So, there may well be a difference between the patient coming in and then patient having

a dictated letter. But between the two of us, we were fulfilling the roles of on-call clinics, theatre, and then discharges to dictate -- and, of course it's a very busy unit so there are lots of discharges for between the two of us to then sit and dictate. And, also, we're reliant upon a set of notes to physically arrive from where they prior were to the office to where we would then have to dictate, and there was likely a delay potentially in that as well, but also in the time which we could go and sit down and potentially do them. 12:11 12:12

103 Q. And what was your experience of what that was like for other registrars when you went back as a consultant in 2019 and 2021? Did you think, well, this system has improved, or is it the same -- does it still operate the same way now? 12:12

A. No, so it operates differently now and that's why the patient leaves with the electronic discharge summary, which is printed out for them, copied to the GP and put onto the Electronic Care Records for Northern Ireland. So that's where it has improved. There is an immediate visible discharge and it's online. So that bit's improved. I can only speak from my practice and certainly my colleagues there at present who dictate letters after procedures, which is the correct thing -- even if I'm on call and it's late at night, that patient will have a dictated letter from me encountered from theatre. 12:12 12:13

104 Q. And is that your own practice or is that something that

is a standard throughout the Trust or throughout urology in Craigavon at the moment? Do you understand the way other people do it?

A. That's the way I believe my current colleagues all work. But to apply the word "standard" and "policy", I am not aware of any standard or policy for the Trust that states that must be done in that way. 12:13

105 Q. I think we've covered the issue that you felt there was sufficient lines of access and support when you were there, was in 2019, and as a registrar should you have any concerns, and you have referenced in your statement that you felt that there was an assurance around risk by the availability of those systems in place, such as Datix that you've mentioned? 12:14

A. Yes. 12:14

106 Q. I just want to go to your statement again just to look at the learnings, some of the issues that you've provided us with some of your comments on -- WIT-42222, paragraph 66.2, and I just want to read this in. We have asked you: 12:14

"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." 12:15

And you say:

"I was a consultant between 24th February 2019 and 16th July 2019, including annual leave. I restarted working for the Trust on 24th October 2021. I am now aware of the following governance concerns:

I have been made aware that there was administrative issues of triage not being returned in a timely manner and that the administration team now ensures that they have accounted for all referrals and that the triaging doctor returns the outcomes in a timely manner. I had no triage concerns during 24th February 2019 to 16th July 2019, as my triage was always undertaken and returned during the on-call week."

Just stopping there for a moment, in relation to triage as it currently is -- I know we've have confined it to 2019 -- currently, what's the position regarding triage? Is that something that is manageable and managed by the consultants at the moment?

A. Well, we did advance triage in 2019. It's no longer completely advance triage now. But, yes, I still fulfil all the triage would be in the on-call week.

107 Q. And when you say it's not advanced triage now, has the system changed again somewhat since 2019?

A. It has, yes. So we used to do advance triage for a lot of the patients, especially the red flags and the urgents, and even just for some routines to try and prevent them from having an appointment if they're not

required. Given, however, there is very much a lack of consultants and the backlog, in doing advance triage at current, what that then does is if you have a hundred patients to triage and say you do a hundred scans, when are you physically going to follow those up? It's not physically possible, at present, to do advance triage in the way we used to do it.

108 Q. And that's because of the numbers, the staffing numbers?

A. That's due to staffing, yes. 12:17

109 Q. Then you say at 66.4:

"The significant waiting times, Outpatient and Surgery, for Urology, from becoming aware that the Trust had long waiting list times for Outpatient routine appointments and routine surgery as of 24th February 2019 to 16th July 2019 as a consultant, which were known to management team and the Urology Department, I have been since informed this was indeed on the Risk Register in 2019 from discussions with Mr. Young in May 2022, and the number of patients awaiting surgery and Outpatient appointments greater than I would have expected."

So in relation to the waiting times, Outpatient and Surgery For Urology, you've mentioned about 2019 again, that period. In your return in 2021, I know you mentioned it was the tail-end of Covid, but what's the position now?

