Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: S21 No.4 of 2022

Date of Notice: 15th March 2022

Witness Statement of: Edward (Eamon) John Mackle

I, Edward (Eamon) John Mackle, will say as follows:-

1. I currently occupy the role of Locum Consultant Surgeon within the Southern Health and Social Care Trust ('the Trust').

2. This statement is made in response to Section 21 Notice No.4 of 2022. It is made to the best of my recollection at this point in time and on the basis of the documents currently available to me. In the circumstances, I acknowledge that I may not have a complete view of all relevant matters.

3. In making this statement, I have had the benefit (with the express permission of the Inquiry) of assistance from the following persons in obtaining documents and information: Emma Stinson, Martina Corrigan and Heather Trouton.

270. Nonetheless, I think the governance structure during my tenure had the ability to have managed the concerns. I believe the human factors mentioned above (e.g., at Questions 65 to 68 meant that we didn't fully utilise the tools available.

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

271. At this stage, equipped with the information currently available to me, I do not believe that there is anything else that I would like to add to what I have stated above.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _ [redacted] _

Date: _____12 April 2022_____

urgency. This review is usually done by consultants within a unit. When I was lead clinician for out-patients in approximately 1996, I was asked to speak to Aidan O'Brien as there was a backlog of triaging and, on investigation, it was discovered that he had a ring binder containing a bundle of untriaged referral letters. He informed me that he had checked the letters and selected any high-risk ones to be seen urgently. He then assured me he would clear the backlog. In approximately 2007 to 2009 I think I was asked to speak to him on two occasions because of his tardiness at triage.

16. The cycle of building up a backlog and then only clearing that backlog when issue was taken with it by persons such as myself continued over the next few years. In September 2011 he reassured Gillian Rankin that all red flag referrals were being triaged within a week and that by November 2011 all triaging would be done within a week. Despite his reassurance the problem recurred. In 2012 his colleague Mehmood Akhtar took responsibility for all red flag referrals. In December 2013 Michael Young offered to assist with triage. In February 2014 Aidan O'Brien agreed to only triage referrals that were named specifically for him. At this stage I believe the bulk of the extra work re triaging was being performed by Michael Young. Then in, I believe, July 2014 he requested and was granted a month with no clinics to allow him to time catch up on administration. I also believe it was in 2014 that Debbie Burns (then Director for Acute Services), in an attempt to mitigate any risk to patients and to ensure chronological booking, changed the way the booking centre treated referrals. From then on, all referrals would be placed on the system according to their general practitioner's grading of urgency and then would be upgraded if necessary, when Aidan O'Brien completed his triaging. However, oversight of his triaging process was poor after this date. In early 2016 we became aware of 253 untriaged referrals and, on direction from Richard Wright, I handed Aidan O'Brien a letter regarding this and other issues we had uncovered and requested a commitment and plan from him on how the issues would be addressed. I note, from the investigation under Maintaining High Professional Standards conducted by Dr Neta Chada that, ultimately, a backlog of 783 letters was identified. At no point during 2015,

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: S21 No.34 of 2022
Date of Notice: 29 April 2022

Witness Statement of: Edward (Eamon) John Mackle

I, Edward (Eamon) John Mackle, will say as follows:-

[1] Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

1. In this witness statement I have attempted to provide as detailed an answer as I can to each of the specific questions at numbers 4 to 14. I consider that, together, my answers to those questions provide a comprehensive and broadly chronological account of my involvement in the matters relevant to sub-paragraph (e) of the Inquiry's Terms of Reference. However, in light of the request made in Question 1, from paragraph 2 to 19 below I offer a narrative overview of my involvement in the relevant issues (referring, where appropriate, to my answers to other questions in this statement). This is not intended to replace, but rather to complement, the more detailed responses given at Questions 4 to 14.

Urology Services Inquiry

45. As acknowledged at the beginning of this statement, whatever else one may say about Aidan O'Brien, no one can say that he wasn't hard working and committed to his patients. He was certainly not the first to arrive in the morning but he was among the last, if not *the* last, to leave in the evening. He was held in high regard by the majority of the staff in the hospital including porters, other ancillary staff, nurses, doctors and his Clinical Director. It was against this background that we judged him and his flaws. On reflection, I consider that there was a failure within the Trust to appreciate that the intermittent / recurring issues regarding Aidan O'Brien could lead to patient harm and serious governance issues. The Acute Directors and the Medial Directors were appraised at my one-on-one meetings of the issues if they were not already aware. I admit and accept that there was a collective failure to appreciate the risks of the issues, in particular, regarding the repeated failure to complete timely triage, and thus to implement the MHPS process prior to 2016.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: [redacted]

Date: 07/06/2022

Urology Services Inquiry

[6] In your role as a clinical manager what, if any, training or guidance did you receive with regard to:

The MHPS framework;

The Trust Guidelines; and

The handling of performance concerns generally.

23. I do not recall the Trust delivering any training or guidance regarding the (i) MHPS framework, (ii) The Trust Guidelines or (iii) the handling of concerns generally. However, on reflection regarding this question, I recall that in, I believe, approximately 2008 I was asked by the Western Trust to assist in a review of one of their consultants. I therefore attended a training session on the MHPS framework that the Western Trust ran for their staff. I cannot be sure if it was a half day or full day course. Ultimately, however, my assistance was not required by the Western Trust. Following this I do not recall any further updates or training on the Framework or its implementation by any other body.

[7] Specifically, what if any training or guidance did you receive with regard to the conduct of "*preliminary enquiries*" under Section I para 15 of MHPS or the undertaking of an *"initial verification of the issues raised"* under paragraph 2.4 of the Trust Guidelines.

24. As detailed in my response to question 6 above, I do not recall the Trust delivering any training or guidance regarding the conduct of "preliminary enquiries" under Section 1, para 15 of MHPS or the undertaking of an "initial verification of the issues raised" under paragraph 2.4 of the Trust Guidelines. However, as also indicated above, I believe I attended a course run by the Western Trust regarding the MHPS Framework in approximately 2008. I believe the course did cover the overall conduct of enquiries but I cannot recall any details.

<u>Handling of Concerns relating to Mr O'Brien</u>

Witness Statement

NAME OF WITNESS	**Mr Eamon Mackle**
OCCUPATION	Consultant Surgeon
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Wednesday 24 April 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. My name is Mr Eamon Mackle. I am employed by the Southern Health and Social Care Trust as a Consultant Surgeon. I was appointed to the Trust in 1992 and have held the positions of lead clinician covering outpatients and medical records and have also held the post of Associate Medical Director up to April 2016.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

3. I agreed to answer questions specifically related to the terms of reference previously shared with me.

4. I explained that I believe I have had to speak with Mr O'Brien at least 3 times regarding his practice relating to GP referrals and keeping referral letters in his office. There has been a long standing history in this regard. He had letters in a file, at 1 time there were 200at this stage I was Lead Clinician for OPD. He said he hadn't made a decision about triage for those – I said he had since he had selected some letters and dealt with them then he had made a decision regarding the others not being as urgent. There also has been a history of Mr O'Brien having charts in his office, he would regularly have huge numbers of charts in his office. Frequently there would have been medical records staff on their knees looking for charts in his office.

5. I was not his line manager for all of this period.

O'Brien. I didn't go through the letter but it set out to him the actions he needed to take and I asked him to address the issues. We did not discuss any supports to address the issues. My role as AMD ceased around this time and so I was not involved in the follow up after the letter went. My involvement ended at that point.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

6. Until my retirement from full time practice in February 2018 I was employed as consultant general surgeon in the Southern Trust, having been appointed to Craigavon Area Hospital in 1992. Following the establishment of the Southern Area Trust, I was additionally appointed Associate Medical Director for Surgery and Elective Care in 2008 and one of my responsibilities was for the urology service.

7. In November 2015, [redacted] it was suggested by Occupational Health that I should consider reducing my stress and come off on-call. In April 2016, I stepped down as Associate Medical Director and, in February 2018, I retired from full-time practice. At the time of my retirement from full-time practice, I had multiple box files in my office in the hospital as well as papers in the two filing cabinets. In these, I had kept relevant minutes and notes regarding each specialty. In 2018, I was unaware of any ongoing investigation into Aidan O'Brien so, during the month of February, I disposed of all papers and notes in my office. During March, I did the same in my study at home for any hospital-related correspondence or notes. I have therefore compiled this document principally from my recollection and what emails etc. I have been able to retrieve. As mentioned at paragraph 3 above, I have also had the benefit of being able to seek documents from the Trust where I believe there may be documents that might aid my recollection and/or relate to an issue I have to address in this statement.

