List of Tables, Extracts and Figures

Executive Summary

Introduction

As we move closer to the opening the National Children's Hospital and the integration of CHI at Tallaght, Crumlin, and Temple Street into one new hospital, delivering high-quality care in a cost-effective manner through innovative technology enablement, we need to ensure we capitalise on the opportunity to deliver tangible change and ensure benefits realisation for the children of Ireland.

This process began with an overarching objective to establish a fully integrated, collaborative, academic and efficacious general surgery and urology service for both children and staff. Children's Health Ireland's (CHI) mission is *'to promote and provide child-centred, research-led and learning informed healthcare, to the highest standards of safety and excellence'*. In order to deliver on this mission, the CHI executive recognised that there were a number underlying concerns and issues in the general surgery and urology service which needed to be explored and understood in greater detail, to ensure supportive action and corrective measures could be put in place.

In living CHI's values of being child-centred, compassionate, progressive, and acting with Respect, Excellence and Integrity, the purpose of this report is to provide clarity on the issues and concerns identified during the general surgery and urology examination and act as a catalyst for the CHI executive to drive sustained change across the organisation.

Background and Context

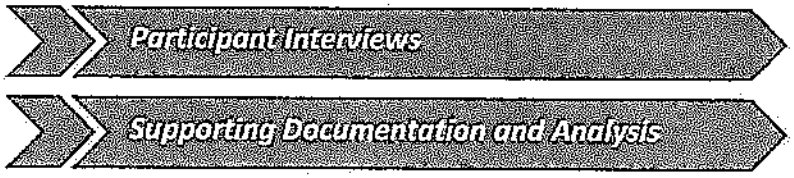
A thorough and methodical approach was undertaken in completing this examination. The department of general surgery and urology, all supporting services that are critical to the department, and additionally CHI's wider structures and systems were explored and reviewed holistically.

There are currently ten consultants working within the general surgery and urology service in CHI. With 14 theatres in operation, CHI at Crumlin has the largest capacity, at nine (to include the Hybrid Cath Lab).

The general surgery and urology future model of care outlines that there will be twelve consultants delivering surgical services in the new hospital, with general surgery and urology operating as two separate departments. There will be 22 operating theatres, shared between circa 19 specialties all operating for 9.5 hours per day.

Approach and Methodology

The exploration and analysis for this report was completed over a four-month period in two distinct phases:

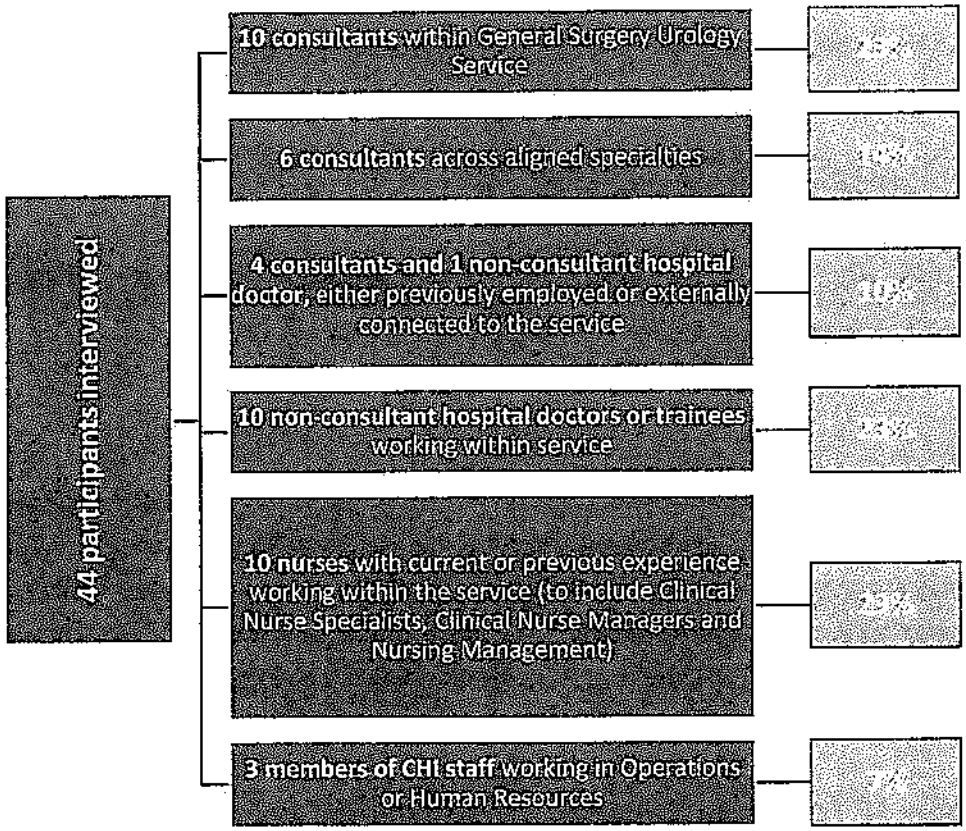


The first phase involved a series of one-to-one meetings with CHI staff and those who have experience of working within or alongside the service. The purpose of this engagement was to gain insight into the general surgery and urology service in CHI and to understand both the individual and collective needs of the department, while also establishing what is required to develop and sustain an effective, integrated, child centred service, within a professional and collaborative working environment.

A summary of the interviews is detailed below:

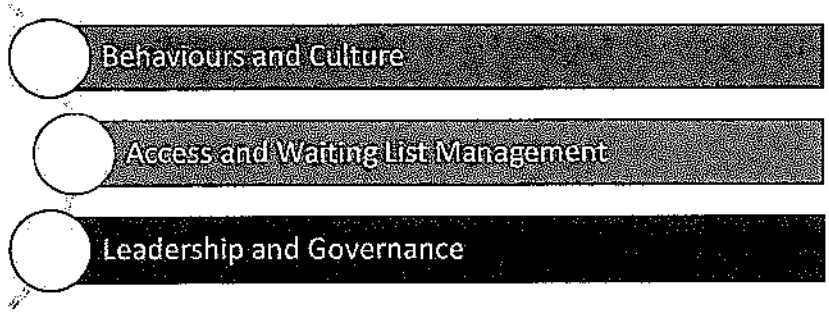
The evidence in this report is taken from **over 49 interviews with 45 participants** conducted and transcribed over a **four-month** period.

Each interview lasted approximately **two hours** and in excess of **10,000 words** were recorded per meeting.



The second phase of this examination involved a robust review of supporting documentation for each theme identified. Hundreds of pages of supporting documentation and international research were reviewed in detail, along with directed standalone data analysis completed specifically for this report.

The themes and areas of concern that will be addressed in detail in this report are:



Theme 1: Behaviours and Culture

The HSE Change Guide explains that culture is influenced by three key elements:

1. The founding values of the organisation

2. The early experiences and thereby acquired values, norms and behaviours of those in the organisation

3. The behaviour of leaders

Consistently throughout this examination, it was found that participant experiences reflected a culture in which challenging behaviours appear to be the norm. Research has shown that organisational culture influences patient safety, quality of care, medical errors, patient and families experiences, clinician satisfaction and burnout. It is critical that an organisation takes time to reflect on and own the culture that exists and then seeks to address the issues and bring about the required change.

> *"Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours"*
>
> NATIONAL ADVISORY GROUP ON THE SAFETY OF PATIENTS

Today, the success of any individual surgeon is no longer dependent on him or her being an independent republic serving as the lone 'captain of their ship'. The notion of the heroic leader is out-dated and inappropriate in a modern health service. Instead, all surgeons, whether they have a clinical or non-clinical role, are expected to contribute to creating a safe working environment for patients and staff in their immediate team and the wider organisation in which they work.

Oncology Service

Paediatric oncology patients have a poor experience, or are harmed, due to the inability of CHI to deliver international best practice standards of paediatric surgical oncology provision
CHI Oncology Risk Assessment, 27th August 2021

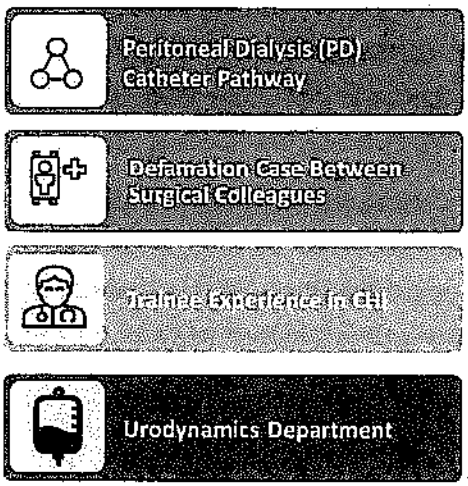
From the outset of this process significant concerns were raised from multiple participants regarding the oncology general surgery service. Leading to this examination requesting an urgent risk assessment of the service. The outcome of that risk assessment was a risk score of 20 (out of a possible 25). This being categorised as a high red risk, which the HSE states, are risks which *"are intolerable, that is they cannot be accepted and require significant management focus to mitigate them"*.

A significant component of this risk score is linked to the existing staffing levels and structure. The oncology general surgery service in CHI depends solely on one consultant to manage the needs of a tertiary speciality. Thus, exists a dependency on one consultant for the management of this complex service for the children of Ireland. This level of dependency on one individual for a critical service is not in line with best practice. The staffing status quo has evolved following numerous interpersonal difficulties within the department which have gone unchallenged. This has resulted in CHI having three consultants currently employed, one who is leading the service and two of whom had the experience to be able to support the service. Indeed, one was specifically employed to work in the oncology general surgery service, however neither consultant have practiced in the oncology service in approximately five years and therefore have not retained the specific skills necessary to support this service today, resulting in one consultant with both the autonomy and responsibility for oncology general surgery in CHI.

Owing to an apparent lack of collaborative working a pattern of behaviours exist within the general surgery oncology service which undoubtedly has the potential to affect patient and staff safety. A summary of the issues identified during this examination as existing within the oncology general surgery service are summarised below and will be explored in detail in the *Behaviours and Culture chapter* of this report.

 **Multi-disciplinary**	It was repeatedly stated by many, that a multidisciplinary surgical team (MDT) approach is not being employed in this very specialist service. Research has shown such a lack of collaborative working is not in the best interests of the child.
 **Wellbeing**	Numerous participants expressed concern for the emotional and physical wellbeing of colleagues working in the service.
 **Relationships**	Dysfunctional relationship played a significant part in leading to two seminal cases, both of which led to surgeries evolving with complications and ultimately children having prolonged recoveries. Potentially the development and outcome for both cases could have been mitigated against if consultant surgeons were working effectively together.

Further services and areas across the general surgery and urology department that have been impacted by negative behaviours and a complex culture include:



A summary of each of the above is described below and will be explored in greater detail in the *Behaviour and Cultures chapter* of this report.

Peritoneal Dialysis (PD) Catheter Pathway

The lack of delineation between the general surgery and urology case mix has led to challenges within the department. The PD catheter pathway is an example of such challenges. The scenario detailed in this report will give an insight into the significant communication difficulties and abhorrent ways of working, unprofessional behaviours and lack of teamwork that exists within the department, ultimately requiring mediation from the Clinical Specialty Lead.

Defamation Case Between Surgical Colleagues

There is an ongoing defamation case between two consultant surgeons in the general surgery and urology department in CHI. As this is an ongoing legal case, this report will not explore the matter further. However, it is reasonable to assume that such a case can only arise as a result of fraught relationships within the general surgery and urology service.

Trainee Experience in CHI

The Specialist Advisory Committee (SAC) play a key role in the development and improvement of postgraduate surgical training in the UK and Ireland. Each SAC works to ensure that training programmes cover all aspects essential to train someone to the level of a day one consultant. In September 2021, following a review of the training programme, SAC submitted a number of recommendations regarding the trainee experience in CHI. Following this report, the Royal College of Surgeons in Ireland (RCSI) confirmed that it was the specialty's view, that there should not be an intake of any new trainees or Specialist Registrars (SpRs) into the programme in 2022. This would remain until the various identified problems with training are addressed. This development impacts not only the current trainees in the programme but also CHI's reputation and mission to a be a first-class academic organisation now and into the future.

The recommendations in the SAC report focus on creating a supportive environment for trainees to learn, with a particular emphasis on work culture and work ethos and the health and wellbeing of trainee. The findings of this examination are entirely consistent with the SAC report. Feedback from trainees both past and present is resolute, in addition to observations from many participants, all describing an environment and working life that is adversely impacted by the *'negative'* and *'toxic'* culture that exists in the department.

During this examination participants provided a broad and varied narrative about their individual training experience, however across multiple participants there was one consultant identified consistently as creating a psychologically unsafe environment not conducive to learning. That is an environment where an individual feels they may be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes. Two specific examples where this consultant's behaviour and actions reportedly had a significant impact on trainee careers and/or well-being were staunchly brought to the attention of this examination through participant interviews. To

understand these events and perspectives, various supporting documentation and clarification were sought by the examination and are explored in detail in the *Behaviours and Culture chapter* of this report.

It is important to acknowledge that a number of other consultants were identified during participant interviews as surgeons committed to training and to creating a safe learning space for those they work with. Indeed, the Clinical Specialty Lead (CSL) was described as what a trainer *"should be"*.

Urodynamics Department

Since 2013, there has been an exceptionally high rate of attrition among Clinical Nurse Specialists (CNS) in the Urodynamics Department at CHI Crumlin. Of three CNS employed to work in the department between 2013 and 2021, all have left, with each CNS stating they left for one reason only – bullying. Each of the three CNS's, described similar experiences of bullying from the same member of staff working in the department. The *Behaviours and Culture chapter* explore how these concerns from staff members were addressed and managed and also detail additional concerns raised regarding patient referrals within the department.

Theme 2: Access and Waiting List Management

The National Inpatient, Day case, Planned Procedure (IDPP), Waiting List Management Protocol (2017), developed by the National Treatment Purchase Fund (NTPF), outlines a consistent standardised approach for hospitals and hospital groups to use as a guide when scheduling patients and managing waiting lists. The purpose of this protocol is to ensure the safe, timely and effective access and treatment for patients in a fair and equitable manner. Within this protocol, fundamentals of waiting list management are detailed to ensure each hospital or hospital group has the guidance and tools it needs to deal with waiting lists in an effective and transparent way. This examination has found that an insourcing agreement with the NTPF for five Urology clinics, which were requested by a consultant urologist and held between December 2020 and March 2021 in CHI at Crumlin, does not appear to adhere to the Memorandum of Understanding (MOU) set out by NTPF and signed by CHI Chief Operating Officer.

A summary of the context and background to theses five NTPF clinics is detailed below:

- This NTPF initiative was submitted under general surgery, incorporating general surgery waiting list numbers and details. There was no urology data included, despite the intention and plan being that the NTPF clinics would be addressing a consultant urologist's waiting list only. This discrepancy or inaccurate details in submission appears to have to be known by the CHI Scheduling Lead and consultant at the time of submission.
- The NTPF clinics did not align to the insourcing principles outlined in the IDPP waiting list management protocol as the consultant urologist who undertook these clinics works solely in one CHI site.
- The case mix seen at these clinics was 95% general surgery. Analysis within this report will illustrate that these patients could have been accommodated in a general surgery outpatient clinic during normal working hours, without the need for NTPF funding.
- The longest waiters were not seen at these NTPF clinics.
- There were 45 children who required surgery but did not receive a date for same and instead were placed back on one consultant's inpatient waiting list, which has a significant wait time.
- Some patients, who were placed on the inpatient waiting list, were confirmed as having undescended testes, a condition which requires surgical intervention within a specific timeframe. Placing these patients on a specific consultant's inpatient waiting list, when it was known there were alternative options which would have ensured these patients could have been operated on sooner, appears not to be in the best interest of child and the specifics of each case warrant further examination.
- The time slot afforded to each NTPF patient, which would be considered a new patient, was 10-minutes. This is less than this consultant's average Outpatient Department (OPD) clinic time slot for new patients. Indeed, up to 48 patients were seen in the NTPF clinics, where one consultant was working alone, however this consultant's public clinic is capped at 23 patients, yet there would be at least one registrar supporting. Was throughput prioritised over patient care in NTPF clinics, noting there is a €200 fee per patient or are the public outpatient clinic failing to operate at full capacity?

Theme 3: Leadership and Governance

Throughout the course of this examination many issues have been tabled that suggest gaps in leadership and governance at site level have a causative effect on culture, staff morale and effective operations across CHI. Three specific areas have come to the fore, which will be explored in detail in the *Leadership and Governance chapter* of this report.

Site Leadership and Service Planning

The HSE Clinical Governance paper outlines that "*each individual, as part of a team, knows their responsibility, level of authority and who they are accountable to*". This clarity around governance is far from steadfast across CHI. The existence of dysfunctional relationships and disruptive behaviours within the general surgery and urology department, coupled with an apparent lack of governance and consistent direction from clinical and operational leadership, has led to the development and of evolvement of a very negative and broken culture.

Services and areas across the general surgery and urology department that have been highlighted as being negatively impacted as result lack of management oversight, accountability and good governance include:

Oncology Service	Urology Service
○ Service Planning	○ Urology Locum Post
○ Recruitment	○ Consultant Urologist Post
○ Risk Management	○ Spina Bifida
○ Site Governance	

A summary of each of the above is areas is described below and will be explored in greater detail in the *Leadership and Governance chapter* of this report of this report.

Oncology Service

There appears to be clear lack of ownership and understanding of the oncology general surgery service from leadership in CHI at Crumlin, a tertiary specialist service, which is exclusively operated from CHI at Crumlin.

Paediatric oncology patients have a poor experience, or are harmed, due to the inability of CHI to deliver international best practice standards of paediatric surgical oncology provision
CHI Oncology Risk Assessment, 27th August 2021

In a recent risk assessment, completed on the 27th August 2021, the oncology general surgery service was given a risk score of 20 out of a possible 25. This being categorised as a high red risk. The HSE states these are risks which *"are intolerable, that is they cannot be accepted and require significant management focus to mitigate them"*. Current leadership in CHI at Crumlin did not identify the need for this risk assessment, despite significant issues relating to the service being brought to leaderships attention over the last number of years, not least an After Action Review (AAR), following a general surgery oncology procedure.

Based on the above Risk Assessment, further details of which can be seen in *chapter 3* and *chapter 5* of this report, along with input from multiple participants, it is observable that the responsibility of such a specialist tertiary service, which is the only such service providing care to the children of Ireland, sits exclusively on one surgeon's shoulders. In addition, there appears to be no substantial succession plan in place.

Our Lady's Children's Hospital Crumlin (now CHI at Crumlin) ran a very protracted recruitment process beginning in August 2014, with interviews only taking place over a year later in November 2015. The process was to backfill a General Surgeon Consultant post, who would be working to support the oncology general surgery service.

Some or all of the delays in the recruitment process, appear to be as a result of a multitude of disagreements between the general surgeons and management at Our Lady's Children's Hospital Crumlin, (now CHI at Crumlin).

The issues appear to range from concerns in relation to:

- Dispute regarding the job specification and details of job advertisement
- Disagreement in relation to the makeup of the interview panel
- Transparency and Fairness surrounding the recruitment process

Further exploration of the effectiveness of recruitment processes in CHI at Crumlin should be considered, given the issues identified in relation to this post:

1. An extremely lengthy recruitment process.
2. Concerns raised in writing to management about the *"transparency"* and *"fairness"* of the process.
3. Changing of weighted scores from the agreed Our Lady's Children's Hospital template.
4. Differing views on the job description – and ultimately the status quo in the department today where the consultant who was recruited, has withdrawn their services and does not now work in the oncology general surgery service.

Urology Locum Post

Throughout the course of this examination, what appears to be a noteworthy level of obliqueness and significant concerns from multiple participants in relation to the ongoing management of a consultant locum post were identified; these include issues relating to

- Contract Management
- Access to Theatre and OPD Clinics
- Interpersonal Relationships and Experience in CHI

Ultimately there appears to be a distinct lack of governance over the general surgery and urology department. Evidence indicates that the Clinical Specialty Lead (CSL) has worked tirelessly at attempting to resolve issues as best as they can and have sought support from leadership on numerous occasions but seem not to have secured the required intervention or any consistent support.

Consultant Urologist Post

The apparent enigma around what is required of candidates for advertised roles, has led to significant disagreements among colleagues in the general surgery and urology department, challenges for medical HR and notably huge costs for CHI. Given a consultant urologist post was advertised three times, with mandatory requirements changing each time without any apparent rationale for these changes, it calls into question the effectiveness of the service planning for the urology service. These issues relating to mandatory requirements have led to ongoing issues with shortlisting of candidates and ultimately resulting on one occasion with a significant court case in which CHI was ruled against.

Spina Bifida Patient Management

Spina Bifida (SB), a neural tube defect, has been described as one of the most complex congenital conditions compatible with life. Ireland has one of the highest rates of Neural Tube Defects in the world, with a prevalence of 1.17 per 1000 live births. It's suggested that at any given time in

Ireland, there are up to 630 SB patients between the ages of 0-18 years. A multi-disciplinary approach is best practice with this cohort of patients, due to the complexity of the condition. In Ireland, the SB service transitioned from Our Lady's Hospital Crumlin (now CHI at Crumlin), to Temple Street Children's Hospital (now CHI at Temple Street) in 2008. Throughout this examination, the management of SB patients was raised as a concern by multiple participants. It was brought to the attention of this examination that a cohort of SB patients remain in the care of CHI at Crumlin. These patients are referred to locally as the *'Crumlin Orphans'*. It would appear, these children are a specific group of SB patients, all of whom were born before 2008, and were from birth managed by general surgeons, in Our Lady's Children's Hospital Crumlin, now CHI at Crumlin. This is despite best practice recommending urologist input for the management and care of SB patients.

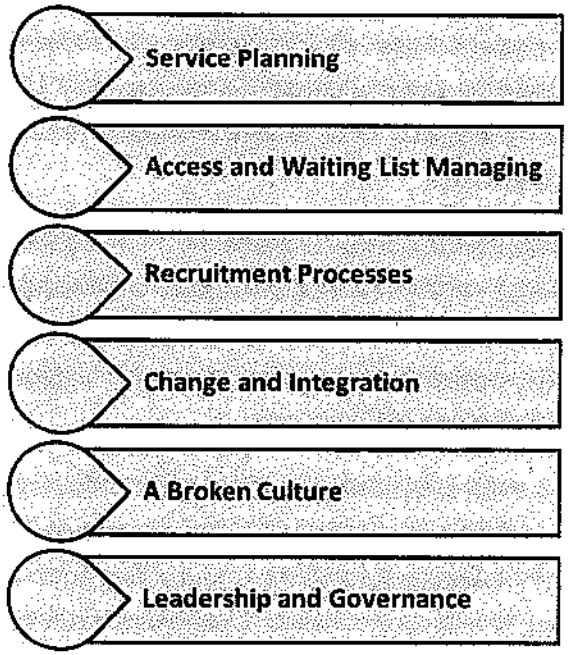
There currently exists an inequitable SB service across CHI. The cohort of patients known as the *'Crumlin Orphans'* continue to receive sub-optimal care in comparisons to those SB patients managed in CHI at Temple Street. SB patients in CHI at Temple Street have access to a consultant urologist and full MDT clinic, however the senior consultant urologist in CHI at Crumlin is not involved in the care or management of SB patients.

The gaps in *operational oversight* and resulting *financial impact* for CHI cannot be overlooked. The surveillance and supervision of NTPF funding across CHI is critical to ensure fair and equitable management of access for children, and good governance and accountability of public funding. Furthermore, the lack of consistent and appropriate *Management of* negative *Behaviours* which appears to have gone unchallenged for a significant period of time has led to a toxic and siloed culture, where many staff feel unsupported and have disengaged from the wider organisation.

Suggested Next Steps

It is critical that the findings of this examination are used as a catalyst to effect real and sustainable change. Momentum is critical in ensuring those that supported this process see that the required action will be taken to bring about positive change for all.

The following are noteworthy challenges facing CHI:



It was not in the scope of this examination or accompanying report to outline recommendations. However, under the themes identified, it is clear a number of decisive next steps are required.

Behaviours and Culture

As an immediate priority, and based on the evidence in this report, the General Surgery and Urology service, to include the Oncology General Surgery service and the Urodynamics Department, require directed intervention from an interpersonal and organisational and development perspective, to support the development of collaborative working relationships, and a safe and inclusive service for all. This will require significant time and effort to build trust and confidence among colleagues and with leadership. Sustainable change will not happen without strong leadership and robust governance. Areas that have been highlighted to currently have significant gaps.

Access and Waiting List Management

A root and branch review of all access and waiting list initiatives, to include NTPF and referral management should be undertaken. This should incorporate a review of governance structures

and processes for approval and sign off, thus maximising patient's timely access to care, ensuring a fair and equitable service for all.

There is a need to both reconfigure and expand our theatre capacity, while optimising current resources and driving efficiencies across the system. The establishment of effective and strong governance structures, ensuring appropriate accountability and enabling consistency and standardisation of best practice across all surgical settings is key. A critical part of this is ensuring clarity around case mix delineation between General Surgery and Urology specialties, which can lead to positive impacts on access to care (see *Appendix 3*). In addition to this, creating a working environment and ethos that is conducive to professional development and learning is essential as we move toward the opening of our new hospital and future operating models.

Leadership and Governance

Strong leadership and consistent good governance are the foundation of running effective, efficient, and best in class services across CHI. This examination consistently identified noteworthy gaps in this area at site level and across operations. This has played a significant role in the serious issues identified across the general surgery and urology service and ultimately underpins the challenges relating to access, and behaviours and culture. A review of all site leadership roles and responsibilities should be undertaken to provide clarity around delineation of accountability at site and executive level. A clear communication and reporting framework should be adopted to ensure certainty and assurance around reporting structures and leadership responsibilities across the organisation. Furthermore, explicitness in relation the transition plan to mobilising cross site Clinical Director governance is essential and confirmation in relation to the roles of Clinical Directors regarding accountability for both operational and strategic issues and ownership for the implementation of any recommendations that fall out of this report.

The above review of structure, roles and responsibilities and accountability, should include patient safety and risk management. This is to ensure CHI adopt an effective, person centred incident management and open disclosure framework through a positive learning culture.

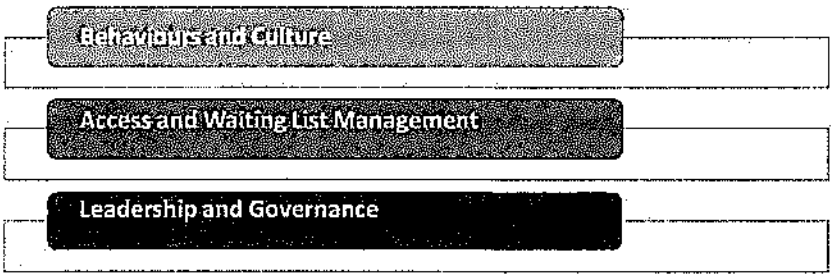
The findings in this report presents a unique opportunity, to act as a catalyst for CHI leadership to make meaningful, strategic, and sustainable change in the General Surgery and Urology service and in overall clinical service delivery. Binding CHI together as a single strong inclusive culture, ensuring it can deliver first-class services for our children, young people, and staff now and into the future as we move toward the opening of our new hospital.

1 INTRODUCTION

As we build a first-class, future focused paediatric hospital and continue to grow and develop the services of our two outpatient and urgent care centres at Connolly and Tallaght, we need to ensure we are capitalising on the opportunity to deliver tangible change and ensure benefits realisation for the children of Ireland. This programme of work began with an overarching objective to establish a fully integrated, collaborative, academic and efficacious General Surgery and Urology service for both children and staff. Early in the process, following one to one meetings with each of the ten general surgery and urology surgeons across CHI, significant re-occurring themes and concerns were identified and it became clear that to successfully achieve the objective, substantial change was required both within the department and across CHI. This view was taken to the Chief Executive Officer (CEO) of CHI, and it was determined that a formal process needed to be put in place, to enable a thorough and detailed evaluation of the re-occurring themes and concerns identified.

From the outset, the CEO unreservedly took on board complex and challenging observations, fully supporting a detailed and thorough examination of the General Surgery and Urology Service. This support and accompanying view that the examination should be as robust and thorough as needed to fully explore and ultimately address all issues, was critical in facilitating the broad scope and rigour of the examination. With this support from the CEO, Executive sign off to undertake this substantial body of work was secured. CHI's Human Resources Director (HRD) and Chief Medical Officer (CMO), were critical to enabling and empowering a detailed and in-depth examination, facilitating the required access and supports at all times. Most significantly, the time, effort, and level of engagement from participants in supporting this examination cannot be underestimated. Without their knowledge, candid reflections, and desire for change, much of this report would not have been possible.

This examination took a systematic approach, looking holistically at the department of general surgery and urology, the supporting services that are critical to the department, and additionally the wider organisations structures and systems. The themes and areas of concern that will be explored in detail in this report are as follows:



These themes were identified during many interviews with CHI staff, both past and present. The report will endeavour to support all findings clearly and accurately with extensive evidence and relevant research.

Currently there are ten consultants working within the General Surgery and Urology Service in CHI:

Mr Sri Paran	*Consultant General Surgeon*	*CHI at Crumlin / CHI at Tallaght*
Mr Brian Sweeney	*Consultant General Surgeon*	*CHI at Crumlin / CHI at Tallaght*
Mr Farhan Tareen	*Consultant General Surgeon*	*CHI at Crumlin / CHI at Tallaght*
Professor Alan Mortell	*Consultant General Surgeon*	*CHI at Crumlin / CHI at Temple St*
Mr John Gillick	*Consultant General Surgeon*	*CHI at Crumlin / CHI at Temple St*
Ms Sinead Hassett	*Consultant General Surgeon*	*CHI at Crumlin*
Mr Brice Antao	*Consultant General Surgeon*	*CHI at Crumlin / Paediatric Network*
Mr Sami Awadalla	*Consultant General Surgeon*	*CHI at Temple St / CHI at Tallaght*
Mr Salvo Cascio	*Consultant Urologist*	*CHI at Crumlin / CHI at Temple St*
Professor Feargal Quinn	*Consultant Urologist*	*CHI at Crumlin*

Across CHI at Temple Street, Crumlin and Tallaght, there are three separate surgical programmes for referral management, out-patient clinics and surgical admissions. There is no central system for the management of referrals which impacts theatre efficiencies. There are 14 theatres in operation across CHI with varying utilisation - CHI at Crumlin has the largest capacity, with nine theatres (to include the Hybrid Cath Lab).

In March 2020, CHI at Tallaght temporarily relocated its acute paediatric services to CHI hospitals at Crumlin and Temple Street, and to the CHI paediatric outpatient and urgent care centre at Connolly due to the COVID-19 pandemic. In September 2020, CHI at Tallaght reopened with a change in surgical service delivery resulting in general surgery moving exclusively to an outpatient and scheduled day case surgery model. The reconfiguration of the general surgery model required the transfer of non-elective surgical activity from CHI at Tallaght to CHI sites at Crumlin and Temple Street.

