c. The new to review ratio is taken as that recommended by the BAUS. The combination of these calculations determines the number of outpatient new and review clinics that are required to meet the overall outpatient demand. Recommended job planning templates as approved by the Urological Specialty advisor sets the number of outpatient clinics, new and review that a Urologist would be expected to do each week and that is calculated over 42 weeks (this allows for annual leave and study leave). To meet the overall demand, the next calculation is the number of Urology consultants that are required to totally deliver the number of outpatient clinics required to meet demand.

d. The same process is gone through, using BAUS guidelines for day case rates, numbers per list, numbers expected on inpatient surgical lists, expected numbers on diagnostic lists, etc. until the totality of demand is calculated and converted into the number of consultant / junior medical staff / nursing sessions which then is converted into the number of additional staff required.

e. This process included, anesthetist sessions, radiologist sessions, pathology sessions, etc., all converted into staff whole time equivalents or part thereof.

f. This is attached for further detail.

117. While the calculations were accurate according to BAUS guidelines, a whole patient service is more than a collection of mathematical calculations. We see people, electively and through an unscheduled hospital admission. The calculations also assume that every clinician works at the same speed whereas, in fact, clinicians are individuals and, as in every walk of life, they will work at different speeds. There are also many factors that can affect productivity: travel time to clinics, complexity in theatre cases, lack of bed availability for elective cases in times of increased unscheduled care demand, patient Can Not Attend and Did not Attend rates, junior doctor support as provided by the Northern Ireland Medical and Dental training agency, staff sick leave, and much more .

118. So with regard to whether the staffing levels funded by the HSCB were optimal from the beginning, my view would be that, on paper and as calculated,

they should have met demand. Practically, and taking into account human factors and the wider challenges with staffing and capacity within the health service, they were not optimal. My experience of the Health and Social Care Board is that they primarily worked within a funding envelope and Trusts were asked to accept what was available from a funding perspective and make the service fit. This was often challenging.

119. The other issue relevant was that the calculations were based on the demand for the service as it was in 2008/9. The commissioning letter was sent in April 2010, the Minister for Health endorsed the new model in March 2010, and the full service was not implemented until 2013. With a known 10% growth in service demand year on year, by the time the model was able to be implemented the demand outweighed the new agreed capacity.

[14] Are you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom. How have staffing challenges within the unit been responded to?

120. I am aware that there were ongoing staffing problems, primarily regarding medical staff and from the outset of the agreement to implement the new Team South structure. As noted in the June 2010 Team South Implementation Plan, page 4, there was at that time 1 Trust Grade Vacancy. *See attachment located in Section 21 2 of 2022, Team South Implementation plan V0 1.*

121. As per the IPT attached, the time line for implementation of the new model was as follows:- *located in Section 21 2 of 2022, 12 Urology Revenue IPT Feb 2012*

25. The funding allocated by the HSCB was based on a calculation of patient demand for Urology services in 2008/2009. It neither took into consideration the backlog of patients waiting for Urology services nor the known year on year growth in demand for Urology services which sat at approximately 10% growth in demand per year. A particular concern for the Trust at that time was the extent of the Urology review backlog and it was noted, referenced and an action plan attached to the Team South Implementation plan in 2010 located in Section 21 2 of 2022 All appendices- App2.

26. There were a number of concerns for the Trust throughout my time as Assistant Director for Surgery and Elective Care relating in general to waiting lists in all specialties across medicine and surgery which most definitely included Urology Services. At that time there was a strong focus on meeting the HSCB waiting time standards for outpatient assessment, day case, and Inpatient surgical procedures and, of course, the cancer 31 and 62 day pathway standards, all of which was completely appropriate. This was in conjunction with a high demand for unscheduled care services, with multiple Emergency Department trolley waits, as described at that time, with a strong focus on meeting the needs of unscheduled patients along with elective patients and keeping patients flowing appropriately through our hospitals.

27. With regard to the Urology service I had four primary concerns at that time (which are addressed in further detail in my response to Question 31).