8. Over the years, several performance issues have been raised regarding Aidan O'Brien's practice. Some of the issues have recurred over the years so, for clarity, I shall take them one at a time and deal with each issue chronologically.

9. Aidan O'Brien was appointed as the first full-time urologist to Craigavon Area Hospital in, I believe, 1993. Following the establishment of the urology service, he was joined by Michael Young in 1998 and then Mehmood Akhtar in 2007.

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

47. I qualified from The Queen's University of Belfast MB, BCh, BAO in July 1980. I obtained a Fellowship of the Royal College of Surgeons in Ireland in 1984 and an MCh from QUB in July 1991. I rotated through Surgical Training posts in Northern Ireland until February 1992 when I was appointed as a Consultant Surgeon to Craigavon Area Hospital.

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

48. During the 1990s for I was Lead Clinician for Out-patients from approximately 1994 until 1997 when I became Lead Clinician for General Surgery. In 2004 I was appointed Clinical Director for Cancer Services, then in 2006 I additionally was appointed Clinical Director Surgery. I held the latter two roles until approximately January 2008 when I was appointed Associate Medical Director for Surgery and Elective Care. I stepped down as Associate Medical Director in April 2016 and continued as a full Time Consultant General Surgeon until 28 February 2018 when I retired. On 1 April 2018 I was appointed as a locum Consultant Surgeon.

49. The Associate Medical Director Job description reflects the duties and responsibilities of the post with the exception of the following: *Document located in Section 21 4 of 2022, SHSCT Associate Medical Director JD.*

    (i) The annual appraisal Report was completed by the office of the Medical Director and was overseen by Anne Brennan, Senior Manager, Medical Directorate. Later, a Medical Revalidation office was set up to

Reference Number:

Southern Health and Social Care Trust
Associate Medical Director – Surgery/Elective Care

Job Description

JOB SUMMARY

The appointee will provide clinical leadership in the Acute Services Directorate, Surgery/Elective Care Division for: medical people management; reform and modernisation, patient and client safety, quality and standards; medical education and research governance.

- To contribute strategically as a member of the Directorate Management Team
- To provide clinical leadership to relevant medical staff in the Directorate and promote the corporate values and culture of the Trust.
- Ensure excellent communication between clinicians, Directorate management team and the Medical Directors Office
- To take responsibility for performance management including appraisal of designated clinicians
- To provide leadership to medical staff to enhance collaboration on Reform and Modernisation agenda

KEY RESULT AREAS:

Strategy Development:

- Contribute to strategy development as part of Directorate Senior Management Team.
- To advise the Management Team of Directorate priorities and pressures and contribute to the development of an Annual Directorate Management Plan and Trust Delivery Plan

level and a stable 5-man consultant team wasn't achieved until 2014. It was also difficult to attract sufficient, good-quality trust grade level doctors. This issue is addressed in more detail below, in particular in my answer to Questions 16-18.

45. The tendency to base judgements on Aidan O'Brien's perceived clinical ability and reputation led, I believe, to a failure to fully assess Aidan O'Brien's administrative shortcomings and their potential governance risks. I think a major learning point is that, no matter the seniority or reputation of a clinician, repeated failures to complete administrative tasks should lead to a fuller investigation and there should have been a fuller assessment of the risk to patient care and safety. The changes in the booking system, introduced in 2014, to attempt to mitigate the delay in triage should have been coupled with an ongoing review and assurance of Aidan O'Brien's triaging.

46. On a personal level, I do not believe that I had sufficient support and time available to fulfil all the duties of the role. I accept there was a failure on my part not to have raised this as a concern. There were other factors outside of work affecting me. Personal Information redacted by the USI The post was very stressful, although I didn't realise just how much until I stepped down from the role in April 2016. Personal Information redacted by the USI Personal Information redacted by USI Personal Information redacted by the USI

Service Delivery

- To function as a member of the Directorate management team with responsibility to contribute to strategic development and operational excellence.
- Provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the directorate
- Use the resources of the Directorate to deliver, in both quality and quantity, the activity and targets agreed for the Directorate
- To support the Trust in planning a response to major incidents and outbreaks.

Professional Leadership

- To develop and lead a team of Clinical Directors and Specialty Leads to assist the Trust in the redesign, modernisation and improvement of service delivery and ensure a senior professional clinical lead on the major Trust facilitiesl
- To identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate
- To ensure the highest standards of clinical effectiveness and medical practice in the Directorate, including the implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports
- Contribute as an effective member of Directorate Governance Committee
- To place Patient Safety at the centre of Directorate activity

Medical Education and Research

- Be responsible for the delivery and development of Medical Education and Research within the Directorate

Leading the Medical Team

- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff and to ensure that personal and professional development plans are in line with corporate objectives

- Implement the consultant contract, within the Directorate, ensuring the contract supports modernisation, quality improvement and achievement of access targets

- Provide leadership in the effective implementation and monitoring of Modernising Medical Careers and The New Deal for Junior Doctors.

- Ensure that doctors within the Directorate comply with arrangements for the assessment of fitness for clinical work and be responsible within the directorate for professional standards and regulation of doctors

- Ensure that a process is in place within the directorate for proper appraisal of all grades of doctors, including locum tenens, in line with regional guidance.

- Take part in the recruitment process for new doctors or ensure that other colleagues do so effectively

- Influence the modernisation of the workforce as systems for delivering care change

- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

Quality & Information Management

- Support the development of clinical indicators and outcome measures relevant to the Directorate clinical specialities.

- Ensure a programme of multi-professional clinical audit is implemented within the Directorate that supports the Trust integrated governance strategy and support the development of benchmarking activities within the Directorate

- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the Directorate

Collaborative Working

- Actively promote the development of clinical and professional networks across primary, secondary and social care.

- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated

- Promote and develop effective multi-professional team working and communication.

Corporate Responsibilities

- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director – Surgery/Elective Care works. Other duties of a similar nature and

reported to Heather Trouton, Assistant Director for Surgery and Elective Care. I had a formal weekly governance meeting with Mrs Heather Trouton at which we discussed all the subspecialties in the Surgical Directorate. For any Urology issues we were joined by Martina Corrigan and these were discussed and then it was agreed who would take responsibility for ensuring any necessary actions were effected. Each month at our Governance meeting Heather Trouton and myself were joined by Michael Young and Robin Brown. Heather reported any operational issues to the Director of Acute Services (Gillian Rankin, Debbie Burns and Esther Gishkori). I also informally met with Heather Trouton and Martina Corrigan at least weekly to discuss and sort issues as they arose.

59. I had a formal one-on-one monthly meeting with the Director of Acute Services (Gillian Rankin, Debbie Burns and Esther Gishkori) to discuss any governance or operational issues within the Directorate and including within Urology. I and would also have met them informally at a minimum weekly. A monthly one on one meeting was scheduled with the Medical Director (Paddy Loughran, John Simpson and Richard Wright) at which time I discussed any significant issues that had arisen in the Surgical Directorate. I also attended the monthly Governance Meeting chaired by the Medical Director.

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

60. The Director of Acute Services (Gillian Rankin, Debbie Burns and Esther Gishkori) and Heather Trouton (Assistant Director) had the responsibility for the budget. Responsibility for nursing, administrative and other support staff was the responsibility of Martina Corrigan (Head of Service), Heather Trouton and Gillian Rankin / Debbie Burns / Esther Gishkori. While responsibility for

Director (Heather Trouton) in the provision of the service. I reported to the Director for Acute Services (Joy Youart, Gillian Rankin, Debbie Burns, Esther Gishkori) and the Medical Director (Paddy Loughran, John Simpson and Richard Wright).

57. I was a member of the Directorate Senior Management Team and I assisted in strategy development and I contributed to the Directorate Management Plan. I assisted in the reform and modernisation of services within the directorate with the support of my Clinical Director/ Assistant Director, Heads of Service and Specialty leads. I helped implement local and national recommendations and Guidelines. I helped oversee the implementation of Modernising Medical Careers and The New Deal for Junior Doctors. I supported the Trust with the implementation of adverse incident reporting, investigation of an SAI (serious adverse incident) and ultimately a Level 3 Independent Review. When requested by the Medical Director or Director of Acute Services I assisted with other tasks and duties.