A. Well, from a -- well, from a stone perspective, much, much better.

110 Q. And do you have any knowledge of any other perspective?

A. For the routines, it has improved because of the outsourcing to the private sector. But, overall, there are still very considerable waiting times for, I would say, the majority of procedures. 12:18

111 Q. And again we mentioned the staffing issue just a moment ago -- would it be your view that the staffing is the major contributor, the sole factor, or are there other areas that you see could have been improved that might assist the Inquiry's considerations? 12:19

A. The predominant issue is a resource and staffing perspective. During the Covid period, there clearly wasn't enough theatre and capacity to keep on trying to decimate what was long lists and, therefore, you have a result of waiting lists going up exponentially, in a way. And therefore, when I returned, I have come back to very long considerable lists of patients who potentially haven't had operations for years. 12:19 12:19

So the access to a theatre and then a surgeon to undertake it, if it hasn't been going on for a period of time, you are going to have a huge backlog. And then you'd have a period of time whereby you are overrunning everything to get rid of the backlog, but it is a considerable backlog to undertake. So an example would be the PCNLs for the complex stones, in the past two years we've undertaken or I've undertaken 12:19

predominantly a huge number of those surgeries, including extra weekends, operating on Saturdays and Sundays, and extra lists to reduce that list considerably, but it's only by over-working can you decimate what is a backlog. 12:20

112 Q. And the availability of those weekend slots to try and catch up, is that something that's regularly provided or is it on an ad hoc basis when the staff can manage to fulfil those roles at the weekend?

A. So it's predominantly on ad hoc basis when there is funding and provision for that to undergo. So I offered myself to do those weekends, but there is limited number of theatre nurses (a) to undertake those extra weekends. So I can offer up weekends and then I'm given a certain number and then we undertake them, 12:21 but it's not something which I found that every weekend you could just go and work and try and reduce these lists.

Then the other thing is I offer extended days too, so 12:21 my Wednesday operating list, can I work and put a third case on in the evening -- so we're trying to find nurses for the next few months to try and extend the day of the operating. So instead of being from 9:00 to 5:00, can we go from 9:00 to 8:00 and add an extra 12:21 complex case upon them?

113 Q. At paragraph 66.5, you said:

"I have been informed of the recommendations from a

department meeting from 31st March 2022 - I could not attend meeting due to clinical commitments - referring to SAI recommendations MDT action plan."

And then you say at 66.6: 12:21

"66.6. Wendy Clayton, Urology Manager, has provided assurance that any urology governance concerns are now discussed at Head of Service meetings.

12:22

66.7. The Head of Service, Wendy Clayton, now provides a weekly update to the Urology team on a Thursday at 12:15 each week, providing any Urology Inquiry updates, team performance and including waiting list times and initiative work to external providers. Vacant urology 12:22 consultant posts x 2 impacting on the delivery of urology waiting lists."

So you've mentioned the staffing previously, but that seems to be a slight change in the weekly updated 12:22 Urology team meetings on a Thursday; is that a generally, if I could describe it, as an open forum for people to discuss any issues arising or of concern or potential concern?

A. It is. And the other thing to note is it's changed 12:23 from a weekly to a monthly meeting, and that's to ensure that everyone can attend and be present, rather than having people missing from a meeting and then decisions being made where people need to be present to

hear what's going on. So it's important to have a meeting with everyone in and flag the time so we can all attend. And the only exception to that is there will always be someone on call and you can't say to someone unwell and needs to be seen by the on-call team during that meeting -- I mean, occasionally, that does happen, as it happened to myself on that meeting, I was the on-call surgeon. 12:23

114 Q. And do you think the attendance is good at the monthly meeting then? 12:23

A. Yeah, the attendance is very good. And the other thing -- credit to, I think, to Wendy Clayton -- it is a very open meeting whereby the middle grades are invited to the meeting. The nurses are invited to the meeting. Because what you want at a department meeting is the department -- the consultants don't make a department, it's the whole team makes the department. 12:24

115 Q. If we move down to 67.1, we have asked you at 67:

"Having had the opportunity to reflect, do you have an explanation as to what went wrong within Urology Services and why?". 12:24

And you say at 67.1:

"what appears to have gone wrong is failings in a process, a process of ensuring that concerns of staff shortages from a doctor and nursing perspective are addressed to provide suitable care, a process of 12:24

ensuring that regular audit of processes is undertaken and disseminating to the department. Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided."

12:24

Now, your experience has focused on the staffing issue that you consider were the contributor during that period of time. The Inquiry has heard evidence more broadly. But the mention of the audit, the regular audit of processes, what's your understanding now of what the audit of processes are that are undertaken that would provide some reassurance about the non-reoccurrence of the issues that we have been discussing?

12:25

A. Well, it's probably best to split that between benign and then cancer because I can speak of my experience of being with the MDM, the audit processes that are now in place are very reassuring -- they are reassuring to many parties, to patients, but also to as yourself, as a clinician, you want to know that what you are doing is right, and what you're doing happens, and so there is an audit process in place to make sure the decisions that are made are undertaken. There are audit processes to show that are the right number of people at meetings and, if not, why not? So audit is massively important.