First Concern re Urology

28. The first concern that was a constant for the first four and a half years of my term as AD SEC was the difficulty the service had in recruiting and retaining Consultant Urology Staff. From April 2014 there was a consistent body of 5 consultant Urologists but prior to that it was inconsistent. Primarily, there was a dearth regionally and across the UK in the availability of Consultant Urologists. This was not particularly unusual as many specialties also found it difficult to secure consultant staff (e.g., Radiology) but with a new extended service to implement, increasing demand for patient care and treatment and in particular the increasing number of red flag referrals coming into the Urology secondary

consultation, diagnosis, and treatment. The effect of gaps in medical staffing in the unit primarily resulted in the following:-

a. Longer waits for a new outpatient appointment;

b. Longer waits for a review appointment;

c. Longer waits for a urology diagnostic procedure;

d. Longer waits for a required day case procedure;

e. Longer waits for an inpatient surgical procedure;

f. Less than optimum availability of medical staff to see inpatients for ongoing treatment and care;

g. Medical rotas and on call rotas that may struggle to meet European Working Time Directive standards;

h. When there are gaps in medical staffing, and medical rotas are small in number, this is not conducive to attracting new medical staff. It is acknowledged that medical staff, both consultants and more junior staff, are more attracted to larger teams where the rota cover can be provided over a larger number of staff. Therefore, having a small team in itself is challenging to grow.

i. Having a small consultant team, often with vacancies, put additional pressure on present consultants and the whole team to provide the patient access that met the standard set by the HSCB.

j. Having a limited consultant capacity, with or without vacancies, to meet patient demand, with a lack of Urology Consultants available to recruit as was the case, creates a Trust dependency to retain employed consultants to meet patient access needs.

k. Less capacity within the team for managerial duties and service improvement.

this impacted on the unit and how these vacancies were managed and remedied.

130. With regard to the number of medical staff vacancies during that time, please see attached table *located in Section 21 2 0f 2022, Medical Staffing Urology 2009 – 2016* showing the start and end dates of consultant staff over this period. However in essence, there were varying vacancies in the 5 consultant model until August 2015, at which point the consultant workforce stabilized.

131. My views on the impact on the Unit of medical vacancies is noted in my response to Question 16 below.

132. How the vacancies were managed and remedied has already been noted in my response to Question 14 above.

[16] In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

133. All services in Health and Social Care are completely reliant on the availability of clinical staff to assess, diagnose, and treat patients appropriately. This is supported by a raft of disciplines to support the provision of the entire service.

134. With regard to patient access times for outpatient new and review appointments, day case procedures, diagnostic procedures, inpatient surgical procedures, and inpatient management, the requisite number of medical staff are essential.

135. Primarily consultant Urologists but also other senior medical staff (Registrars, staff grades, and Trust Grade doctors) are responsible for patient

care service, not having the required number of clinical staff to see and treat patients was a concern. This was compounded by no funding within the new service model for middle grade support staff, nor any increase in Urology training staff by the Northern Ireland Medical and Dental Training Agency. It is widely recognized that an effective medical team is made up of a number of doctors, supporting the service at different levels, across the 24/7 period. This was challenging for the Urology service. There was active recruitment throughout this period but retaining consultant staff was at times equally difficult in a service with a relatively small team and significant service demands.

29. While the Urology Unit was made up of a number of professionals, teams, support staff and services, the core of any service is the Consultant team. Without the requisite number of staff at that level, meeting patient demand is very challenging. Enhanced nursing roles were of course developed and effective but they were limited on addressing the overall capacity deficit.

30. Please see my response to Question 31, part 1 for further detail regarding the concerns on medical staffing, actions taken to address it, the impact of the concern on patient care and safety and how we monitored all actions taken.

Second Concern re Urology

31. My second concern during that period was the long patient access times and the large volume of patients waiting for secondary care Urology Services. As already stated demand for Urology services was already larger than the three consultant service could meet. In-Trust demand was rising year on year and the additional population of the lower part of the Western Trust was added in the new regional model and, while funding was supplied in 2012 for the additional staff to meet this demand, waiting times had grown in the interim period and, as noted in this statement, securing staff was difficult.