[7] With specific reference to the operation and governance of urology services, please set out your roles and responsibility and lines of management

58. When I was appointed AMD for Surgery and Elective Care there only was one CD, Robin Brown. Robin was a General Surgeon with an interest in some urological procedures and was based in Daisy Hill Hospital. I asked Robin Brown to be the CD for General Surgery in Daisy Hill, to oversee the Urology Services and to be line manager for the Urology Lead Clinician, Michael Young. This seemed to be the most prudent path as Robin had a significant interest in Urology and he also attended the Urology MDMs. Robin Brown was Michael's Young's line manager but because Robin was based in Newry and I was based in Craigavon issues would have been fed directly to me by Mr Michael Young or Martina Corrigan, both of whom were based at Craigavon. Mrs Martina Corrigan was the Head of Service in Urology and worked closely with Michael Young and the other Urologists. For operational issues Martina

2. As indicated in my earlier Witness Statement (S.21 Notice No.4 of 2022), I was appointed Associate Medical Director for Surgery and Elective Care in the Southern Trust in 2008. One of my responsibilities was for the Urology Service. While I was aware that policies and procedures existed within the Trust for when one had concerns regarding a doctor's practice, I would have had to ask for advice to identify the policies and/or procedures to be followed.

3. While reflecting on this S.21 Notice, I recalled that in, I believe, approximately 2008, I was asked by the Western Trust to assist in a review of one of their consultants. I attended a training session on the MHPS framework that the Western Trust ran for their staff. I cannot be sure if it was a half day or a full day course. Afterwards, however, my assistance was not required. Following this I do not recall any further updates or training on the Framework or its implementation. In particular, I do not recall the Trust organising any training.

4. On review of the minutes of the AMD meeting held on 17 September 2010 I note that a draft of the document "Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance" was tabled. I was on leave at that time and I do not recall reading the draft nor a final non-draft copy. I cannot recall the Trust organising any training in respect of its implementation.

5. In approximately March 2009 (and as outlined in my statement in response to No.4 of 2022), the issue of IV fluids and IV antibiotics arose in respect of urology. Paddy Loughran, Medical Director, oversaw the investigation of the practice and obtained independent advice. He introduced a protocol involving a multidisciplinary team that was to be followed in respect of the management of these patients. On 9 September 2010, Gillian Rankin, Acute Services Director, and I met with Aidan O'Brien and informed him of the process to be followed. We required to meet with him again on 9 June 2011 to reinforce the process and I emailed him on 15 June 2011, following a further breach, informing him that the protocol was not-negotiable.

6. On 1 September 2010, Dr Diane Corrigan, Consultant in Public Health Medicine, wrote to Paddy Loughran regarding the high number of benign cystectomies being

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

19. Issues around timely surgical reviews of referrals/daily consultant reviews/DNAR discussions.
20. M&M meeting dysfunctional.
21. JOB PLANS

That's what has appeared so far. Basically a very disturbing picture. Significant governance risks.

I'd be interested in your thoughts.

Charlie

10. The review of urological services, completed in 2009, proposed a configuration model with three teams serving the province. The 'Team South' configuration had Craigavon Urology as the core service for the southern part of the province and included Enniskillen. As part of the case for implementation of the review, the Trust set up various groups to meet the expectations of the commissioner. At that time there was an extensive review backlog, the Trust had the worst 'new to review' out-patient ratio of the three proposed teams as well as long waiting lists for surgery. There were significant regional concerns about our ability to be able to deliver the activity to cope with the growing demand, and to modernise the service to make it fit for the proposed expanded service.

11. To enable the expansion of the service, multiple workstreams were set up to deliver an implementation plan. Initially Joy Youart and then Gillian Rankin chaired weekly meetings with the three urologists. These meetings were met with almost unanimous resistance by the urologists, and it involved a huge effort and dogged determination on our part to gradually achieve agreement on the issues needed to modernise the service. The changes in practice that were expected by the commissioners were many and included: management of red flag referrals, triage, pre-operative assessment, length of stay, number of patients per clinic (and thus length of appointment), transfer of radical pelvic surgery to Belfast, role of Nurse Specialists, and team job plans. Throughout these meetings it was obvious that the main resistance to embrace change came from Aidan O'Brien, although as stated above, he did get support from his two colleagues. Aidan O'Brien had quite fixed views on how he wished to practice and deliver a urological service and these did not match those of the commissioners. My main role at the meetings was to provide a clinical challenge function to the opinions re delivery of the service that were being expounded by the urologists so that Gillian Rankin could achieve the desired consensus and outcome.

12. While the weekly meetings were continuing we also had the issue of job plans, both individual as well as for the proposed 5-man urologist team. Despite productivity of the urology service being considered low, Aidan

4. **Patient Admission for Surgery**
   - Patients are not to be brought in the days prior to surgery for IV fluids and IV antibiotics without discussion with and agreement from both Ms Sloan (as CD) and a Consultant Microbiologist (Dr Damani/Raj).
   - All patients are to be brought in for elective surgery on the morning of surgery with the exception of the very complex patient who requires essential inpatient management prior to major surgery.

5. **Urodynamics**
   Consultant input – it was agreed following discussion that Mr O'Brien would require 20 minutes per patient to review the results of their urodynamics studies and agree/provide a management plan for each patient. This would be factored into workload but does not require a full dedicated urodynamics session.

6. **Pooled Lists**
   Agreement on the need to manage all daycase patients in a chronological manner. To support Mr O'Brien in managing the chronological booking process Mrs Sharon Glenny, Operational Support Lead and Mrs Andrea Cunningham, Service Administrator for Urology will contact Mr O'Brien to discuss support/input required.

7. **Cancer Pathway**
   Discussion was had around Specialist Interest within Urology.
   With regard to Outpatient time required to see Day 4 Cancer patient it was agreed that a 30 minute slot would be required.

8. Discussion regarding the leadership requirement of all senior staff (inclusive of Consultants) to give confidence to all ward/department nursing staff regarding patient care and to take action to improve patient management rather than projecting a negative and critical attitude within the clinical team.

I would appreciate if you would advise if the above is an accurate reflection of discussions had and actions agreed or if any amendments are sought.

Mrs Heather Trouton
Assistant Director of Acute Services – Surgery and Elective Care

HSC Southern Health and Social Care Trust

Quality Care - for you, with you

Memorandum **By E-Mail**

To: Mr Aidan O'Brien, Consultant Urologist

From: Mrs Heather Trouton, Assistant Director of Acute Services – Surgery and Elective Care

Date: 1st July 2011

Subject: **Issues and Actions from Meeting held on 9th June 2011**

Following our discussions on Thursday 9th June 2011 please see following a summary of our discussions and actions agreed.

1. Dr Rankin outlined the Trust requirement for updated Job Plans to be complete prior to end of June 2011. Dr Rankin also placed the meeting in the context of the Regional Urology Review and the necessity of demonstrating the provision of an effective, efficient and productive Urology Service if further funding was to be secured from the Regional Board. This productivity was also set in the context of the SBA Capacity Modelling exercise underway for all specialties across all Trusts.

2. **Job Planning**
   - Mr O'Brien to submit current breakdown of activities to Mr Mackle for planning into updated Job Plan as per Trust action for all Consultants Trust wide to agree an updated Job Plan by end of June 2011.
   - Update – this was submitted on Thursday 16th June 2011. Draft Job Plan to be constructed for discussion.

3. **Review Backlog**
   - Heather Trouton to meet with Mr O'Brien to discuss way forward in managing review backlog in a timely manner. Heather Trouton to set up meeting. Also to ensure that responsibility is taken to manage all outpatient appointments in such a way as to only review those who clinically require review and thereby reduce the formation of a review backlog unnecessarily.
   - A discussion was also has regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog or review appointments.

Surgery and Elective Care Division, Acute Services Directorate,
Admin Floor, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
E-mail: [redacted] Personal Information redacted by USI

Comments relating to Draft Job Plan Proposals of 01/07/2011

In considering the Job Plan Proposals, I have categorized my comments into those that are 'General', and those that are 'Specific' to the weekly schedule. There may be some overlap and duplication in application of the 'General' to the specifics of the weekly schedule.

The comments are ordered to comply with the order in which the topics / issues appear in the Proposed Job Plan. The order does not imply any other significance.

General

Job Plan Dates

It would be possible for the proposed plan to be effective from 01/07/2011 for several reasons:

- The draft proposals were only issued on 01/07/2011
- I only became aware of their issue on 03/07/2011
- The invited comments are being submitted on 14/07/2011
- Most importantly, it is now impossible for the proposed changes, if agreed, to be implemented before 01/09/2011

Summary of Programmed Activities

- I believe that the total number of 8.18 PAs allocated to Direct Patient Care is inappropriate, inadequate and unsafe for reasons that are detailed below
- One of the main reasons for my transfer to the New Consultant Contract was that it had within the basic job plan an allocation of 2.5 PAs to Supporting Professional Activities. For years, I have looked forward to having a Job Plan with 2.5 SPAs to enable me to conduct audit, and audit-generated research. It has been my understanding that the allocation of 2.5 SPAs is a contractual right, with the agreement of the Trust with respect to activities conducted. For reasons detailed below, an increased allocation of SPAs will be required to conduct such audit.