12:25

12:25

From a stone perspective, which I can speak of in certainly a lot more detail, in 2019 I instigated an

audit on the outcomes of ESWL to make sure that what treatments patients were having were in keeping with recognised standards and, therefore, the outcome from it is they are in keeping with the recommendations as regards success rates, as well as very low complication rate, and so we have made sure that we have looked at that. It's also a rolling process, so this isn't something which you do once and forget about. Audit is a cycle. 12:26

So we then have to have periods of time of when do we then re-audit to make sure that these things are still maintained. And from the audit itself, if improvements are required to meet a standard or a guideline, that then things are improved, and just not changed. 12:26

And then there's other audits we undertake as well for the stones, such as the calcium audit which has been undertaken numerous times, to ensure that patients who do present to the Emergency Department, part of the protocol which we wrote ensured the patients who came in had a calcium done, because we know very rarely if you're high in serum calcium, it could be very dangerous to a patient. And there is a World Health Organisation case study of a patient who presented in another hospital somewhere else who died of a high calcium that wasn't picked up. 12:27 12:27

So it's having these processes in place and making sure

that you recognise what the standard and guideline is, and then to re-audit, is vitally important for the running of a department and a process.

116 Q. And does that take place currently?

A. Yes. 12:27

117 Q. And when you talk about the stone, I know that's your area of expertise, is there an appetite or, in reality, does it happen that there's shared best practice between, for example, benign and cancer, and you talk to each other about what works for each specialty? 12:27

A. Yes, so it's very important that as a team and a department, also viewing the wider view of urology in Northern Ireland, that we all talk and we are all on the same page. And this is where we move towards having regional services, but also in the departments 12:28 themselves, everyone is on the same page of what is going on -- because you have to understand what is going on to understand how you access even services in your own specialty, and what is available and how these things work. So it's vitally important that any 12:28 process in any department and the wider picture, everyone is on the same page of understanding how these things work and how things can be improved and where we're going. So you need to have a roadmap and everyone on the same page. 12:28

118 Q. And while that may be the ideal scenario, in practice has it been your experience that when you do identify potential areas of improvement -- I know we talked about one of them earlier in relation to your specialty

-- that management, medical management, other types of management within the Trust, is that embraced when you bring those suggestions to them? Is there an appetite to bring about change that will result in a better service? 12:29

A. In our department at present, there's definitely an appetite of improvement to make things better. Bringing it to, say, more senior aspects of management in a Trust and then the broader picture of Northern Ireland itself, there's always an appetite to improve. 12:29 What I can't comment on is the pressures that are put on then on other parts of services and how can they provide for us, when knowing they have other things to provide for as well. There are other factors which I can't per se take into consideration from their 12:29 decisions. An example being is that I would recommend there are two nurse specialists for stones -- there are not two nurse specialists for stones. But from a funding perspective and a management perspective, I can advocate and say why that needs to happen. But 12:30 from their perspective, they then have to look at the broader picture of saying, well, how do we fund all these services and provide for them? I can only advocate and then keep on advocating why that needs to happen. 12:30

119 Q. I have covered a lot of topics with you. We've gone through the main parts of your statement that I want to highlight. Given what you have read about the Inquiry and the information you have been provided to inform

your statement, and the ultimate aim of the Panel is to make recommendations that might assist in preventing any recurrence of governance failings that they may consider have been found on the evidence, is there anything you'd like to add or to contribute at this point, given your experience to date? 12:30

A. On the top of my head, no, but if you come back to me when I leave, probably, yes!

120 Q. If you think of something on the way home! But just at the moment, are you content that we have covered all of the information you consider relevant for your evidence? 12:31

A. Yes.

MS. McMAHON: Chair, I have no further questions.

CHAIR: Thank you, Ms. McMahon. We can't just let you go just yet, Mr. Tyson! I am going to hand you over first of all to Mr. Hanbury, who I am sure will have some questions for you. 12:31

MR. TYSON WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS 12:31

121 Q. MR. HANBURY: Thank you very much, Mr. Tyson, very interesting. I've just got a few clinical questions, which hopefully you can answer them fairly quickly. Your research in Birmingham, what was that related to? 12:31

A. That was medical education.

122 Q. Do you still do a lot of that now or...?

A. Yes, I'm the Urology lead for Ulster University -- the module lead for Urology at Ulster university. I also

have responsibilities for training the registrars as their clinical supervisor or educational supervisor, as well as a role of the FY1 for their clinical supervision as well. And I have also had a lot of students for projects for audits. I also help to facilitate the current registrars -- I have a quality improvement for audit projects as well.