The general surgery and urology future model of care outlines that there will be twelve consultants[1] delivering surgical services in the new hospital, with general surgery and urology operating as two separate departments.[2] There will be 22 operating theatres, shared between circa 19 specialties in the new hospital all operating for 9.5 hours per day.[3] This is an additional 8 theatres from the status quo across CHI today. There will be pre-assessment clinics for all children undergoing anaesthetic, which will improve the efficiency of theatres by reducing delays and cancellations. All referrals will be managed centrally leveraging the electronic healthcare record. Each of these aspects is a significant shift from current ways of working and will need to be managed appropriately to minimise potential patient safety issues.

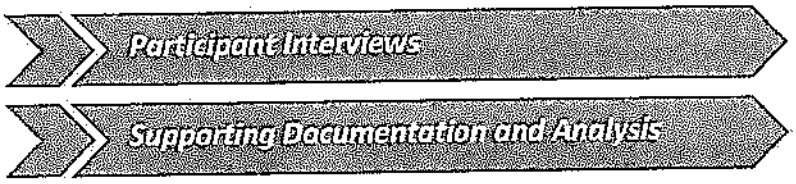
While digesting the details of this report, one must be cognisant of the immense change underway across all CHI sites for the last number of years. This is coupled with the business-as-usual challenges of safely and effectively operating three children's hospitals, and the additional and unprecedented impact of an ongoing pandemic and recent malware attack on the HSE. However, without real and measurable change and a shared purpose across CHI, we cannot grow as a collaborative, dynamic, innovative organisation, putting our patients and our people first.

The findings in this report presents a unique opportunity, to act as a catalyst for CHI leadership to make meaningful, strategic, and sustainable change. Binding CHI together as a single strong inclusive culture. Ensuring it can deliver first-class services for our children, young people and staff now and into the future as we move toward the opening of our new hospital.

[1] CHI Workforce Requirements. Definitive Business case. 2016.
[2] Clinical Operating Model General Surgery and Urology. 2019.
[3] Clinical Operating Model Theatre Department. 2018.

2 APPROACH AND METHODOLOGY

The exploration and analysis for this report was completed over a four-month period in two distinct phases:



2.1 Phase 1 – Participant Interviews

The initial phase of this process involved a series of one-to-one meetings with each of the ten General Surgeons and Urology Consultants across CHI. In addition, there were also meetings held with two Consultant Anaesthesiologists and Theatre Management in CHI at Crumlin. The purpose of this engagement was to gain insight into the General Surgery and Urology Service in CHI and to understand both the individual and collective needs of the department, while also establishing what is required to develop and sustain an effective, integrated, child centred service, within a professional and collaborative working environment.

Clinicians were very open in their engagement and frank with their feedback. Very quickly, the outputs of these engagements identified consistent themes that were serious in nature. Considering this feedback, the CEO sought approval from the Executive in July and commissioned a formal examination process. Committing a senior Clinical / Operations Lead and CHI's Human Resources (HR) Integration Manager, under agreed Terms of Reference (ToR) to undertake a formal examination of the General Surgery and Urology Service. The ToR allowed this examination to widen the parameters as required to resolutely explore all areas of concern and ensure all issues raised were robustly and comprehensively examined. See *Appendix 1* for further information.

The evidence in this report is taken from over 49 interviews with 44 participants conducted and transcribed over a four-month period. Each interview lasted approximately two hours and in excess of 10,000 words were recorded per meeting. The participants interviewed were selected as they worked directly in the General Surgery and Urology department or provided critical support services to the department (see figure 1). The participants interviewed described in detail, very personal experiences of the impact of the complex dynamics within the General Surgery and Urology Department. From these many interviews, which were held with both current and previous staff of CHI, issues and themes identified were persistent across a majority of participants. A standard set of questions were developed at the outset of this examination for use at each interview (See *Appendix 5*). As the examination progressed, additional areas for exploration were highlighted by participants, to include but not limited to training, urodynamics

department, risk management and behaviours of some consultants, nurse specialists and administration support staff. Questions for some interviews were then tailored to address the specific issues raised relating to certain areas, for example urodynamics department. Many anonymised quotes from these interviews will be detailed in this report to provide context. In some quotes small grammatical changes are made to allow for ease of reading. As per this examination's ToR, all transcribed notes from interviews were shared with the participants for validation.

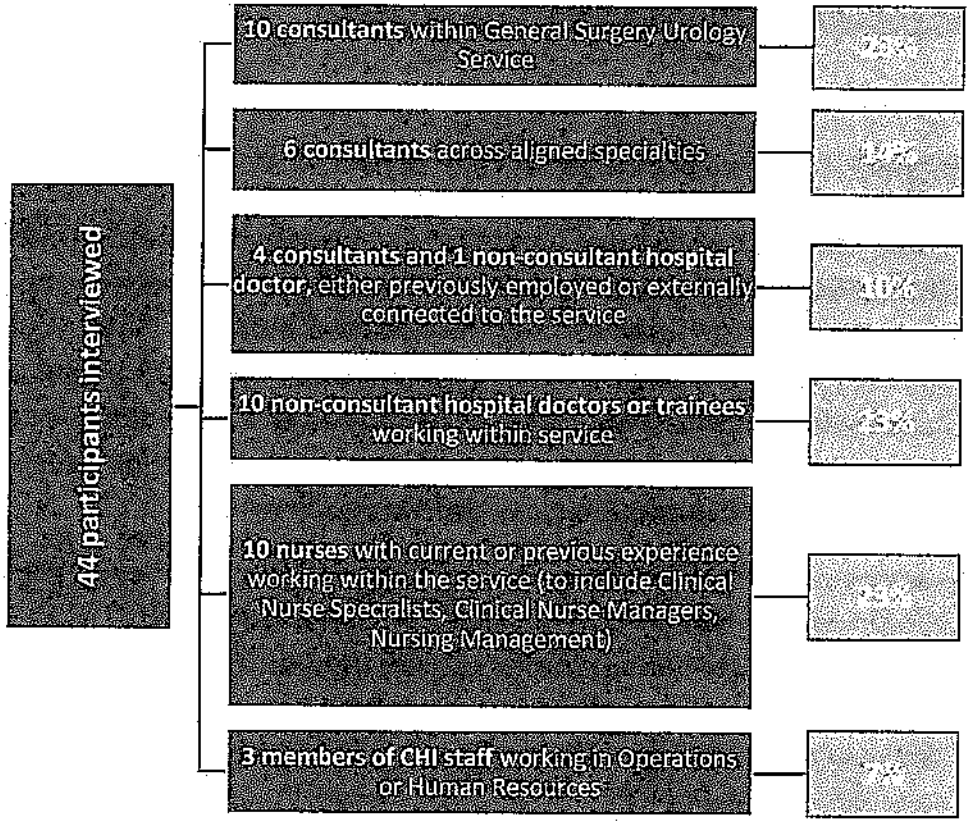


Figure 1 Breakdown of participants interviewed

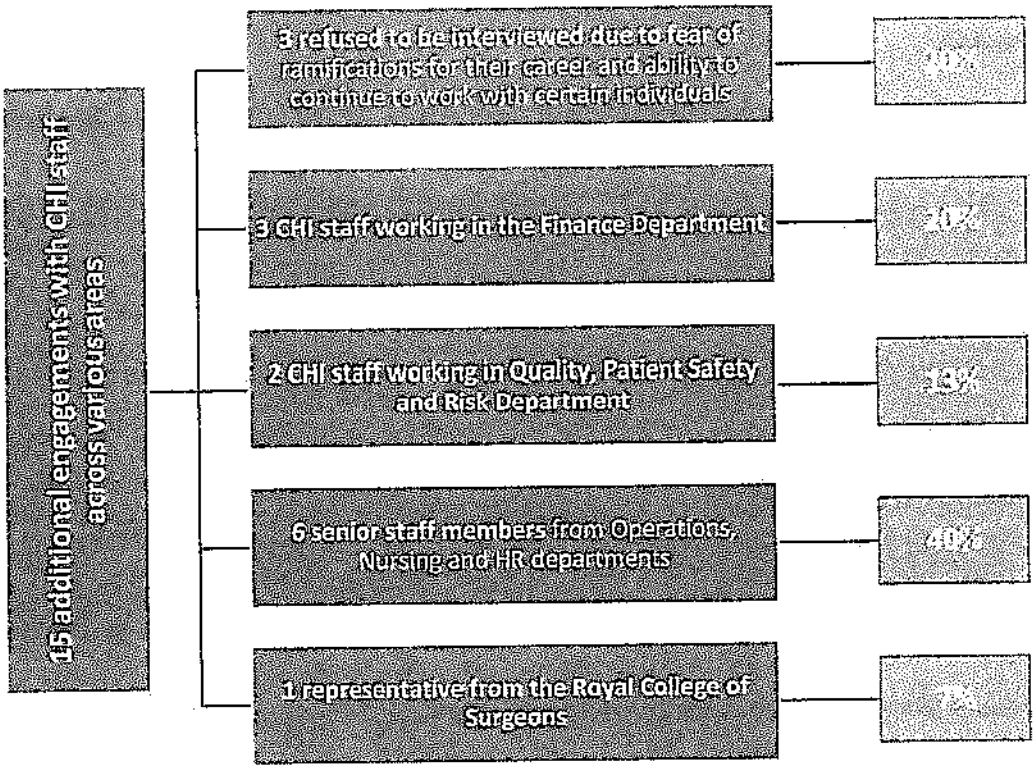


Figure 2 Breakdown of Engagements

Participant's anonymity is maintained at all times throughout this report. Participants will be identified only as P1, 2, 3 etc. The general surgery and urology consultants' titles will be used for context, but again anonymity maintained. The consultants pertinent to each chapter, will be detailed at the outset of that chapter as Consultant A, B, C etc to ensure clarity for readers.

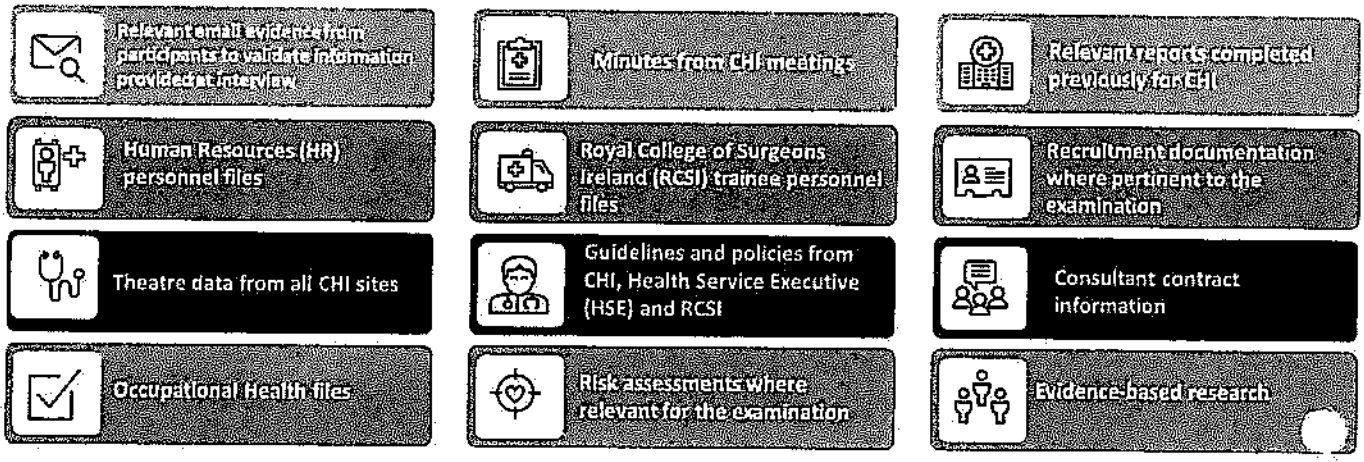
It is noteworthy and relevant to highlight that a number of staff both current and previous very adamantly declined to partake in the examination. Among reasons cited were fear of ramifications for their career and ability to continue to work with certain individuals within their hospital site. Others did not want to revisit past issues. The culture which exists in CHI will be explored further in the *Behaviours and Culture chapter* of this report.

2.2 Phase 2 – Supporting Documentation and Analysis

In addition to the interviews undertaken, hundreds of pages of supporting documentation were sought and examined in detail. Further data analysis was also completed working closely with CHI stakeholders to validate findings. This additional documentation was sought and reviewed to ensure a 360-degree evidence-based approach was applied to this examination and to substantiate and support themes and issues raised. All documentation reviewed is referenced

within the body of this report and will further attest to the recurring themes and issues raised by participants.

The substantiating documentation sought and reviewed as part of this examination includes:



An overview of the evidence-based research and international guidance reviewed as part of this examination is detailed below.

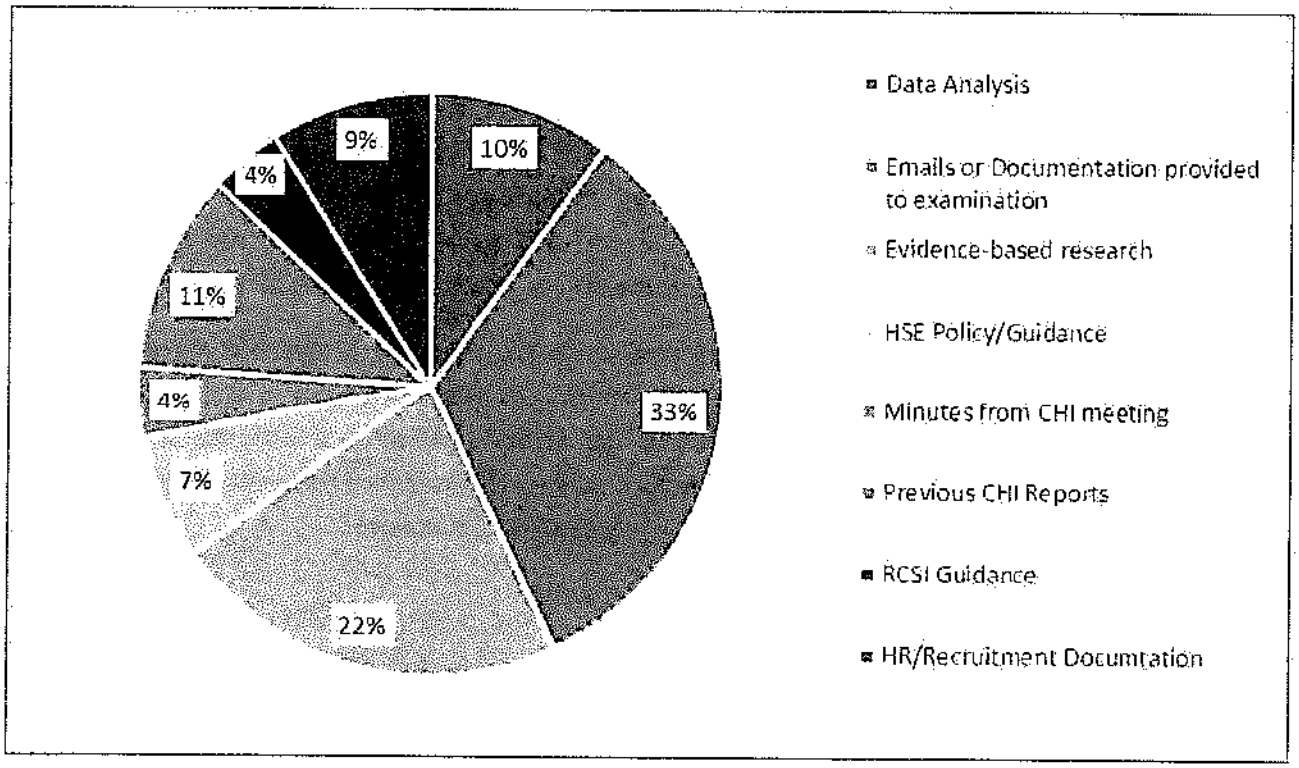


Figure 3 A breakdown of the types of evidence based undertaken

#	Title	Year
1	Rates of medication errors among depressed and burnt-out residents: prospective cohort study	2021
2	Undescended Testicles: What Is It & Treatment.	2021
3	Associations Between a New Disruptive Behaviours Scale and Teamwork, Patient Safety, Work-Life Balance, Burnout, and Depression.	2020
4	Urologic guidelines for the care and management of people with spina bifida.	2020
5	Self-management and independence guidelines for the care of people with spina bifida.	2020
6	HSE Incident and Management Framework.	2020
7	Burnout in Surgery Viewed Through the Lens of Psychological Safety.	2019
8	Reference Guide for Specialist Surgical Training in Ireland.	2019
9	The Shame–Blame Game: Is It Still Necessary? A National Survey of Shame-based Teaching Practice in Canadian Plastic Surgery Programs.	2019
10	Surgical Leadership: A Guide to Best Practice.	2018
11	Code of Practice for Surgeons in Ireland.	2018
12	HSE Change Guide: People's Needs Defining Change.	2018
13	HSE Integrated Risk Management Policy	2017
14	Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents.	2017
15	National Treatment Purchase Fund, National Inpatient, Day Case, Planned Procedure, Waiting List Management Protocol.	2017
16	Hypospadias, all there is to know.	2017
17	Clinical Directorates Underpinning Principles and Operating Framework.	2017
18	HSE Clinical Governance.	2017
19	Towards Successful Consultant Recruitment, Appointment and Retention.	2017
20	Psychological Safety and Learning Behaviour in Work Teams.	2016
21	The effects of power, leadership and psychological safety on resident event reporting.	2016
22	Teamwork in Health Care: Maximizing Collective Intelligence via Inclusive Collaboration and Open Communication.	2016
23	Health Consequences of Bullying in the Healthcare Workplace: A Systematic Review.	2016
24	Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review.	2016
25	The European Association of Urology/European Society for Paediatric Urology Guidelines.	2016
26	Framing for Learning: Lessons in Successful Technology Implementation. 2015.	2015
27	British Association of Paediatric Surgeons, Commissioning guide: Paediatric orchidopexy for undescended testis.	2015
28	HSE HR Circular 021/2015: Conditions and process by which permanent consultant posts may be filled with locum appointments or temporary appointments.	2015
29	Impact of organizational leadership on physician burnout and satisfaction.	2015
30	Good Surgical Practice: A Guide to Good Practice.	2014
31	Neural tube defects in the Republic of Ireland in 2009-11.	2014
32	Spina Bifida	2014
33	Troublesome Knowledge in Pediatric Surgical Trainees: A Qualitative Study.	2014
34	Ideal timing of orchiopexy: a systematic review.	2014

35	National Advisory Group on the Safety of Patients in England. A promise to learn – a commitment to act.	2013
36	eHealth Strategy for Ireland	2013
37	The impact of leadership and change management strategy on organizational culture.	2012
38	Perspective: organizational professionalism: relevant competencies and behaviours.	2012
39	The future of leadership and management in the NHS – No more heroes.	2011
40	Optimizing health care for children with spina bifida.	2010
41	Stress and Burnout Among Surgeons Understanding and Managing the Syndrome and Avoiding the Adverse Consequences	2009
42	Continuity of care for children with complex chronic health conditions: parents' perspectives.	2009
43	Health Service Executive, Code of Standards and Behaviour, Framework for the Corporate and Financial Governance of the Health Service Executive, Document 2.1.	2009
44	Demands, values, and burnout: relevance for physicians.	2009
45	Leadership, surgeon well-being and non-technical competencies of Pediatric cardiac surgery.	1999
46	The Importance of Continuity of Care in the Likelihood of Future Hospitalization: Is Site of Care Equivalent to a Primary Clinician?	1998

Table 1 Reports Reviewed

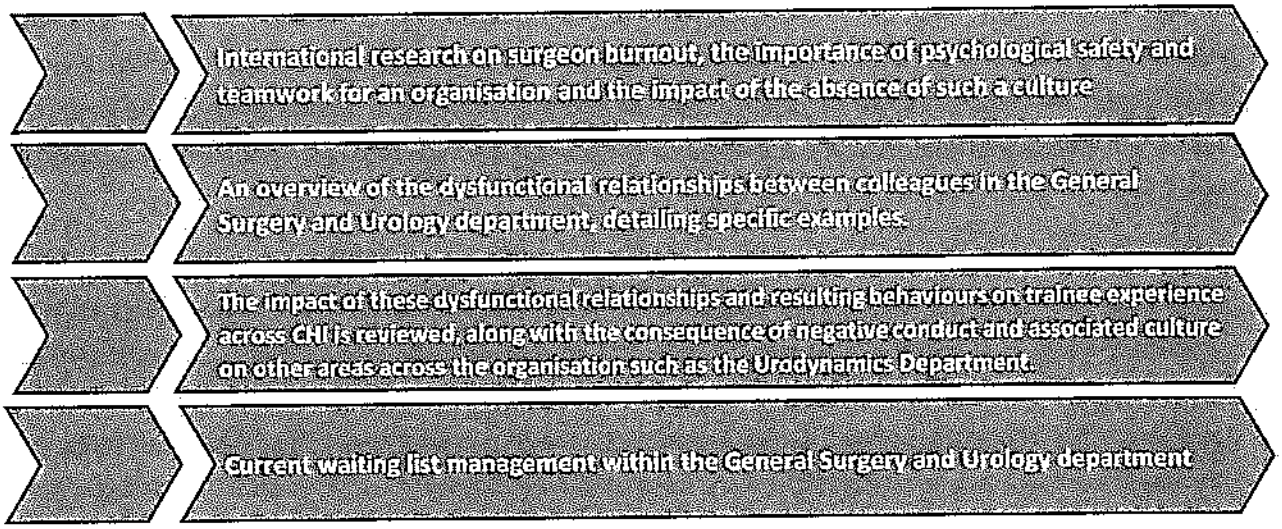
Obtaining the required background documents for this examination and ultimately this report, took a significant amount of time and effort, requiring multiple follow ups with CHI staff, some of whom at times were not always forthcoming. This pattern of behaviours will be explored further in the *Behaviours and Culture chapter* of the report.

Significant, robust and onerous data analysis was undertaken and validated by specific CHI staff, whose input and support were invaluable. This will be detailed further in the *Access and Waiting List Management chapter* of this report.

3 BEHAVIOURS AND CULTURE

3.1 Chapter Overview

In this chapter, the following areas will be examined:



Throughout this chapter anonymized quotes from participants will be used to give context to the themes being explored. The consultants highlighted specifically in this chapter are as follows:

Consultant A
Consultant B
Consultant C
Consultant D
Consultant E
Consultant F

While reviewing this section of the report it is important to keep at the forefront of one's mind the influence senior leaders have in shaping an organisation's culture[4] –

> *"Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours"*

[4] National Advisory Group on the Safety of Patients in England. A promise to learn – a commitment to act. 2013.

3.2 Context and International Research

The operating theatre is a highly stressful environment.[5] One participant during this examination described it as *"a high pressure, high stress, fast-paced environment...People in theatre don't walk, they run. They don't eat, they inhale. You are never off duty."* [6] The majority of participants in this examination all work in this high-pressured environment, which is known to cause premature burnout of staff.[5] Much of the programmes designed to prevent burnout among healthcare staff focus on the individual, however interventions at an organisational and systemic level are needed to make tangible changes to the working and learning environment to prevent burnout.[5,7]

Research acknowledges that *"destructive maladaptive behaviours"* can exist amongst surgeons, but that as we move towards more effective ways of delivering care and team working, a new dynamic model is needed to support these teams during extreme stress.[7] Left unchecked, research has shown that destructive behaviours, create a negative culture which hampers patient safety, as staff become unwilling to speak up and report process and outcome failures.[8,9] As healthcare advances and patient care becomes more complex, the need for a strong team-based approach in hospitals to ensure the delivery of quality patient care is paramount. [10]

A culture of psychological safety in organisations is key to this team-based approach, that is, where staff have a belief that they will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes.[8,11] CHI describes its mission to promote *"child-centred, research led and learning informed healthcare, to the highest standards of safety and excellence"*. However, to truly live this mission every day, fundamental shifts in culture are required to embed psychological safety and an environment conducive to continuous learning and improvement across the organisation.

Over the course of this examination 89% of participants interviewed described a culture where change was slow, which lacked governance and robust processes, and was heavily influenced by strong and exceptionally challenging personalities working in the organisation. Within the General Surgery and Urology department specifically, 66% of participants interviewed acknowledged that there was a lack of collaborative working in the specialty. During the interview process multiple participants described unprofessional and disruptive behaviour from consultants that significantly contributes to the culture which exists today. 27% of participants

[5] Swendiman R.; Edmondson A. and Mahmoud NJ. Burnout in Surgery Viewed Through the Lens of Psychological Safety. 2019.
[6] Participant Notes (See *Section 2.2* for more details)
[7] Winlaw D., Large M., Jacobs J., and Barch P. Leadership, surgeon well-being and non-technical competencies of Pediatric cardiac surgery. 2011.
[8] Edmondson A. Psychological Safety and Learning Behaviour in Work Teams. 1999.
[9] Appelbaum NP, Dow A, Mazmanian PE, Jundt DK, Appelbaum EN. The effects of power, leadership and psychological safety on resident event reporting. Med Educ. 2016 Mar;50(3):343-50. doi: 10.1111/medu.12947.
[10] Mayo A. and Williams Wooley A. Teamwork in Health Care: Maximizing Collective Intelligence via Inclusive Collaboration and Open Communication. AMA Journal of Ethics. 2016.
[11] Edmondson A. Framing for Learning: Lessons in Successful Technology Implementation. 2015.

described unprofessional behaviour from Consultant A, and 52% from Consultant D. As this examination progressed, additional areas for exploration were highlighted by participants, which directly related to behaviours of particular staff within the General Surgery and Urology Service. CNS A and a senior admin staff member were described as having considerably challenging behaviour by 100% of their colleagues with whom these concerns were specifically explored. That is 7 participants identified CNS A as having challenging behaviours and 6 participants recognised a senior administration staff member within the general surgery and urology service as exhibiting similar behaviours.

These behaviours which appear to have gone unmanaged by site leadership have incrementally led to a number of challenges for the organisation such as staff attrition, overall staff health and wellbeing, operational and financial impacts and of huge significance quality issues which ultimately have significant potential for impacting patient safety. 48% of participants interviewed voiced concerns about the effectiveness and decision-making of site leadership. This will be explored further in the *Leadership and Governance chapter* of this report.

It is important to acknowledge that despite the challenging behaviours outlined in this chapter many participants interviewed described the importance of patient safety, ensuing the child is at the centre of all decision making and ultimately wanting to deliver a best-in-class service for the children CHI serve. In fact, of the participants interviewed, 43% expressed that they wanted to see real change across CHI and were willing to be part of the solution to address the cultural challenges they see as existing.

Within the General Surgery and Urology service the Clinical Specialty Lead (CSL) was described as an exceptional leader and asset to CHI by 23% of participants. One participant described the CSL as *"a gentleman"* and the *"epitome of what they all should be"*.[6] If these members of staff are nurtured and empowered by leadership to make necessary changes, it can only benefit CHI and the transition to the new children's hospital.

3.3 Dysfunctional Relationships Between Colleagues

Today, the success of any individual surgeon is no longer dependent on him or her being an independent republic serving as the lone 'captain of their ship'.[12] The notion of the heroic leader is out-dated and inappropriate in a modern health service.[12] Instead, all surgeons, whether they have a clinical or non-clinical role, are expected to contribute to creating a safe working environment for patients and staff in their immediate team and the wider organisation in which they work.[11, 13] A safe, effective surgical team means accountability and empowerment are distributed rather than invested in one individual leader. [13]

Throughout the examination of the General Surgery and Urology service, many participant's described significant interpersonal difficulties among the surgical team, leading to what many

[12] The Kings Fund report. The future of leadership and management in the NHS – No more heroes. 2011.
[13] Royal College of Surgeons. Surgical Leadership: A Guide to Best Practice. 2018.

narrate as a *'toxic environment'*.[6] This subsection will give an overview of findings, using quotes from interviews and supporting documentation to illustrate the challenges which currently exist within the department.

a) Peritoneal Dialysis (PD) catheter pathway

There exists a dysfunctional and disruptive relationship between General Surgeons and Urologists in CHI - a consistent message coming through from participants in this examination.[6] A recent and very specific example of this ineffective way of working, can be highlighted by an issue relating to the management of peritoneal dialysis (PD) catheters. For this example, there follows details of a series of emails back and forth between general surgeons and urologists disputing what is in the remit of their role. The tone of the emails between the parties, suggests a complete lack of professionalism by some. Ultimately wasting professional consultants time, negatively impacting relations, and significantly potentially affecting patient care. Below is a summary of events over a three-month period from 30th August to 9th November 2021:

- Monday morning, 30th August, CHI Nephrologist requests an urgent PD catheter insertion in CHI at Crumlin. A General Surgeon, who is on call is asked to do this by the Nephrologist. This General Surgeon advised they were not in Crumlin, but operating in CHI at Tallaght at the time, and suggested that a Urologist, Consultant D, with an elective list that day could possibly support.[14]

- Consultant D is then asked to do this on their urology elective list. Following this, Consultant D sends a note to the Clinical Specialty Lead (CSL), outlining that *"[General Surgeon] is "unhappy" to do this as the person on call. I have been asked to do this. This is*
    - NOT a urological procedure
    - Carried out by general surgeons on duty in Temple Street (indeed I believe one carried out there by general surgeons over the weekend)
    - Should be no different in Crumlin from a request in Temple St" [14]

- Consultant D then goes on to complete the PD catheter insertion on their elective list.