Regional Job Planning Guidance

I am unaware of the Regional Job Planning Guidance referred to in the Template. I would appreciate being provided with a copy of the Guidance, or advice on its access.

Developments and Objectives

On discussing Job Plan Proposals with my two colleagues, there has been uncertainty and disagreement concerning whether objectives discussed in recent months come into effect when these proposed job plans come into effect, or instead do not do so until the 5 consultant model has been established. This particularly relates to outpatient clinic. I do believe that it should be explicitly clarified whether the new / review ratio of 1:1.5 and 15 appointments per 4 hour clinic etc., are expected to be implemented when the proposed job plans are agreed and come into effect. This will allow us to advise on any conditions or resources required to achieve the objectives.

Inpatient Management

I presume that it has been an oversight, the almost complete lack of any time allocated to inpatient management from one Thursday to the next when Grand Rounds take place. I presume that it does not need to be said that such would be entirely untenable and unacceptable, and that a daily agreed period be allocated to inpatient management.

Administration

The allocation of 2.5 hours per week for all of the administration involved in the effective execution of my job, is wholly inadequate, and reflects how detached the proposed plans are from the realities of our jobs. There are four main planks of administration which require allocation of adequate time:

- Administration arising from outpatient clinics
- Administration arising from enquiries from GPs, patients
- Dealing with all correspondence, including referrals for triage
- Arrangement of all admissions

Unremunerated Periods

There would appear to be a tendency to have unremunerated periods during the course of some days in the proposed plan. This would be a departure from the practice to date, and, in my view, will be counterproductive. In reality, we do not take lunch breaks. I do not want to have a lunch break. I would not want to have a break during the day when I would do nothing. If you can do without on an Theatre day, why would it be different any other day.

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 26 August 2011 17:13
To: aidan [redacted]
Cc: Corrigan, Martina
Subject: RE: O'Brien Aidan DRAFT job plan Jun 2011
Attachments: O'Brien Aidan DRAFT job plan Aug 2011v2.doc

Aidan

Thank-you for your email

Re the points raised.

- The fifth Monday occurs X4 per year equally bank holiday Mondays also equal X4 per year
- The specialist clinic is in Thorndale on a Friday so I cannot understand your point
- I have swopped your ward round on a Tuesday for the occasional patient who needs admitted the day before. You have a total of 4 hours for in-patient ward round per week.
- I note the comment re administration time and following reassessment of the admin time allocated to your colleagues I have reduced your allocation to 4.25 hours per week which is now similar to your colleagues.
- SPA time as I have stated at our meeting is a core of 1.5 SPAs. Any requests for increased SPA will be considered in the future on provision of further detail including Audit Tool, benefits and measureable outcomes.

If you are not able to agree to this job plan by 1/9/11 I am happy to request facilitation.

Eamon

From: aidan [redacted]
Sent: 24 August 2011 11:05
To: Mackle, Eamon
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

I do not accept the revised Job Plan proposal of 10 August 2011 for following reasons:

- I find it unacceptable the proposal to travel to Banbridge on the morning of the fifth Monday of the month, to conduct a clinic, lasting four hours, without credit in a Job Plan. If it cannot be accredited, I would prefer that it would not be included in a Job Plan.
- I believe that it was both important and reasonable to have time allocated to addressing patient management issues arising in Thorndale Unit. Last Friday, I spent one hour doing so. That included contacting the GP of a patient whose serum PSA had increased from 8 ng/ml to 803 ng/ml in less that one year. I had proposed the inclusion of a nominal time allocation of 30 minutes per week (on Tuesdays 1.00 to 1.30 pm). I believe that Urology ICATS cannot function safely without consultant urologists providing advisory input, and I believe time allocated to that function should be included in Job Plans.
- I believe that it remains a necessity to allocate time to conduct a ward round on Tuesday evening. Irrespective of practices in other specialties, I would anticipate that we will continue to have some patients undergoing surgery, and who will not have been admitted electively on the day of surgery. In any case, all patients admitted electively will have given prior consent. Even if that prior consent is in written form, I believe that it would be better practice to review the patient following admission, and that it would be inappropriate to defer that review to the morning of surgery. Moreover, this round is not solely for the purpose of obtaining written consent from patients undergoing surgery the following day, but for all inpatients.
- The time allocated to administration remains inadequate. I note a recent expectation that the results of all investigations (presumably of outpatients) be read by consultants as soon as the results are available. How much administrative time will this consume? How much time will be allocated in Job Plan?

Southern Health and Social Care Trust
Quality Care - for you, with you

12th October 2011

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

PRIVATE & CONFIDENTIAL

Dear Mr O'Brien,

I am writing to advise you that following your facilitation meeting on Wednesday 28 September 2011 and a subsequent meeting held with Mr Mackle on Friday 7 October 2011, I have considered the issues raised and reviewed all the necessary information.

I have compared your proposed job plan with those of your colleagues in Urology and am content that the time you have been allowed for administration seems appropriate. One of your colleagues has been allowed slightly more time; however he has agreed to undertake an additional clinic which will generate more administration.

I do accept however, that you have historically worked significant amounts of administrative time and as a result I feel it is appropriate for me to agree a transitional period to allow you time to adjust your working practices. I am therefore recommending that you should be offered an additional 0.75 PA per week for administration until 28 February 2012. This will result in a total of 2.75 PAs over and above 10 programmed activities. From 1 March 2012 however, you will reduce to 12 PAs per week.

This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.

In the meantime, it is important for you to be aware that if you are not satisfied with the outcome of the facilitation process and wish to proceed to a formal appeal, you must notify the Chief Executive in writing by Tuesday 25 October 2011.

Yours sincerely

Dr PP Murphy
Associate Medical Director
Medicine & Unscheduled Care

Clegg, Malcolm

From: Personal Information redacted by USI
Sent: 10 November 2011 00:56
To: Clegg, Malcolm
Subject: Re: Amended 2011/12 Job Plan

Malcolm,

Thank you for your email of 03/11/11, and for clarifying that the total PAs accompanying the Amended Job Plan will be 12.75.

As discussed with you yesterday, I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Even though I has brought attention, in writing and verbally, and over a period of two months, to the physical impossibility of earlier Job Plans offered, a possible (whether acceptable) Job Plan was submitted for the first time on 31 October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1 September 2011. Upon query, now it is to be effective from 1 October 2011, a month before it was offered, and on the grounds that another consultant's job plan, presumably both possible and accepted, had become effective from that date. Surreal relativism comes to mind!

By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate.

Aidan O'Brien

-----Original Message-----
From: Clegg, Malcolm Personal Information redacted by USI
To: aidan Personal Information redacted by USI Personal Information redacted by USI
Sent: Thu, 3 Nov 2011 12:16
Subject: RE: Amended 2011/12 Job Plan

Mr O'Brien,

The hours in the amended job plan total 12.63 PAs, so when this is rounded to the nearest 0.25 PA it results in a total of 12.75 PAs.

With reference to the effective date of the job plan, it had originally been intended that your job plan would be effective from 1st September 2011; however because of delays with Facilitation etc this will no longer be appropriate. If you are prepared to accept the amended job plan it is expected that this will become effective from 1st October 2011. This is the same date that has been applied to one of your consultant colleagues who has also accepted a reduced job plan in Urology.

I trust this helps to clarify your queries.

Regards

Subject: FW: Amended 2011/12 Job Plan
From: Clegg, Malcolm [redacted]
To: Mackle, Eamon <[redacted], Corrigan, Martina
<[redacted]>
Sent: 11/16/2011, 1:03:57 PM
Mr Mackle/ Martina,

Please see response from Mr O'Brien to his job plan offer following Facilitation.

I have responded to Mr O'Brien today to inform him that arrangements have been made with salaries and wages to implement the 12.75 PA job plan from 1st October 2011. I also advised him that I would be notifying you both of the comments he had made as you might need to discuss these issues further with him.

We have decided to proceed with implementation of the 12.75 PA job plan from 1st October 2011 as Mr O'Brien never formally requested an appeal despite now indicating his disagreement with the job plan. I do feel however that we cannot ignore Mr O'Brien's comments. Mr O'Brien was informed in his notification letter following Facilitation that the new job plan will require him to change his working practices and administration methods and that the Trust will provide any advice and support it can to assist him with this. It is important therefore in view of the comments made by Mr O'Brien that we follow through with this.