123 Q. Okay. So, moving on to -- then, you did a research project at the Southern Trust?

A. Yeah. 12:32

124 Q. That was stone-related again, was it?

A. That was stone-related, yes --

125 Q. And --

A. -- in the ESWL.

126 Q. -- were there particularly sort of audits you did or part of that that drove your enthusiasm for what came next and the regional initiatives? 12:32

A. Yes, it comes down to the obvious thing. It's when you have a single centre that has an on-site lithotripter and you have a region and you have one area that has access to it and everyone else doesn't, or some centres have access to it but the rest don't and other centres have a lithotripter coming on the back of a lorry, on a ferry, may or may not arrive, depending on if there's a storm, isn't there all the time, it seems like a very obvious thing to offer your neighbours equity. 12:32 12:33

127 Q. So, going on from that, in your statement, it seems to be only running, or was in 2021, about three days a week, or something like that; I mean, has that been

a source of frustration, to not get that --

A. Yes, it was a huge source of frustration, back when I did the research for them, to show that you could reduce your inpatient elective -- sorry, your inpatient operating on ureteric stones, you could decrease the number of patients who went to theatre by using the machine that's not being used. 12:33

128 Q. And so how did you take that forward - with the Clinical Director or the Head of Service?

A. So, myself and Mr. Young presented the data at a senior management meeting, to show that, I think it was around 55% of patients could avoid going for theatre but be offered ESWL. It's not to say every patient would want that choice; it's about giving patients choice. But running a lithotripter three days a week - which often wasn't even a full three days a week, I think it was two-and-a-half sessions - doesn't really make much sense. So we were trying to give the data to show that, actually, if you provide and resource this piece of equipment, we could reduce the number of patients and the pressure on an emergency list and, electively, you could do more patients by giving them timely treatment because they will opt for it if they say, "right, what's the current waiting list for ESWL?" I can tell you, currently, you could have it within two weeks. Back then, it was months to years. So, patients would look at it and go, "well, hang on a minute, I will probably just go for the operation then". 12:34 12:34 12:34 12:35

129 Q. Okay. So, thanks for that. When you came back in 2019, you then ran a prospective audit of the lithotripter again. Did that seem to stop when you left or did that carry on?

A. So, it carried on, and Una Lappin was the research radiographer. I tasked her with the -- in one of her parts of her role was to audit the outcome and complication from using the lithotripter, to ensure that the treatments we were providing were in keeping with the treatment success rate in current literature, and they are, and also to reassure that the machine itself didn't have overly high complication rates, and, reassuringly, it doesn't. It also then raised other aspects of, how do you then future-plan for a regional service as regards staffing? And also, even the machine we use, based on, can we get parts for it? And the parts need to be on the island of Ireland, the engineer needs to be on the island of Ireland to keep the service running. 12:35 12:35 12:36 12:36

130 Q. Yes, okay. Thank you. So, you came back to Southern Trust, and then moved on after six months or so; that was a fellowship, was it?

A. Yeah, yeah, a fellowship.

131 Q. What was the subject? What was that?

A. That was only into complex stones, so I only took a lot of PCNL surgeries. 12:36

132 Q. And that was in?

A. New Zealand.

133 Q. You seemed to stay at that a long time; was that --

that was Covid-related, was that --

A. Subject to Covid- and family-related meant we couldn't come back, so I stayed on and then I came back in -- I restarted in October 2021.

134 Q. But your original intention was not to stay quite that long, was it? 12:36

A. No.

135 Q. Okay. Thank you. That's enough on stones. We have heard quite a lot about waiting-list management and how it's done differently, perhaps, in Southern Trust. I mean, what was your view of the -- being sent Excel spreadsheets of all the patients under your name every week or every period to try and sort out -- I mean, did you think that you needed more help in that respect, or what was your personal view on that? 12:37

A. My personal view is that there now is a urology booker --

136 Q. Yes.

A. -- and you need administrative help to fulfil that role because the waiting lists are so large that they can be a little bit overwhelming; you are thinking, right, who do you pick and how do you operate? The obvious thing everyone says is, right, well, it's the person who is last on the list. The reality of that is, it isn't the case, and the reality is you need a three-pronged approach and then it is very time consuming. So I give an example of PCNLs, is, I can't just take the exact last person, but I'm very aware of them and I plan to then do them, but I have to update their imaging, I 12:37 12:37

have to see them in clinic, because time has changed that person, their comorbidities in the situation. So you have to be very mindful of taking the next person who is due on the list, and, at the same point, you have to say, right, who on this list is going to come to harm? Who is hiding in that list that needs to actually be next on that list? And then the third thing is, you have to be aware of, well, what happens if you have cancellations? You need to maximise the resources you have. So I have been very clear on having a shortlist of people I can bring in very last minute who I know are really well and aren't going to cause the anaesthetic department -- and I know their urines will be negative when they get tested, so the list is used. So you have to do it in three different approaches to try and maximise, one, your resource and also try and tackle the problem. 12:38 12:38 12:38