- The CSL replies and highlights that if this request had been proposed out of hours, the General Surgeon would have undertaken the procedure. Also, as the General Surgeon was not on site in CHI at Crumlin, it would seem most appropriate for Consultant D to accommodate this request. The CSL also highlights the ongoing issue of the definition of what constitutes a urological procedure, and that it has not yet been clearly delineated

[14] Urologist email to Clinical Specialty Lead. PD Catheter. Dated 30th August 2021.

in the department. The CSL suggests Consultant D attend the Department of Surgery (DOS) meeting to discuss with colleagues. [15]

- Wednesday 1st September, DOS meeting occurs, without any urologist representation. Here the PD catheter issue is discussed at length by the attendees, and a pathway agreed.[16]

- Thursday 9th September, a letter describing the PD catheter pathway is sent from the CSL to Consultant D, copying in all General Surgeons, Urologists and Nephrologist consultants across CHI.[16]

  - This letter explains that at the DOS meeting, colleagues agreed that between 9am to 5pm Monday to Friday, PD catheter insertion should be part of the Urology workload. However out of hours and at weekends, General Surgeons will complete this procedure.[16] The letter also clarifies that the Nephrology consultant originally requested that the Urology team undertake the procedure, and that the variance in service across both sites is minimal despite what Consultant D's email may suggest. [16]

- Thursday 16th September, Consultant D replies and further clarifies that the Nephrology team contacted their team to ask who should insert the PD catheter - the Urology team in CHI (on their elective list) or the General Surgery team on call. As Consultant D had just sent for a major case, it was requested that the emergency team on call complete the request. Then Consultant D proceeds to highlight a case where Consultant E, after the DOS meeting, removed the PD catheter from the patient in question electively during working hours. Consultant D calls this *"unprofessional behaviour"* and *"abuse of the emergency list"*. Then Consultant D continues and explains *"the department cannot have things both ways. This is why I have stopped going to these meetings. Decisions are made and apparently agreed and then after the meeting individuals just do their own thing"*. [17]

- Friday 17th September, the CSL speaks to the Consultant E, to seek clarity on the events leading to the consultant removing the PD catheter. Consultant E confirmed they removed the catheter, while Consultant D was not in the country, at the request of the parents to accommodate the child attending their communion the following day - Saturday.[18] In addition to this, Consultant E was approached multiple times by Consultant D's Registrar and the Consultant Nephrologist asking for this procedure to be completed on Friday prior to the child's communion.[19] Consultant E then goes on to explain that Consultant D's *"conduct and actions have the potential to undermine professional*

[15] Clinical Specialty Lead reply to Urologist. PD Catheter. 30th August 2021.
[16] Department of Surgery Minutes. 1st September 2021.
[17] Urologist email to Clinical Specialty Lead. 16th September 2021.

working relationships and patient care. This unfortunately has not been an isolated incident but rather a pattern of behaviour."[18]

- Monday 27th September, the CSL replies to Consultant D stating that they had *"hoped you could attend the DOS meeting to discuss the PD catheter pathway as that would certainly have helped clarify your position and your involvement in this matter"*. Then the CSL goes on to emphasise that Consultant D's comments in relation to Consultant E are unwarranted, unacceptable and inappropriate and respectfully requests Consultant D to withdraw these comments as they are not in keeping with CHI's values or in the best interests of patients cared for in CHI. [19]
  - This email received no response from Consultant D for a period of 6 weeks.

- Tuesday 9th November, the CSL followed up and requested an acknowledgement or reply to the email sent on the 27th September.[20]

- Consultant D responded promptly on the 9th November. There was no retraction of their original statement as was requested by the CSL. The reply states *"I acknowledge receipt. I have nothing further to add."* [21]

The above scenario is a snapshot of the problematic communication and fraught relationships that exist between general surgeons and urologists. Although patient care was not compromised in this instance, the communication style, accusatory language and indeed unprofessional antics, that continued over this period, add to further compromise interpersonal relations, heighten levels of mistrust among colleagues, and ultimately are a distraction from patient centric care. Research has shown poor behaviours, such as verbal abuse, publicly humiliating others, and discontinuation of communication such as not engaging in meetings, destabilise psychological safety and undermines speaking up about patient safety issues. This increases the risk of harm to patients.[26] This situation may not have transpired if there was appropriate and direct professional patient centred communication between the general surgeons and urologists. A team-based collaborative approach to address this issue at the department of surgery meeting two days after the problem arose could have rectified this issue earlier, however not all consultants attend this meeting. [23] [17]

[18] General Surgeon email to Clinical Specialty Lead. 17th September 2021.
[19] Clinical Specialty Lead email to Urologist. 27th September 2021.
[20] Clinical Specialty Lead email to Urologist. 9th November 2021.
[21] Urologist email to Clinical Specialty Lead. 9th November 2021.

b) Oncology Service

Paediatric oncology patients have a poor experience, or are harmed, due to the inability of CHI to deliver international best practice standards of paediatric surgical oncology provision
CHI Oncology Risk Assessment, 27th August 2021

This is a documented risk following a recent risk assessment of the oncology general surgery service in CHI.[22] The factors that have resulted in this risk score and the interpersonal challenges that exist in this service are detailed below.

At present, there is only one consultant delivering services in the oncology general surgery practice.[22] Consultant A is the lead for the oncology general surgery service since replacing their predecessor in 2012.[6] In 2017, following a formal recruitment process a second consultant, Consultant B, was hired on a permanent basis to support Consultant A in the oncology general surgery service.[6] Prior to the appointment of Consultant B, a locum consultant, Consultant C had been taken on to support the service between 2012 and 2017. [6]

Despite there being two consultant surgeons with experience in oncology general surgery albeit to a lesser extent than the service lead, employed by CHI, the service depends solely on Consultant A to manage the needs of the children of Ireland.[6] [22] Due to significant gaps in service governance and site management of the General Surgery Oncology service to include service planning, Consultant B and Consultant C have not practiced in the oncology service in approximately five years and therefore have not retained the specific skills necessary to support this service today. Thus, exists a dependency on one consultant for the management of a tertiary speciality.[22] This level of dependency on one individual for a critical service is not in line with best practice. [23] Based on this recognised dependency and vulnerability of the service coupled with additional concerns that were consistently coming through from participants, all of which will be explored further in this section, this examination at the very outset called for an urgent risk assessment of the oncology general surgery service. The outcome of that risk assessment was a risk score of 20 (out of a possible 25). This being categorised as a high red risk, which the HSE states, are risks which *"are intolerable that is they cannot be accepted and require significant management focus to mitigate them"*.[24]

Throughout the course of this examination a very clear and consistent narrative in relation to the breakdown in communications and working relationships among consultants in the oncology general surgery service emerged.[6] In fact, during the interview process, 41% of participants acknowledged that the Oncology Service was not delivering best practice. For the purpose of this

[22] CHI General Surgery / Oncology Surgery Risk Assessment. Completed 27th August 2021.
[23] Royal College of Surgeons Ireland. Code of Practice for Surgeons. 2018.
[24] HSE Integrated Risk Management Policy Part 2. Risk Assessment and Treatment Guidance for Managers. 2017.

report, as the experience of both Consultant B and Consultant C is somewhat comparable and to ensure confidentially is maintained, the individual experiences will not be distinguished.

What follows below is a series of quotes that focus on Consultant A's behaviours and ways of working within the oncology general surgery service. These come from fellow consultant colleagues in the department, and outside the department, as well as others healthcare professionals who have interacted with Consultant A while working in the service.

Source	Quote
Participants 12, 15, 26, 34, 35, 36, 37.	*"Part of it, lot of it, is the [Consultant A] dynamic. 2013, when [Consultant A] and [Consultant C] were working together, it was ok. Progressively that was less productive... Then they appointed [Consultant B]. Now it's fallen apart, not working, and there's no remedy."* *"In the background, I can understand why that decision was made - That is a short coming of [Consultant A]. [They] can make rash decisions without employing a significant MDT approach to give [them] the infrastructure to support the procedure...* *[Consultant C]... had some skills [Consultant A] didn't have, specifically laparoscopic surgery. But also, this was a stumbling block, two surgeons operated differently. [Consultant A] isn't a laparoscopic surgeon... [Consultant A] is not a teacher/senior and did not want to take responsibility for [Consultant C]'s training"* *"[Consultant A] would speak in a derogatory way about [Consultant B] to trainees."* *"There were supposed to be two consultants, but we only have one consultant... There is a lack of collaboration. If you ask for help, the issue is taken over. Oncology – around the world tends to have 3-4 surgeons. You need a team, not a one-[person] band."* *"[Consultant B] and [Consultant C] proposed it. They haven't got hard core oncology surgery experience. They could help, but I don't think there is teamwork... This individual likes to work on their own and closes down any reaching out. Individuals that have come, haven't been as fully trained or experienced as they are. There is only one person's opinion currently in the service but the ideal would be to have two people to bounce ideas. It is possible that [Consultant B] and [Consultant C] may be disempowered."* *"It's a massive risk. [Consultant A] is decision maker in oncology service."* *"My sense, there are risky cases, did [Consultant B] feel supported? Not sure the level of connection was there with [Consultant A]. It's difficult to work with another surgeon - ways of working and relationship are critically important to enable that. If relationship is not there – it can be a challenge."*

Table 2 Oncology Service Quotes

The quotes above, appear to demonstrate a pattern of behaviour of Consultant A, and an approach to work which one participant described as *"Not a team player. a Soloist"*.[6] It is very clear and repeatedly stated by many, that a multidisciplinary team (MDT) approach is not being employed in this very specialist service.[6] Research has shown such a lack of collaborative working is not in the best interests of the child.[9] [10] It would also appear that Consultant A did not feel obliged to or provide support or mentorship to their lesser experienced colleagues working in the service, again something which is not in line with best practice. [25]

Furthermore, and what is critically important to note, is that the management and responsibility of the national paediatric oncology general surgery service rests with one individual.[22] The potential impact of this level of responsibility and pressure on an individual's shoulders cannot be underestimated. Consultant A's colleagues have expressed concern for their emotional and physical wellbeing. This level of concern was compounded after a seminal case involving a neonatal patient that resulted in significant complications during surgery and a difficult recovery. Consultant A was undertaking this surgery alone.

Source	Quote
Participants 11, 15.	*"After [Consultant A]'s case, [they were] talking about how many more years [they] had to work. [They were] very vulnerable after that. I really felt quite concerned for [them]... The people who were called to help at that time were quite concerned about [Consultant A], [their] health, [their] mental health. [Their] ability to carry on. So, people were concerned and are concerned. I'm not sure how much longer [they] can keep going like this."* *"Things can happen fast with [Consultant A]... [They were] concerned for [Consultant A]'s wellbeing to undertake these operations with such complications."*

Table 3 Consultant A Seminal Case

The workload that Consultant A completes compared to their consultant colleagues in the general surgery and urology department is significant; approximately 28% more activity than the next highest consultant (see Figure 4). In a period between November 2020 and April 2021, Consultant A completed 18% of all General Surgery and Urology surgical activity in CHI. Research looking at stress and burnout among surgeons lists the professional consequences, which include, but are not limited to, poor judgment in patient care, decision making, medical errors, adverse patient events, and difficult relationships with co-workers.[26] It is clear that an intervention is needed for both surgeon wellbeing and patient safety.

[25] Royal College of Surgeons. Good Surgical Practice: A Guide to Good Practice. 2014.
[26] Balch C, Freischlag J, Tait D, Shanafelt MD. Stress and Burnout Among Surgeons Understanding and Managing the Syndrome and Avoiding the Adverse Consequences. 2009.

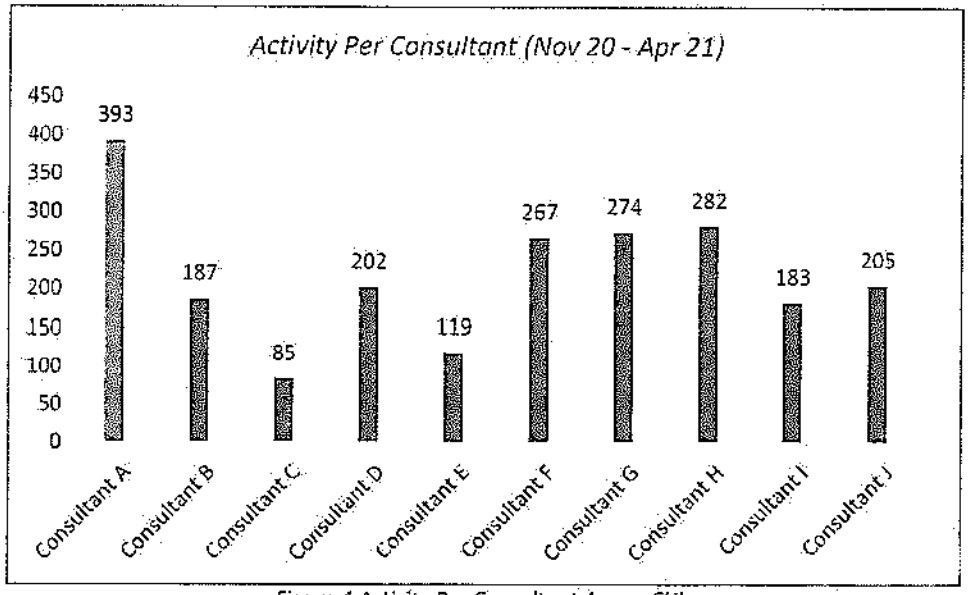


Figure 4 Activity Per Consultant Across CHI

An additional seminal case which further highlights the lack of collaborative working, and what one might describe as dysfunction within the general surgery oncology service is important to reflect on. Consultant B completed an oncology surgical procedure, where the case went on for a prolonged period of time, far in excess of what was initially anticipated.[6] This led to patient complications. The case triggered an After-Action Review (AAR), which very much highlighted how the challenging interpersonal relationships were impacting patient safety and care within the service.[6 22]

Source	Quote
Participants 6, 11, 15.	*"In this case, it was a substantial procedure. From my understanding, this case would have been a two-person surgery in [Country] were [they] practiced. It was a very difficult case... [Consultant A] wasn't there and [Consultant B] didn't seek [their] help... MDT meetings don't happen because [Consultant A] wouldn't organise MDTs."* *"To be honest, a few of us felt [Consultant B] was quite vulnerable. So, we actually did try to back [them] up. We tried to take [them] aside to give [them] some reassurance... There are some people... who did not want to work with [Consultant B] following that case, whereas others of us obviously thought that [they] needed some support after it."* *"I am not sure if it was, that support was requested and was not forth coming, or if the decision was made by [Consultant B] to undertake surgery [themselves].. I think having second surgeon would be beneficial."*

Table 4 Consultant B Seminal Case

An AAR is:

> *"a structured facilitated discussion of an event, the outcome of which enables the individuals involved in the event to understand why the outcome differed from that which was expected and what learning can be identified to assist improvement."* [27]
>
> **HSE, 2018:21**

Every incident can be reflected on and learned from as a multi-disciplinary team in order to understand what happened, why it happened and what's required to prevent a reoccurrence. [27] However, this depends on a collaborative and supportive approach from the team, allowing everyone to contribute equally. [27] The AAR which occurred post Consultant B's seminal case did not transpire in this way:

Source	Quote
Participants 6, 15, 17, 21	*"It was the worst thing I have attended - that AAR. It was appalling... Can't see how [Consultant B] wouldn't be impacted by it."* *"A meeting has lost sensibility if someone of importance has left the room."* *"What happened was there was a case that [Consultant B] was involved in that turned out to be case which went on for much longer than initially planned. Normally you might call for help. That didn't happen. [Department] involved in case, said [they] shouldn't have gone on so long. Very much a near miss. AAR may have been the wrong format to use. This is non-confrontational and discusses what happened in a non-judgemental environment, respectful. However, it was very aggressive, very confrontational."* *"One person did leave the room, soon after it started... We started with expectations... They felt there was finger pointing and said "If there's going to be blame or finger pointing... It's important we all engage in this..." and left...[The AAR attendees] did participate. I didn't feel that they left feeling angry. They did engage. Often AARs are uncomfortable, often why it's requested initially..... I didn't sense it was happening in isolation. Maybe back to trust in the organisation."*

Table 5 After Action Review

Owing to an apparent lack of collaborative working a pattern of behaviours exist which undoubtedly has the potential to affect patient safety. In the foreword of the Royal College of Surgeons guide on Good Surgical Practice (which is endorsed by RCSI), Clare Marx, President of the Royal College of Surgeons England, rightfully states -

[27] HSE Incident Management Framework. 2020.

> *"Surgery, as we all know, is not a solitary activity. Patient safety and good practice certainly depend on the individual surgeon, but also on effective teamworking both within the surgical team and the wider multidisciplinary team"*[27]

In this case, one might argue the surgeon may not have felt comfortable to ask for help because a culture of seeking support or asking for help, is not present in the department.

c) Defamation Case between Surgical Colleagues

There is an ongoing defamation case arising from challenges between two consultant surgeons in the general surgery and urology department. As this is an ongoing legal case, this report will not explore the matter in detail. However, it is reasonable to assume that such a case can only arise as a result of fraught relationships across a department. This can only impact negatively on the department, those that work within it and the children that access its services.

The lack of leadership oversight and intervention must not be overlooked with regard to the above. Leadership accountability and governance will be further explored in chapter 5. However, it is important to note that, what appears to have started as poor and unamenable communication between consultants in the general surgery and urology department, very quickly escalated. What was ultimately personal contention between two consultants, was taken on by clinical and site leadership in CHI at Temple Street and has now evolved to a place where CHI are embroiled in a defamation case.[6]

3.4 Surgical Training Programme in CHI

CHI's mission is to promote and provide child-centred, research-led and learning informed healthcare, to the highest standards of safety and excellence. CHI promise to *'truly value'* future employees *'expertise and passion'*.[28] In partnership with the RCSI, CHI work to enable specialist surgical training in Ireland. An overview of the supporting structures and governance of the Surgical Training Programme is outlined below.[29]

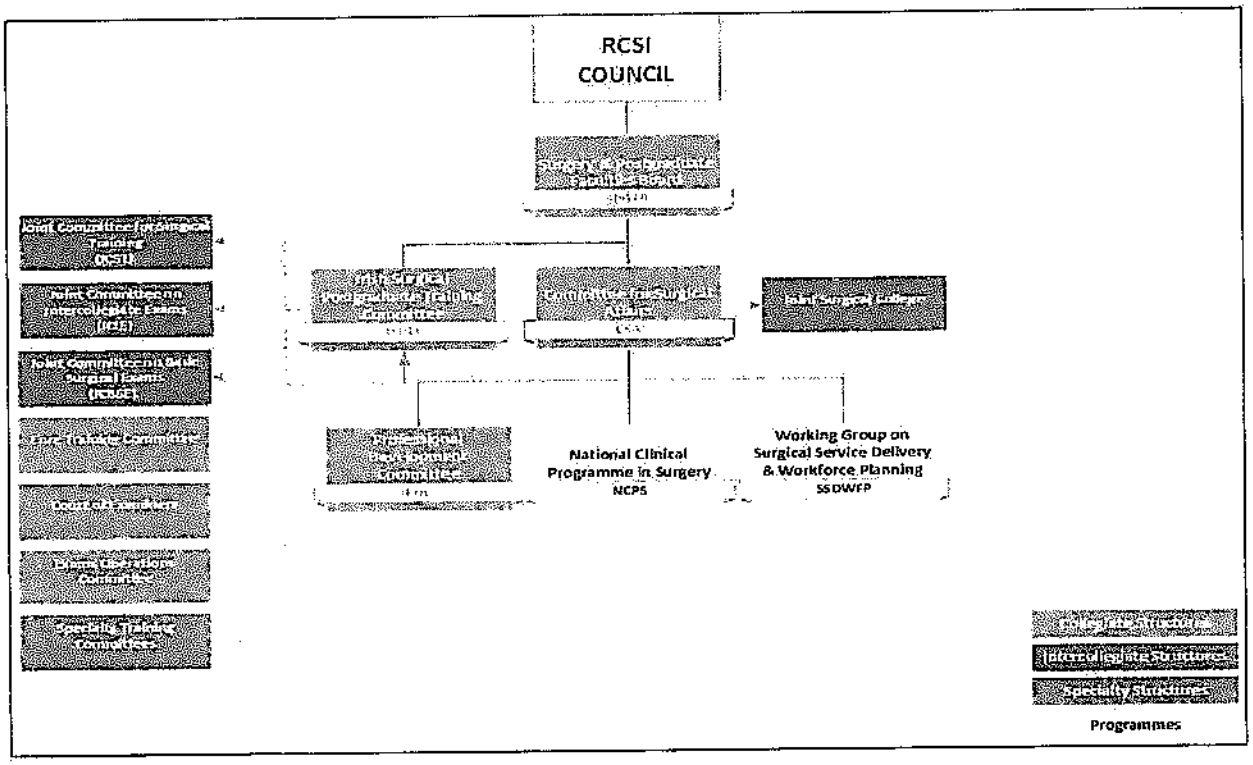


Figure 5 Surgical Training Governance

In September 2021, following a review of the training programme [30], SAC submitted a number of recommendations regarding the trainee experience in CHI. Following this report, the RCSI confirmed that it was the Department of General Surgery and Urology's view, that there should not be an intake of any new trainees or Specialist Registrars (SpRs) into the programme in 2022, until the various identified problems with training are addressed.[31] This development impacts not only the current trainees in the programme but also CHI's reputation and mission to a be a first-class academic organisation now and into the future.

The recommendations in the SAC report focus on creating a supportive environment for trainees to learn, with a particular emphasis on work culture and work ethos and the health and wellbeing of trainees.[30] The findings of this examination are entirely consistent with the SAC report.[6] Feedback from trainees both past and present is resolute, in addition to observations from many

[28] CHI jobs homepage. Accessed November 2021.
[29] Reference Guide for Specialist Surgical Training in Ireland. RCSI 2019.
[30] SAC Report Summary. 2021.
[31] Email from RCSI Managing Director to CHI Chief Executive Officer. Dated 7th September 2021.

participants, all describing an environment and working life that is adversely impacted by the *'negative'* and *'toxic'* culture that exists in the department.[6] The concerns raised around the surgical trainee experience across CHI will be explored further in this subsection.[30] It is important to acknowledge however that within this challenging culture are consultant surgeons committed to training and creating a safe learning for those they work with. Consultant C, Consultant G, Consultant H, Consultant I and Consultant J were all identified during participant interviews as what a trainer *"should be"*.[6]

a) Trainee Learning Environment

Over thirty hours of interviews were conducted with trainees both past and present as part of this examination. The participants were extremely honest and open in their feedback. Although, at the outset a majority of trainees raised concerns about the potential negative impact on their careers, of partaking in the examination and reflecting their views.[6]

Participants provided a broad and varied narrative about their individual training experience, however across 50% of trainees there was a consultant identified consistently as creating a psychologically unsafe environment not conducive to learning.[6 11] There follows below a variety of quotes from CHI staff across the board, from consultants to trainees, nurses to operations staff and management, who have witnessed or experienced behaviour which they have deemed to be unprofessional, from Consultant D. In some cases, questions have been included for context.

Source	Quote
Participants 15, 19, 22, 23, 25, 27, 31.	*"If I have a case where [Consultant D]'s expertise would be helpful, my heart sinks. [They don't] make it easy. Bridge blower-upper not builder."*
	"I'm fairly resilient. I can take the hit for the team, probably a bit tough, but because of how I feel around [Consultant D], I felt powerless. Compared to any other person on the planet, I felt powerless to challenge [them]."
	"Q: If you had to continue working with [Consultant D]... how would you feel about it? *I wouldn't do it...if it was the same, I wouldn't do it...when it comes to that point of losing yourself and you're not sure of your abilities... [your] disabilities highlighted on day to day basis...constantly feeling inadequate..."*
	"I didn't want to call [Consultant D] because [they] would punish and exclude you, belittle you and say you were no good. I felt fearful, felt unsafe to ask [Consultant D] for help."
	"There's a lot of people who have come across [Consultant D]'s path and it has had a detrimental impact on their lives."

"Scrub nurses don't like scrubbing with [them], only a few will. [Consultant D] would be giving them a hard time when they are trying to do their best. It's been bullying type behaviour in the past."
"That conversation got back to [Consultant D], [they] said I shouldn't be telling people I was working these hours even if I was because it made [Hospital] look bad."

Table 6 Consultant D Behaviour

The above reflections, from very personal experiences, appear to highlight a pattern of abrupt, unprofessional, intimidating, and volatile behaviour.[6] The atmosphere such behaviour creates, and its impact on anyone who witnesses or experiences it, either directly or indirectly should not be underestimated.[32] This is particularly compounded for trainees who in many instances are dependent on a consultant to enable their career progression.[33] Intimidation and shaming of trainees has been shown to lead to deteriorated emotional health, including loss of self-confidence, depression, professional isolation, and poor job performance.[34] One study reviewing the effects of depression on medication errors, showed that depressed residents were up to 6.2 times more likely to make errors than their non-depressed peers. [35]

Behaviours displayed by this consultant appear to be consistent with and reflective of conduct that has been identified as leading to and creating a psychologically unsafe environment, that is an environment where an individual feels they may be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes. [36] Research on disruptive behaviours in healthcare show that medical trainees in particular, fear speaking up about these types of behaviours due to concerns around getting someone else in trouble, escalating conflict, and eliciting anger and alienation from other team members.[37] The consequences for the health and wellbeing of staff of working in such an environment, the impact on patient outcomes and subsequent effect on an organisation's performance cannot be underestimated. [38] Recent research shows higher levels of disruptive behaviours were associated with lower levels of teamwork and safety culture[10], confirming that collaboration within a team is preferable to risk.[10]

Over the course of this examination 16% of participants have called out the impact of Consultant D's behaviour on trainee's mental health and wellbeing.[6] In fact, a SAC liaison member also

[32] Lever I; Dyball D; Greenberg N; and Stevelink S. Health Consequences of Bullying in the Healthcare Workplace: A Systematic Review. 2016.
[33] Blackburn SC and Nestel D. Troublesome Knowledge in Pediatric Surgical Trainees: A Qualitative Study. 2014.
[34] The Shame–Blame Game: Is It Still Necessary? A National Survey of Shame-based Teaching Practice in Canadian Plastic Surgery Programs. 2019
[35] Rates of medication errors among depressed and burnt out residents: prospective cohort study 2021
[36] Associations Between a New Disruptive Behaviours Scale and Teamwork, Patient Safety, Work-Life Balance, Burnout, and Depression. Rehder et al. 2020
[37] Martinez W, Lehmann LS, Thomas EJ, et al. Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. BMJ Quality & Safety 2017;26:869-880.
[38] Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review 2016

expressed concerns around trainee mental health and wellbeing in an email to CHI's CEO in July 2021.[39]

Source	Quote
Participants 16, 19, 20.	*"It is a long standing and historical issue. Trainees are scared of [Consultant D]. They are used as go between's for consultants to settle scores... It's a toxic environment, describing the time spent training in [Department]. You are just trying to survive with mental health intact. It's not a psychological safe department."* *"You would see with [their] trainees. In fairness they wouldn't discuss it, they keep it in. They don't talk... When it comes to patient safety everyone's voice must be heard. Then to be in an environment created by [Consultant D] where you feel you can't stand up."* *"[They] became more upset stating that [they were] hating [their] Reg post with the urology service as "[Consultant D] was making [their] life a misery and making [them] doubt [their] ability as a good doctor". [Consultant D] would question [them] and criticise [them] at every opportunity. I then said [Consultant D] was a bully and [they] said yes [they are] ... I asked had [they] spoken to anyone or [colleague] as [Clinical Specialty Lead], [they] said, "what's the point nothing changes here"."*

Table 7 Trainee wellbeing concerns

b) Trainee Experience

The behaviour of Consultant D towards trainees has been highlighted to HR in Our Lady's Children's Hospital Crumlin (now CHI at Crumlin) and the RCSI in the past. A previous trainee advised they chose to not progress or finish their training due to the bullying and intimidation they experienced from Consultant D.[6] This trainee raised the issue with HR in Our Lady's Children's Hospital Crumlin and the RCSI at the time. A specific example of their experience with Consultant D is detailed below. Note the extracts cited are from a letter sent to the Professor of Postgraduate Surgical Training in RCSI about this trainee's experience.[40]

Extract
"Since I started, I have been experiencing a lot of bullying / harassment mainly from two consultants [previous General Surgeon] and [Consultant D]. I feel that I am working in a hostile environment, waiting to be victimized. I am subjected to humiliating and intimidating experiences. They are always undervaluing my performance. It has reached a stage that it is affecting my self-esteem, confidence and performance at work in hospital and also at home affecting my family life. The thought of doing on call with these consultants makes me so nervous and stressful."

[39] Email from SAC Liaison to CHI CEO. Dated 19th July 2021.
[40] Trainee letter to Professor of Postgraduate Surgical Education RCSI.

"Once [Consultant D] told me that there was a complaint against me from a parent. The allegation was that I refused to see a patient and finally when I saw the child I was rude and arrogant and told the mother that nothing can be done now, let the team come tomorrow and sort it out.

I told [Consultant D], that's not the case. When I spoke to the mother, she was actually happy and there was no problem. [Consultant D] said – you are lying. If it is true you have to face serious consequences. When I went and spoke to the mother she told me that it was not me, but the other doctor (SHO). She volunteered herself and went down to the patient support and cleared me. Later on, when I went to the patient support group and asked them to let [Consultant D] know that I am not involved in this case, they told me that they are not going to ring [Consultant D] because it was [Consultant D] that told the mum to go down and complain to the patient support group. I have confirmed this with the mother"

Extract 1 Letter to Professor of Postgraduate Surgical Training

During the course of this examination, multiple participants raised concerns regarding a far more recent process involving Consultant D and a trainee who was in their final stage of training. The outcome of the process ultimately leading to the trainee having to undertake an additional uniquely devised assessment to demonstrate their basic surgical skills.

In October 2020, during what should have been the final six months of assessment for this trainee, the Training Programme Director (TPD) was stopped in the corridor in a CHI site by Consultant D to advise they were going to speak to the Professor of Postgraduate Surgical Education in the RCSI about this trainee's skills, as they were not happy with them.[41]

The TPD confirmed that this concern was not shared by any of the other consultants in the department.[41] In fact it was outlined by the TPD to the Professor of Postgraduate Surgical Training in late October 2020, that the opinion of Consultant D was *'in contrast to the other members of the department and did not mirror the [trainee's] ARCP [Annual Review of Competence Progression] outcomes.* [41] A number of participants throughout this examination questioned the manner in which the concerns relating to this trainee were raised and reflected that it did not allow for or take into consideration other consultants points of view.[6]

Having undertaken an exhaustive analysis of documentation and correspondence in relation to this matter, to include:

- Trainees Personnel file from CHI
- Trainees Personnel file from the RCSI
- All records and details contained in the trainees ISCP portfolio
- All correspondence from the RCSI with Consultant D in relation to their concerns about this trainees
- All correspondence between the TDP, the RSCI and Consultant D in relation to the disquiet regarding this trainee

[41] TDP Email. 12th November 2021.

It appears that the only written documentation from Consultant D in relation to their concerns about this trainees' capabilities or skills are notes from a meeting Consultant D held with the trainee on October 9th, 2020.[42] In this regard the below points are observable:

- The meeting notes are recorded by Consultant D [42]
- These notes were shared with the Trainee by the TDP on January 28th, 2021 requesting that they be uploaded to the trainees portfolio[43] – this was over 3 weeks after the trainees assessment had taken place on January 5th. [44]
- These notes do not align to the Assigned Educational Supervisor (AES) report template approved by the ISCP (see figure 6).
- The following day on January 29th – The Trainee uploaded to their portfolio, their 'reflections' on the meeting notes from Consultant D.[45] Much of the notes documented by Consultant D are contested by the Trainee. [45]
- In an email from Kieran Ryan, Managing Director of RCSI on the 8th November 2021, [46] it states:

> *'From your email below, you seem to be requesting written documentation on the concerns raised by [Consultant D] with RCSI which then led to the subsequent assessment on foot of these concerns. Such documentation is with [trainee] on [their] ISCP account. This comprehensive note from [Consultant D] which provides detail of both the competency and skills concerns along with reference to the conversations that [Consultant D] had with [trainee] relating to these concerns are all clearly documented on [trainee's] ISCP account'*
>
> **Kieran Ryan, Managing Director of RCSI**

This 'note' that the RCSI Managing Director refers to, is in fact the notes are recorded by Consultant D from the meeting which took place between Consultant D and the Trainee on the 9th October 2020. [46]

This note was not in the Trainee's personnel file as received from the college. There is no detail on this note advising that it is or is intended to be a report for the RSCI from Consultant D in relation to their concerns around the trainee's skills and capabilities.