Regards

Malcolm

Malcolm Clegg
Medical Staffing Department
Southern Health and Social Care Trust
Craigavon Area Hospital
BT63 5QQ

Tel: [redacted]

From: aidan [redacted]
Sent: 10 November 2011 00:56
To: Clegg, Malcolm
Subject: Re: Amended 2011/12 Job Plan

Malcolm,

Thank you for your email of 03/11/11, and for clarifying that the total PAs accompanying the Amended Job Plan will be 12.75.

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By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to

Subject: Post Facilitation
From: Mackle, Eamon <Personal Information redacted by USI>
To: O'Brien, Aidan <Personal Information redacted by USI>, McCorry, Monica <Personal Information redacted by USI>
Cc: Trouton, Heather <Personal Information redacted by USI>, Rankin, Gillian <Personal Information redacted by USI>, Corrigan, Martina <Personal Information redacted by USI>, Clegg +1 More
Sent: 12/5/2011, 4:46:43 PM
Dear Aidan

As you are aware in the letter post your job plan facilitation it was stated: “This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.”

I as a result, organised a meeting to discuss same. I note however, that you cancelled said meeting. I am therefore concerned that we haven’t met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without need for Trust support then you obviously do not need to contact me to organise a meeting.

Kind Regards

Yours Sincerely

Eamon Mackle

following the change in the booking centre system, or at any other time did Aidan O'Brien say he had stopped performing triage.

17. Triage is discussed in more detail below, in particular in my responses to Questions 54-57.

IV Fluids & IV Antibiotics

18. In early 2009, we became aware of a practice in the urology department of admitting certain patients with urinary tract infections for administration of IV fluids and IV antibiotics. This practice did not seem to conform to any recognised standard or guideline. My understanding is that the practice extended back to the early 2000s. Paddy Loughran was informed and he sought advice from the external advisor to the Northern Ireland Urology Review, Mark Fordham, and Dr Jean O'Driscoll, consultant microbiologist, who both confirmed that this was an unusual and not recognised as routine practice. A pathway was introduced whereby a multidisciplinary team would be convened to review each individual case and advise on avoidance of the practice. Despite agreement from Michael Young and Aidan O'Brien, we became aware in July 2010 that the pathway was not being followed and that 13 patients were still being treated with the combination and that two of the patients had been admitted for central line insertion as peripheral veins were proving difficult to cannulate. In September 2010 a formal protocol was tabled that was expected to be followed. In June 2011 I believe there was a breach of the protocol and then, a week later and despite a meeting to reinforce the protocol, I was made aware of a planned further breach. Following this, I sent an email to Aidan O'Brien and I am not aware of any further breaches occurring after that.

19. IV fluids & IV antibiotics is discussed in more detail below, in particular in my responses to Questions 54-57.

Benign Cystectomies

20. Many of the patients having the IV fluid & IV Antibiotic treatment had previously had a cystectomy (removal of bladder) for benign disease. Dr

Corrigan, Martina

From: Mackle, Mr E [redacted]
Sent: 19 July 2010 15:09
To: Brennan, Anne
Subject: IV Antibiotics in Urology

Anne

Paddy as you know had a report from Mark Fordham regarding the use of long term IV antibiotics for urology patients. I mentioned to Paddy recently that I understood that they were still not adhering to the guidance which he gave to them (in conjunction with advice from Dr Damani). Paddy stated that I should check the numbers concerned and then if necessary meet with them. I have discovered there are 13 or 14 patients still getting IV treatment. I am organising a meeting but would appreciate if you could forward me a copy of Mark Fordham's report and if there were minutes of his meeting with Urology so I can be sure I am singing from the same hymn sheet.

Eamon

Southern Health and Social Care Trust

Medical Directorate

Memorandum

Our ref:	PL/lw	**Your ref:**	
To:	Dr Gillian Rankin, Interim Director of Acute Services		
From:	Dr Patrick Loughran, Medical Director		
c.c.	Mr Eamon Mackle, AMD for Elective Care/Surgery Division, Acute Roberta Wilson, Governance Lead		
Date:	2nd September 2010		
Subject:	Urology Services		

Dear Gillian

Since the end of March 2009 the Trust has been examining the practice of IV antibiotic and fluid therapy as a prophylaxis for recurrent UTI's. I have received expert advice from Mr Mark Fordham (an acknowledged expert from Manchester) and Dr Jean O'Driscoll Consultant Microbiologist in Stoke Mandeville Hospital.

As a result of the expert external opinions and following several meetings and related correspondence with Mr O'Brien and Mr Young, I met with the 2 Urologists on 4th August 2009. During this meeting the surgeons agreed:

a) to compile an accurate list of patients who were on the IV programme
b) that each surgeon would review the treatment regime for each patient
c) that a multi-disciplinary group would be convened to look at a treatment plan for each patient. The core of this treatment plan would be to convert the patient from IV to oral therapy or another non-intravenous treatment (review/watchful waiting ??).

On 7th August 2009 Dr Damani and I agreed that he would provide Microbiology support for point's b and c above.

In the intervening period I understand that there has been a significant reduction in the number of patients within the cohort. I had expected that the number of patients would be extremely small by now and that the patients with central venous lines or long peripheral lines would have had the lines removed. You, Mr Mackle and I met on Wednesday 1st September 2010 and discussed the progress of this matter.

It is of concern to me that the agreement as set out above has not been followed by Mr Young and Mr O'Brien. In particular I understand that there are at least 7 patients remaining on the IV treatment and that 2 (and possibly 3) have permanent intra venous access. We agreed that Mr Young and Mr O'Brien should be informed of the meeting on Tuesday and should also be informed that I remain concerned that <u>any</u> patient is receiving this intra venous treatment.

Southern Health and Social Care Trust

Quality Care - for you, with you

Process to review all cases of people currently and intermittently receiving IV fluids and antibiotics for recurrent UTIs.

Steps required:

- Each patient who is currently on a regular or intermittent regime of IV antibiotics to have a case review, in order to agree a management plan which may require oral antibiotics but not IV antibiotics and not regular admission as an inpatient.

- The case review meeting will be chaired by Ms S Sloan, Clinical Director for Surgery & Elective Care, and minuted by Mrs M Corrigan, Head of Urology. The relevant urologist will present each case and Dr Damani, Consultant Microbiologist, will provide expert advice on appropriate antimicrobial therapy.

- If agreement cannot be reached for a particular patient on oral therapy, a further meeting will be held to involve Mr E Mackle, Associate Medical Director for Surgery and Elective Care, and involving the same team as before.

- Please note that there are unlikely to be circumstances accepted by the Commissioner or the Southern Trust where the use of IV fluids and antibiotics is an evidence based or acceptable treatment for a patient with recurrent UTIs.

9th September 2010

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 15 June 2011 16:33
To: O'Brien, Aidan; [redacted]'; Rankin, Gillian; Walker, Helen; Trouton, Heather
Subject: Antibiotics and Urology Patients

Dear Aidan

I am seriously concerned that you don't seem to recall our conversation at the meeting last thursday. At that meeting I informed you that if you wanted to admit a patient for pre-op antibiotics or for IV fluids and antibiotics that a meeting had to be held with Sam Sloan and a microbiologist and that this prerequisite was non negotible. You have also been given this in writing following a previous meeting with Dr Rankin and myself.
I now find that you initially planned to admit a patient this week without having discussion with anyone and then when challenged you only spoke to Dr Rajesh Rajendran.
Would you please provide me with an explanation by return.

Eamon Mackle
AMD

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 30 January 2012 15:08
To: Stinson, Emma M
Subject: FW: IV Antiobiotics

From: Mackle, Eamon
Sent: Monday, January 30, 2012 3:08:01 PM
To: Hall, Sam
Cc: O'Brien, Aidan; [redacted]; Corrigan, Martina; Rankin, Gillian
Subject: IV Antiobiotics
Auto forwarded by a Rule

Dear Sam,

I have been advised that a patient [redacted] may have been admitted last week to Urology by Mr O'Brien and under his instruction was given IV Antibiotics the latter necessitating a central line to be inserted.

I have checked with Dr Rajendran and he advises me that no discussion took place prior to the administration of the antibiotics.

I would be grateful if you could formally investigate this and advise me of your findings.