137 Q. So when did that schedule come in?

A. So the schedule had started in the past few weeks.

138 Q. Right. So, up until then, it was purely down to the Urologist to sort it out? 12:39

A. Yeah.

139 Q. Yes, okay. Thank you. We are aware of one particular sort of poor outcome when the theatre checklist, the pre-ureteroscopy urine culture hadn't been done or there was a problem with pre-assessment and it went ahead and there was perhaps a poor outcome there. I mean, do you have rules that you abide by in terms of -- 12:39

A. Yeah.
140 Q. -- that particular surgery?
A. I do, and I want just to state that patient was not my patient. I chaired the SAI for that case. It is very clear that stone surgery has risk and it's very important to have a negative urine culture or, if you have a positive urine culture, to undertake antibiotic either treatment or prophylaxis, and I say prophylaxis because certain patients you can only decolonise, you can't eradicate them of their infection until you have removed, often, an infected stent or the infected stone itself, but there are very clear guidelines in the EAU and NICE on a requirement of urines, and the NICE guideline, I think, states, if it will change your practice, you should undertake a urine culture. If that urine culture is positive for stones, it would change your practice because you wouldn't operate on. 12:39 12:40 12:40
141 Q. So, looking back, that patient should not have got through the surgical huddle or the WHO checklist --
A. I believe when we look -- 12:40
142 Q. How do you think that should have went?
A. I believe the one from which I -- which I am recollecting for the SAI which I chaired on behalf of the Trust, that patient had had a urine and that patient had been on antibiotics. 12:41
143 Q. All right. Just a couple of things on the Urologist of the Week and job planning. You've stated that recruitment was a problem, you never really had more than about five urologists, but yet it seemed to be

done on a one-in-seven, is that correct?

A. Yes.

144 Q. Why did you do that rather than just doing a prospective cover and then -- I don't quite understand the thinking behind it? 12:41

A. I think before I had taken my first consultant role there, there was six consultants, seven to be appointed. I have -- I would have to go back and do the maths exactly on how many were there. The unit was set up to provide a one-in-seven consultant unit and 12:42 they wished to make sure they filled these vacancies. Why have they not decreased it to a one-in-five? It's because, if we are always on call, then a lot of elective work will not be getting done. So the unit has relied on locums to come and do on-call weeks in 12:42 order for elective work, to ensure that also then keeps on going.

145 Q. Okay. Thank you. That clarifies it. Just in terms of the always being on-call every day for a whole seven-day period, most departments I have had -- asked, 12:42 don't do that. I mean, that's a lot of time without downtime, without rest, whatever, and you have a busy night. What's your view on that? Do you think, you know, if you have got a young family, do you think that fits well with family life and other responsibilities? 12:43

A. It's not something which you would want to undertake for the rest of your career, because it is a very busy unit. If a unit wasn't that busy, then it would be a very reasonable on-call period, potentially, but

given the busyness of the service, I would personally advocate to splitting the on-call week up into two sections, to have two separate on-call periods. I agree with you, from a personal perspective and a career-longevity perspective. 12:43

146 Q. And did you have those discussions at your management meetings or --

A. Yes, we have, and there are proposals to split the on-call week up into two sections.

147 Q. To change things, okay. That's very useful. I guess one other thing: You specialise more in benign cases, so just my question really is, referring more complex cases, is that easy, say - I am thinking about paediatrics, andrology, complex gynae, and things like that - is that easy to do or are you -- do you feel 12:44 that -- is there a departmental feeling you have to do it in-house?

A. No, there's definitely not that feeling. It's providing the best form of care for a patient to go to the best person who should do that, and that's why the 12:44 regional -- looking at our regional models is incredibly important, and sometimes looking outside of Northern Ireland, to make sure that person goes to the right place, and so there are times we've referred -- have referred to David Ralph in order to make sure 12:44 patients go to the right person with the right experience. As regards paediatrics, ideally, from a stone perspective, we should have a paediatric stone service. The only paediatrics I provide for stones is

ESWL, but we are not funded for a paediatric service and nor do we have the numbers of consultants to undertake that.

148 Q. I suppose, maybe, mid/lower tract paediatric dysfunction -- 12:45

A. Well, then we refer to the paediatric urologists in the Royal Victoria.

149 Q. Okay. One final question: This is the sort of -- there seems to be a lack of weekly X-ray meeting. I know it did happen historically on a Thursday 12:45 morning, maybe before you started or maybe it was there when you were a registrar. What's the opportunity for you and your colleagues to discuss complex cases, not necessarily stones - say, renal abscesses, prostate abscesses, complex duplications, PJ obstructions, that 12:45 doesn't fit into a cancer MDT obviously, and there doesn't seem to be a forum for that?