Furthermore, and of huge relevance is that given that this note was only shared with the Trainee for uploading to their ISCP account on January 28th 2021[43] – it would appear that the college did not have sight of any written documentation relaying concerns relating to this trainee in advance of either an assessment being determined as necessary or indeed the assessment taking place. As this 'note' was not contained in the Trainee's RCSI file the college shared and was only

[42] Consultant D and Trainee meeting minutes / AES Report. Dated 9th October 2020.
[43] TPD to Trainee email with AES Report. 28th January 2021.
[44] Paediatric Basic Technical Skills Scoresheet 2020. Dated 5th January 2021.
[45] Trainee reflections on ISCP. 29th January 2021.
[46] RCSI Managing Director email. 8th November 2021.

uploaded to the Trainee's ISCP account on the 28th January, after the assessment had taken place it could not have been used as the RCSI Managing Director advises as the documentation that *"led to the subsequent assessment on foot of these concerns".* [46]

To understand the entire journey of the trainee through this process, the below (Table 8) reviews the sequence of events over a seven-month period which led to this assessment. Quotes from the trainee are also highlighted.

Date	Key event
June 2020	Trainee expresses an interest in Urology and requests to work with Consultant D to prepare for their fellowship the following year.6 *"Wouldn't have said [they were] ecstatic. [Consultant D] said, "There are other trainees who need to do or are asking to do urology, talk to [TPD] about it". Didn't say brilliant. I gave a wide latitude of allowance"*
July 2020	Trainee, in final six months of training, begins working with Consultant D.[6]
September 2020	Disapproval from Consultant D following the Trainee fulfilling their registrar rota requirement in CHI at Tallaght. Consultant D, who was 'quite annoyed' with the situation, used a 'raised tone' when speaking to the trainee about it.[6] This was witnessed by an SHO colleague. [6] Consultant D did not agree that CHI at Tallaght was approved for trainees, although this had been discussed at DOS meeting and was a direction from CHI after the reconfiguration of surgery services in CHI at Tallaght.[47]
October 2020	Soon after the contention at the end of September over the trainee partaking in assigned rota in CHI at Tallaght,[47] the trainee undertook a complex pyeloplasty case. This case did not go as hoped and the trainee confirmed they were '*struggling*'. Ultimately Consultant D took over. [6] *"It was the last case of the day and I was doing badly. I was struggling to access the kidney, [Consultant D] came into OT. [They] tutted and scrubbed in, I came back in an assistant role, I struggled but I was going through the steps. I hadn't done pyeloplasty independently, but I had been supervised. It's an operation you can struggle with. I was struggling. [Consultant D] was in a supervisory and not a coaching role. [They were] getting annoyed."* 8 days following this case, Consultant D called the trainee into their office, without prior notification, to discuss the surgery and assess their

[47] Email from Clinical Specialty Lead confirming direction. 23rd November 2021.

	performance. The trainee does not recall Consultant D taking notes during this meeting or stating that they would.[48] [6]
	The TPD was stopped in the corridor by Consultant D to advise they were going to talk to Professor of Postgraduate Surgical Education about the trainee skills as they were not happy with them.[49]
	The Professor of Postgraduate Surgical Education contacted the TPD by text on the 29th October 2020 to discuss concerns raised by Consultant D related to this trainee. [41] The Professor of Postgraduate Surgical Education advised that an assessment of the trainee's surgical skills was required in order to draw out any issues which had been raised. [41]
	"During the conversation with [Professor of Postgraduate Surgical Education] I stated that [Consultant D]'s opinion was in contrast to the other members of the department and did not mirror [trainee's] ARCP outcomes. [Professor of Postgraduate Surgical Education] felt that as the issue was raised by a senior consultant trainer, that the college had an obligation to treat the matter seriously despite my opinion and the opinion of his other consultant trainers." [41]
November 2020	The TPD contacted trainee on the 3rd November about the issues and the proposed/requested assessment. The TPD advised the trainee that it was their view that in order to sort this matter out and validate the trainees' position, the trainee should agree to the assessment. The TDP advised the trainee they were *'confident'* the trainee would pass *'without issue'* and it would *'vindicate the trainee's position'*. [41]
December 2020	The TPD and Professor of Postgraduate Surgical Education at RCSI organise basic skills assessment for trainee at the beginning of January.
January 2021	Trainee passes basic skills assessment with assessors reporting they were *'happy with performance'* and did not have any concerns. 20th January - the Trainee's ARCP takes place where the decision was taken that the trainee needed to extend their training for an additional six months in order to complete the required index cases.[41] [6] 26th January, after asking for the AES report from Consultant D, the TPD receives the documented meeting notes from the meeting of 9th October 2020. [49] The AES report is a *'key document'* for the ARCP however the

[48] Trainee email. Dated 18th November.
[49] TPD email. 22nd November 2021.

notes and content provided by Consultant D do not align to the approved AES template.[50]

28th January, the trainee receives their AES report in the form of meeting notes from the 9th October meeting which took place with Consultant D. The TPD shares these with the trainee with a request for them to upload to their ISCP account.[43]

29th January, the trainee uploads the AES report along their reflections of the report, which they belief is not an AES report but rather details captured by Consultant D of an informal conversation that took place during an unplanned meeting on October 9th, 2020.[48] In their reflections many details of the account by Consultant D is contested by the trainee (see Extract 2 below).

Trainee requested a move to CHI at Temple Street for three months prior to moving abroad to finish their training and fellowship.[6]

Table 8 Summary of events between Trainee and Consultant D

The table below is an extract of the Trainee reflections on Consultant D meeting notes. The consultant's notes are numbered and highlighted in blue, followed by the Trainees reflections.

Extract

"Attached is the submission of [Consultant D] to the TPD. It comprises an account of an informally convened discussion regarding a pyeloplasty performed in early October, rather than an AES report. I have reviewed the report and have identified the following comments which are not reflective of what took place during this discussion:

1. *"Breaching the Peritoneum in a retro-peritoneal dissection. (This happens to everyone occasionally but [trainee] admitted that happens on a regular basis)".*

   The suggestion that this happens on a regular basis was made by [Consultant D], and not me.

2. *"Didn't recognise crossing vessels to lower pole of kidney therefore stay suture in wrong place-hadn't demonstrated the main pedicle vessels."*

   Stay suture was placed to provide traction to allow dissection of the renal pelvis in a very rotated kidney, the elaboration of which would have led to the confirmation that the vessel seen was a crossing vessel, albeit after this observation was vocalized by [Consultant D] intra-operatively.

[50] ISCP AES Report Template 2014.

3. *"Handling needle holder wrongly"*

   Not an observation that the 20-odd other surgeons who have evaluated me has made in the last 2 years. Nonetheless, in the spirit of learning and I agreed to adjust my technique to one [they were] more approving of.

4. *"Doesn't tie square knots. Was used to tying two handed knots while in [Country] but has difficulty tying one handed again."*

   I have no difficulty in executing one-handed square knots. The discussion regarding the context of a widely utilized initial granny knot technique when working at depth has been omitted from this account. I also did not suggest that I had difficulty tying one-hand knots as a result of my experience in the [Country], rather [Consultant D] suggested a two-handed knot may prove more reliably square at the time, which I agreed with. The one-handed knot is still my more comfortable knot.

5. *"Lot of difficulty with instrument tying of knots- multiple attempts to catch free end in needle holder- admits that tremor may be a causative factor in this."*

   This is not an admission that I made. In fact, I said that I had not noticed that I required multiple attempts to catch the free end during instrument knots. This was entirely [their] suggestion.

6. *"At the end of the meeting I asked [trainee] if there was anything, I had said which was either overly harsh or untrue."*

   I agreed with this statement at the time in the context of the surgery in question, as most trainees do when critiqued by a senior consultant, who few trainees deign open to disagreement. This agreement was later cited out of context in later conversations with other consultants and the Professor of Post-Graduate Surgical Education in the RCSI as to mean I agreed with [their] comments as they pertained to my general operative skills and ability.

7. *"I suggested to [the trainee] that at the present time that I could not allow [them] to get an ARCP 6 at [their] next assessment."*

   The ARCP was never discussed in this meeting and had [they] suggested that, regardless of my remediation of the deficiencies [they] proposed, and ARCP 6 would be off the cards, I would have immediately escalated this to the TPD. In fact, I pointed out to [them] that I had to be ready to commence fellowship in [Hospital] in March.

8. *"to see if some appropriate models could be developed such as pyeloplasty and neonatal oesophageal anastomosis."*

   This was discussed and I was able to re-appropriate a neonatal simulation model I

> fabricated while on fellowship for the purpose of performing pyeloplasty within 3 days. [Consultant D] declined to review the model and insisted that only the simulation department of the RCSI could supply a satisfactory animal model.
>
> *The summary also omits that [Consultant D] indicated I "could not be allowed to 'practice' on actual patients when it came to things like pyeloplasty and nephrectomy'" something which I would not have so readily accepted had I thought an opportunity to demonstrate remediation would not arise."*

Extract 2 Trainee reflections on Consultant D meeting notes

There are several aspects of the above extract which clearly show that much of what was recorded by Consultant D on October 9th, 2020 is contested by the Trainee.[42]

Furthermore, these meetings notes, deemed to be an AES report by RCSI[46] and Consultant D[42], do not align with the AES template provided by the ISCP. The AES template is a three-page document specifying various areas for assessment (see Figure 6).[50] This is significant to note, given the seriousness of the process that was undertaken by Consultant D and the RCSI, and the consequential burden and stress that had to be shouldered by the trainee at such a late stage in their training. As was attested by multiple participants, this process had the potential for *'destroying someone's career'*.[6]

Area	Agreed actions	Comments on actions that have taken place in these areas
Curriculum objectives		
Knowledge		
Clinical skills		
Operative skills		
Professional behaviour and leadership skills		
Workplace-based assessment		
Portfolio evidence		
Examinations		
Courses (including e-learning)		
Audits		
Research		
Projects		
Presentations / Posters		
Publications		

Teaching sessions given by the trainee	
Conferences and meetings	
Feedback from patients including compliments and complaints	
Educational Programme to be attended by the trainee	
Timetable and on call rota	
Internal teaching sessions and meetings attended	
External conferences and meetings attended	
Other supporting information	
Continuing Professional development	
Quality Improvement Activity	
Significant Events	
Reflective Practice	

Figure 6 Sample Section of AES Report

Given the nature of the concerns raised by Consultant D in October 2020 and the subsequent assessment of basic surgical skills that the trainee had to undertake in January 2021, it should be highlighted that between November 2020 and December 2020, this trainee completed 22 procedures of varying complexity on Consultant D's elective list 'unsupervised'. [51] Indeed, this trainee supervised and trained junior colleagues during this period. In total there were 41 procedures that the trainee undertook during this timeframe, completing 54% of these 'unsupervised'. These 'unsupervised' procedures ranged from cystoscopies, removal of JJ stents, orchidopexies, Botox injections and a hypospadias fistula repair. Despite Consultant D having concerns around the trainee's basic surgical skills, the trainee was permitted to undertake a significant number of surgeries 'unsupervised'.

Between November 2020 and December 2020 Consultant D completed 50 procedures either by themselves or with SHO colleagues, who would be junior to the Trainee. These included a number of complex urology procedures, which would be index cases required by a trainee to complete training.[33] [51] Such cases include nephrectomy, urethrostomy or pyeloplasty. [51] It might have been beneficial for the trainee to either observe or support with these procedures – instead it appears that these are missed opportunities for learning for the trainee to remediate some of the issues identified by Consultant D in October 2020.

[51] Activity analysis November 2020 to April 2021

c) Cultural Influence

The RCSI confirms that *"everyone involved in Surgical Training has a responsibility to treat colleagues with dignity and respect"*. However, it would appear from feedback of participants and the evidence thus far,[6] to include the SAC report,[30] that the support structures around the trainees have failed to either identify or advocate for those they are designed to protect.

Research validates the importance of the surgical trainee and trainer relationship, as the trainer is seen to govern access for trainees to gain operative skills which are needed to complete training.[52] Given this, one can understand how the behaviours displayed by consultants, if negative or unsupportive can create heightened levels of anxiety and stress for those which depend on them for training.

It would appear, based on the feedback and input of staff both current and previous, that a culture exists in CHI and in particular in the Department of General Surgery and Urology and across Theatre, where too often issues or concerns are not being reported because 'nothing changes' or when issues are reported there is a feeling that they are not addressed, leading to a belief or narrative of 'this is how it's always been' and 'just get on with it'.[6]

3.5 Urodynamics Department

a) Clinical Nurse Specialist (CNS) Attrition

Over the course of this examination, the working environment of the Urodynamics Department at CHI Crumlin has been highlighted on multiple occasions.[6] Since 2013, there has been an extremely high rate of attrition among Clinical Nurse Specialists (CNS) in the department.[6] Of three CNS employed to work in the department between 2013 and 2021, all have left, with each CNS stating they left for one reason – bullying. [6] Each of the three CNS's, described similar experiences of bullying from the same member of staff working in the department. For the purpose of this section, these staff members will be referred to as:

CNS A

CNS B

CNS C

CNS D

The personal reflections and details of the impact of the working environment within the Urodynamics department on staff's wellbeing and mental health are outlined below:

Source	Quote
CNS B, C, D	*"I went to occupational health. Driving into that hospital again, I didn't want to go in. The idea of bumping into somebody. I just had a real distaste about the hospital.*

[52] Troublesome Knowledge in Pediatric Surgical Trainees: A Qualitative Study. 2014

Occupational health asked how I was, I couldn't stop crying, I wasn't sleeping. Told him the best way to protect myself was to resign."
"I went to my doctor. I was having panic attacks in work. I hadn't realised the anxiety was so bad till it all happened... For 3 weeks later I never felt so sick. That's the impact [they have] on you. You could meet [them] and think [they're] quite nice, but when you're listening to [them] all day, you start to believe it. I was thinking why should I go to another job, who would hire me? [CNS A] made me believe that."
"I was thinking, I shouldn't have applied. I started to feel like I must go to work only because I have a job to do. I didn't enjoy it. I felt so sad and lonely all the time. I felt so isolated, like, I've never felt so isolated because it was the most difficult time."

Table 9 CNS B, C, D reflections.

Other colleagues also witnessed the behaviour and dynamics within the department:

Source	Quote
Participants 13, 20, 22	*"The problem is with [CNS A]. Nursing admin were involved before. [They were] back a few days then there was a large row. When I was in Urodynamics, [CNS A] was questioning why the girls needed help: "Are they a bit stupid, why do they need help?" "*
	"[CNS A] is the issue. [CNS D] would never work with her again. [CNS B] and [CNS C] were happier without [CNS A]. [CNS B] has left and [CNS C] is on long term sick leave."
	"I don't know how they did it. That last day was really bad, every day I worked with them it was horrendous, and that's not an exaggeration. [CNS A] literally chipped away at them. I could see it physically when [CNS A] came back that day working with [CNS C].... [CNS C] was physically shrinking."
	"I hear everything like "[CNS B] why would you do that? That makes no sense. I wouldn't have done that. That's stupid", in such a cross angry tone. It was the tone all the time. It was never nice and friendly."
	"The combination of [Consultant D], [Senior admin staff member], and [CNS A] is very bad for the department, especially a department going through three really good CNSs in three years."

Table 10 Colleague's experience of Urodynamics department

Nursing management, HR and the Consultant Urologist in CHI at Crumlin were all made aware of these issues.[53] [54] [55] One of the CNS's reported verbally only while the other two CNS's documented their concerns.[6] Each documented letter outlines similar experiences of working in the Urodynamics department.

Extracts [53] [55]

"Sept 2016 – 2021 [CNS A]'s mood was unpredictable, this dictated how my day went. It created a negative and hostile working environment. [They] would have outbursts, I would associate these as 'rants' in which [they] would lecture me in a dominant tone. I would dread the day ahead. I found myself very quiet, suppressed, not wanting to engage in conversation. I felt low morale on the days I worked with [CNS A] and looked forward to the days in which [they were] off.

Jan – April 2020 I was asked by an Organisation to present a Catheterisation Workshop as was my colleagues [CNS A] and [CNS C]. When discussing with [CNS A] who would be available to present from the department [CNS A] commented directly that there would be other people there at the event more experienced than me .i.e. audience members, this was said with a strong patronizing tone and with raised eyebrows. I felt undermined and it reduced my self-esteem. I am open to constructive criticism within my job, however the delivery of this statement was unwelcoming."

"[CNS A] has showed contempt and at times utter disdain for any ideas put forward to improve departmental matters and flow. This occurred multiple times in early 2019 when a change in departmental management was being introduced.

The behaviours outlined in this complaint and lack of resolution to same, despite my numerous efforts, has ultimately affected my mental health. I have lost confidence in myself, my professional ability and my enjoyment of my job, I am anxious and fearful attending the workplace which has become a toxic environment. I also fell that it is not possible for CHI at Crumlin to provide a safe working environment for me in my current role."

Extract 3 CNS letters to CHI Crumlin Leadership

It appears from the evidence thus far that significant behavioural and cultural issues exist in the Urodynamics department. Formal complaints on the matter have been raised with HR. These issues are long standing and appear not to have been addressed either consistently, in a timely manner or conclusively by senior management or leadership.

Despite there being an open complaint against a member of the department, as of October 2021, a new CNS has taken up post, replacing the two CNS's who have resigned having formally submitted grievances relating to bullying. It is not clear if any formal processes or supports have been put in place to ensure a similar pattern of events does not reoccur, and to make certain the health and well-being of staff in the department is a priority.[6]

[53] Letter to HR from INMO under Dignity at Work Policy. Dated 23rd June 2021.
[54] Letter to Director of Nursing. Dated 2nd June 2021.
[55] Letter to Assistant Director of Nursing. CC'd to HR Director CHI Crumlin and Director of Nursing, Dated 25th May 2021.

As a result of the working relations and behaviours in the Urodynamics department, CHI have lost three specialist trained CNSs from the service in recent times. CHI invested in specialist urology training for these CNS's, and indeed they invested personally in their training – which included significant time spend in centres in UK, all at substantial financial cost to CHI. Of these three skilled and speciality trained Urology CNS's – none now work in Urology in CHI. Two have left CHI entirely.

The vision for the future of children's nursing aims to create *"seamless journeys through the healthcare system for the child and family."* [56] The high attrition rate within the Urodynamics department impacts CHI's ability to deliver on this vision as continuity of care is interrupted. Furthermore, the importance of continuity of care is significant with research showing that higher continuity of care decreases the likelihood of future hospitalization.[57] Lack of continuity also affects overall patient and family experience, especially when the child has a life-long chronic condition.[58] Currently there are 163 nursing vacancies across CHI, 32% of these vacancies are equal to or above a Clinical Nurse Manager grade.[59] This means there is a substantial gap of senior nurses in CHI, and yet CHI have lost two specialist trained CNS in as many months as a result of what appears to be longstanding issues within a department that have failed to be addressed.[56]

b) Urodynamics Administration Support Challenges

Throughout this examination, four participants referenced the way patient records were filed within the urodynamics department. One participant described that the office *"looks like a grenade went off, paperwork everywhere".*[6] In an email from Consultant D to CHI's CEO it was highlighted that due to the *"lack of clerical help, patient records were found filed in cabinets with many cases never closed off".* [60] This situation impacted up to 400 children, leading to a process where both parents and GPs had to be contacted. [6] [60] CHI CEO sought action, as a result of the concerns raised in the email from Consultant D with leadership in CHI at Crumlin. CHI CEO also shared this email, to ensure the issues raised within could be included as part of this examination.

During this examination a number of participants provided feedback describing the perceived negative behaviour of a senior admin staff in Urology. It was narrated that this behaviour compounded a tense and challenging atmosphere across the department. Some quotes from participants are detailed in Table 11.

[56] Leading the Way: A National Strategy for the Future of Children's Nursing in Ireland 2021 – 2031. October 2021.
[57] Mainous AG and Gill JM. The Importance of Continuity of Care in the Likelihood of Future Hospitalization: Is Site of Care Equivalent to a Primary Clinician? American Journal of Public Health. 1998.
[58] Miller AR; Condin CJ; McKellin W; Shaw N; Klassesn A; Sheps S. Continuity of care for children with complex chronic health conditions: parents' perspectives. BMC Health Services Research. 2009.
[59] Confirmation of Nursing Vacancies from HR. Dated 11th November 2021.
[60] E-mail Consultant Urologist to CEO. 15th July 2021.

Source	Quote
Participants 8, 9, 19, 22, 23	*"[Senior admin staff member] is a very strong, dominant person. For a [senior admin staff member], [they have] such power. I've often wondered how. [They have] bullying tactics [themselves]."* *"Again, [Senior admin staff member] is very like [Consultant D] and [CNS A], very opinionated, very argumentative... I'd keep distance as much as possible, [they were] either ranting about or at you..."* *"I would not trust [them]. I would never ring [them]... I was always led to believe [Senior admin staff member] was riling [Consultant D] up."* *"[Their senior admin staff member] was bully-ish towards a junior trainee, if [Consultant D] sides with [Senior admin staff member], that's it"* *"[They are] very difficult... [They have] a powerful influence; [they are] more like a manager."*

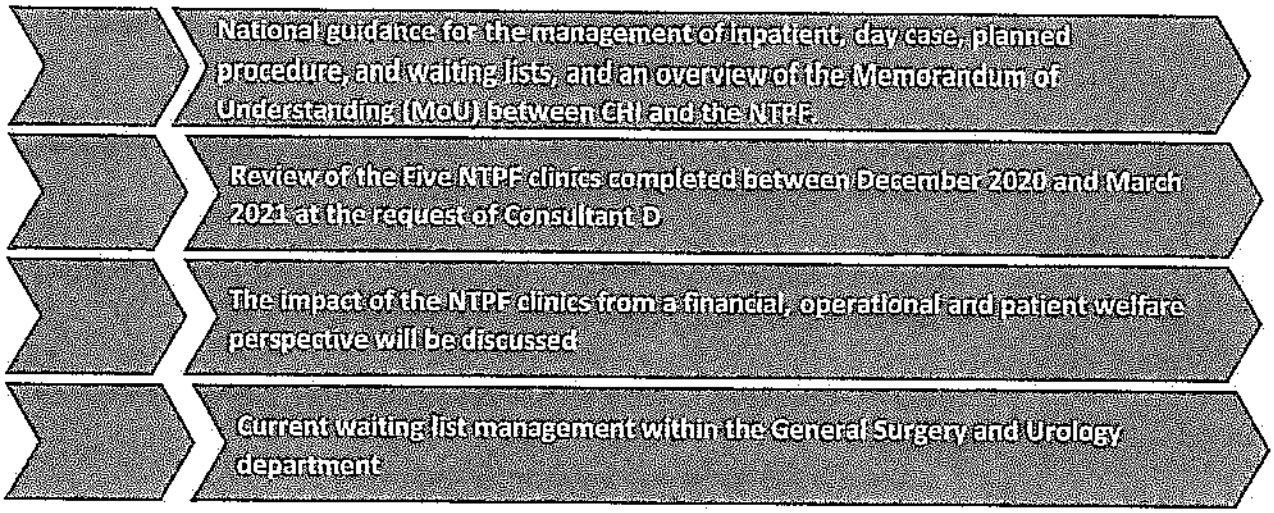
Table 11 Colleague experience of senior admin staff member

Further to the issues raised around patient record management and staff attrition, the Urodynamics Department was also significantly impacted by the HSE malware attack. As of July 2021, there were 850 patients active on the urodynamics waiting list with 290 complex and 560 non-complex. [60] Consultant D in that same note to CHI's CEO, outlines that as a result of the issues in the department – staffing and lack of administration support, the urology department is *"no longer accepting any clinically non-urgent referrals from GPs, or paediatricians for urodynamic studies"*. [60] Instead, the referrals were to be returned to the source explaining the issues currently within the department. [60] Thus, it appears that owing to significant challenges and behaviours with the urodynamics department, and at the sole discretion of one consultant, unless urgent the children of Ireland can no longer access urodynamic studies if deemed appropriate for their clinical situation. This contradicts CHI's vision and values to provide the highest standard of care to the children of Ireland.

4 ACCESS AND WAITING LIST MANAGEMENT

4.1 Chapter Overview

In this chapter, the following areas will be examined:



Throughout this chapter data received from CHI Operations has been analysed to support the themes raised. The consultants highlighted specifically in this chapter are as follows:

Consultant D

Consultant F

4.2 NTPF Principles

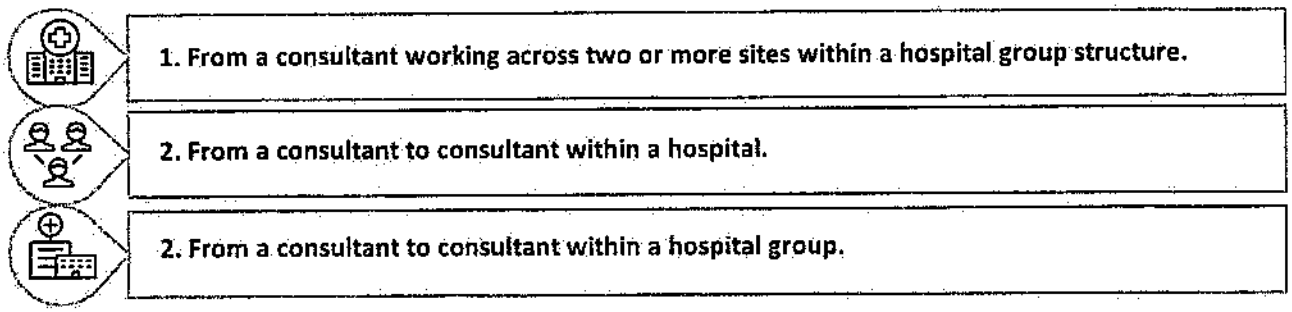
The National Inpatient, Day case, Planned Procedure (IDPP) and Waiting List Management Protocol (2017) developed by the NTPF, outlines a consistent standardised approach for hospitals and hospital groups to use as a guide when scheduling patients and managing waiting lists. The purpose of this protocol is to ensure the safe, timely and effective access and treatment for patients in a fair and equitable manner. Within this protocol, fundamentals of waiting list management are detailed to ensure each hospital or hospital group has the guidance and tools it needs to deal with waiting lists in an effective and transparent way. It is clearly stated that in order to minimise risk to patients, all hospitals or hospital groups must "*ensure that capacity for routine patients is tailored towards those with the longest waiting time*". Following the identification of these capacity deficits within the system, hospitals are required to identify "*remedial, sustainable proposed action plans*". [61] The overall purpose of the NTPF is to provide an opportunity for patients, who are waiting the longest, to access to care they require.[62]

[61] National Treatment Purchase Fund, National Inpatient, Day Case, Planned Procedure, Waiting List Management Protocol, 2017.

The MoU between CHI and NTPF outlines specific mutual agreements regarding relevant expectations and responsibilities of both organisations. In this document, certain principles are outlined which both parties have agreed to fulfil, some examples of CHI's responsibilities are outlined below.[62]

- CHI commits to provide treatment with "due diligence and in full compliance of all appropriate professional standards and relevant policies".[62]
- CHI commits to provide treatment "exercising such skill, care, diligence, prudence, experience, expertise, foresight and judgement as would be expected from a highly skilled and highly experienced person engaged in the provision of the treatment".[62]
- CHI commits to facilitating the provision of treatment to patients while prioritising "the provision of outpatient services to those patients waiting the longest for such services as evidenced by the Hospital Group's outpatient waiting list".[62]

According to the National IDPP Waiting List Management Protocol (2017), an insourcing agreement means patients on waiting lists in one hospital may be offered the opportunity to have care and/or treatment in an alternative hospital within their hospital group.[61] This enables optimisation of capacity utilisation where resources are available.[61] This type of insourcing arrangement occurs when a patient is offered treatment via one of the following referral pathways:



From the outset, hospital group stakeholders must agree the profile of patients suitable for the insourcing initiative and pathways must be agreed to support those patients requiring further treatment, after the initial episode of care is received.[61] Patients must be contacted and offered the opportunity to receive care or treatment in an alternative hospital within the hospital group structure.[61]

This section will outline how the insourcing agreement for five NTPF Urology clinics, held between December 2020 and March 2021 in CHI at Crumlin, did not adhere to the principles and standards set out by NTPF above.

[62] National Treatment Purchase Fund, Children's Health Ireland, Memorandum of Understanding OPD, 2019.