Many thanks

Eamon

I am not aware of any further instances of violation of the protocol after this. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20111218 Email IV Fluids and antibiotics in urological patients.*

Benign Cystectomies

203. Dr Diane Corrigan, Consultant in Public Health Medicine, on 1 September 2010 wrote to Paddy Loughran and copied in Gillian Rankin and myself, noting that, when she read the review of the IV Fluid and IV antibiotic therapies, that there was a comment re major bladder surgery. She had recently informed me that she was going to conduct an N.I.-wide audit of the number of procedures being performed. This she reported as showing a higher than expected number of cystectomy and/or ileal conduit procedures for benign disease than would be expected. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100901 – email urology.*

204. On 9 September 2010, at a meeting held by Gillian Rankin and myself and attended by Aidan O'Brien and Michael Young, a statement regarding the screening process the Trust was planning to undertake was tabled. Aidan O'Brien at this point said that, if Mark Fordham was appointed to carry out a review, then under no circumstances was he prepared to meet with him. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100910-email urgent.*

205. On instruction the most recent 12 cystectomies for benign disease, dating back to 2006, were collated with the assistance of Martina Corrigan and reviewed by myself. I was unable to reassure the Trust on at least 6 of the cases. A decision was made by the Trust that an independent reviewer should be sought. I therefore drove to Aldergrove Airport hotel one evening to meet with Mark Fordham who was staying there for the night prior to a flight early the next morning, following a visit to NI in respect of the Urology Review. He advised on how he thought any review should be performed and said he would get back to me with a suggested expert. On 9 February 2011 I wrote to

CYSTECTOMY CASES UNDERTAKEN FOR BENIGN URINARY CONDITIONS, SOUTHERN TRUST OF NORTHERN IRELAND.

MARCUS DRAKE, SENIOR LECTURER, UNIVERSITY OF BRISTOL

I am currently practicing as a Consultant Surgeon at the Bristol Urological Institute, Southmead Hospital, Bristol, UK. I subspecialise in Female and Reconstructive Urology, Neurourology and Urodynamics. I am Senior Lecturer in Urology at the University of Bristol, and Visiting Professor in Health and Applied Sciences at the University of the West of England. I am Chairman of the International Continence Society Standardisation Committee and of the Urogenital Specialty Group in the UK's Comprehensive Clinical Research Network. I am Editor of the BJU International Website, and a member of several journal Editorial Boards. I undertook my medical training at the Universities of Cambridge and Oxford and was awarded my Doctorate Thesis by the University of Oxford, studying the physiological effects of spinal cord injury on the human bladder. I have written several publications in peer-reviewed journals.

A brief review of medical records was undertaken to ascertain the key issues relating to the decision processes leading up to cystectomy. This should not be taken as a comprehensive evaluation, in view of the limited time available to me. Below are presented the key features derived from the notes and my opinion relating to management of the patients on whom I was asked to comment

PATIENT [redacted]

Cystectomy Date: 28 July 2010

KEY FEATURES FROM NOTES

Dr Lamont, Consultant Psychiatrist, saw her on 12 March 2008 concluding that there was no evidence of major mental illness. She had been reviewed in the context of a planned urostomy and the overall conclusion appears to support that psychologically, this would not be inappropriate.

Urodynamic studies 23 March 2010. alluded to showing bladder hypersensitivity and detrusor hypocontractility.

Operation note 23 September 2009. Admitted for elective procedure of hydrostatic bladder dilation and mucosal biopsies 23/9/10. Background of recurrent bladder infections for several years. Treated for vesicoureteric reflux (including a reimplantation). Diagnosed with chronic interstitial cystitis. Problems passing urine – self-catheterising, some dysuria.

25th March 2011

Personal Information redacted by USI

OPINION

I was unable to undertake a sufficient review of this lady's notes.

8.1 Diagnosis of interstitial cystitis needs to have some objective confirmation to describe pain scores, reduced functional bladder capacity (i.e., low maximum void volume on frequency volume chart), and endoscopic procedure in which the bladder was distended to ascertain its maximum anaesthetic bladder capacity- including visualisation to observe the emergence of an ulcer or post-distention glomerulation.

CONCLUSIONS

9.1 The majority of cases appear to have been managed with compassion and consideration

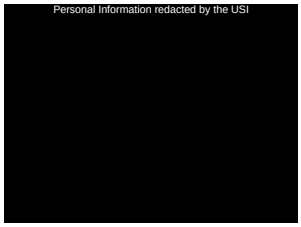
9.2 The cases in general appear to have been supportable clinical grounds.

9.3 The documentation is insufficiently comprehensive, and in order to warrant proceeding to cystectomy, clear description of the following is needed; severe pathology, substantial functional impairment and impact on quality of life, attempts to undertake conservative measures, discussion of risks involved.

9.4 More comprehensive review of notes may identify documentation addressing some of the points in 9.3

9.5 An issue that stands out is failure to plan for possible voiding dysfunction in a lady receiving bladder botulinum injections who was averse to catheterisation.

9.6 Inpatient management of infection as seen in one of the cases should be undertaken in the context of specialist input from a multidisciplinary team including microbiology



Mr Marcus Drake, MA (Cantab), BA, BM, BCh, DM (Oxon), FRCS (Urol).

Consultant Urological Surgeon, Bristol Urological Institute

HEFCE Senior Lecturer in Urology, University of Bristol

Visiting Professor, University of West of England.

Corrigan, Martina

From: Loughran, Patrick [redacted]
Sent: 28 July 2011 09:03
To: Corrigan, Diane
Cc: John Simpson [redacted]); Mackle, Eamon; Brennan, Anne
Subject: Urology Review

Dear Diane,
Thank you for your help with the CEA reviews yesterday. I had intended but forgot to give you an update on the above. The independent assessment of the cystectomies by Marcus Drake from Bristol is almost complete. I have seen the interim report prepared for Gillian and Eamon as I read it there are no gross errors or faults. There are some questions in relation to pre-operative alternative treatment plans and assessments. Overall I expect the final report will be supportive/indeterminate. In the meantime I can assure you that this surgery, nor will it be undertaken in the Southern Trust.
Regards, Paddy

5.0 CONCLUSION

The investigating team took into account the information provided by Mr O'Brien in relation to this matter and would conclude that the following allegation is proven.

That on 15 June 2011, Mr O'Brien disposed in the confidential waste a section of filing from a patient's chart. This consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription form and a prescription kardexes.

Mr O'Brien readily admits that he inappropriately disposed of patient information in the confidential waste. He readily admits that this was in error, that he should not have done it and will not do it again. I think that it is also important to note that Mr O'Brien says that he spends more time writing in and filing in charts than probably any other Consultant and from my own personal experience I can confirm that that is the case. Mr O'Brien has the utmost respect for patients, for their information and for the storage of records. This was an unusual behaviour which was the result of frustration from dealing with a large unwieldy chart, difficulties retrieving important information from the chart, and from the difficulty finding anywhere suitable to make good quality records.

The motivation for the incident was honourable in that Mr O'Brien was trying to make an entry in the chart, though the solution to the problem was clearly wrong. I am satisfied that Mr O'Brien has accepted his error and agreed that it will not happen again. I do not think that a formal warning is appropriate to the scale of the case and I would recommend an informal warning, this has effectively already taken place as part of the process.

Mr Robin Brown
Clinical Director
General Surgery

Mrs Zoe Parks
Medical Staffing Manager

Mobile: Personal Information redacted by USI

Email: martina.corrigan@ Personal Information redacted by USI

From: Trouton, Heather

Sent: 25 July 2011 15:07

To: Reid, Trudy; Devlin, Louise; Corrigan, Martina

Cc: Mackle, Eamon; Brown, Robin; Sloan, Samantha

Subject: Results

Dear All

I know I have addressed this verbally with you a few months ago , but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them.

I will need assistance when replying to this email.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: aidan Personal Information redacted by the USI
Sent: 25 August 2011 15:37
To: Corrigan, Martina
Subject: Re: Results and Reports of Investigations

Martina,

I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:

- Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?
- Are all results or reports to be reviewed, irrespective of their normality or abnormality?
- Are they results or reports to be presented to the reviewer in paper or digital form?
- Who is responsible for presentation of results and reports for review?
- Will reports and results be presented with patients' charts for review?
- How much time will the exercise of presentation take?
- Are there other resource implications to presentation of results and reports for review?
- Is the consultant to report / communicate / inform following review of results and reports?
- What actions are to be taken in cases of abnormality?
- How much time will review take?
- Are there legal implications to this proposed action?

I believe that all of these issues need to be addressed,

Aidan.