32. As appropriate, those patients referred by GP colleagues to the service who met the criteria for red flag designation were given priority access to the service. This was important as the diagnosis could have been life threatening and early diagnosis meant early treatment and care. However, as the number of red flag

referrals grew, they had to displace those referrals categorized as either urgent or routine. In essence, the waiting time for those categories continued to grow. This was a concern.

33. At this time there were often opportunities for services to avail of additional waiting list funding, both for outpatient activity and theatre activity. The Urology team would have availed of this opportunity to see and treat patients as their availability allowed. This was paid as additional to the consultant staff at an enhanced rate and was voluntary.

34. These sessions did go some way to reducing patient waits, however capacity was often limited, not only by the limits of consultant availability but limits on the availability of the supporting services. As the Inquiry will appreciate, all surgical specialties were trying to secure the same theatre capacity for their additional waiting lists and theatre capacity was limited. Outpatient additionality was somewhat easier as additional clinics would have happened in the out of hours period, however they depended on securing nursing and support staff to run the additional clinics. This was often difficult to secure.

35. Throughout this period a huge focus of the Head of Urology and ENT and the Operational Support Lead for the Division was on all aspects of waiting list management. The Director of Acute Services held weekly meetings with all Heads of Service to monitor waiting times across all specialties and all access points with often focus on specific patient pathways.

36. There were also monthly senior management team meetings at Director and Assistant Director level where senior staff from the Directorate of Performance and Planning would have attended to report on waiting list data and, from an independent perspective, to challenge and support the delivery of services.

37. While I was not a member of the Trust Senior Management Team, nor Trust Board, at that time, it was my understanding that performance data in its entirety was tabled at these senior meetings.

38. There were monthly meetings held in Linen Hall Street Belfast, the offices of the Health and Social Care Board, with each Trust, collectively and individually to go

through all waiting time and cancer pathway data. This data was extracted directly by the HSCB from Trust data systems. Trusts were held to account at these meetings for their performance and areas of concern were escalated to the HSCB by Trusts regularly.

39. The concerns relating to Urology waiting times, new and review outpatient waits, day case and inpatient surgery waits, and the cancer 31 and 62 day pathways were regularly escalated to the HSCB at these meetings and throughout the course of my tenure as Assistant Director.

40. As well as managing the waiting times through additionality, ensuring outpatient clinics and theatre lists were filled appropriately and so forth, there were also continual efforts to improve the patient pathway and, in that way, try to reduce patient waits. Please see paper attached that shows the vision for Urology services in 2014located in Relevant to PIT, Ref 77, Evidence added or renamed 19 01 2022, Evidence No 77, No 77, Heather Trouton amended emails with attachments, 20170915 Email Urology Board Paper V2 1st Sept and 20170915 Email Urology Board Paper V2 1st Sept A. A new Urology Outpatients and diagnostic centre was opened in 2013/4 which enabled a one-stop assessment, diagnostic and diagnosis pathway to be implemented for Red flag and urgent patients. This process commenced in January 2015. The Consultant staff worked with GP colleagues to try to agree patient pathways across primary and secondary care to improve access to appropriate care and monitoring for patients and our specialist Nurses were supported and mentored to train in cystoscopy and Trus biopsy, again to support as a multidisciplinary team good access to diagnosis and treatment.

41. Please see the answer to Question 31, section 2 for further detail on this concern, actions taken to address it, the impact of the concern on patient care and safety, and how we monitored all actions taken.

Third Concern re Urology

42. The third concern was regarding the amount and extent of the Urology review backlog. While patients had been seen initially by a consultant / senior doctor,

and an assessment made, diagnostics requested or a treatment plan commenced, with the lack of ability to offer patients a consultant review in the timescale specified by the consultant, we were unable to offer follow up / treatment review and assess development of symptoms as would have been required. The review backlog was already established when I took up post. General demand for services was increasing year on year. With the regional drive to meet the access standards for new outpatient appointments, specifically those designated as red flag, with no regional standard for review appointments and the funding of additional waiting list clinics without commensurate additional funding for the follow up review appointments, it was extremely difficult to catch up on the review backlog demand. There was a Trust plan in place to address the concern and a number of actions to address both the backlog and review practice at source to minimize the review demand, however while it was actively managed, we were not able to eradicate it completely, certainly with the clinical resource available at that time. Please see my response to section 3 of Question 31 below for further detail on actions taken to address this concern, the impact of the concern on patient care and safety, and how we monitored all actions taken.