***Figure 7** shows the top 10 largest waiting lists across specialties in CHI at the time of NTPF submission for the Urology Clinics. Note Paediatric Surgery is 8th while Urology is 10th on this list in November 2020.* [63]

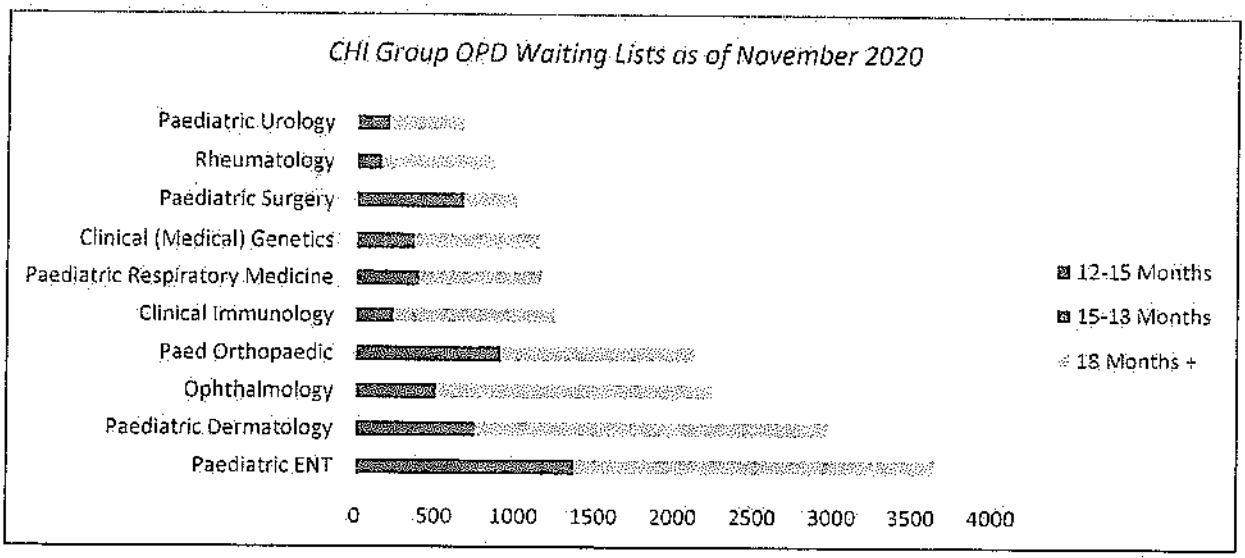


Figure 7 NTPF Extract November 2020

4.3 Non-adherence to NTPF Standards and Principles

a) NTPF Submission

In late 2020, after being approached by Consultant D,[6] a submission went to NTPF to address the *General Surgery* long waiters, with planned clinics to see 660 patients between the remainder of 2020 and all of 2021.[64] In this submission it was not highlighted or reflected in any way that the proposal was in fact for a urology patient waiting list, starting with CHI at Crumlin only and was planned to be undertaken by a consultant urologist who works exclusively in CHI at Crumlin.[64] The data included in the submission related to *general surgery* wait times and patient numbers only and not urology data.[64] In fact, urology was not mentioned in the submission at all.[64]

Despite this, the number of patients proposed to be seen under the submission, 660 in total, was a figure clinically determined[65] by the consultant urologist who was the consultant that was planning to run these clinics and to see patients from the urology waiting list .[66] It is also stated in the submission that clinics would be held in the HSE Facility in City West, not on any CHI site.[64] Based on the submission approval, NTPF provided funding to CHI to address *general surgery* long waiters, despite there never being an intent from operations to address general surgery long waiters under this submission.[72] The NTPF funding was used to address patients on a urology waiting list. These details were known to the CHI Scheduling Lead and Consultant Urologist from

[63] National Treatment Purchase Fund, Outpatient Waiting List by Group Hospital, 2020.
[64] NTPF Submission for General Surgery Clinics. Dated 19th November 2020.
[65] Confirmation email from CHI Scheduling Lead. Dated 18th October 2021.
[66] Confirmation email from CHI Scheduling Lead. Dated 18th October 2021.

the outset and is not in line with waiting list management best practice. Evidence can be seen in *Appendix 2*.[67]

The patients for these clinics were identified and selected by Consultant D, the consultant who would be running these clinics that were held exclusively in CHI at Crumlin in the first instance. It's also important to note that the majority of patients seen were seen by the consultant they had been initially referred to,[68] a consultant who works exclusively at a single hospital, a complete nonadherence to the insourcing pathways and MOU outlined above.[61 62]

***Figure 8** shows the waiting list extract attached to the above mentioned NTPF submission. Note this submission is documented under General Surgery not Urology.* [64]

CHI AT CRUMLIN : OPD WAITING LIST : GENERAL SURGERY AS OF 19/11/20

Specialty	WL Status	6-9 Months	9-12 Months	12-15 Months	15-18 Months	18-21 Months	21-24 Months	24-36 Months	Grand Total
Paediatric Surgery	Has Appointment Date	51	32	13	4	6	1	1	108
	No Appointment Date	188	83	5	3	1		1	281
Grand Total		239	115	19	7	7	1	2	389

CHI AT TEMPLE STREET : OPD WAITING LIST : GENERAL SURGERY AS OF 19/11/20

Specialty	WL Status	6-9 Months	9-12 Months	12-15 Months	15-18 Months	18-21 Months	21-24 Months	24-36 Months	Grand Total
Paediatric Surgery	Has Appointment Date	12	6	2	1	2	5		28
	No Appointment Date	184	360	333	303	157	31	5	1373
Grand Total		196	366	335	304	159	36	5	1401

CHI AT TALLAGHT : OPD WAITING LIST : GENERAL SURGERY AS OF 19/11/20

Specialty	WL Status	6-9 Months	9-12 Months	15-18 Months	18-21 Months	21-24 Months	24-36 Months	Grand Total
Paediatric Surgery	No Appointment Date	34	11	1	1	16	72	135
	Has Appointment Date		5			14	7	26
Grand Total		34	16	1	1	30	79	161

Figure 8 Extract from NTPF submission

At no time in advance of the NTPF submission, was any effort made to exhaust all internal options within CHI to see if any one of eight general surgeons could have seen any of the identified 660 patients.[69] Thus, not optimising capacity utilisation of other available and suitable resources in CHI – a direct non-observance of NTPF guidelines.[61] The consultation fee agreed with the consultant undertaking the NTPF clinics was €200 per patient, with additional costings for two administration staff and one healthcare assistant.[64] The cost impact of these clinics and other issues highlighted will be explored further in the *Leadership and Governance chapter* of this report.

c) Identification of Patients for NTPF clinics

Over the five NTPF clinics run between December 2020 and March 2021, 179 CHI at Crumlin patients were seen.[68] Of the 179 patients seen, 60% were patients originally referred to the consultant undertaking the clinics. The remaining 40% of patients had been originally referred to a second urology consultant, working in the same site.[68] As per the NTPF insourcing standards,

[67] Email from CHI Scheduling Lead to Consultant Urologist. Dated 23rd November 2020. See Appendix 2
[68] NTPF Clinic Data Review. Dated 21st September 2021. See Appendix 3.
[69] Email and letter from General Surgeons to COO confirming this. Dated 29th January 2021.

a consultant working within one hospital site should not see patients for insourcing NTPF initiatives, if those patients had been originally referred to them, and if the patients currently sit on that consultants public waiting list.[61] Such a scenario is only deemed appropriate if there is no other consultant in the hospital group that can manage these patients. This report will later outline that of the 179 patients seen, 95% could have been seen and managed by one of eight consultant general surgeons in CHI within their public outpatient clinics.[70]

In addition to the above, the cohort of patients selected for the NTPF outpatient clinics were not the longest waiters. In fact, the most recent referral seen at the NTPF clinic on 20th February 2021, was a patient whose initial referral date was the 20th July 2020.[68] The graph below (Figure 9) highlights that despite running five NTPF outpatient clinics, 147 patients that remain on the urology outpatient waiting list as of the 07/10/2021 in CHI at Crumlin, have a waiting time that is longer than that of each of the 179 patients selected at the time for the NTPF clinics in December 2020 – March 2021.[71] This illustrates that the longest waiters were not seen in these clinics, instead patients were selected for reasons other than their wait time. There was no indication in the NTPF submission that this insourcing agreement was to see a specific cohort of patients, thus overriding the longest waiters criteria.[64] This undermines a fundamental of waiting list management, which endeavours to provide fair and equitable access for patients where possible, not to mention the MOU between CHI and NTPF. [62]

Figure 9 shows the distribution of patient referrals up to the 20th July 2020. This illustrates that patients with referrals dated the 20th July 2020 were seen in NTPF clinics ahead of patients who remain on the waiting lists from 2018, 2019 and some of 2020 (n=147, as of the 07/10/2021. Note one referral date not recorded in the NTPF clinic so it is not included in graph below n=178). [68] [71]

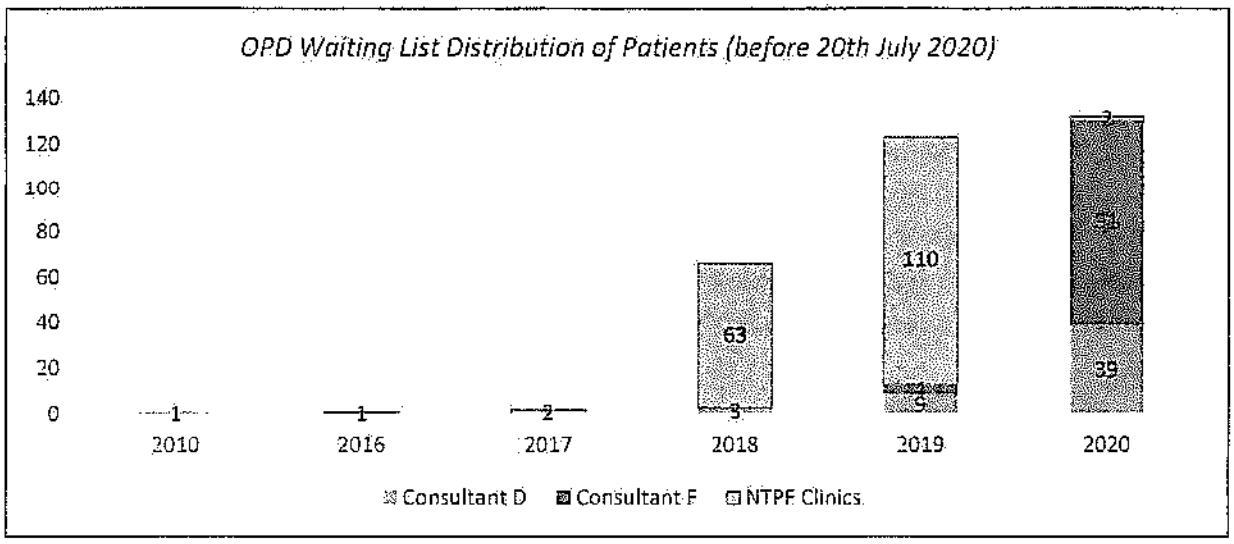


Figure 9 Distribution of patients (before 20th July 2020)

[70] NTPF Clinic Data Review by General Surgeon. Dated 1st October 2021. See *Appendix 3*.
[71] Outpatient Waiting List Urology. Dated 7th October 2021.

On review by CHI's Paediatric Network Lead, a Consultant General Surgeon, who undertook similar reviews on behalf of CHI Executive previously, noted of the case mix of patients seen in the five Urology clinics: [70]

- Excluding Hypospadias, approximately 50% of these patients could have been seen by one of 8 General Surgeons in CHI, who do not have significant wait times.
- When Hypospadias is included, the number of patients which could have be seen by General Surgeons increases to approximately 95%.
- In CHI at Crumlin, in addition to the two Urologists, there are three general surgeons who have the capability, experience, and indeed manage similar amount of Hypospadias to one of the two urologists (See Figure 10 and 11 below).

Thus, the analysis and review undertaken by CHI's Paediatric Network Lead, would determine that of the 179 patients seen under NTPF initiatives, approximately 95% could have been seen by general surgeons during their regular public outpatient clinics. Therefore, indicating that NTPF funding were not used in the most appropriate and effective way.[70, 62]

***Table 12** shows that of the patients seen in the five NTPF Urology clinics 95% of patients could have been by a General Surgeon. This was validated through review of the referral letters by CHI Paediatric Network Lead and Consultant General Surgeon. Only 5% of patients required Urologist specific input.*[70]

Category	Number of Patients	% of Total (n=171*)
Eligible to been seen by General Surgery i.e., phimosis, orchidopexy, balanitis (excluding hypospadias)	**85**	**50%**
Number of Hypospadias in NTPF clinics	**77**	**45%**
Total patients seen in Urology NTPF clinics, eligible to be seen in General Surgery clinics during working hours (including Hypospadias)	**162**	**95%**

Table 12 Breakdown of patients in Urology NTPF Clinics

* 8 patients excluded due to absent referral letter

***Figure 10** shows the breakdown of surgeons in CHI at Crumlin who have completed Hypospadias procedures between 2019 and 2021. It shows one consultant General Surgeon completes a similar number of Hypospadias procedures to one of the urologists.*

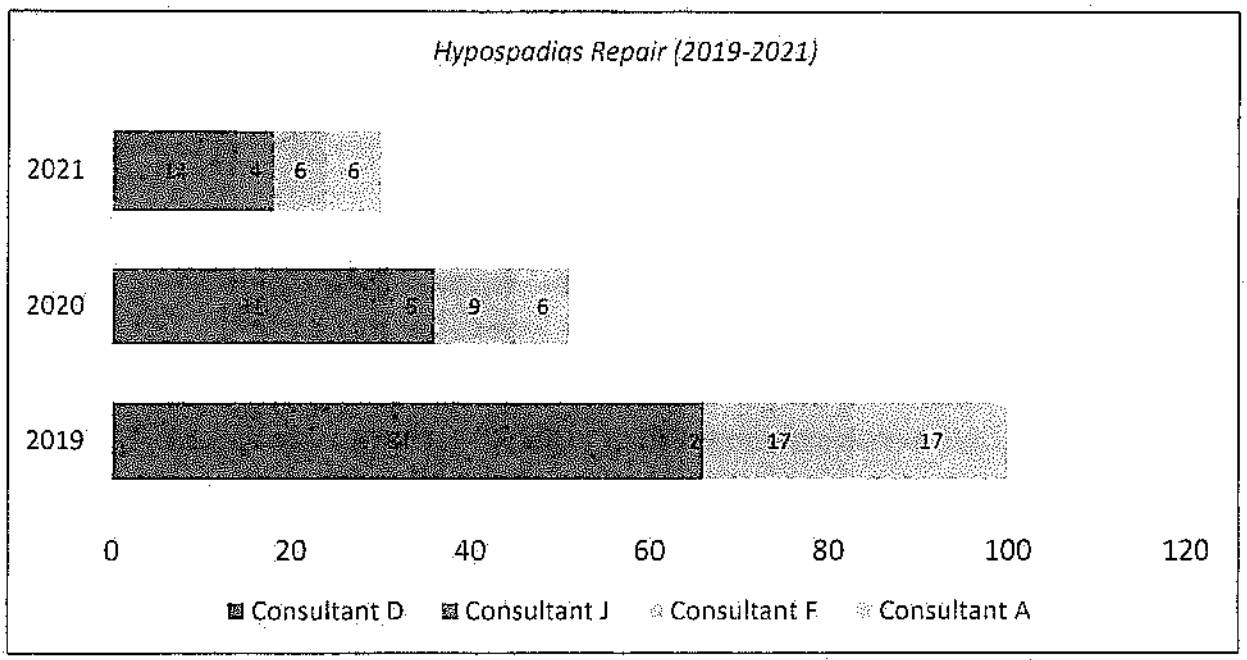


Figure 10 Hypospadias repair in CHI at Crumlin (2019-2021)

***Figure 11** shows the percentage breakdown of surgeons across CHI who have completed Hypospadias procedures between November 2020 to April 2021 (n=75). One General Surgeon has completed 5% more than one of the Urologists.*

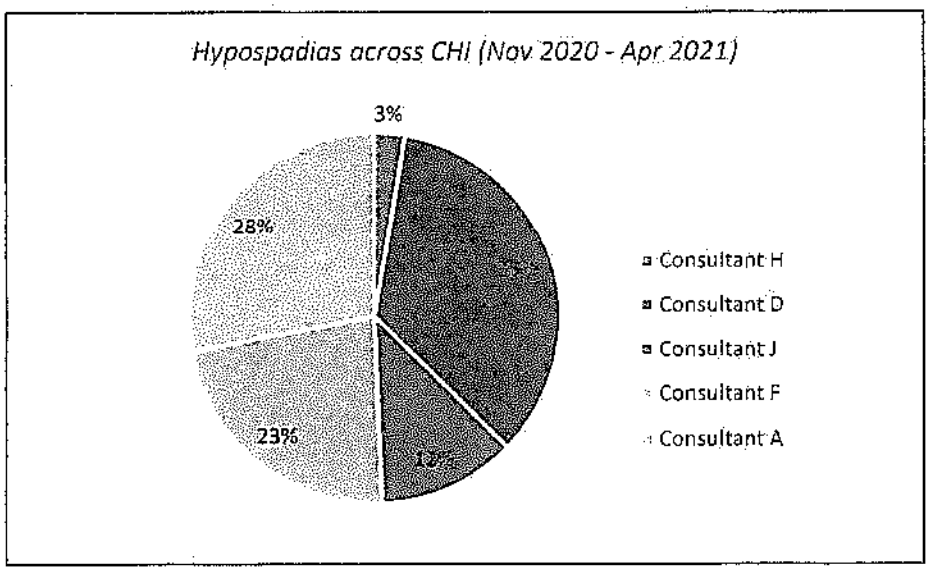


Figure 11 Surgeons completing Hypospadias procedures (Nov 20-Apr 21)

d) Outcome of patients from NTPF Urology clinics

Of the 179 patients seen in the Urology NTPF clinics, 30% (n=53) had a documented outcome of requiring surgery.[68] The National IDPP Waiting List Management protocol (2017) states that *"Patients who are added to a planned procedure waiting list must be advised on the day of an*

indicative date or approximate timeframe in the future for their procedure. No Patient should be added to a planned procedure list without an Indicative date or approximate timeframe." [61]

Of the patients who were identified as needing surgery, 50 were not given an indicative date for surgery at the time of their NTPF outpatient appointment.[68] Furthermore, as of September 2021, those 50 patients still have no indicative or planned date for surgery.[72] Consultant D who ran all five NTPF clinics placed those 50 patients onto their own inpatient waiting list (IPWL).[73] As of the 30th September 2021, the average waiting time for those on the urology IPWL is 13 months while for general surgery is 6 months.[74] CHI's Paediatric Network Lead, upon review of the referral letter and outcome of the NTPF clinics, determined that 95% of the patients seen at the NTPF clinics could have been seen and manged by general surgeons.[70] Thus it can be determined that a significant proportion of the patients placed on the urology inpatient wating list, could have been seen and operated on by a general surgeon on their routine elective lists in a much shorter timeframe, in fact those patients could have had their surgery completed by October 2021.[80] [68]

The majority of patients without a date for surgery require a Hypospadias repair or Circumcision.[68] Five patients without a date for surgery, have a requirement for a procedure known as orchidopexy.[68] The European Association of Urology/European Society for Paediatric Urology Guidelines (2016), state that this procedure should be carried out early in a child's life, by 12 – 18 months (at the latest), to minimise risk of cancer and infertility in later life.[75] Prior to being seen at the NTPF clinics, these five patients had already been waiting since 2019 on the Urology outpatient waiting list.[68] The Outpatient Department (OPD) waiting list for urology currently has an average wait time of 4 months longer than that of the General Surgeons.[76] It's likely in 2019 the wait time to see a general surgeon was shorter (See Figure 12). If those children had been placed on the general surgery waiting list initially, it is reasonable to assume they would have been seen on a public list well in advance of the two – three years that it took to be seen on an urology list and only then though an NTPF funded clinic.[68] [24] As of September 2021, those five children remain on an inpatient urology waiting list for surgery.[72] At least seven months after they were seen at an NTPF clinic, at which point they were already well beyond the recommended timeframe for surgery.[75] [77] [78] [79] Once again, there was an opportunity, when these children were seen at the NTPF outpatient clinic, to manage them in a more efficient and effective manner. One can argue there was a requirement for these children to be placed as urgent on the general surgery waiting list, upon being seen at the

[72] Email confirmation from CHI Operations. Dated 18th October 2021.
[73] Email confirmation from CHI Operations. Dated 4th August 2021.
[74] NTPF Inpatient Waiting List Data. Dated 30th September 2021.
[75] The European Association of Urology/European Society for Paediatric Urology Guidelines, EAU Paediatric Urology Guidelines, 2016
[76] NTPF Outpatient Waiting List Data. Dated 30th September 2021.
[77] Chan E, Wayne C, Nasr A; FRCSC for Canadian Association of Pediatric Surgeon Evidence-Based Resource. Ideal timing of orchiopexy: a systematic review. Pediatr Surg Int. 2014 Jan;30(1):87-97.
[78] Cleveland Clinic. 2020. Undescended Testicles: What Is It & Treatment. Available at: <https://my.clevelandclinic.org/health/diseases/17594-undescended-testicles> Accessed 8th October 2021.
[79] British Association of Paediatric Surgeons, Commissioning guide: Paediatric orchidopexy for undescended testis, 2015

NTPF clinic, to ensure they were operated on ASAP, given how far beyond the recommended timeframe for surgery they were.[68]

By knowingly placing these patients who require surgery urgently or as soon as is possible on the urology inpatient waiting list, which has a significant average wait time of 13 months,[74] while there are eight general surgeons capable of completing the procedure in a much shorter timeframe (84% are seen in <12 months[80]), is far from in the best interests of the child, and one could argue potentially negligent. This represents a significant patient safety issue which needs to be reviewed as a matter of urgency.

Table 13 *shows the 5 patients requiring orchidopexy who were not given a date for surgery in the NTPF clinics and instead were placed on the Consultant D's inpatient waiting list. As per cited international guidance*[75 77 78 79] *- these patients are currently at risk. Please note the date referral was initially triaged, each of them have been waiting >1 year.* [68]

Clinic Date	Date referral was triaged	Condition stated on referral letter	Type of surgery listed	Date of Surgery	Outcome
12/12/2020	07/05/2019	LEFT SIDED UDT	ORCHIDOPEXY	NO SURGERY YET	SURGERY
12/12/2020	02/10/2019	UDT	PROSTHESIS INSERTION	NO SURGERY YET	SURGERY
16/01/2021	17/07/2019	LEFT UDT	LEFT ORCHIDOPEXY	NO SURGERY YET	SURGERY
06/03/2021	07/04/2019	UDT	ORCHIDOPEXY	NO SURGERY YET	SURGERY
20/02/2021	01/03/2019	UDT	RIGHT ORCHIDOPEXY AND HERNIOTOMY	NO SURGERY YET	SURGERY

Table 13 Patients at risk post NTPF clinics

CHI employ eight general surgeons who can complete some non-complex urology procedures for conditions such as undescended testes and circumcision. A portion of the general surgeons can also undertake distal hypospadias.

- Research shows that about 70% of hypospadias are distally located and considered a mild form of urogenital deformity.[81]
- The remaining 30% of hypospadias cases are proximally located which requires specialist input from a urologist.[81]
- The General Surgeons working in CHI, mostly full time, have significantly less demand on their service compared to the Urologists. In fact, the wait time from an OPD appointment to surgery is generally <12 months i.e., 68% of referrals are seen within this timeframe.[80] General Surgeons also have the most theatre time which is an expensive CHI resource that needs to be managed in the most effective and efficient way.[82]
- General Surgeons theatre utilisation is on average, over a 6-month period between November 2020 and April 2021 1% higher than that of the Urologists. The General Surgeons had a range of theatre utilisation from 75% to 93% while the urologist's range

[80] General Surgery and Urology Waiting List. Dated 7th October 2021.
[81] van der Horst HJ, de Wall LL. Hypospadias, all there is to know. Eur J Pediatr. 2017 Apr;176(4):435-441.

of utilisation was from 73% to 87%.[82]

***Figure 12** shows the **General Surgery Outpatient** waiting list trajectory from January 2019 to March 2021. Note the minimal numbers in 2019 waiting more than 9 months. In 2020, the impact of COVID 19 can be seen but still majority of patients are seen within 12 months.* [83]

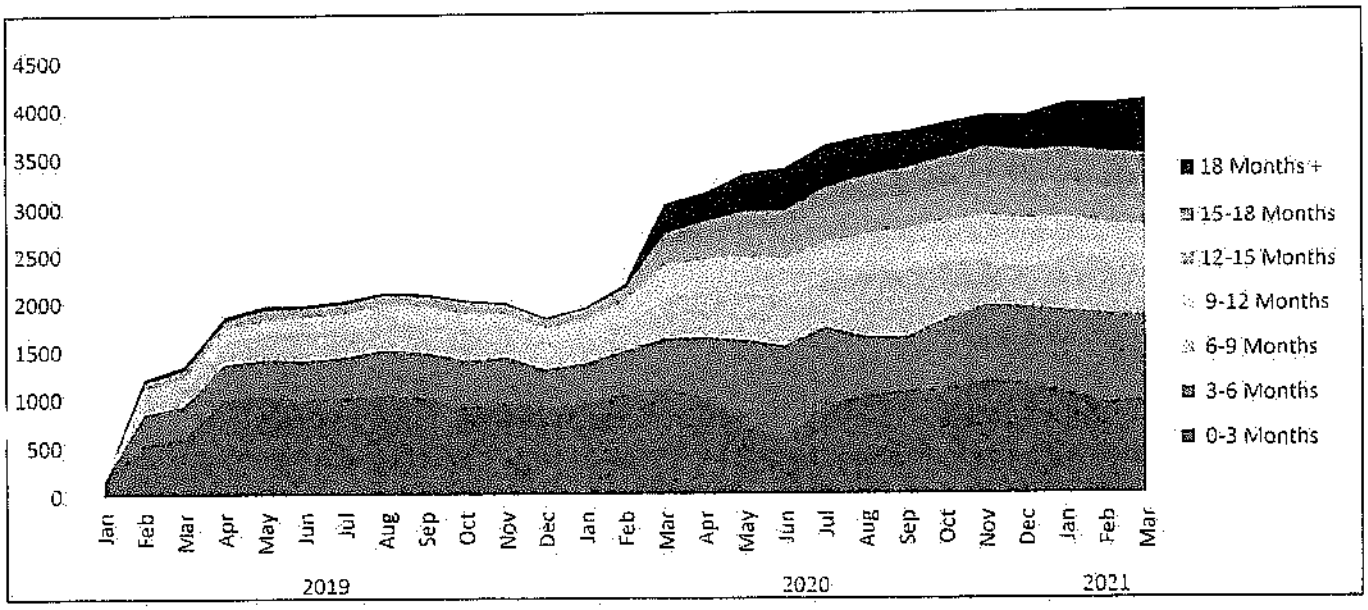


Figure 12 General Surgery OPD waiting list 2019, 2020, 2021

***Figure 13** shows the **Urology Outpatient** waiting list trajectory from January 2019 to March 2021. Note the consistent long waiters > 12 months. The impact of Consultant C's work can be seen with the removal of 1000 patients from the waiting list in early 2020. Note the volume of patients is about half of General Surgeons.* [24]

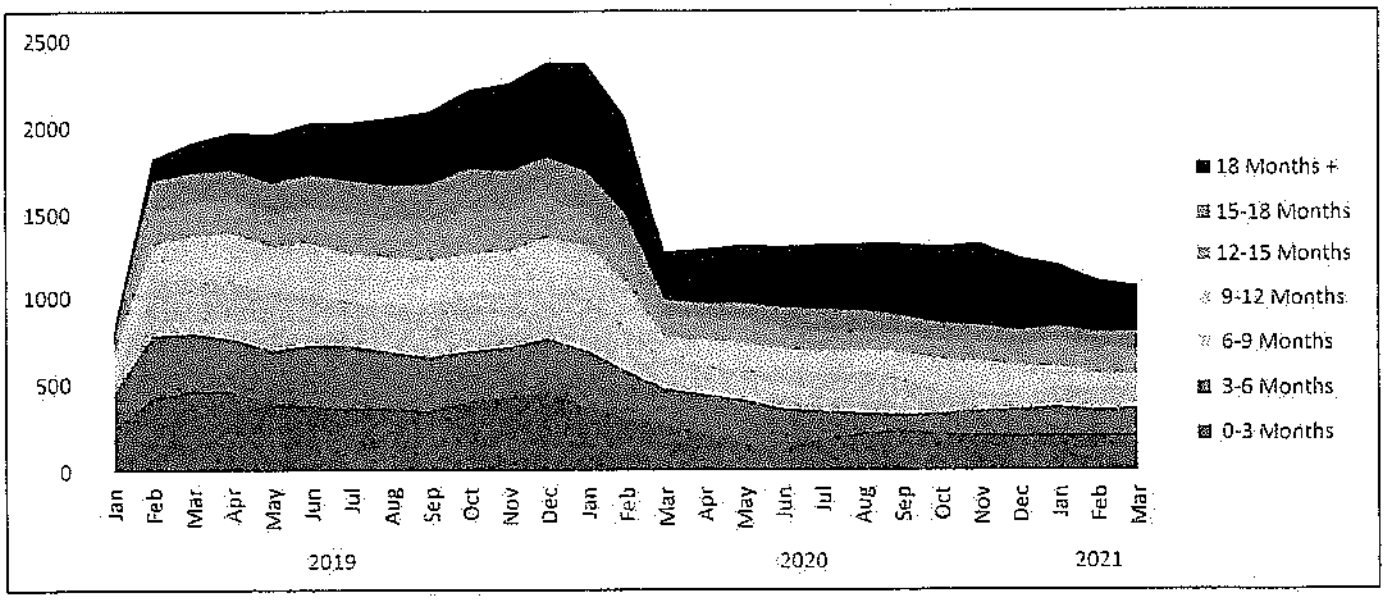


Figure 13 Urology OPD waiting list 2019, 2020, 2021

[82] CHI Crumlin Theatre Utilisation Data. November 2020 to April 2021.
[83] NTPF Outpatient Waiting List Extract. 2019. 2020. 2021 (until March)

Taking the above into account, it is not unreasonable to suggest that until the waiting lists management in general surgery and urology are in a sustainable position, Hypospadias patients can be seen by general surgeons in the first instance. This would ensure costly consultant resources are being used effectively and patient waiting lists are being managed in an efficient way, which in turn should improve patient experience.

It should also be noted that in an email from 2017 to consultant general surgery colleagues and of which it was advised a copy was to be shared with management team at CHI Crumlin, Medical Board and Radiology, Consultant D outlined:

See Appendix 4, for full details.