-----Original Message-----
From: Corrigan, Martina < Personal Information redacted by USI >
To: Aidan Personal Information redacted by the USI >; Akhtar, Mehmood Personal Information redacted by USI >; O'Brien, Aidan < Personal Information redacted by USI >; Young, Michael < Personal Information redacted by USI >
CC: Dignam, Paulette < Personal Information redacted by USI >; Hanvey, Leanne < Personal Information redacted by USI >; McCorry, Monica < Personal Information redacted by USI >; Troughton, Elizabeth Personal Information redacted by USI >
Sent: Wed, 27 Jul 2011 5:30
Subject: FW: Results
Dear all

Please see below for your information and action

Thanks

Martina

Martina Corrigan

Head of ENT and Urology

Craigavon Area Hospital

Tel: Personal Information redacted by USI (Direct Dial)

Willis, Lisa

From: Mackle, Eamon
Sent: 16 November 2011 18:07
To: Trouton, Heather
Subject: Fw: Results and Reports of Investigations

Follow Up Flag: Follow up
Flag Status: Flagged

From: Rankin, Gillian
To: Mackle, Eamon
Cc: Corrigan, Martina; Trouton, Heather
Sent: Thu Sep 08 07:29:02 2011
Subject: RE: Results and Reports of Investigations

Dear all,

I am concerned that we have not been able to sort this one out yet despite trying to have a conversation with Mr O'Brien.

Heather I wonder if when you are meeting the 3 surgeons regarding speciality interests this whole area of how results are read when they arrive rather than waiting for review apt could be discussed.
The secretaries need to be given a brief as to what is expected of them and tis would need discussed and agreed.
Perhaps a protocol for secretaries is needed when there is not currently a system in place which I hope is not more widespread.
Can I leave it with you until ~I return?
Thanks,
Gillian

From: Mackle, Eamon
Sent: 26 August 2011 16:37
To: Rankin, Gillian
Cc: Corrigan, Martina
Subject: FW: Results and Reports of Investigations

Gillian

I have been forwarded this email by Martina and I think it raises a Governance issue as to what happen to the results of tests performed on Aidan's patients. It appears that at present he does not review the results until the patient appears back in OPD.

Eamon

From: Corrigan, Martina
Sent: 25 August 2011 16:22
To: Mackle, Eamon
Cc: Trouton, Heather
Subject: FW: Results and Reports of Investigations

Eamon,

TRU-250590

Meeting re a consultant urologist

Rankin, Gillian <[redacted]>

Fri 02/09/2011 14:16

To: Donaghy, Kieran <[redacted]>; Simpson, John <[redacted]>;

Cc: Mackle, Eamon <[redacted]>; Walker, Helen [redacted];
Stinson, Emma M [redacted];

Dear all,

I think there would be merit discussing current issues around one of our senior staff. Is there any chance we could meet 2-3 pm Monday next?
Eamon and I have this is our diary and as we both go on leave shortly it would be good even if we could get 30 minutes.
Let me know,
Thanks,
Gillian

Willis, Lisa

From: Trouton, Heather
Sent: 29 January 2016 12:51
To: McAlinden, Matthew
Cc: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: Radiology and Patholoy results

Follow Up Flag: Follow up
Flag Status: Flagged

Matthew

Could you please send the email below to all the consultant surgeons that I gave you this am ?

Happy to discuss if required
Thanks

Heather

From: Trouton, Heather
Sent: 18 January 2016 14:49
To: Trouton, Heather
Subject: Radiology and Patholoy results

Dear All

Following the outcomes of several SAI's, we are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed.

Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance.

Kind regards
Eamon and heather

Performance data was also reviewed at the Governance meetings and any concerning trends noted.

[39] How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

125. The systems are as detailed in my answers above from Questions 33 to 38. At the time we thought the systems were effective and that concerns, as they arose, were being escalated and action taken. As such we did not have any significant governance concerns.

126. The issue regarding the number of benign cystectomies being performed was appropriately investigated, the practice was stopped and compliance monitored.

127. Likewise the issue regarding IV fluids & IV antibiotics was escalated and a protocol produced to change practice. Compliance was monitored and any breaches/ potential breaches followed up and stopped.

128. Regarding triage, this was an ongoing problem. The first time I became aware of it was approximately 1996. I spoke to Aidan O'Brien and he assured me that the "red flag" patients were being triaged and, in response to the intervention, he then completed his triage. Intermittently over the years it would be noted that he was behind on triage and, when challenged, would catch up. Heather Trouton and the Directors (Gillian Rankin, Debbie Burns) were aware that he was slow at performing triage but that, when he was challenged, he would do it. I did inform Paddy Loughran and John Simpson of the issue but I admit I didn't raise it as a serious governance concern and neither did they question it as being one. On reflection due the repeated failure to perform timely triage a thorough investigation should have been undertaken.

129. As mentioned above, in 2014, Debbie Burns introduced a new system into the booking office so that patients were placed on the waiting list according to GP grading and in chronological order. The patients would then be upgraded, if necessary, when triage was completed. I was not informed if there was ongoing monitoring of compliance, the results of any monitoring nor did I request any audit of his practice. On reflection, in light of his past history there should have been continuing audit. It was only at the end of 2015 that I was made aware that there appeared to be an issue. His delay in triaging allowed a significant governance risk to arise. The introduction of electronic triage using NIECR in approximately 2018 has increased the governance oversight of the process.

130. The issue re charts at home developed because of Aidan O'Brien's attendance at a urology clinic in Enniskillen. I don't recall being made aware that consultants were transporting the charts back from the clinic rather than the usual method of hospital transport.

131. To the best of my knowledge, pre the introduction of digital dictation, there was no mechanism to monitor that dictation was being done after the clinic other than a secretary flagging it to her line manager. The consultants were given in their job plan 30 minutes at the end of the clinic for dictation, we wrongly assumed the dictation was being performed and the clinic outcomes recorded. I believe that Aidan O'Brien attended the clinic in Enniskillen from 2011 but it was only from approximately 2015 that the issue non-dictation of clinic letters became apparent. Once his colleagues raised concerns with Martina Corrigan, the problem was escalated to Heather Trouton, Esther Gishkori and myself. Esther Gishkori recommended that Richard Wright should be notified. Richard, on having the issues detailed and the past history, advised the approach to be taken to investigate the extent of the issue and to manage it.

[40] How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting

[49] Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

a. properly identified,

b. their extent and impact assessed,

c. and the potential risk to patients properly considered?

Medical Staffing

179. The issue was identified and it was well known by the Trust and Commissioners that insufficient staff meant that the model would not provide sufficient capacity to meet demand. Emergency and Reg Flag patients were prioritised then urgent and finally routine. Waiting list initiatives were funded to reduce the backlog.

Review Backlog

180. The review backlog was recognised by both the Trust and the Commissioners and the extent and impact well recognised. The potential risks to patients was considered and it was concluded it was safer to prioritise the reg flag, urgent and emergency referrals and cases.

Triage

181. The issue had been identified and it was known to be a recurring problem. It was assumed that the extent of the problem was known. However it became obvious in early 2016 the problem, far from having been managed by the system introduced in 2014, had continued unabated and a significant number of patients had been put at risk.

Benign Cystectomies

To: Young, Michael [redacted]
Cc: Mackle, Eamon [redacted] Gibson, Simon
[redacted]
Sent: Wed Dec 03 09:51:37 2008
Subject: FW: URGENT - Urology ICATS referrals

Dear Michael

What solutions could you propose to this continuing problem?

Kind regards

Simon

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
[redacted]

P Please consider the environment before printing this e-mail.

-----Original Message-----
From: Cunningham, Teresa
[mailto:[redacted]
Sent: 02 December 2008 17:22
To: Gibson, Simon; Mackle, Eamon
Subject: URGENT - Urology ICATS referrals
Importance: High

Dear Simon/Eamon

Please see attached a spreadsheet showing the numbers of referrals which have not as yet been triaged.

As you know this problem has been raised on a number of occasions and for a short while, the situation had improved. Mr O'Brien was triaging the referrals last week and I appreciate that he only returned from a week's leave last Monday. Unfortunately however, as we are working to a
6 week target, the current situation is intolerable.
When I ran the PTL's yesterday, there were only 12 patients on the PTL to be appointed for January, because the referrals have not been triaged. This will undoubtedly lead to a panick situation later on this month in the run up to the Christmas holidays, trying to get patients booked. I think it is unfair that undue pressure is being exerted on me to ensure patients are treated within target dates, and subsequenty on the appointments staff, because I put pressure on them to ring patients to get them appointed.

The service is not manageable under these circumstances and I feel I can not continue to manage it unless this issue is properly addressed. If Mr O'Brien is constantly facing difficulties triaging his referrals within the timeframes specified within the IEAP, then we need to put something else in place to faciitate the smooth operation of the service and to ensure that we can offer patients reasonable notice.

I would appreciate if you could let me know what action will now be taken to resolve this problem once and for all.

Regards

Mackle, MR E

From: Mackle, MR E
Sent: 02 June 2009 13:10
To: 'Simon.Gibson [redacted]; Youart, Joy; O'Brien, Aidan
Subject: Request for leave to clear administration

Simon

Thanks for discussing with me Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork.