A. So there used to be an X-ray meeting where there was the forum for that. Certainly, in returning in 2021, that forum no longer exists. The radiologist -- the 12:46 Radiology team themselves are very short-staffed in the Southern Trust, and it is something which I believe everyone is aware that does need to happen, but we need the numbers and the time to undertake that, and I completely and 100% agree with you, that forum is 12:46 required.

150 Q. Okay. Thank you very much. Thank you.

CHAIR: Thank you, Mr. Hanbury. Dr. Swart?

151 Q. DR. SWART: Just following on from that, we have, I am sure you know, seen a lot of evidence in relation to various lookback reviews and the whole variety of cases. When you were a registrar, for example, and certainly when you came back, was there any kind of regular meeting where the consultants would challenge each other on perhaps unusual operations or things that were extremely tricky, such as benign cystectomy or various operations of that sort? Were you exposed to that as a registrar at all? 12:46 12:47

A. Not as a meeting, no, not that I can think of.

152 Q. No. Was there any sort of practice of discussing it at the end of ward rounds or any other forum that you came across? You may not have been as a registrar, but...

A. There was a, what they called a grand round in 2012. 12:47

153 Q. What happened at that?

A. So that was a ward round where all the consultants would be present to view -- to go around the patients, to discuss their management.

154 Q. And what was the level of challenge provided to people's management in that atmosphere, or can you not remember? 12:47

A. I can't remember anything overtly that would come to my mind of saying that...

155 Q. But in the Outpatients scenario, would people have a way to bring difficult cases? Because we have seen some of these that have come through -- 12:48

A. Yes.

156 Q. -- and I wouldn't want to comment on the -- the actual

clinical cases themselves, but just to think of the forum for saying, "Look, I have got this really tricky case, you know, what would you do? What would you do? Who would you ring in England, or in America, even? What would you do?" Did you come across any of that? 12:48

A. Well, certainly, in 2012, there was the X-ray meeting still being present, so there was the ability, at that meeting, to bring cases to say --

157 Q. But it might not have been an X-ray type of meeting/discussion. Were there any other quality meetings that you were aware of? 12:48

A. No, no. But certainly, I don't think the title of the meeting should stop someone bringing --

158 Q. It shouldn't, but it's a question of what the practice was. 12:48

A. Right, okay, yeah.

159 Q. So, you could say, "while we are all here together, can I ask you", but do you think people were open to that? Do you think they discussed each other's practice to that degree, going back then? 12:49

A. I mean, certainly from the time of the X-ray meeting, I can only --

160 Q. Yes.

A. -- that's the only forum I can think and describe, there was conversation of "What would you do? I am bringing this case. What would you do? What's everyone's view?" And from that perspective, yes, from there, yes. 12:49

161 Q. And you felt that was an open atmosphere? It wasn't --

A. That X-ray meeting was an open atmosphere. It was early, I think around eight or half eight on a -- I can't remember the day.

162 Q. Okay. Just going on to audit, clearly that's improved in recent years. When you were a registrar, was there a big focus on audit at that time, that you can remember? 12:49

A. I wouldn't say there was an overly big push on audit, so to speak. I did undertake audits --

163 Q. Mm-hmm. 12:50

A. -- because, as a trainee, we recognise the importance of undertaking an audit.

164 Q. Yeah.

A. And so, as trainees, we did undertake them.

165 Q. But there wasn't a regular programme that you were aware of, in terms of the department having prioritised audits along a -- 12:50

A. No, not that I can remember and, once again, I was there for a short period of time and I -- they may or may not have had a role in an audit programme that we were unaware of, but we come in for a short period of time, we do an audit, we go, and they then do it again the following year or the year after. I couldn't comment on that time because -- we did do audits. 12:50

166 Q. But you are doing them now for -- 12:50

A. Yes, yes, I did them as a registrar and I do them now.

167 Q. Yes, okay. There's a nice little e-mail where you come up with your ideas for improving the stone service, and we have talked about that. My question to you was:

was that worked up into a proper business case with an agreed incremental approach and did they involve you in that? Did they sort of say, "well, this is what's happening, this is the cost, this is the cost benefit"? Was that given any kind of formal credence? 12:51

A. So the cost benefit side I had already done myself and presented to them, so they had the data from me, and that, then, formed the business case with the managers' - and the managers then showed me the business cases.