> *"Conditions such as UTI, hydronephrosis, calculi, hypospadias (excluding proximal hypospadias), will not be considered as specialist urology and therefore can be manged on an ongoing basis by the general surgeons"*
>
> CONSULTANT D

***Table 14** shows the remaining 45 patients who were not given a date for surgery in the NTPF clinics and instead were placed on the Consultant D's inpatient waiting list.[73] Please note the initial date referral was triaged. Of the below list following review by CHI Paediatric Network Lead and Consultant General Surgeon 13% could be operated on by one of the eight General Surgeons across CHI, 82% could be reviewed by a General Surgeon in first instance with experience in Hypospadias, and 5% only require specialist Urologist input. Therefore 95% could be seen by a General Surgeon, who has a significantly less waiting time.[70]*

Clinic Date	Date referral was triaged	Condition stated on referral letter	Type of surgery listed	Date of Surgery	Outcome
12/12/2020	02/10/2019	TIGHT FORESKING	PREPUCIOPLASTY	NO SURGERY YET	SURGERY
12/12/2020	20/11/2019	HYPOSPADIAS	CIRCUMSISION + MEATOTOMY	NO SURGERY YET	SURGERY
16/01/2021	17/06/2019	HYPOSPADIAS	2 STAGE REPAIR	NO SURGERY YET	SURGERY
16/01/2021	06/06/2018	CORONAL HYPOSPADIAS AND CHORDEE	CIRCUMSISION	NO SURGERY YET	SURGERY
16/01/2021	06/02/2018	PHIMOSIS	CIRCUMSISION	NO SURGERY YET	SURGERY
16/01/2021	12/02/2018	HYPOSPADIAS AND MILD CHORDEE	2 STAGE HYPOSPADIAS	NO SURGERY YET	SURGERY
06/03/2021	22/05/2019	HYPOSPADIAS	HYPOSPADIAS REPAIR	NO SURGERY YET	SURGERY
06/03/2021	12/04/2019	HYPOSPADIAS WITH CHORDEE	MODIFIED CIRCUMSISION	NO SURGERY YET	SURGERY
06/03/2021	13/01/2020	HYPOSPADIAS	MODIFIED CIRCUMSISION	NO SURGERY YET	SURGERY
06/03/2021	18/01/2018	MILD CHORDEE AND HOODED FORESKIN	REPAIR	NO SURGERY YET	SURGERY
06/03/2021	29/03/2019	HYPOSPADIAS	MEATOTMY	NO SURGERY YET	SURGERY
06/03/2021	15/12/2018	HYPOSPADIAS	HYPOSPADIAS STAGE 1 REPAIR	NO SURGERY YET	SURGERY
06/03/2021	25/06/2019	BALLUNING OF FORESKIN	PREPUTIOPLASTY	NO SURGERY YET	SURGERY
06/03/2021	28/03/2018	HYPOSPADIAS	CIRCUMSISION	NO SURGERY YET	SURGERY
06/03/2021	27/02/2019	HYPOSPADIAS	SINGLE STAGE REPAIR	NO SURGERY YET	SURGERY
06/03/2021	14/08/2019	HYPOSPADIAS AND HOODED PENIS	SINGLE STAGE REPAIR	NO SURGERY YET	SURGERY

06/03/2021	25/09/2019	HYPOSPADIAS WITH HOODED FORESKIN	CIRCUMSISION	NO SURGERY YET	SURGERY
06/03/2021	13/01/2020	HYPOSPADIAS	SINGLE STAGE REPAIR	NO SURGERY YET	SURGERY
06/03/2021	13/01/2020	HYPOSPADIAS	HYPOSPADIAS REPAIR	NO SURGERY YET	SURGERY
06/03/2021	05/12/2018	HYPOSPADIAS	CIRCUMSISION AND MEATOTOMY	NO SURGERY YET	SURGERY
13/02/2021	01/10/2018	HYPOSPADIAS AND CHORDEE	MODIFIED CIRCUMSISION	NO SURGERY YET	SURGERY
13/02/2021	07/02/2018	HOODED FORESKIN AND ABNORMAL URETHRA OPENING	CIRCUMSISION AND MEATOTOMY	NO SURGERY YET	SURGERY
13/02/2021	16/01/2019	CONGENITAL HYPOSPADIAS	CIRCUMSISION AND MEATOTOMY	NO SURGERY YET	SURGERY
13/02/2021	10/10/2018	BALANITIS	CIRCUMSISION	NO SURGERY YET	SURGERY
13/02/2021	25/09/2019	RETRACTED FORESKIN, CHORDEE, HYPOSPADIAS	FORMAL REPAIR	NO SURGERY YET	SURGERY
13/02/2021	12/12/2018	HYPOSPADIAS	CIRCUMSISION AND MEATOTOMY	NO SURGERY YET	SURGERY
13/02/2021	23/10/2019	HYPOSPEDIAS	CIRCUMSISION AND MEATOTOMY	NO SURGERY YET	SURGERY
13/02/2021	12/04/2019	HYPOSPADIAS	SINGLE STAGE REPAIR	NO SURGERY YET	SURGERY
20/02/2021	12/04/2019	HYPOSPADIAS	SINGLE STAGE HYPOSPADIAS REPAIR	NO SURGERY YET	SURGERY
20/02/2021	23/09/2019	PHIMOSIS AND HYPOSPADIAS	SINGLE STAGE REPAIR	NO SURGERY YET	SURGERY
20/02/2021	28/08/2019	PHIMOSIS AND HYPOSPADIAS	SINGLE STAGE REPAIR	NO SURGERY YET	SURGERY
20/02/2021	07/08/2020	LEFT SCROTAL SWELLING	PATENT PROCESSUS VAGINALIS	NO SURGERY YET	SURGERY
20/02/2021	06/09/2019	HYPOSPADIAS	HYPOSPADIAS STAGE?1/?2	NO SURGERY YET	SURGERY
20/02/2021	14/08/2019	HYPOSPADIAS	CIRCUMSISION	NO SURGERY YET	SURGERY
20/02/2021	14/08/2019	CORONAL HYPOSPADIAS	CIRCUMSISION	NO SURGERY YET	SURGERY
20/02/2021	30/07/2019	HYPOSPADIAS	HYPOSPADIAS REPAIR	NO SURGERY YET	SURGERY
20/02/2021	19/06/2019	HYPOSPADIAS	HYPOSPADIAS	NO SURGERY YET	SURGERY
20/02/2021	22/05/2019	HYPOSPADIAS	HYPOSPADIAS	NO SURGERY YET	SURGERY
20/02/2021	16/05/2019	HYDROCELE	HYDROCELE	NO SURGERY YET	SURGERY
20/02/2021	19/06/2019	HYPOSPADIAS	HYPOSPADIAS REPAIR STAGE 2	NO SURGERY YET	SURGERY
20/02/2021	07/05/2019	HYPOSPADIAS	HYPOSPADIAS STAGE 1 REPAIR	NO SURGERY YET	SURGERY
20/02/2021	12/04/2019	HYPOSPADIAS	HYPOSPADIAS	NO SURGERY YET	SURGERY
20/02/2021	20/02/2019	HYPOSPADIAS	2 STAGE REPAIR HYPOSPADIAS	NO SURGERY YET	SURGERY
20/02/2021	17/06/2019	HYPOSPADIAS	CIRCUMSISION	NO SURGERY YET	SURGERY
20/02/2021	19/06/2019	HYPOSPADIAS	MEATOTMY+MODIFIED CIRCUMSISION	NO SURGERY YET	SURGERY

Table 14 Patients not given a date for surgery at NTPF Clinics

e) Current Urology General Surgery Waiting List Management

On review of the current Urology inpatient waiting list (22/09/2021 extract) in CHI at Crumlin there are 189 patients, split between two urologists. [84]

- Of these 189 patients, on review by CHI Paediatric Network Lead and General Surgeon, up to 60% (113 patients) are eligible to be seen by General Surgeons in the first instance i.e., conditions such as undescended testes, circumcision, and hypospadias. [85]
- Ten patients currently on the inpatient waiting list require orchidopexy and are at risk if their wait time extends past their first birthday as previously outlined.85 75

It is also important to highlight that all data included in this paper relates to inpatient waiting lists in CHI at Crumlin only, CHI at Temple Street data is not included. Based on the above analysis

[84] Urology Inpatient Waiting List with Conditions. Dated 22nd September 2021.
[85] Urology Inpatient Waiting List Review by General Surgeon. See Appendix 3.

and detail, a review of the urology inpatient waiting list in CHI at Temple street should be undertaken immediately, to determine if any patient safety issues exist.

***Table 15** shows the current breakdown of patients on both urologist's inpatient waiting lists in CHI Crumlin, as reviewed by CHI Paediatric Network Lead, Consultant B.[85] Extract taken on the 22/09/2021.[84]*

Consultant D	Day Case	Inpatient	Grand Total
Total patients on Inpatient Waiting List	58	34	92
Total patients eligible to be seen by General Surgeons85	24	18	42
Consultant F	**Day Case**	**Inpatient**	**Grand Total**
Total patients on Inpatient Waiting List	54	43	97
Total patients eligible to be seen by General Surgeons85	35	36	71

Table 15 Casemix on Consultant D and F waiting list

Of further concern, is that the above analysis is not the first piece of work undertaken to review the urology waiting lists across CHI, to address concerns relating to equitable referral management and waiting list issues. Between October 2019 and March 2020, a number of recommendations were made to the CHI Executive around referral management of urology patients by CHI's Paediatric Network Lead.[86] At that time over 1000 referrals, which were sitting on the urology waiting lists were identified as suitable for general surgery.[86] In January 2021, a paper on NTPF initiatives in CHI was approved by the Executive, which states that additional options (outside of NTPF) will be explored for the urology and general surgery waiting list management, given the success of the work completed by CHI's Paediatric Network Lead previously.[87]

The NTPF clearly outlines that when it comes to waiting list management, action plans must be sustainable.[61] A sustainable solution, for equitable referral management was identified through CHI's Paediatric Network Lead work, yet significant challenges around waiting list management within the General Surgery and Urology service still exist.[86] Despite the work undertaken by CHI's Paediatric Network Lead and the evidence presented indicating that a significant number of referrals sitting on the urology waiting lists could and should be shared among the general surgeons, NTPF funded urology clinics were sought through operations by Consultant D and approved, immediately thereafter.[64] As outlined previously, five clinics took place between December 2020 and March 2021.[68] This approval and the subsequent clinics very much undermined the extensive work undertaken by CHI's Paediatric Network Lead and the follow up support provided by the General Surgeons in seeing close to 1,000 referrals in their public outpatient clinics. [86]

On review of the five NTPF approved outpatient clinics and the case mix of patients seen, it was confirmed by the CHI Paediatric Network lead, who previously undertook such a review on behalf of the CHI Executive that 95% of those referrals could have been seen by a general surgeon[70] (see table 15 above).

[86] Paediatric Urology / Paediatric Surgery Referral Management Initiative. Dated 1st February 2020.
[87] CHI Executive: NTPF Insourcing Requests. Dated 26th January 2021.

A consultant seeking to undertake NTPF clinics for patients they have placed on a waiting list, without exploring all other options to determine if those patients could safely, effectively and more efficiently be seen and manged in routine clinics, with no additional requirement for public funding, by any one of eight other general surgeons across CHI, is hugely questionable in terms of code of conduct and ethical practice. Not to mention the inappropriate use of public funds. Furthermore, by placing these children on an individual inpatient waiting list, instead of seeking to determine if an alternative appropriate intervention could be provided by any one of eight general surgeons across CHI, whose inpatient waiting list is significantly shorter, is at best, a non-adherence to the fundamental of waiting list management, which endeavours to provide fair and equitable access for patients where possible (see table 16).[61]

***Table 16** shows the 5 patients requiring orchidopexy who were not given a date for surgery in the NTPF clinics and instead were placed on the Consultant D's inpatient waiting list. As per cited international guidance[75 77 78 79] - these patients are currently at risk. Please note the date referral was initially triaged, each of them have been waiting >1 year.* [68]

Clinic Date	Date referral was triaged	Condition stated on referral letter	Type of surgery listed	Date of Surgery	Outcome
12/12/2020	07/05/2019	LEFT SIDED UDT	ORCHIDOPEXY	NO SURGERY YET	SURGERY
12/12/2020	02/10/2019	UDT	PROSTHESIS INSERTION	NO SURGERY YET	SURGERY
16/01/2021	17/07/2019	LEFT UDT	LEFT ORCHIDOPEXY	NO SURGERY YET	SURGERY
06/03/2021	07/04/2019	UDT	ORCHIDOPEXY	NO SURGERY YET	SURGERY
20/02/2021	01/03/2019	UDT	RIGHT ORCHIDOPEXY AND HERNIOTOMY	NO SURGERY YET	SURGERY

Table 16 Patients with undescended testes at risk

In October 2021, Consultant D contacted CHI's Schedule Care Lead seeking to undertake further NTPF outpatient clinics, to address urology waiting list issues in CHI at Crumlin and Temple Street.[88]. By continuing to plan additional NTPF urology clinics, which have already been shown to, in the past, contain up to a 95% case mix which could be seen by general surgeons[70] (of which there are eight across CHI) is facilitating behaviours and practices that is not in the best interests of the NTPF or most importantly the patients of CHI.

Furthermore, Consultant D, in the past has outlined unequivocally that specific conditions such as *"UTI, hydronephrosis, calculi, hypospadias (excluding proximal hypospadias)"*[89] are not considered specialist urology conditions and should be seen by General Surgeons.[89] However, three years later this consultant urologist is willing to complete an NTPF clinic which has been shown to have a case mix of patients of which 95% are of a general surgery.[68] At no point in advance of undertaking these NTPF clinics, did Consultant D identify that these patients could be seen by a general surgeon - ultimately negating the need for NTPF funded clinics. (See <u>Appendix 4</u>).

By seeking to undertake any further NTPF clinics, without looking for validation of the waiting list to determine if there are children who can be seen by any one of the eight general surgery

[88] Email confirmation of NTPF clinics restarting from CHI Scheduling Lead. Dated 27th September.
[89] Email from Consultant Urologist to General Surgeon. Dated 19th September 2017. See Appendix 4.

consultants, in as short a time frame in their public clinics, is acting in a manner that is against the HSE code of standards and behaviour (2009) which states that "employees are required to have due regard for State resources to ensure proper, effective and efficient use of public money".[90] See *Appendix 2.*[67]

4.4 Cost Impact of NTPF Clinics

The five NTPF clinics which were held over five Saturdays between December 2020 and March 2021 each ran from 09:00-15:00 with one hour for lunch during that time.[91] Based on the number of patients seen across the five clinics, during the 5 hours of a clinic, the consultant saw an average of one new patient every 10 minutes. For each consultation, the consultant was paid €200 per patient, meaning after reviewing 179 patients the total funding required from NTPF to pay the consultant was €35,800.[64] Additional funding was needed to pay the support staff – consisting of two operations resources (Grade IV and Grade III Healthcare Records) and one Healthcare assistant.[64]

When the NTPF clinics carried out by Consultant D are compared to that consultant's regular Friday morning general clinic [92] (where the consultant had originally triaged the patients be seen – documented on original referral letter), there is a significant difference in the through put of patients (See table 17). For every one patient in a regular OPD clinic, an average of approximately 2 patients were seen in the NTPF clinic.[68,92] It is important to note that each patient seen in an NTPF clinic is a new referral, therefore the consultant will not be familiar with the patient's medical history or other relevant information, and in general a longer time slot is assigned for new patients.

In the consultants routine OPD clinic on a Friday morning, there is a 15-minute time slot given for new patients, and clinics are capped at 23, furthermore at the routine outpatient clinic the consultant has the support of at least one registrar, so the consultant may not even see all patients.[91] In the NTPF clinics, a shorter time slot of 10 minutes was assigned to these patients, even though the consultant is working alone (no registrar support) and would therefore need to see all patients.[68] There was no cap put on the number of patients to be seen, and over the course of the five Saturday clinics, the consultant alone saw between 29 – 47 patients at any one clinic [68] (see table 17 below). It was a clinical decision taken by the consultant who would be running these clinics to see the volume of patients that were seen.[66] It's also important to note that originally 197 patients were identified and scheduled for these clinics, meaning the through put could have been much more if there wasn't 18 patients who did not attend. [73]

[90] Health Service Executive, Code of Standards and Behaviour, Framework for the Corporate and Financial Governance of the Health Service Executive, Document 2.1, 2009.
[91] Email confirmation from CHI Operations. Dated 13th October 2021.
[92] Consultant Urologist Friday Morning General Clinic Activity. 1st June 2021 to 1st October 2021.

If the throughput on an NTPF clinic differs so significantly to the normal OPD clinic, one must question if the consultant is working to full capacity for CHI on a regular basis at routine public clinics, or should a concern be raised as to whether the patients seen in NTPF clinics were afforded the same dedicated time by the consultant that they would have had in routine public clinics? [68] [92]

Furthermore, it must be highlighted that this consultant is not currently fulfilling their public contract commitments due to health issues.[93] Over three years ago this consultant was taken off call for health reasons and a locum consultant was employed by CHI to facilitate the on-call commitment. The last Occupational Health Report for this consultant in relation to their inability to cover on call dates back to 1st October 2019. This report details the clinical assessment as "*unremarkable*" and recommends that Consultant D remain off call "*indefinitely*". Furthermore, it states that there is no requirement for another "*scheduled appointment*". The Occupational Report was signed off by the Crumlin HR Deputy Director on the 8th October 2019.[93] The cost of employing an additional consultant to cover this on call commitment thus far for CHI is approximately €450k.[94]

It needs to be explored how one consultant can undertake a series of NTPF clinics over numerous Saturdays and during these clinics see a much greater number of patients than they are able to see in their routine public clinics, working at a very fast pace with significant throughput - a substantial undertaking of additional work, yet is unfit for any on call duties for the past three years.[68] [73] [93] These NTPF clinics were not sought by or offered to any of the other eight general surgeons across CHI.[69] Indeed, the requirement for the NTPF clinics at all is questionable and is a significant cost to the exchequer which potentially could have been avoided, given the conclusion of the review by CHI Paediatric Network Lead and Consultant General Surgeon that of the case mix of patients seen at these NTPF clinics, 95% could have been safely and effectively managed by general surgery (see table 15). [70]

***Table 19** shows the number of patients per NTPF clinic and compares against Consultant D's regular OPD clinic.*

Date of NTPF Clinic	Number of Patients Seen	[illegible]
12th December 2020	**29**	*Average of 19 patients seen per clinic. Note each clinic is generally supported by 1-2 SHOs/Registrars meaning if this consultant worked alone, he would see 6-10 patients only, i.e., 16-24mins per patient.*
16th January 2021	**31**	
13th February 2021	**33**	
20th February 2021	**47**	
6th March 2021	**39**	
Total	**179**	

Table 17 Number of patients at NTPF Clinics

4.5 Patient Safety Impact

[93] Corporate Health Ireland to Director of HR Crumlin. Dated 1st October 2019
[94] Email confirmation of salary from HR at CHI Crumlin. Dated 19th October 2021.

The details outlined in this paper would strongly suggest that patients are being placed onto waiting lists, despite an existing alternative option being available for quicker treatment and care.[70] Patients with undescended testes, who require orchidopexy, are waiting far in excess of the recommended timeframe for treatment, placing those patients at real and known risk for fertility issues and or cancer in later life.[77 78 79] This activity is taking place when there is an alternative cohort of experienced general surgery consultants who can safely and effectively manage their care in a much shorter timeframe, thus mitigating or eliminating the risks outlined above.[74]

As the national centre for Paediatric Urology in Ireland, CHI should strive to adhere to recommended international best practice and guidelines. There are numerous studies and guidelines which outline that optimum timing for undertaking orchidopexy is between 6 months – 18 months of age.[75 77 78 79]

- As outlined above, there are ten patients currently sitting on a urology inpatient waiting list, referred through these NTPF clinics, who require orchidopexy surgery in CHI. [85]
- These children are beyond the threshold of 18 months as they were referred for care and treatment in 2019 (see table 14). [75 77 78 79]
- Furthermore, on review of the urology waiting list for OPD, as of 7th October 2021, there are an additional 20 patients referred with undescended testes.[71] The current wait time for a urology outpatient appointment is 14 months, yet for General surgery is 10 months.[76 85]

A question needs to be asked as to why these patients are sitting on an inpatient urology waiting list for a longer period than is necessary, given they could be seen by any one of eight general surgeons across CHI. Research and guidelines would indicate that these patients are currently at risk of fertility issues or malignancy of the testes later in life if not seen and treated by the time they are 18 months.[75 77 78 79] Their treatment should be a matter of priority. CHI must strive for international best practice and excellence in care where possible.

4.6 Actions for consideration

There have been a number of areas highlighted in this paper which need to be addressed as a matter of urgency. Outlined below are a number of initial recommendations for CHI to implement in both the short and medium term.

Immediate Actions:

- Any plans for further NTPF clinics in Urology need to be reviewed in detail to ensure they are in the best interests of the patients and best use of public funding.

- Move any patient with undescended testes on the urology waiting list (across both sites) to the General Surgeons waiting lists to ensure they are addressed promptly and in line with international best practice. [75] [77] [78] [79] [85]
- To address any inequitable or unfair access for patients, CHI should adhere to the sustainable recommendations for referral management put forward by Brice Antao working with the operations team on each hospital site.[86]

Short term Actions (within next 3 months):

- For a longer-term sustainable solution to referral management, a central referrals system for the General Surgery / Urology service needs to be put in place and followed. This should be a matter of highest priority in order to address the inequitable and questionable practices currently in play, and which are very clearly not in best interest of the child or in keeping with the vision of CHI; *Healthier children and young people throughout Ireland*. In 2017, the CHI executive approved a model for implementation of central referrals, which was based on 30 different international and national models. An effective central referrals solution enhances patient safety and patient experience, as well as enabling consistent, timely and equitable access to care.[95] This model needs to be rolled out consistently across CHI for specific vulnerable specialities as priority.
- Furthermore, any and all consultants who have been identified as directing, supporting or facilitating the inequitable and unfair distribution and management of referrals for whatever reason, should be held to account and consideration given as to whether the matter should be referred to the Irish Medical Council and or any other relevant body or organisation. CHI, and indeed the HSE, cannot and will not stand over behaviour or practice which undermines the integrity of public organisations. CHI strives at all times to promote and provide child-centred, research-led and learning informed healthcare, to the highest standards of safety and excellence. The scenarios outlined in this paper go against this and the CHI values of integrity and child-centredness that staff are expected to uphold.

[95] Health Service Executive, eHealth Strategy for Ireland, 2013

5 LEADERSHIP AND GOVERNANCE

5.1 Chapter Overview

In this chapter, the following areas will be examined:

- Overview of the clinical directorate model of governance and the transition underway to fully implement this new way of working across CHI
- Governance and accountability challenges across the general surgery and urology department owing to a lack of collaboration and robust team working
- Site Leadership Accountability and Service Planning relating to the oncology general surgery and urology, to include concerns relating to recruitment processes, risk management and Spina Bifida Services across CHI
- Operations oversight of access initiatives and impact of governance gaps financially and on department dynamics and interpersonal relationships
- Overview of research into the impact of organisational culture and how it influences staff well-being, patient safety and the effective operations of services and critically leadership's role in shaping and driving culture

Throughout this chapter anonymized quotes from participants will be used to give context to the themes being explored. The consultants highlighted specifically in this chapter are as follows:

Consultant A
Consultant D
Consultant E

5.2 Transition to Clinical Directorates

The introduction of the clinical directorate model, incorporating the appointment of Clinical Directors with formal authority to lead, is one of the most significant changes to occur in the Irish Healthcare Service for many years. [96] It represents an unprecedented opportunity for change and improvement in the way health services are delivered through clinical leadership. [96] CHI has commenced a phased transition to a cross-city clinical directorate governance structure that will be in place in advance of, and in preparation for, the move to the new children's hospital.

The transition to this re-structured model and new ways of working is being managed through distinct phases. Progressing from site-based structures, to a cross-city model of delivery, and

[96] Clinical Directorates Underpinning Principles and Operating Framework 2017.

finally to a model with leadership centred in the new children's hospital. At present, the focus remains on establishing a consistent and robust approach to governance across each of the CHI sites. Currently the Clinical Directors are accountable for the safe and efficient governance and operations of their respective sites, as well as working incrementally towards adoption of a single collaborative clinical governance structure and cohesive ways of working across CHI.[97] Since forming as a single entity, transition to a single governance structure has been protracted due to the capacity challenges of the site leadership teams.[98]

This slow transition from site to cross-city governance may have contributed to a lack of clarity and trust among a majority of participants regarding leadership responsibilities and accountability across CHI. Throughout this examination, site and operational governance was highlighted as a significant challenge in the effective and efficient operation of services across CHI. This was evidenced by the limited understanding and confidence among participants of where responsibility lay at site level, leading to the Office of the CEO being inappropriately pulled into site operational issues on various occasions for decisions and direction.[6]

a) General Surgery Urology Governance

The RCSI Code of Practice for Surgeons clearly outlines that a surgeon should *"work effectively and amicably with colleagues in multi-disciplinary teams, participate in multi-disciplinary team meetings, share decision making, develop common management protocols, where possible, and discuss patients' problems with colleagues."*[23] Within the general surgery and urology department, all consultants do not meet as a department regularly or participate in team meeting such as;

- The Department of Surgery (DoS) meetings [21]
- The Morbidity and Mortality (M&M) meeting[6]

As a result of the lack of collective engagement in such meetings, many participants voiced the view that it has led to and continues to cause significant communication challenges and a lack of a supportive and collegial working environment. [6] [19] The HSE Clinical Governance paper outlines that *"each individual, as part of a team, knows their responsibility, level of authority and who they are accountable to"*.[99] This clarity around governance is far from steadfast across CHI. The existence of dysfunctional relationships and disruptive behaviours within the general surgery and urology department, coupled with an apparent lack of governance and consistent direction from clinical and operational leadership, has led to the development and of evolvement of a very negative and broken culture. [100]

[97] Clinical Director Job Description 2021.
[98] Organisation and Remuneration Board Update Clinical Directorates. November 2021.
[99] HSE Clinical Governance 2012.
[100] The Impact Of Leadership And Change Management Strategy On Organisational Culture. 2014.

Source	Quote
Participants 11, 12, 18, 25	*"It's one of the things we need looking at in theatre – we need a robust governance structure. We need transparency and good communication, both of which don't really exist at the moment. Unexpected cases should automatically trigger an After Action Review (AAR), or at least some sort of MDT discussion."* *"From my experience, head of department had responsibility, everyone reported to them... Here they have no power and no decision-making ability. Can all say and do what [they] want. This does not work towards building the new children's hospital."* *"Difficult consultant can be a sole trader. The culture is not cohesive. Other than the medical council, I don't know what structure there is."* *"I was never aware of any good clinical governance... people don't get challenged. Things are put in place for a person or a team, but the clinic is not there for the team, it's for the patient. If you look at it from a patient's perspective, how do you make it better? Not something I felt was there in children's surgery...."*

Throughout the course of this examination many issues have been tabled that suggest gaps in leadership and governance at site level have a causative effect on culture, staff morale and effective operations across CHI. [100] Three specific areas have come to the fore:

- ***Site Leadership and Service Planning***
- ***Operations Oversight and Financial Impact***
- ***Management of Behaviours***

5.3 Site Leadership and Service Planning

a) Oncology Service

Background

Within *chapter 3* of this report, the substantial interpersonal challenges within the Oncology General Surgery Service are highlighted. This is a longstanding issue which appears to remain unaddressed by leadership in CHI at Crumlin. It was through the process of the examination of the general surgery and urology service, that a risk assessment was identified as an urgent requirement for CHI. Although the Risk Assessment Owner and the Risk Assessment Co-Ordinator is identified as the Clinical Director for CHI at Crumlin, the assessment called out that there is a *"Lack of clarity over whether one or two surgeon are actively participating in the surgical oncology service"*, furthermore somewhat contradictory the assessment acknowledges that the second surgeon who had been working in the service *"withdrew from the service following an incident in 2019."* [22]

There appears to be clear lack of ownership and understanding of the oncology general surgery service from leadership in CHI at Crumlin, a tertiary specialist service, which is exclusively operated from CHI at Crumlin. Based on the above identified details from the Risk Assessment and input from multiple participants,[6] it is observable that the responsibility of such a specialist tertiary service, which is the only such service providing care to the children of Ireland, sits exclusively on one surgeon's shoulders. In addition, there appears to be no substantial succession plan in place.[6] [22]

Service Planning – Recruitment

A recruitment process began in August 2014 [101], in Our Lady's Children's Hospital Crumlin (now CHI at Crumlin), to backfill a General Surgeon Consultant post. The understanding was that the newly appointed consultant would support the General Surgery Oncology Service. 6 The entire recruitment process lasted a prolonged period - although the proceedings began in August 2014, interviews did not take place until November 2015.

Some or all of the delays in the recruitment process, appear to be as a result of a multitude of disagreements between the general surgeons and management at Our Lady's Children's Hospital Crumlin, (now CHI at Crumlin).

The issues appear to range from concerns in relation to:

- Dispute regarding the job specification and details of job advertisement
- Disagreement in relation to the makeup of the interview panel
- Transparency and Fairness surrounding the recruitment process

[101] HR email to General Surgeon. Dated 15th August 2014.

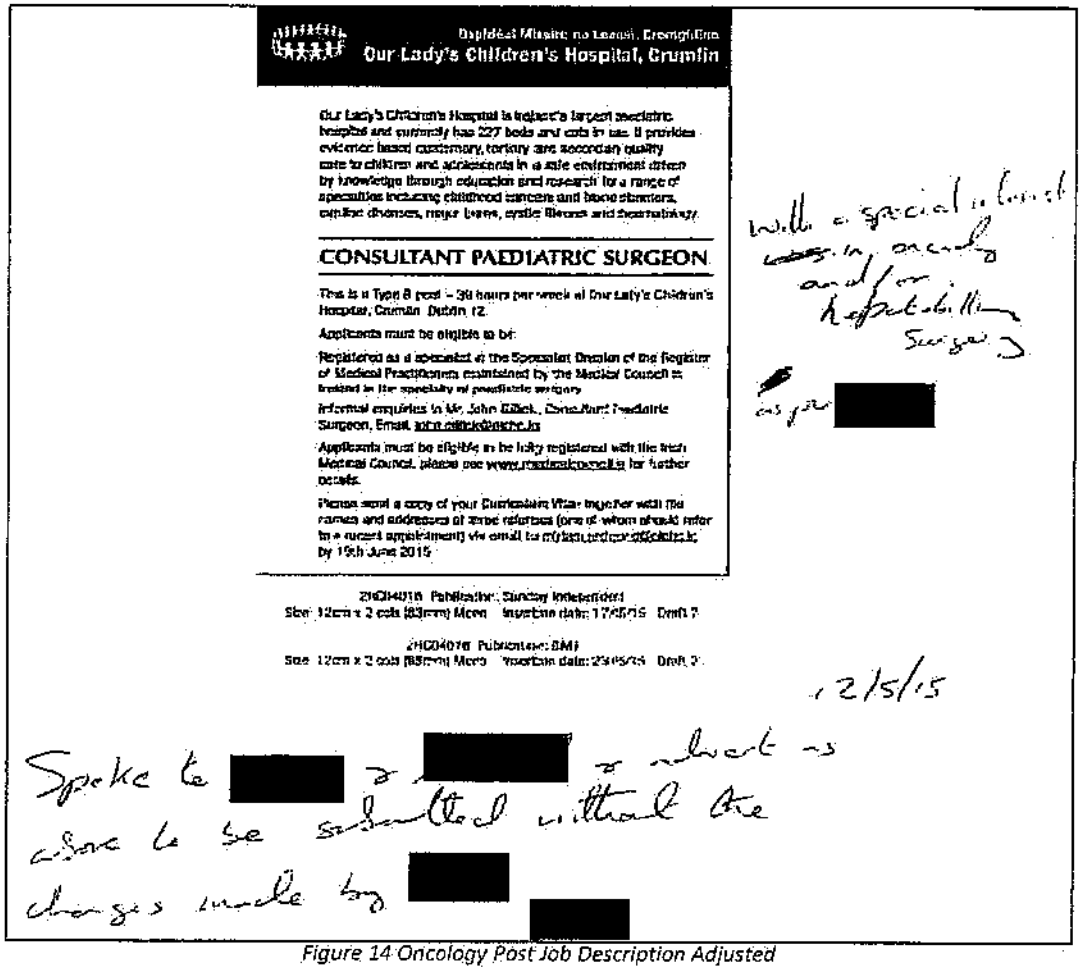
Dispute regarding the job specification and details of job advertisement

Figure 14 below, is a copy of the draft job description and advert for the general surgeon consultant post.[102] This document displays a dated handwritten note, which highlights a disagreement in relation to the job description.[102] It warrants reflection for several reasons:

- Consultant A requests applicants to have *"a special interest in oncology or hepatobiliary surgery"* which would appear be in line with the requirements of the department. [102]
- Another note on the same job description states *"Spoke with [Clinical Director] and [Consultant D] and advert as above to be submitted without the changes made by [Consultant A]"*. [102]

Given the role was for a general surgeon to support the general surgery oncology service, the following should be noted:

- It was determined that it was not necessary to have an interest in 'oncology or hepatobiliary surgery'
- The opinion of a consultant urologist is sought and taken into account for a role to support the oncology surgical service, however the opinion of the consultant general surgeon who is leading the service is not taken on board.