I have several serious concerns regarding the request:

1. I think approximately 2 years ago the trust funded a similar exercise to allow Aidan to catchup. It was agreed then that this was a one off and it was his responsibility (as per consultant contract) to prevent such a baglog developing again.

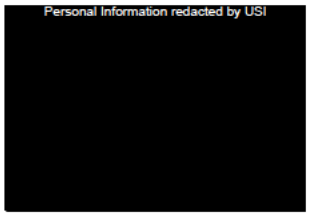
2. There are already 3.87 PAs of admin time in his current job plan. This is way in excess of any other consultant in the trust and is excessive when compared to eg Mr AKhtar (Cons Urologist) who has 1.12 PAs in his job plan for admin.

3. To expect the trust to fund the shortfall in clinical activity in light of Aidan's baglog (despite an over generous allowance of PAs in his job plan) would thus be unreasonable. If his colleagues feel that the request from urology is reasonable then I would expect the sessions to be covered at no additional cost from within the speciality.

4. If as you state Aidan feels there is now a clinical risk because he has allowed the backlog to develop then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may also need to consult with the Medical Director regarding the performance issues raised.

Eamon

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust



12 June 2009.

Mr. Eamon Mackle,
Associate Medical Director,
Surgery and Elective Care,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Eamon,

Two days ago, I opened and read the copy of the email that you sent to Simon Gibson and to Joy Youart on 02 June 2009, and the accompanying cover slip from you, addressed to me. I did so only then as I had mistakenly gathered from you that it had something to do with the arrangements for ward configuration in July. I was shocked beyond words, appalled and flabbergasted on reading both.

In your email addressed to Simon (and sent to Joy), you thank Simon for discussing with you 'Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork'. I certainly did not make or submit to anyone any request to do so.

These past three months have been the most stressful and distressing that I (and everyone else caring for urological patients) have had to endure since I was appointed 17 years ago. Not only have we had to cope with the imposed loss of our ward, and the fragmentation of inpatient urological services posing a potential existential threat to care, we have also had to cope with the reality of the deliberate lack of information and consultation with those most directly and intimately involved in the delivery of the care. Worse still, we additionally had to cope with the reportage that we had not only been informed and consulted, but were in agreement with the plans. Not only have I endeavoured to seek compromise, I have gone to every length to restore some degree of confidence in the credibility of management, when that was at an unprecedented low.

Then I read your email!

I do believe that it would be reasonable to request and expect an acknowledgement, in writing, that I did not make or submit the request recorded in your email,

Yours Sincerely,

Aidan O'Brien.

Southern Health and Social Care Trust

Meeting re Urology Service

Tuesday 1 December 2009

Action Notes

Present:
Mrs Mairead McAlinden, Acting Chief Executive
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Mrs Paula Clarke, Acting Director of Performance & Reform
Mrs Deborah Burns, Assistant Director of Performance
Mrs Heather Trouton, Acting Assistant Director of Acute Services (S&E Care)
Dr Gillian Rankin, Interim Director of Acute Services

1. **Demand & Capacity**
   Service model not yet agreed, outpatients and day patients not finalised, no confidence that this will be finalised. Theatre lists not currently optimised and recent reduction in number of flexible cystoscopies per list. Recent indication that availability for lists in December 2009 will be reduced.

   Action
   - Sarah Tedford to be requested to benchmark service with UK recognised centres regarding numbers, casemix, throughput (eg cystoscopies per list). **Action – urgent within 1 week.**

   - Team/individual job plans to be drafted – Debbie Burns/Mr Mackle/Zoe Parks, for approval at meeting on 11 December 2009. To be sent to consultants and a meeting to be held within a week with consultants, Mr Mackle, Heather Trouton and Dr Rankin.

2. **<u>Quality & Safety</u>**

   <u>Key Issues</u>:-

   1. Evidence-base for current practice of IV antibiotics for up to 7 days repeated regularly requires urgent validation. Current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009.

Action:-

- Dr Loughran to have phone discussion with Mr Mark Fordham to get urgent professional opinion on appropriateness and safety of current practice. Mr Mackle will meet Mr Fordham next week (w/c 7 December 2009) and report to be ready for discussion

- Discuss outcomes at meeting to be arranged for 11 December 2009

- Depending on the outcome of the professional assessment, management actions may be required as follows:-

    - Commissioner to be informed if practice not safe
    - Letter to be issued to relevant consultants regarding requirement to change clinical practice, with clear indication of sanctions if this change were not to happen
    - Professional assessment of full cohort of patients (38)

2. Triage of Referrals
   Undertaken by 1 of the 3 consultants within required timescale. 1 consultant's triage is 3 weeks and he appears to refuse to change to meet current standard of 72 hours.

3. Red Flag Requirements for Cancer Patients
   1 consultant refuses to adopt the regional standard that all potential cancers require a red flag and are tracked separately. This results in patients with potential cancers not being clinically managed within agreed timescales.

4. Chronological Management of Lists for Theatre
   1 consultant keeps patients' details locked in the desk and refuses to make this available. Current breaches of up to 24 weeks which may or may not include urgent patients, while non-urgent vasectomies are booked for 2 weeks after listing.

Actions for Points 2, 3 & 4:-

- Written approach from Dr Gillian Rankin, Interim Director of Acute Services to consultants to require patient lists/details to be made available immediately, in order that all urgent patients can be booked (Debbie Burns to draft). Safe management of patients is a requirement in the consultants' contracts.
- If no compliance, further written correspondence to be drafted on issues of lack of conformance with triage and red flag requirements, clearly setting out the implications of referral to NCAS if appropriate clinical action not taken.

- Dr Loughran, Kieran Donaghy & Dr Rankin to agree relevant correspondence

2. Other Issues

- Dr Loughran to ensure circulation of recently adopted policies to all consultants (SPA, full job planning, WLI)
- Funding base and recruitment process for Clinical Fellows in Urology to be reviewed before proceeding to any further appointments

Corrigan, Martina

From: Young, Michael Mr <[redacted]>
Sent: 30 March 2010 17:34
To: Trouton, Heather; O'Brien, Aidan
Cc: Mackle, Mr E
Subject: RE: Triage

March 25th is my longest letter !!!!
MY

From: Trouton, Heather
Sent: 25 March 2010 17:14
To: Young, Michael Mr; O'Brien, Aidan
Cc: Mackle, Mr E
Subject: Triage

Michael and Aidan

I really appreciate that you both have been extremely busy in recent weeks and we are grateful for the effort that you have all put in to meet the access standards by the end of March.

However it has been brought to my attention that there are still 60 patient letters that urgently need to be triaged.

Can I request that you give this matter your urgent attention as there may be patient who require an urgent appointment.

Many thanks

Heather.

Stinson, Emma M

From: Rankin, Gillian <[redacted]t>
Sent: 09 September 2010 11:57
To: Stinson, Emma M
Subject: FW: Urology Referrals that are breaching
Attachments: image001.gif

Importance: High

From: Corrigan, Martina
Sent: Thursday, September 09, 2010 11:56:35 AM
To: Rankin, Gillian
Subject: FW: Urology Referrals that are breaching
Importance: High
Auto forwarded by a Rule

Dr Rankin,

As discussed earlier re: triage of Red Flags and the email I sent to Mr O'Brien.

Thanks

Martina

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

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Corrigan, Martina
Sent: 02 September 2010 10:58
To: McCorry, Monica
Subject: FW: Urology Referrals that are breaching
Importance: High

Hi Monica,

As discussed, can you check has Mr O'Brien triaged letters as listed below?

Can you let me know and if these have not been triaged can you highlight again to Aidan for me?

Many thanks

Urology Triage

Update Monday 4 April 2011

There were a total of 129 letters for triage from Mr O'Brien's office – longest date was 1 February 2011 and these were a mixture of GP and other Consultant referral letters.

On Friday 1 April - Mr Young triaged 14 letters to allow for patients to be sent for ICATS clinics week beginning 4 April.

On Friday 1 April – Mr Akhtar triaged 53 letters which included 3 red flags sent up from Mandeville. From these three 2 were downgraded.

9 were upgraded to red flag and these have been left with Mandeville for appointments at Mr Akhtar's additional clinics next week. Longest wait in this is 3 February.

13 patients to GPWSI (including 1 of the downgraded red flag)
1 patient to stone service
8 patients to LUTS
1 patient was for an urgent appointment at consultant clinic
18 patients for routine consultant clinic (including 1 of the downgraded patients)
2 need to be brought into the ward
1 needs to be discussed at MDT

There are 62 letters still to be triaged by Mr O'Brien –

30 dated February (longest wait is 1 February)
32 dated March (dated from 1 March onwards)

The above figures include internal referrals – consultant to consultant