168 Q. But did you get a formal idea of the desire to strategically implement that over a period of years in terms of the staffing and resource that you have drawn attention to? 12:51

A. Yes, so if I give you an example of ESWL, there was a strategic plan from Wendy Clayton to show how we roll out the service, for which I was involved in how we clinically roll it out, to make sure that we don't sort of jump too fast -- 12:51

169 Q. Yes.

A. -- and make sure we roll it out. The staffing thing has always been an issue. 12:51

170 Q. But you can't roll it out without the staff, so that's really my question: where does that sit? From your perception, where did that sit in the Trust hierarchy? Was your Clinical Director involved, for example, or did you have any other information as to how that sort of tension between finance and quality and other priorities was going to be resolved? Did you get any feedback from people about that? 12:52

A. So I received feedback from Wendy Clayton and Lynn Lappin, who is now the Acute Director of Surgical Services, on what is currently available and what funding we have to advertise for those roles, so there is funding, and I was very, very clear that a service doesn't get rolled out if you don't have people to do the work. 12:52

171 Q. No. I mean, again, though, did you have support from a Clinical Director in that, or who was your main support? You have mentioned Mark Haynes? 12:53

A. So, Mark Haynes and Wendy Clayton were two big supporters, but I think it's very, very important, in a regional service, to note the other supporters and the other stakeholders involved in this, and that would be David McCormack from the Civil Service, who was massively proactive and behind us. 12:53

172 Q. I am just trying to get a sense of where it went in the Trust hierarchy, because, theoretically, you have a Clinical Lead, a Clinical Director, an Associate Medical Director, a Medical Director, plus all the management hierarchy and Acute Services, and there needs to be a link in terms of how the Trust supports you with the Civil Service, as you state. Did you think that -- was that clear to you, how that worked? 12:53

A. It was clear that Wendy Clayton and Mark Haynes were talking to the management structure above them within the Trust, and I and Mark Haynes and Wendy Clayton spoke directly to the Civil Service for our requirements as well. 12:53

173 Q. Okay.
A. So -- but it's not for me to jump up above Mark Haynes and Wendy Clayton --
174 Q. No, no, I am not suggesting that --
A. -- those conversations -- 12:54
175 Q. I am trying to sort of get a sense of how you were interacting with some of the other intermediaries in the Trust, because mostly it goes through a Clinical Director kind of structure?
A. Yes. 12:54
176 Q. It's not material in any other way, just how you were supported. It's really obvious, we have got huge numbers of patients waiting in every corner of every service to do with elective surgery in Northern Ireland. These patients, as you have said, will be 12:54 coming to harm, they will be changing, things will be happening. Who do you think is setting the tone for dealing with this and is there anybody giving direction to clinical teams as to how they should approach assessing the harm for people on waiting lists and 12:55 prioritising it in the way you have described? Are you getting any sense of that?
A. Well, I can only speak from experience from urology, and it's very important to appraise the waiting lists to find those patients and know what's going on, know 12:55 who still needs an operation, know who needs one sooner and know people who can actually come off the waiting lists, because there will be people who will come off it, and so I can speak from a stone perspective. We

did a piece of work where either I, myself, or Laura McAuley have appraised parts of our waiting list, but also David Connolly has also appraised the Southern Trust's ureteroscopy waiting lists as well, to ensure that those patients are appraised, and so it's very important that that actually happens; it forms recommendations as part of, I think, the GIRFT report as well, so we are reviewing what's there. 12:55

177 Q. Is there any central direction in this regard? Do you think that Northern Ireland, as a whole, is saying all teams must do this, or is this something you just realised you had to do? 12:56

A. No, certainly David McCormack, at our regional meetings, as well as being very clear upon making sure we are appraising waiting lists, so David McCormack has been excellent and certainly champions to make sure those things are happening, and if we need help -- 12:56

178 Q. You can get it?

A. You can get it. And it's about knowing the stakeholders involved in order to benefit these patients. Can I talk for all the other specialties and everything else in Northern Ireland -- 12:56

179 Q. No, no, I realise you can't. I just wondered whether there was a general direction to this very obvious problem. 12:56

A. Yeah.

180 Q. What do you think should be done at this point? You have, several times, mentioned Northern Ireland as a whole. Reorganisation, you know, if you had a blank

page, what sort of approaches are needed to actually overcome this problem, which is now not that obviously easily soluble?

A. To sum it up in a very brief way would be very difficult and I am very mindful of not oversimplifying the issue in hand. There are multiple problems and I -- and I like your approach of saying, if we had a blank page, what would we do, and certainly I would agree that may be a very good way of looking at it, going "hang on, how do we start again?" It's very important to look at the Bengoa Report and GIRFT Reports and actually look at their recommendations and action them. We have actioned certain parts in Urology, such as ESWL and what will be a complex stone service, but I completely agree that, from the broader picture - I can't speak for all other specialties - but certainly, as a region, that is what needs to happen. There are five Trusts for a population of 1.9 million. Why are there five Trusts for a population of 1.9 million? How much duplication of work is there potential? Do patients all have equity depending on where they live? I am going to guess the answer to that is no. So I think the Bengoa Report and the recommendations need to be -- 12:57 12:57 12:57 12:58

181 Q. And are you aware of any progress that's actually been made against the Bengoa Report? 12:58

A. So I can only speak for the part I'm involved in, for Urology, so an example of that would be an elective care centre, such as Lagan Valley.