Our Lady's Children's Hospital, Crumlin

Our Lady's Children's Hospital is Ireland's largest paediatric hospital and currently has 227 beds and cots in use. It provides evidence based customary, tertiary and secondary quality care to children and adolescents in a safe environment driven by knowledge through education and research for a range of specialties including childhood cancers and bone disorders, cardiac diseases, major burns, cystic fibrosis and haematology.

CONSULTANT PAEDIATRIC SURGEON

This is a Type B post – 30 hours per week at Our Lady's Children's Hospital, Crumlin, Dublin 12.

Applicants must be eligible to be:

Registered as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the speciality of paediatric surgery

Informal enquiries to Mr. John Black., Consultant Paediatric Surgeon, Email: [redacted]

Applicants must be eligible to be fully registered with the Irish Medical Council, please see www.medicalcouncil.ie for further details.

Please send a copy of your Curriculum Vitae together with the names and addresses of three referees (one of whom should refer to a recent appointment) via email to [redacted] by 15th June 2015

2HC04018 Publication: Sunday Independent
Size: 12cm x 2 cols (83mm) Mono Insertion date: 17/05/15 Draft 2

2HC04078 Publication: BMI
Size: 12cm x 2 cols (83mm) Mono Insertion date: 23/05/15 Draft 2

with a special interest in oncology and/or hepatobiliary surgery

as per [redacted]

12/5/15

Spoke to [redacted] & [redacted] & advert as above to be submitted without the changes made by [redacted]

Figure 14 Oncology Post Job Description Adjusted

[102] Adjusted draft job description Oncology Post. Dated 12th May 2015.

Disagreement in relation to the makeup of the interview panel

A letter from the general surgeons to the Clinical Director of Our Lady's Children's Hospital Crumlin, details their reservations about management restricting the interview panel for this post to six. A partial extract from this letter is detailed below: [103]

Extract [103]

"It is vital that our collective input as Paediatric Surgeons is taken into consideration when appointing a new Paediatric Surgeon. In the interest of good clinical governance, it is essential to have transparency, fairness and accountability as core components of the entire appointment process. A larger panel will bring more depth of experience and expertise to the panel and can only serve to enhance it.

In the interests of openness, fairness, and transparency we, as a Department, cannot participate in the interview process as is currently proposed"

Extract 4 Letter from General Surgeons to Leadership

Following a meeting on the 4th September 2015 with the Clinical Director and Site CEO (now CHI at Crumlin Site Clinical Director), where the General Surgeons expressed their reservations regarding the interview panel, the original proposed panel is accepted, with just two General Surgeons representing the department. [104]

Transparency and Fairness surrounding the recruitment process

Thereafter, notes from interviews held for this post, show one applicant had substantial oncology experience, had already reached out to Consultant A *"to collaborate on oncology"* and were operating on *"70-90 solid tumours per annum"*. [105] This same level of experience was not held by Consultant B, who ultimately secured the post. Consultant B stated at interview they had completed *"20-30 tumours per annum"*. [105]

On review of the interview notes, it can be seen that there was changes made to the weighting template and how each section scored, although this was the agreed weighting template that brought to interview (see Figure 15).[106]

[103] General Surgeons Letter to Our Lady's Children's Hospital Management. 13th August 2015.
[104] Email from General Surgeon to Clinical Director and Site CEO. Dated 10th September 2015.
[105] Consultant Surgeon Post – OCKSKS02. Interview notes. 13th November 2015.
[106] Consultant Surgeon Post – OCKSKS02. Interview score. 13th November 2015.

The interview panel altered the weightings as follows:

Area	Template Weighting	Adjusted Weighting
Knowledge (Training)	25	20
Experience (Quality/Extent)	25	20
Research / Publications	15	15
References	15	5
Interview	20	40

CONSULTANT PAEDIATRIC SURGEON POST

This is a Type B post – OCKSKS02 and is structured
39 hours per week at Our Lady's Children's Hospital, Crumlin, Dublin 12

Interviews to be held in the Boardroom, Our Lady's Children's Hospital, Crumlin, Dublin 12 on Friday, 13th November, 2015 at 9.00a.m.

NAME	KNOWLEDGE (Training) 20	EXPERIENCE (Quality/Extent) 20	RESEARCH/ PUBLICATIONS 15	REFERENCES 5	INTERVIEW Suitability 40	TOTAL 100
Consultant C	19	16	9	5	32	81
Consultant E	18	12	10	5	14	59
Consultant B	17	15	12	5	36	85
External Applicant	17	18	8	5	30	78

Candidate Selected Consultant B **Substitute Candidate** (1) Consultant C (2) External Applicant

SELECTION COMMITTEE

Figure 15 Interview score Oncology Post

In advance of interviews weighting guidelines, parameters and templates should all be agreed, and it would not be good practice to adjust such detail post interview. Such actions leave the process open to scrutiny and challenge. In Figure 15, above the word *"suitability"* is handwritten under the interview section. 40% of the total score was afforded to this section, the same score as knowledge and experience combined. The term suitability could be interpreted as rather nebulous in this context, most significantly as it was adjusted to be weighted so heavily. The above details do not align with an open transparent process.

Further exploration of the effectiveness of recruitment processes in CHI at Crumlin should be considered, given the issues identified in relation to this post:

- An extremely lengthy recruitment process.[101]
- Concerns raised in writing to management about the *"transparency"* and *"fairness"* of the process.[103]
- Changing of weighted scores from the agreed Our Lady's Children's Hospital template.[106]
- Differing views on the job description – and ultimately the status quo in the department today where the consultant who was recruited, has withdrawn their services and does not now work in the oncology general surgery service.[102]

Risk Management and Governance

In a recent risk assessment, completed on the 27th August 2021, the oncology general surgery service was given a risk score of 20 out of a possible 25.[22] This being categorised as a high red risk. The HSE states these are risks which *"are intolerable, that is they cannot be accepted and require significant management focus to mitigate them"*.[24] Current leadership in CHI at Crumlin did not identify the need for this risk assessment, despite significant issues relating to the service being brought to leaderships attention over the last number of years, not least an AAR, following a general surgery oncology procedure. [6]

Given this, further deliberation on the oversight and governance in place for this service should be afforded. Below is a summary of events related to the Oncology Service Risk Assessment:

Date	Key event
8th June 2021	Request from this examination to carry out a risk assessment on the Oncology General Surgery Service.[107]
21st July 2021	Over a month later, CHI CEO seeks an update, and it is confirmed by the Site Clinical Director at CHI Crumlin that the Risk Assessment has not yet commenced. CEO calls for actions and re-iterates importance of prioritizing this assessment [108]

[107] Turnaround of General Surgery Urology Service. June 2021.
[108] Confirmation email from CEO. July 2021.

23rd September 2021	An update is sought on the Risk Assessment.[109] The Site Clinical Director confirms the *"assessment is in a process at present"* but that they were *"happy for it to be shared"*. [110] The risk assessment shared was dated as follows: • *Risk Assessment Date - 27th August 2021* [22] • *Initial Assessment Date - 10th June 2021* [22] The Risk Assessment as shared did not indicate it was a draft version and there is no version control contained within the document. On review of the particulars contained within the assessment, it would appear details seem somewhat contradictory. For example: • *Lack of clarity over whether one or two surgeons are actively participating in the surgical oncology service* [22] • *...the second surgeon has largely withdrawn from the primary oncology surgical service, focusing on other areas of specialism. This change was not made as part of a formal planned service development process.* [22] • *Inconsistent division of workload between two surgeons providing oncology surgery*[22] It should be known if there is there one to two surgeons working in a tertiary specialist service? Indeed, if the second surgeon had withdrawn then there must only be one, and if there is only one how can there be an inconsistent division in workload, as the load could only sit with one. The Risk Assessment Owner and Risk Assessment Co-Ordinator is identified as the Site Clinical Director at CHI Crumlin. Should it not be known at site and operational level who is working within a service, especially given the involvement of site leadership in the recruitment of a second surgeon to work in the Oncology General Surgery Service?
22nd November 2021	For completion, this examination requested an update on specific actions from the Oncology Risk Assessment shared in September, to confirm if actions had been completed.

[109] Email to Risk Manager requesting update on risk assessment. Dated 23rd September 2021.
[110] CHI at Crumlin Site Clinical Director Email. Dated 23rd September 2021.

	What was shared in response was what appears to be an amended risk assessment - there is no version control or new review date recorded. The assessment date remains the same. However there appears to be slight differences to the original shared assessment. [111] Namely the contradictions (as had been highlighted by this examination at the time of original receipt) are either removed completely or very poorly edited: *"Clinical Director and CMO to undertake specific review of the surgical element of the Oncology service and seek clarity on current status and intention of both surgeons" becomes* *"Clinical Director and CMO to continue specific review of the surgical element of the Oncology service and seek"*[111] Any original actions recorded around improving working relationships between the two consultants has been removed – this despite it being listed as a concern under *"Why are we concerned about this risk?"*. [111] As seen thus far in this report, the working relationships and dynamics in the general surgery and urology department has a significant impact both operationally and on patient and staff well-being and experience and should be a priority addressed by leadership appropriately. Furthermore, the above risk assessment process appears to lack a transparent and ownership approach. Processes relating to risk assessments, patient safety, staff welfare and a departments overall capacity to run effectively should be managed as a high priority and with a transparent and accountable mindset.

Table 18 Summary of Oncology Risk Assessment

b) Urology Service

Urology Locum Post

Throughout the course of this examination, what appears to be a noteworthy level of obliqueness and significant concerns from multiple participants in relation to the ongoing management of a consultant locum post were identified. Throughout the course of this examination, what appears to be significant indistinctness and queries in relation to the appointment and ongoing management of a consultant locum (Consultant E post) were identified. Consultant E was employed by Our Lady's Children's Hospital Crumlin commencing 7th September 2018, under a locum contract, with the purpose of covering the on-call

[111] Updated Oncology Risk Assessment. Dated 28th October 2021. Received 22nd November 2021.

requirement of Consultant D.[6] It was first identified in 2018, through a self-referral, that Consultant D was unable to complete their contractual on call requirement due to health issues.[112] Consultant D remains off call as of end of November 2021 for these reasons, although the last formally documented occupation health note in this regard, dates to 2019.[93] Furthermore, within this occupational health report, the clinical assessment was noted as '*unremarkable*' and no additional follow up checks were called for.[93]

The HSE conditions and process by which permanent consultant posts may be filled with locum appointments, very clearly outline when locum appointments can be made: [113]

- *The permanent post holder is on a period of leave, e.g.: maternity leave, sick leave, unpaid leave, leave of absence, career break etc.*[113]
- *The permanent post holder is seconded to another role on a temporary basis, e.g.: clinical programme lead, clinical director, etc.* [113]
- A permanent post holder has been appointed to the post but has not yet commenced employment. [113]

None of the above conditions apply to Consultant E's appointment as a locum to Our Lady's Children Hospital Crumlin (now CHI at Crumlin). This appears to have led to numerous issues for the department and CHI.

A HR report published by the HSE in 2017, relating to consultant posts, states that:

> *"Taking account of the regulatory functions of the HSE, health service employers are required to seek the prior approval of the HSE before making a Consultant appointment (whether permanent or non-permanent) and comply with the HSE Letter of Approval in making the appointment. Where an application for a permanent, temporary or locum Consultant post is refused or deferred, it would be illegal for an employer to proceed with the appointment and any employer proceeding to create a post which has not been approved by the HSE leaves itself open to legal risks arising from claims involving holders of unregulated posts."* [114]
>
> **HSE February 2017**

Within Consultant E's contract, this 'HSE Letter of Approval' is referred to on multiple occasions. However, no such letter is contained in any section where asked.[115]

[112] Corporate Health Ireland to Ireland to Director of HR Crumlin. Dated 26th June 2018.
[113] HSE HR Circular 021/2015. Dated 25th September 2015.
[114] Towards Successful Consultant Recruitment, Appointment and Retention. HSE February 2017.

Neither HR CHI at Crumlin nor Tallaght were able to provide the 'HSE Letter of Approval' for Consultant E's locum post. CHI at Crumlin advised such a letter *didn't exist due to the nature of the requirement for the locum appointment (i.e. hired to cover Consultant D's on call).*[94]

Consultant E contract renewal

In June 2019, Consultant E's contract was extended to include an additional obligation of 19.5 hours to CHI at Tallaght. [115] As of November 2021, Consultant E continues to work 19.5 hours in CHI at Tallaght and 19.5 hours in CHI at Crumlin.[6] However, much discontent exists within the general surgery and urology department as a result of what appears to be a very disjointed and uncollaborative way of managing Consultant E contract and renewal. [6]

Correspondence from the General Surgery and Urology Clinical Specialty Lead (CSL) in March 2021 states *'contrary to what we had agreed at our last meeting, as we were led to believe that* [Consultant E] *contract would be renewed from March 2021 and* [CHI at Crumlin Site Clinical Director] *was to follow up with HR in Crumlin regarding this'*. [116]

This correspondence is in response to an email from Medical HR in CHI at Tallaght, to Consultant E on 23rd March 2021, advising their contact would end on 30th April 2021. This notice period is contrary to the twelve weeks' notice period that is detailed in Consultant E contract.[115] This follows concerns raised a full year earlier with the Deputy Clinical Director of CHI at Crumlin,[117] in relation to the *'lack of respect and dignity'* being shown to Consultant E, by management in Crumlin with regard to the management of their contract, which was deemed to be *'grossly unfair'* by the Clinical Speciality Lead and incoming Department of Surgery Chair. [116]

Consultant E access to theatre and OPD in CHI Crumlin

Furthermore, an additional point of concern that has been highlighted on multiple occasions to leadership in CHI at Crumlin, by both the CSL, Department of Surgery Chair and Consultant E directly, is the lack of regular and consistent access to both theatre and OPD in CHI at Crumlin and Tallaght.[6 116 118 119 120 121 122]

"Despite repeatedly asking for access to theatre and OPD on both sites (and being assured multiple times that this would be addressed), [Consultant E] has never been given a theatre list

[115] Consultant E Contract. Dated 25th June 2019.
[116] Clinical Specialty Lead email. 25th March 2021.
[117] Clinical Specialty Lead email to CHI Crumlin Site Clinical Director. 24th October 2018.
[118] General Surgery and Urology - Meeting 2 Minutes. Dated 18th December 2019
[119] General Surgery and Urology - Meeting 3 Minutes. Dated 5th February 2020
[120] General Surgery and Urology - Meeting 4 Minutes. Dated 4th March 2020
[121] General Surgery and Urology - Meeting 5 Minutes. Dated 24th June 2020
[122] General Surgery and Urology - Meeting 9 Minutes. Dated 24th February 2021

on either site or an OPD slot in Tallaght."[116] A summary of these repeated asks, over a 14-month period, at the General Surgery and Urology meetings are outlined below:

Date	Action / Update	Action owner
18th December 2019	*Action to look at OPD access for [Consultant E] in Tallaght and bring proposal back to group*[118]	Chief Operating Officer and CHI at Tallaght and Connolly Sites Clinical Director
5th February 2020	*[Consultant E] getting OPD access and needs surgery time.* *Action to look into getting [Consultant E] theatre time for Crumlin patients in Tallaght*[119]	CHI at Tallaght and Connolly Sites Clinical Director
4th March 2020	*[Consultant E] to be given access to theatre in both Crumlin and Tallaght for a 6 month period.* *Action to address with CHI at Crumlin Theatre Manager.*[120]	Deputy Clinical Director CHI at Crumlin
24th June 2020	*[Consultant E] to have one theatre list per month – progressing.*[121]	CHI at Crumlin Site Clinical Director
24th February 2021	*[Consultant E] reported that getting theatre time was still an issue.* *Action to link with Operations regarding clinics.*[122]	CHI at Tallaght and Connolly Sites Clinical Director

Table 19 Repeated requests to Leadership

The above table clearly outlines a lack of decision making, ability to give clear direction and implementation capability from senior leadership, leaving Consultant E without regular theatre and OPD access and frustrated that the organisation has not fulfilled their promise given at interview of theatre access.

Both a member of the interview panel at Consultant E's Locum interview on 2nd August 2018 and Consultant E have outlined that leadership in Our Lady's Children Hospital Crumlin, (now CHI at Crumlin) committed to ensuring the necessary theatre access and OPD clinics required to manage the work generated from on call would be provided.[25] [6] The member of the interview panel confirmed that the Site Clinical Director *"very specifically stated that Theatre time would be given"*. [6]

Both the CSL and Department of Surgery Chair have documented their overall concerns regarding *'Crumlin's lack of willingness to support [Consultant E]'*.[116] As of November 2021, nearly

3 years and 3 months after Consultant E took up their locum post, and despite the issue being raised multiple times with leadership, and commitments of action given and indeed minuted, no formal supports have been put in place. This remains a well-documented significant concern for the General Surgeon group. [116] [117]

As of 7th October 2021, Consultant E has an outpatient waiting list of 81 children and an inpatient waiting list of 53 children across CHI Crumlin and Tallaght,[80] however, has no formal or regular access to either theatre sessions or OPD slots.[6] Thus, there are a total of 134 children on a consultant's waiting list, with no apparent pathway in place to ensure timely access for these patients to receive either the consultations or interventions they need.[80]

Figure 16 shows the activity of Consultant E over a six-month period up to April 2021.[51] On review this consultant's activity is slightly less than their colleagues, but not by a substantial amount (64 case difference).[51] This shows despite Consultant E's experience in CHI, they continue to be proactive and accommodating, working with their colleagues to obtain the access they need for their patients.

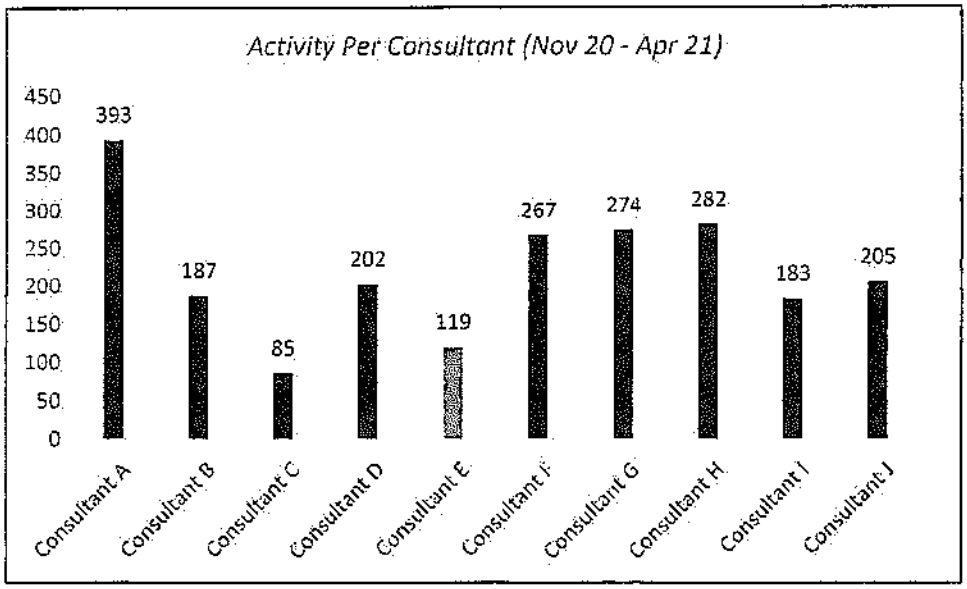


Figure 16 Consultant E Activity

Impact on Interpersonal Relationships and Experience in CHI

The challenges that have arisen as a result of Consultants E's contract management, and the perceived view of several their department colleagues that Consultant E has been treated *'unfairly'* has had a significant impact on the interpersonal relationships across the department.

Indeed, some detail gathered over the course of the general surgery and urology examination might suggest some inequitable patterns of behaviour towards Consultant E. In an email from Consultant D to the DOS and CHI leadership on 4th of February 2020, Consultant D states that

"hypospadias surgery has a significant morbidity in the form of partial or complete breakdown of repair, stenoses, fistula repair. Anyone accepting to perform this surgery must be able to deal with this morbidity. It should not be assumed that complications will be accepted by the urologists. As this morbidity can occur over a period of years after the original surgery, this surgery should not be undertaken by locums. After a locum leaves who will take over the follow-up and/or surgery for complications?"[123]

The CSL responds to this point advising that:

"To single out locums as being at risk of these complications is unfair and unfounded. This is especially relevant since [Consultant D] [themselves] *was a locum for approximately seven years and* [Consultant C] *was a locum for 5 years. I do not believe either of them were told what they could or couldn't operate on when they were in that position. If someone has been well-trained, is on the specialist register and is happy to undertake a particular type of surgery then others should not be allowed to tell them whether they can or cannot operate on these patients."*[123]

Consultant E, notes, *'as I am the only locum in the department' 'I believe that this is clearly directed towards me'.*[124] Based on the above recorded and written detail, it certainly appears difficult to argue with Consultant E's interpretation.

Consultant E in a note to CHI leadership in March 2020, states that *'on February 5, 2020 at 3.45 pm, just 15 minutes before the start time for the combined CHI/CD/Surgery monthly meeting'* CHI at Crumlin Site Clinical Director called [them] advising [them] *'not to attend'.*[124] Consultant E noted the *'reason given was that it might conflict with my locum post'.* [124]

As part of the supporting documentation analysis for this examination, minutes from the meeting on the 5th February 2020[119] were reviewed and it does not appear that any issue was discussed or tabled that could possibly conflict with Consultant E's post. [119] Furthermore, it is worth noting that in recorded minutes of the meeting on the 5th February 2020 (See Figure 17 below), apologies are noted from Consultant E, which based on Consultants E email as detailed above is not a true reflection of the reason for Consultant E absence from the meeting.[124]

Apologies:	
[redacted]	Consultant Urologist
[redacted]	Clinical Director, CHI at Temple Street
[redacted]	Clinical Director, CHI at Crumlin Street
[redacted]	Clinical Director, CHI at Tallaght
[redacted]	Consultant Urologist, CHI at Temple Street
[redacted]	Director of Patient Safety and Quality, CHI
[redacted]	Consultant Paeds Surgery / Paeds Network Lead, CHI
[redacted]	Consultant Paeds Surgery, CHI

Figure 17 Apologies from 5th February. Consultant E is the last person on the list.

[123] Consultant D email. Dated 4th February 2020.
[124] Consultant E Letter. March 2020.

Consultant E details in writing another incident that is worth reflecting on, as it outlines a similar rationale for exclusion: [124]

'during the 2nd CHI monthly meeting dated December 18, 2019 when [Consultant D] raised objections stating that I should not be part of the meeting due to a 'conflict of interest' as my presence in the meeting might favour me in my upcoming Interview for the General surgery with a special interest in urology consultant position.' Consultant E then goes on to state that *'Thankfully, the Chair at that meeting felt that this was not the case and the meeting continued in my presence.'* [124]

Unfortunately, the evidence and experience of Consultant E is significant and not aligned to the CHI values of acting with respect and integrity. The behaviours of leaders is key to shaping an organisation's culture,[147] and these examples do not support CHI's mission of working in 'partnership with each other' to deliver the 'highest standards of safety and excellence'.

Earlier in this section Consultant D references morbidity issues in their email relating to locums not undertaking hypospadias. It is worth noting that multiple participants in this examination outlined their discontent and concerns for patient safety given that Consultant D does not attend Morbidity & Mortality meetings and has not done so for at least the last four to five years. [6] [123]

The CSL has raised this issue with the CHI Crumlin Site Clinical Director on multiple occasions noting in one email that *'There are major clinical governance issues with this'* - as a result of not attending the Morbidity & Mortality meetings Consultant D *'has asked that [their] complications are not discussed in [their] absence'*. The CSL goes on to confirm that *'surgeons have an obligation to have their complications discussed in a forum that facilitates open discussion and learning for all.'* [116]

There appears to be a distinct lack of governance over the general surgery and urology department. Evidence indicates that the CSL has worked tirelessly at attempting to resolve issues as best as they can and have sought support from leadership on numerous occasions but does not seem to have secured the required intervention or any consistent support. [116] [117]

As Consultant E is employed under a locum contract, they do not have an approved CAAC number – these numbers are assigned only when a full-time permeant consultant post has been approved in advance by the HSE. [113]

There are currently four locum consultants employed in CHI at Crumlin. It has been confirmed that apart from Consultant E all locums can bill VHI for private patients, and in turn CHI at Crumlin can process the hospital part of the claim.[125] [126]

[125] Confirmation from HR on Locums at CHI at Crumlin. Dated 12th August 2021.
[126] Confirmation from CFO. Dated 23rd November 2021.

Consultant E cannot have claims processed as they have been unable to receive a replacement CAAC number or equivalent, relative to the original post they are covering – In the case of Consultant E, as they are not employed as a locum under the *'HSE conditions and process by which permanent consultant posts may be filled with locum appointments'*[113] but employed to cover Consultant D's on-call commitment only, they are unable to claim.[113] In turn CHI at Crumlin are unable to claim. This has resulted in a significant potential loss of revenue for CHI at Crumlin.[127]

As of November 2021, the value of the claims submitted to VHI by CHI at Crumlin for Consultant E which have been pended/or not paid owing to the registration issues outlined above is €227,482.[127] The potential value for claims is far higher than this amount, however at a point in time CHI at Crumlin would have ceased claiming for Consultant E, given the challenges with registration. [127]

In addition to the above lost revenue for CHI at Crumlin, the cost to CHI as a result of Consultant D being unable to fulfil the on-call aspect of their contact is significant. Consultant E's salary is circa €150,000 annually since 2019 and approximately half of that in 2018.[94] Over half a million in basic salary costs.

Consultant Urologist Post

A Urologist Consultant post has been advertised on three separate occasions over the past seven years, across both CHI Temple Street and Crumlin.

On all three occasions the successful candidate was required to work as a consultant urologist across both CHI at Crumlin and Temple Street and undertake a general surgery on call rota. However, on all three occasions the basic specifications for the role changed. There appears to be no consistent logic or documented reason as to why the job specification changed so frequently. Summary of these changes are outlined below:

Year	Specifications Required
2014	a) Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of Paediatric Surgery b) One-year certified postgraduate training in paediatric urology. Completion of a specialist paediatric urology fellowship or equivalent, of at least one year's duration.[128]
2019	*Requirement for a fellowship in urology is removed.* [129]
2021	a) Registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in

[127] Confirmation from Finance. 11th November 2021.
[128] Consultant Urology Post. Dated 20th April 2014.
[129] Email from Consultant requesting removal of fellowship. Dated 3rd April 2019

	the specialty of Paediatric Surgery and one-year certified postgraduate training in paediatric urology b) Post CCST Clinical Fellowship in Paediatric Urology or equivalent qualification[130]

- Correspondence in advance of the shortlisting process in 2019, highlight that there was significant contention across the short listing and interview panel as to what qualified as meeting the job specification or criteria. The shortlisting process was challenged by a potential candidate which resulted in long delays, a magnitude of senior management time and input and ultimately a high court proceeding.[6] The candidate was successful in their challenge against CHI and was shortlisted for interview. This process resulted in huge costs for CHI.[131]
- Then in 2019, the role requirements changed, with the necessity for fellowship in urology being removed. Given this was a condition for a urology consultant post only three years earlier – there is no detail recorded as to why the requirements changed.[129]
- There appears to be a very unclear pathway for sanctioning or determining how role requirements or job descriptions are decided on. Email correspondence from Medical HR would indicate that corridor conversations with consultants often are the deciding factor.

The apparent enigma around what is required of candidates for advertised roles, has led to both significant disagreements among colleagues in the general surgery and urology department, challenges for medical HR and notably huge costs for CHI. Given a consultant urologist post was advertised three times, with mandatory requirements changing each time without any apparent rationale for these changes, it calls into question the effectiveness of the service planning for the urology service.

[illegible]

Spina Bifida (SB), a neural tube defect, has been described as one of the most complex congenital conditions compatible with life. [132] Ireland has one of the highest rates of NTDs in the world, with a prevalence of 1.17 per 1000 live births. [133] It's suggested that at any given time in Ireland, there are up to 630 SB patients between the ages of 0-18 years.[134] A multi-disciplinary approach is best practice with this cohort of patients, due to the complexity of the condition. [135] In Ireland, the SB service transitioned from Our Lady's Hospital Crumlin (now CHI at Crumlin), to Temple Street Children's Hospital (now CHI at Temple Street) in 2008. The majority of SB patients moved at

[130] Consultant Urology Post. Dated 30th May 2021.
[131] Consultant E VS Children's Health Ireland. High Court Judicial Review. 2019.
[132] Liptak GS, El Samra A. Optimizing health care for children with spina bifida. Dev Disabil Res Rev. 2010;16(1):66-75. doi: 10.1002/ddrr.91. PMID: 20419773
[133] McDonnell R. et al. Neural tube defects in the Republic of Ireland in 2009-11. 2014.
[134] Dickson A. Paediatric Urology Services in Ireland with particular reference to Spina Bifida and Neuropathic Bladder. 2017.
[135] Saavedra A, MacLellan D, Gray G. Spina Bifida. 2018.

that time to Temple Street Children's Hospital, while some remained with Our Lady's Children's Hospital Crumlin. [134] It is unclear the reason why the majority of patients moved with the service to Temple Street Children's Hospital, while some remained under the care of Our Lady's Children's Hospital, Crumlin.

Throughout this examination, the management of SB patients was raised by multiple participants. [6] Up to 27% of participants agreed that the care delivered to Spina Bifida children in CHI was not best practice. The cohort of SB patients who remain in the care of CHI at Crumlin (as outlined above) are referred to locally as the 'Crumlin Orphans'.[6] It would appear, these children are a specific group of SB patients, all of whom were born before 2008, and were from birth managed by General Surgeons, in Our Lady's Children's Hospital Crumlin, now CHI at Crumlin. This is despite best practice recommending urologist input for this cohort of patients. [135] [136] Participants of this examination, some of whom are key stakeholders in the delivery of services to SB children, provided individual estimates of the number of these 'Crumlin Orphans' that exist, however these numbers are hugely varied.[6] The understanding as to how a specific group of children with SB, appear to be in limbo and unable to access the MDT and urology specialist care that children in CHI at Temple street can, is extremely vague and far from consistent. See quotes from participants below:

Source	Quote
Participants 13, 14, 18, 38, 39.	*"It's <20 children who fell between the hospitals because they were born before change over and linked to services in Crumlin. They were born before 2008/2009... Average age of patients are 13-17 years old..."*
	"Most are coming to transition now. Youngest is 12/13. Numbers are dwindling. Some of them are under general surgery."
	"Spina bifida is time consuming, huge population in Ireland. [It's a] job for many people. How can you have patients that aren't someone's responsibility?... I think there was around 12-15 patients"
	"Theatre time is the problem. There's full capacity in OPD. Spina Bifida patients being seen at the weekend is out of the question, as they need to see a cohort of [the] MDT... There are 5, 3 about to go to adults."
	"Spina Bifida need to be seen by a urologist. [There's a cohort of patients] called the "Crumlin Orphans" – there's 80 children and nobody is looking at it."

Table 20 Spina Bifida Patient Management

The above highlights a clear discrepancy across participants – is it 12-15 patients, 5 patients or even 80 patients? This examination has sought to clarify the exact number of these patients but have been unable to get confirmation. Whatever that number is, the undisputable fact is that

[136] Josepha D. B. et al. Urologic guidelines for the care and management of people with spina bifida. 2020.

there is a cohort of SB patients, who are not currently able to avail of the MDT and specialist urology care that SB patients in CHI at Temple Street can. In line with best practice, children with SB should be given care from a consultant urologist. [134] [135] [136] A consultant urologist in CHI at Crumlin stated that the rationale for not providing this care was because they *"couldn't physically help"* due to their waiting list burden. Critically a consultant urologist in CHI at Crumlin acknowledged that *"General surgeons [are] not trained for Spina Bifida"*.[6] Thus confirming that these 'Crumlin Orphans' are left with suboptimal care by not having a consultant urologist. As outlined in *section 4.3 of this* report, consideration needs to be given to the management of patients between General Surgery and Urology to determine if patients on Urology waiting lists could be redistributed to General Surgery.

In 2017, a consultant urologist, Alan Dickson was commissioned, by Temple Street Children's Hospital CEO at the time, Mona Baker to complete a report on *"Paediatric Urology Services in Ireland with particular reference to Spina Bifida and Neuropathic Bladder"*. This report is now commonly referred to as the as the Dickson Report by many of the participants in this examination.6 In completing his report, Alan Dickson interviewed or met with eight people linked to Temple Street Children's Hospital. These ranged from the CEO, consultants, nursing and operations representatives, to parents of patients attending the service. One person was interviewed from Our Lady's Hospital Crumlin, a consultant urologist, Consultant D. Research and patient charts were also reviewed in order to finalise and create the report. [134]

There is no reference in the Dickson Report as to why, although there are two paediatric consultant urologists working in either or both Temple Street Children's Hospital and Our Lady's Children Hospital Crumlin (now CHI at Temple Street and CHI at Crumlin) only one consultant urologist is engaged in the care of SB patients. In fact, the 'Crumlin Orphans' referred to earlier, for reasons which are unclear, have not been and continue to not be under the care of the consultant urologist working full time in CHI at Crumlin. Instead, the Dickson report appears to challenge the perceived lack of General Surgeon input into the management of SB patients, outlining that given their training in the management of neuropathic bladder they should be competent to manage this patient group. [134] This has led to a general surgeon being left to manage the SB patients, apparently resulting in these patients not been afforded consistent specialist urology input in CHI at Crumlin. The findings in the Dickson Report further underlines the lack of collaborative thinking between General Surgeons and Urologists across CHI, with a potential impact on patient care and experience.

The Dickson report also clearly calls attention to concerns surrounding patient well-being and experience, stating *"evidence from the gathered patient information shows that patients in both Temple St and Crumlin have been neglected and have not received the level of care, which would be expected in the modern day in a country with developed healthcare."* [134] This is a significant statement to have been called out in a report commissioned by Temple Street Children's Hospital in 2017. Today, nearly four years on, it appears there is lack of clarity about what mitigating actions have been taken to address this SB patient welfare concern.

It is not in this examination's scope to review whether recommendations from the Dickson Report have been implemented, however, there are a few key recommendations contained in that report which should be reflected on;

1. The potential of Dublin becoming a world-class facility for Spina Bifida research is highlighted [134], which is closely aligned with CHI's mission of delivering research-led learning-informed healthcare to children.
2. Secondly, a recommendation that both consultant urologists in CHI should be released from the responsibility of post on-call general surgery inpatient care and should be relieved from all general surgery on-call as soon as possible [134]. This recommendation has come to fruition, however not by means of a formal service planning at leadership level.
3. Finally, a recommendation that there is recruitment of up to five consultant urologists to develop the urology service, but if this cannot be reached or is delayed, a general surgeon should be appointed and trained to care for these patients. [134]

Since the Dickson report, in CHI at Temple Street, a Clinical Specialist in Bladder Management has been appointed to support the SB service and to work with and support both the existing consultant urologist and the new consultant urologist, once appointed. Some of the responsibilities of this registrar level role include:

- Investigation and management of the urological issues in the SB population in CHI
- Urodynamics testing and interpretation working with the Clinical Nurse Specialist (CNS)
- Attending fortnightly SB clinics in conjunction with the multidisciplinary team (MDT)
- Performing a weekly operating session for diagnostic and therapeutic procedures.[137]

Although appointment to this post is complete and in place since 8th July 2019,[138] it is our understanding that the weekly operating session has not yet been enabled, due to both capacity issues and concerns relating to governance of the list, in CHI at Temple Street.

As these children were born prior to 2008, the majority are now either entering or currently in adolescence. This means that these patients will be soon leaving CHI and transitioning to the adult system. This period of transition to adult care is a significant and important time for any patient with a chronic condition, and an opportunity to teach self-management and gain independence. Research shows that effective self-management of SB is particularly important for preventing co-morbidities and secondary complications such as skin breakdown, renal dysfunction, and bladder and bowel incontinence. [139] In fact, it's recommended that clinicians and families of children with SB should engage in intentional and targeted planning for self-management skills development prior to transition to adult services. [139] There appears to be

[137] HR confirmation of Clinical Specialist in Bladder Management Job Description. Dated 9th November 2021.
[138] HR confirmation of start date. Dated 24th November 2021.
[139] Logana LR; Sawinb KJ., Bellinc MH., Breid T and Woodward J. Self-management and independence guidelines for the care of people with spina bifida. 2020.

inequalities across CHI's services for SB patients, and therefore the recommended level of supervision and guidance for these patients transferring to adult services may not always be achieved, particularly in CHI at Crumlin, where there is no Urologist oversight or MDT approach to care. A situation that is possibly reflective of or as a direct result of the lack of collaboration across the general surgery and urology service and interpersonal challenges that appear to exist.

5.4 Operations Oversight and Financial Impact

Chapter 4 of this report highlighted concerns regarding the effective management of access initiatives. The oversight and supervision of NTPF funding across CHI is critical to ensure fair and equitable management of access for children, and good governance and accountability of public funding.

A paper on NTPF insourcing requests was brought to CHI Executive[87] in January 2021, following significant concerns raised by a majority of general surgeons about the provision of 'general surgery' NTPF clinics.[140] [141] This paper fully acknowledged issues regarding NTPF approval processes and led to a request for interim changes in the approach and management of such initiatives. [87] At this Executive meeting following presentation of the paper the COO confirmed that "*no further lists be planned*" until the Scheduled Care Lead returned to Executive with the results of "*mini-review*". [142]

This examination did not receive any details of the outcome of this review by the Scheduled Care Lead. It is not clear if one exists. It appears that there has been no follow up with the Executive in this regard. It is important to note that following on from the above meetings, commitments and papers three subsequent NTPF clinics with 119 patients attending were completed under a 'general surgery' initiative between January and March 2021. This initiative was managed by CHI operations.

Furthermore, as mentioned in *section 4.4*, Consultant D received €200 per patient in these NTPF clinics. However, through discussions and documentation reviewed during this examination, it appears that the payment per patient for these clinics is non-compliant with public pay agreements. To overcome this, it would seem that work arounds were introduced by the CHI Scheduled Care Lead in order for Consultant D to receive the agreed €200 per patient – see figure 18 below. [143]

[140] BS letter to COO. 29th January 2021.
[141] BS letter to CEO. 13th January 2021.
[142] COO response to General Surgeon letter on NTPF. Dated 2nd February 2021.
[143] Email from Scheduling Lead regarding Payment for NTPF. Dated 16th December 2020.

[redacted]

From: [redacted]
Sent: 16 December 2020 17:58
To: [redacted]
Subject: Remuneration NTPF Clinics
Attachments: NTPF & Projects Extra Hours Claim Form November 2020.docx

Dear [redacted]

I just wanted to clarify with you the process for remuneration for the additional NTPF clinics

You may be aware that a straight forward payment per patient cannot be processed through any HSE payroll structures as it is non-compliant with HSE pay structures and would not be acceptable by Financial Auditors.

Therefore I have been working with the Finance and Salaries leads to work through a structure to facilitate these NTPF clinics and we have agreed on the following:

Remuneration General Surgery /Urology NTPF Clinics
In order to ensure HSE pay policy compliance – a claim based on hourly rate will be made for each patient which will equate to the agreed NTPF payment per patient.
In other words, for yourself, I have linked with the Salaries Team and they have calculated that a claim from you of **2.19 hours per patient** will equate to the NTPF rate.
If you could complete the attached document following each clinic please, sign off and submit thi[redacted] in the Salaries Department, these payments will then be processed each month as per normal structures.

Hope that clarifies

Let me know if I can help with anything else

Kind regards

[redacted]

hello my name is…

[redacted]

Scheduled Care Lead
Children's Health Ireland (CHI)
Herberton, St James's Walk, Rialto
D08 HP97, Ireland
[redacted]

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Figure 18 Email from Scheduling Lead to Consultant D

5.5 Management of Behaviours

Throughout this report, feedback from participants and events detailed would indicate there are various individuals across CHI who at times demonstrate challenging and disruptive behaviours. This impacts both the well-being of staff and the effective operations of services. These behaviours appear to have gone unchallenged for a significant period of time leading to a toxic and siloed culture, where many staff feel unsupported and have disengaged from the wider organisation.[6 30] Research has shown that organisational culture influences patient safety, quality of care, medical errors, patient and families experiences, clinician satisfaction and burnout.[144 145 146] It is critical that an organisation takes time to reflect on and own the culture that exists and then seeks to address the issues and bring about the required change.

The HSE Change Guide explains that culture is influenced by the:

- Founding values of the organisation[147]
- Early experiences and thereby acquired values, norms and behaviours of those joining the organisation[147]
- Behaviour of leaders[147]

Following hours of interviews with participants and reviewing multiple correspondences between it is inarguable that the experience of those working in CHI is hugely varied.6 The recent professionalism survey,[148] which includes responses from 35% of staff working in CHI, completed in 2020 details some concerning findings:

67.5% (864 participants) encounter disrespectful behaviour at least monthly	
At least monthly, CHI staff surveyed experience:	
Excluding from decision making or failing to respond to phone call, bleeps, emails	***50%***
Blaming	***More than 40%***
Dismissing behaviour (hanging up phone/end conversation abruptly) or shouting	***More than 30%***
Discrimination based on gender, race religion	***11.7%***

[144] Leiter MP, Frank E, Matheson TJ. Demands, values, and burnout: relevance for physicians. Can Fam Physician. 2009;55(12):1224–5.
[145] Shanafelt TD, Gorringe G, Menaker R, Storz KA, Reeves D, Buskirk SJ, et al. Impact of organizational leadership on physician burnout and satisfaction. Mayo Clin Proc. 2015;90(4):432–440.
[146] Egener B, McDonald W, Rosof B, Gullen D. Perspective: organizational professionalism: relevant competencies and behaviours. Acad Med. 2012;87(5):668–674.
[147] People's Needs Defining Change. HSE Change Guide. 2018
[148] CHI Professionalism in the Workplace Survey. February 2021.

Given that over half of CHI staff who responded to the survey experienced disrespectful behaviour on a frequent basis, it is unsurprising that feedback from participants of this Examination indicates that there is a sense of resignation among staff that negative and toxic behaviours are accepted and part of the norm in CHI.

Most importantly to note however, that as culture is dynamic and shifts incrementally and constantly in response to internal and external changes,[147] there is a real and tangible opportunity to now shape a new and progressive CHI culture, ensuring we fully realise our values of being child-centred, compassionate and progressive.

6 SUGGESTED NEXT STEPS

The evidence presented in this report would indicate that there are significant challenges ahead for CHI. Although this examination focused on the General Surgery and Urology Service, consistent and strong feedback would suggest that the issues identified in this report are far from isolated to one service.

Service Planning, Access and Waiting List Management, Recruitment Processes, Change and Integration all underpinned by a *Broken Culture* and significant gaps in *Leadership and Governance* are noteworthy challenges facing CHI. This examination however, without question has demonstrated that there is a huge cohort of committed, diligent, people centric staff across CHI willing and wanting change and reform. It is this cohort of staff with the support of strong leader's and good governance that will mend our culture and enable positive change across CHI. It is critical that the findings of this examination are used as a catalyst to effect real and sustainable change. Momentum is critical in ensuring those that supported this process see that the required action will be taken to bring about positive change for all.

It was not in the scope of this examination or accompanying report to outline recommendations. However, under the themes identified, it is clear a number of decisive next steps are required.

Behaviours and Culture

As an immediate priority, and based on the evidence in this report, the General Surgery and Urology service, to include the Oncology General Surgery service and the Urodynamics Department require directed intervention from an interpersonal and organisational and development perspective, to support the development of collaborative working relationships, and a safe and inclusive service for all. This will require significant time and effort to build trust and confidence among colleagues and with leadership. Sustainable change will not happen without strong leadership and robust governance. Areas that have been highlighted to currently have significant gaps.

Access and Waiting List Management

A root and branch review of all access and waiting list initiatives, to include NTPF and referral management should be undertaken. This should incorporate a review of governance structures and processes for approval and sign off, thus maximising patient's timely access to care, ensuring a fair and equitable service for all.

There is a need to both reconfigure and expand our theatre capacity, while optimising current resources and driving efficiencies across the system. The establishment of effective and strong governance structures, ensuring appropriate accountability and enabling consistency and standardisation of best practice across all surgical settings is key. Creating a working environment and ethos that is conducive to professional development and learning is essential as we move toward the opening of our new hospital and future operating models.

Leadership and Governance

Strong leadership and consistent good governance are the foundation of running effective, efficient, and best in class services across CHI. This examination consistently identified noteworthy gaps in this area at site level and across operations. This has played a significant role in the serious issues identified across the general surgery and urology service and ultimately underpins the challenges relating to access, and behaviours and culture. A review of all site leadership roles and responsibilities should be undertaken to provide clarity around delineation of accountability at site and executive level. A clear communication and reporting framework should be adopted to ensure certainty and assurance around reporting structures and leadership responsibilities across the organisation.

The above review of structure, roles and responsibilities and accountability, should include patient safety and risk management. This is to ensure CHI adopt an effective, person centred incident management and open disclosure framework through a positive learning culture.

The findings in this report presents a unique opportunity, to act as a catalyst for CHI leadership to make meaningful, strategic, and sustainable change. Binding CHI together as a single strong inclusive culture, ensuring it can deliver first-class services for our children, young people and staff now and into the future as we move toward the opening of our new hospital.

7 CONCLUSION

This programme of work began with an overarching objective to establish a fully integrated, collaborative, academic and efficacious General Surgery and Urology service for both children and staff. As we move closer to the opening the National Children's Hospital and integrate CHI at Tallaght, Crumlin and Temple Street into one new children's hospital, to deliver high-quality care in a cost-effective manner through innovative technology enablement, we need to ensure we are capitalising on the opportunity now to deliver tangible change and ensure benefits realisation for the children of Ireland.

The themes and issues identified during this examination have been unambiguous and consistent:

Behaviours and Culture

- CHI has a broken culture - created by dysfunctional relationships and challenging behaviours.
- Negatively impacting service delivery, department dynamics and staff experience and has the potential to put patients at risk.

Access and Waiting List Management:

- There are significant concerns relating to the prudent and beneficial management of NTPF funding and lack of oversight of access initiatives, which are ultimately not in keeping with the MoU between CHI and the NTPF.
- The lack of clarity, consistency, and transparency regarding management of referrals and waiting list oversight is negatively impacting interpersonal relationships, operational efficacy and significantly, not in the best interest of the child.

Leadership and Governance:

- A substantial and persistent message of concern and apathy regarding the lack of strong site leadership and good governance, along with poor operational oversight and accountability came through very strongly during this examination. There is a lack trust and faith in leadership in being able to adequately challenge and address issues

There is a real and tangible opportunity now to shape a new and progressive CHI, ensuring we fully realise our vision of being a child-centred, compassionate, progressive organisation acting with respect, excellence and integrity, while delivering on our mission to promote and provide child-centred, research-led and learning informed healthcare, to the highest standards of safety and excellence.

Without real and measurable change and a shared purpose across CHI, we cannot grow as a collaborative, dynamic, innovative organisation, putting our patients and our people first. The challenge therefore is not about defining "*what needs to happen*". The challenge is in the "*how*" - putting the right structures, governance and supports in place to deliver the change that is needed and that has been envisioned by so many.

Appendix 1 – Terms of Reference

23rd June 2021

Examination of underlying concerns and issues within General Surgery and Urology Services

CHI is a workplace where all our staff are respected, their opinions valued and where we treat each other with dignity and respect. We work hard to provide a work environment which fosters open, challenging, and honest dialogue and where patient care and wellbeing is at our core.

With those guiding values, a series of meetings took place over time between General Surgery, Urology consultants and members of the Executive Team. Many concerns and issues were uncovered, some of which have been addressed, however, a number of apprehensions remain and require further and detailed examination.

This examination will be guided by the principles as set out above. Ms Yvonne Bradford CHI Turnaround Surgery Project Lead and Mr Patrick Ward Human Resources Integration Manager (Examiners) shall undertake an examination into matters. They may at their sole discretion vary the terms of reference as set out herein, including extending the scope beyond General Surgery and Urology Services should circumstances warrant it necessary. The Executive and surgeons will be informed of material changes to these terms of reference.

1. The Examination will be conducted in a fair and timely manner, applying the principles of natural justice and in a manner that is consistent with CHI policy. Every effort will be made by all concerned to ensure that the Examination is carried out and completed within a period of 28 days from its commencement or, if that is not possible, as soon as possible thereafter.

2. The Examiners will make such enquiries, conduct such interviews, seek, and be provided with such documentation and information, and engage in such correspondence as they consider relevant to and appropriate for the purposes of the Examination.

3. The Examiners shall provide each person whom they have interviewed with a note of their meeting in order to give each interviewee the opportunity to confirm the factual accuracy ofthe meeting. Failure to confirm the factual accuracy of the note, does not prevent the meeting note from forming the basis of the Examiners' findings.

4. In the event of an individual being identified during the course of the interview process for alleged wrongdoing and/or inappropriate conduct/behaviour, they shall be provided with a copy (redacted where appropriate), of such statement(s) gathered during the Examination.They shall also be provided with the opportunity to respond to or comment on the note of the interview and/or statement with each or any such person(s).

5. During the course of the Examination, all parties are required to respect the privacy of all others involved in the Examination. Confidentiality will be maintained throughout the Examination to the greatest extent practicable in the circumstances, but subject always to the requirement to conduct a fair Examination. All parties shall be instructed to refrain from discussing the matter with other work colleagues or persons outside CHI, save on a need to know basis. Any breach of confidentiality may result in disciplinary action.

6. Refusal or failure by any person to cooperate with the Examination shall not prevent the Examiners issuing a written report based on the information available.

7. The Examiners will be provided with whatever professional advice/clarification, facilities, information and/or documentation as may be required to assist with the Examination, including administration support at meetings.

8. The findings of the Examination will be set out in a written report which will not determine or recommend actions to be taken. The report will determine matters of alleged behaviour/conduct/action(s) and fact. This report will be delivered to Mr Trevor Murphy, Director of Human Resources and Mr Alan Goldman, Chief Medical Officer.

9. On receipt of the report the Director of Human Resources and the Chief Medical Officer willthen determine what next steps are to be taken, if any.

10. Parties to the Examination may be accompanied by a trade union representative, or a workplace colleague throughout the Examination process, but no one else unconnected withCHI.

Arrangements will be made for the initial meetings as soon as is practicable by the Examiners.

Appendix 2 – Email from CHI Scheduling Lead to Consultant D

[redacted]

Sent: Monday 23 November 2020 21:20

[redacted]

Subject: CHI City West Clinics

Dear [redacted]

As per our telephone conversation on Friday, I've done some work on a model for General Surgery clinics in City West on Saturdays, potentially beginning in December

First question to ask you is if you have been on site in City West? If not, I'd be happy to arrange a site visit in the next week or two, so you can get a sense of the set up and identify any particular requirements you might have
I've also spoken with [redacted], our [redacted] who will work on this with me to ensure we get it over the line

I have then called out a number of questions below if you could take a look and maybe we could link in then when you're free to talk

NTPF Submission
Our first step is to submit our costings to NTPF to ensure we have the financial support for this. Attached please find draft submission. If you click on the calculations tab there, could you take a look at the professional fees for me please – just to ensure you're comfortable with that figure
I've also added in some Admin support as you will need that on site plus support from healthcare records in case there are a number of children with previous CHI charts – we have a process in place around this already so shouldn't be an issue to replicate it
In terms of resources then, the final piece is a HCA on site when you're holding clinics which will be a support for you and the patients
This is a replication of the resources we currently have in place for the Orthopaedic Clinics which we started on site in City West today – [redacted] and it seemed to work very well

Could I also ask you to take a look at the equipment list please? Again, this is a copy of the list we are using for orthopaedics – nothing particularly complicated there – but if there is anything else you need please do let me know and we can include in the costings

NTPF Cost Calculation
I have calculated costs on the basis of 30 patients per clinic and made the assumption that we would get 2 clinics done before the end of this year
I've then calculated 2 clinics per month up to the end of May in 2021 – taking into account that we then run into the summer and you will likely be taking leave at that point. The HSE contract with City West also expires at the end of June next year
Does this volume of patients sound reasonable to you?

CHI Waiting List
This then brings us to the patients being seen in City West
If you click on the waiting list tab, I've pulled the Gen Surgery waiting lists for patients waiting in excess of 6 months for the three sites. You will note that the list for Temple Street far exceeds Crumlin and Tallaght
What do you think is the best approach here? Would you prefer to concentrate on the Crumlin patients to begin with or would you be happy to see patients from any of the sites if we pull our longest waiters regardless of which site W[illegible] they are on?
Also, do you think it would be worth having a conversation with your colleagues to see if they might like to also complete some of these clinics?
Would be interested in your thoughts here

More than happy to talk this through if you let me know a good time to give you a call?

Appendix 3 – NTPF case mix review

In September 2021, at the request of the Examiners undertaking the Examination of the General Surgery/ Urology service in CHI, a CHI operations team of four people, as determined by the examiners sourced the 179 charts for patients that were seen over the course of the five NTPF Urology clinics between December 2020 and March 2021. These 179 charts were reviewed, and referral letters were photocopied and numbered. When the NTPF clinics were being set up, referral letters were used by the Consultant Urologist to determine patient suitability. A database was created by the operations team for the examiners with the following information:

1. Referral letter number
2. NTPF Clinic Date
3. Date referral received
4. Date referral was triaged by Consultant
5. Name of Consultant who triaged referral
6. Condition stated on the referral letter
7. Whether condition on referral letter changed following consultant review? (Yes/No)
8. If the condition changed, what did it change
9. Whether patient is listed for surgery (Yes/No)
10. Type of surgery listed
11. Date placed on inpatient waiting list
12. Date of Surgery
13. Patient Outcome (Discharged, Review, Surgery)

Once this activity was completed, the database with the above information for the 179 patients was used for analysis in this report. The photocopies of the referral letters were also reviewed to cross reference the information in the data base. As requested by the examiners any and all patient identifying data was excluded. There were 9 referral copies missing due to inability to locate patient chart, however these patients were still included on the database with any relevant information that could be sourced without the chart. During this review by the operations team, each patient was checked to see if in September 2021, these patients had a date for surgery yet. It was confirmed the 50 patients did not.

Following this undertaking by the operations team, selected by the examiner -in October 2021, a consultant General Surgeon and Paediatric Network Lead, who had completed similar work previously in early 2020 on behalf of CHI Executive, reviewed this database and referral letters. From this review, it was determined that 95% of patients in the NTPF clinics could have been reviewed and manged by a General Surgeon. During this time, the CHI Crumlin consultant urologists' inpatient waiting list was also reviewed and assessed as to whether any patients on this list could be seen by a General Surgeon. It was determined from this review that 60% of the 189 patients on the inpatient urology waiting list, could be seen by a General Surgeon in the first instance.

Appendix 4 – Urology case mix email 2017

From: [redacted]
Sent: Tuesday, December 19, 2017 10:52:32 PM
To: [redacted]
Subject: Specialist Urology Service

Dear [redacted],

As you are aware, I have been for some time now, requesting that the non-urological members of our department would take over my general surgery patients on an ongoing basis. For the most part this hasn't happened. For many years I have been giving an almost 24/7 urological service to OLCHC, the exception being when I am not in the country. [redacted] arrival has eased the burden, but as he is the sole urologist in CUH providing the bulk of the service there, I still provide a significant service to OLCHC.

With few exceptions, I have been unable to transfer general patients to other colleague's care following my on-call commitments. This, as I have stated on many occasions at our meetings, is no longer sustainable and particularly as operating lists have now been given back to hospital management because of an apparent lack of available work!! Until there is an agreement within the department [redacted] and I will only be offering an emergency urological service on that those days that we are on call. This means apart from those days on call we will not be available for:

1. Urology Referrals from other hospitals
2. Urology consults from paediatricians and nephrologists within the hospital
3. Difficult catheterisations in the radiology department (apart from our own patients) and cardiac anaesthetic room

This applies to both CUH and OLCHC. Referrals or consults, deferred by the on-call surgical team to another day will not be accepted.
We will however, accept patients with specialist urological conditions e.g bladder exstrophy, posterior urethral valves, from those services which currently accept general patients from the urology service.

Conditions such as UTI, hydronephrosis, calculi, hypospadias (excluding proximal hypospadias), will not be considered as specialist urology and therefore can be managed on an ongoing basis by the general surgeons.

This applies with immediate effect. This arrangement can of course be changed when there has been a meaningful discussion about how to manage specialist paediatric surgery **AND** on the appointment of another paediatric urologist.

It is a pity that [redacted] and I have had to take this path but recent events have brought these issues into much sharper focus and we cannot sustain the service we are trying to provide in the present circumstances.

We are informing Medical Board, Hospital management and the radiology of the above.

Yours sincerely

[redacted]

Appendix 5 – Interview Questions

1. There have been a number of patient safety and quality care issues relating to the Oncology service
   - Can you speak to that? Have you any concerns in relation to that service?
   -There appears to be only one consultant currently undertaking / overseeing the 'oncology general surgery' practice - Is that the case / would you deem that as best practice?
   - A number of what one might call seminal cases have been brought to our attention – are you aware of any specific cases?

2. There appears to be concern about the lack of consistent and equitable operational processes and procedures in terms of referrals / waiting list management / access to NTPF lists etc. Can you talk to me about your views on how these are managed?
   - Specifically, the potential for referrals that could be managed on a Gen Surg waiting list sitting on a urology waiting list?

3. Connected to my initial two questions / areas that we have discussed - there have also been concerns raised in relation to the Spina Bifida Service and the need for access to specialist Urologist intervention and indeed waiting list timelines, ultimately impacting patient care - are you aware of issues in this regard?

4. Another consistent theme arising is that of ineffective leadership specifically leading to lack of governance and accountability, unprofessional behaviour being accepted and unchallenged – would you agree with that view?
   - Do you feel there is an absence or lack of trust in leadership?
   - What is your understanding of the role and remit of the Clinical Director?

5. It has been mentioned at some collective team meetings that the Gen Surg./ Urology consultant team work well together – however there appears to be a strong message coming through, that the team are not a collaborative team - that there is a level of dysfunction across the team / department
   - Specifically, feedback would suggest that there is a lack of teamwork and a collaborative way of working. The absence / lack of a non- judgemental working environment?
   - Can you talk to me about M&M – how they are run, participation levels – would you consider them as beneficial and achieving what one would hope / expect from an M&M?

6. FT – I understand that FT was brought on to take FQ on call – however there are consistent views / would might argue dismay that FT does not have a OT list nearly three years into his role. What are your views on this?
   - Can I sense check who you understand should/would be responsible for providing / assigning a regular theatre list?
   - Why do you think that FT has to date not been given a theatre list?

7. Training / Trainees – Some concerns seem to exist in relation to level of oversight of trainees and the quality of training / support given to trainees – is that something you would see / agree with?

   - Specifically, there appears to be concern around the impact of the cessation of on call in Tallaght for Gen Surg / Urology and the additional number of pts now being seen in Crumlin. the number of NCHDs that have transferred over and their workload?
   - It would seem that over recent months a trainee had to undergo an additional academic / technical assessment as a result of a team member raising concerns about their ability – although those concerns may not have been widely held by other team members – there is a narrative that the trainee may have been unfairly treated – are you aware of that situation?

Appendix 6 – Suggested Next Steps

Further to some actions for consideration outlined in *section 4.6*, below are a list of some suggested next steps to develop and reform surgical specialities across CHI and address the challenges with access across both OPD and Theatre. These changes will ultimately support the General Surgery and Urology service.

- Optimise day surgery (theatre/day-care admissions) in CHI at Tallaght.
- Clearly define General Surgery and Urology case mix to support the efficient management of referrals and deliver optimal patient experience and care.
- Set up a single surgical programme within central referrals, which includes the scheduling of OPD clinics and surgical admissions, supporting equitable and efficient theatre access across CHI at Crumlin, Temple St & Tallaght.
- Reconfiguration and optimisation of theatre in Crumlin and Temple Street to include addressing emergency theatre access and utilisation according to demand.
- Reform of governance and work practices across theatres including addressing cultural challenges.
- Workforce planning with a focus on talent management, succession planning, and proactive identification of areas for skills development and specialist interest areas for expansion in the short and medium term.
- Development of a Paediatric Interventional Radiology (PIR) service and progression or enhancement of other services such as endoscopy, which will help to address effective and efficient utilisation of theatre now and as we move to new hospital.
- Support the development of a network of surgical services in regional centres working with the National Paediatric Network Lead.
- Optimise CHI as a centre for paediatric surgical training and education, with a key focus on developing this ethos and culture prior to the opening of the new hospital.

With sufficient engagement, investment and commitment, many of the above initiatives can be implemented in advance of the new children's hospital.

Appendix 7 – Glossary of terms

ABBREVIATIONS	
CEO	Chief Executive Officer
CHI	Children's Health Ireland
CSL	Clinical Speciality Lead
CMO	Chief Medical Officer
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
DON	Director of Nursing
DoH	Department of Health
DOS	Department of Surgery
HR	Human Resources
HRD	Human Resources Director
HSE	Health Service Executive
MDT	Multidisciplinary Team
NTPF	National Treatment Purchase Fund
OPD	Outpatients Department
PD	Peritoneal Dialysis
PIR	Paediatric Interventional Radiology
RCSI	Royal College of Surgeons
SAC	Specialist Advisory Committee