182 Q. Yes.
A. So, there, that got started in 2022, and the idea behind that is, patients who are fit and healthy enough to be discharged the same day, so, for that, that is a lot of ureteric stones, to try and prevent stents being in for a long time; that is, potentially, bladder outlet surgeries and that is inguinal scrotal pathologies. So, from that perspective, that has been really good, and that is something which could be, for other specialties, looked at as well. Is Lagan Valley enough for Urology in Northern Ireland? The answer is no, you need more than one centre. And I have said this at many regional meetings, that Omagh needs to come online as is the next elective-care setting, because Lagan Valley is not enough. 12:58 12:59 12:59
DR. SWART: Okay. Thank you, that's all from me.
183 Q. CHAIR: Thank you. Mr. Tyson, just a couple of things that I'm not clear about in respect of triaging. The expression "advanced triage", what exactly do you mean when you talk about "advanced triage"? 12:59
A. So, advanced triage is looking at the referral you have from the GP and going, does this patient require a scan or a blood test before that patient arrives to the service as regards urology? So it could be that that patient requires a CT urogram for visible blood in the urine, which means that, when they turn up for their flexible cystoscopy, their imaging has already been done, so you can -- you reduce, potentially, the number of appointments the patient has, for urology, to be 13:00

seen, so it's -- it's facilitating investigations in many ways. What's the outcome of that? Well, that means the person who has ordered them will get all the results.

184 Q. Yes. And you have said that, because you may have 100 patients who you engage in this advanced triage for, you then don't have the time to follow up, is that what you are saying? Is that why the advanced triaging has gone by the wayside? 13:00

A. It's -- probably one of the predominant reasons it's gone by the wayside is because there's a lack of consultants in the Trust, which means all the elective work and day-to-day work that has to go on, and on top of our virtual work because that would then form virtual work, so we have to physically operate and see people, at the same point then review, dictate and action virtual scans. And I already do a lot of virtual work; if I added onto that a huge amount of virtual triage, when would I do it? 13:00 13:01

185 Q. And coming back to your terminology so that I am clear in what you mean, virtual triage and virtual -- 13:01

A. Sorry, triage. Just ignore the word "virtual".

186 Q. Okay. So you talked about virtual follow-up, and by that do you mean having a virtual meeting with a patient or -- 13:01

A. Not necessarily. So, certain patients, you will put a plan in place that they will have a serial number of scans, so to speak, for follow-up for certain pathology, or a surveillance, say, of a stone-related

incident, and then you are writing to the patient to say, "This is your result. We agreed this plan. I have booked you another scan for one year's time. If you wish to see me in clinic or wish to see me for any other reason, please let me know and I will see you, otherwise all the information has been given." 13:02

So, every month, I will sign and dictate potentially around 200, so I -- so I, sign off, sorry, around 200 scans a month; the majority of those are virtual.

187 Q. Okay. Now, coming back to what you are now doing in terms of triage, is there a risk there, if the scans aren't done, does that mean that the person languishes on a waiting list for longer and may be deteriorating on that waiting list? 13:02

A. The answer is yes, there is always that potential, but not every Urology Service in the UK and Ireland undertake advanced triage, so it's not a standard upon which we've suddenly stopped, and there is still the ability to bring a patient to a hot clinic to see that week or to book that patient to scan, so there will still be certain occasions when you think they are not quite wanting to be seen in a hot clinic, you know that they're a red flag patient, I am going to book them that scan because there is something in it that's worrying from the GP information given. But can you do it for every single person then? Well, there's not the resource at present to have that time, at present, to do it for everyone. 13:02 13:03 13:03

188 Q. Thank you, that's helpful. Just one final question

from me: Are you -- you have obviously given in your notice and you are moving on to pastures new, but are you aware of any steps that the Trust have taken to fill your role?

A. Yes, so recruitment and retainment are two different things, but recruitment is something I have been very vocal about at our meetings, on how we recruit. And there are, I'm told, three new urologists coming in some part of the first half of 2024, which have been recruited from the initiative in India. 13:03 13:04

189 Q. And again, retention is something that clearly is still in issue for the Trust?

A. It is, but, in leaving, I have also been very mindful of making sure that everything I have left has a succession plan in place, to make sure services do keep on running. 13:04

CHAIR: Thank you very much, Mr. Tyson, I have no further questions. Ms. McMahon?

MS. McMAHON: I have no further questions.

CHAIR: Okay, ladies and gentlemen, that concludes today. We are due to sit again at 10 o'clock tomorrow morning and, unless you hear otherwise, we will see you all then. 13:04

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 8TH NOVEMBER 2023 AT 10 A.M. 13:05