Fourth Concern re Urology

43. The fourth concern during the 2009 to 2016 period was ensuring that all patients who were referred from a GP or by another secondary care consultant and designated as red flag were seen urgently, had the appropriate diagnostic tests completed, appropriate diagnosis made, and (if cancer was diagnosed) accessed their first definitive treatment in line with the 31 and 62 day cancer pathway standards.

44. Due to the staffing concerns noted earlier in the statement and the overall increasing demand for the service, meeting these standards was a continual challenge for every patient .As the whole cancer pathway involved other disciplines, the availability of diagnostic tests in the general Radiology department, the availability of consultant radiologists to report on the test result, timely pathology support in Trust and oncology support as an outreach service from Belfast and on occasion transfer to Belfast for treatment, lack of capacity / delay at any point in the cancer pathway could have had a detrimental effect on

a. Datix reporting and review of clinical incidents registered,
b. Screening serious adverse incidents for a serious adverse incident investigation,
c. Complaints review,
d. Patient feedback,
e. Audit,
f. Implementation of nursing quality indicators,
g. Good recruitment standards,
h. Continual Education and Training,
i. Monitoring workforce data,
j. Monitoring medical appraisal compliance and Personal development plans and clinical supervision for other professions,
k. Reviewing national and regional published standards and guidelines and ensuring implementation of same were possible,
l. Reviewing risks to service delivery and patient safety,
m. Reviewing national safety alerts and reports,
n. Clinical Benchmarking from the Comparative Health Knowledge System (CHKS),
o. Process for Escalation of concerns that could not be addressed at certain level,
p. The promotion of the Trust Whistleblowing policy encouraging staff to escalate concerns at any level, involving any member of staff or process if it was deemed to have an adverse impact on patients or other members of staff,
q. Implementation of RQIA recommendations following Inspections,
r. Ensuring Information governance processes to maintain patient confidentiality were in place and utilized appropriately,
s. Ensuring staff were aware of and managing child and adult safeguarding concerns by reporting through designated teams,
t. Having a culture of continuous improvement and in latter years using Quality Improvement methodologies,
u. Seeking digital solutions to support effective and efficient clinical practice, e.g., Digital Dictation, Computers on wheels, etc.,

• 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.

173. *Please see relevant job descriptions as attached located in Section 21 No.2 of 2022, –Consultant Urologist JD, Clinical Director Surgery and Elective Care, see attachment General Surgery CD JD- Mr Brown, Associate Medical Director Surgery and Elective Care, see attachment Associate Medical Director JD, Assistant Director Surgery and Elective Care see attachment 1-AD of Surgery and Elective Care band 8C, as these will be helpful is establishing roles and responsibilities regarding the consultants and clinicians in the Unit, including matters of clinical governance.*

174. As per Urology consultant job description, '*The Chief Executive has overall responsibility for Acute Services within the Southern health and Social Care Trust. The consultant will have accountability to the Chief Executive, through the Director of Acute Services, the Associate Medical Director and the Lead Consultant for the appropriate and smooth delivery of the service.' Page 12*

[22] Who oversaw the clinical governance arrangements of the unit and how was this done? How did you assure yourself that this was being done appropriately?

175. The clinical governance arrangements for all medical and surgical specialties, including Urology, were made up of a number of systems and processes designed to ensure good governance and safe and effective care.

176. The range of systems and processes used to ensure, review, monitor, learn and improve patient safety and care were as follows;-

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

52. The Director of Acute Services held two monthly governance meetings. One was with the Assistant Directors of Acute Services and was attended by the Governance lead, clinical audit lead, and standards and guidelines officer, who presented data and updates on progress with the implementation of guidelines, clinical audit data, and other governance information on complaints, compliments, adverse incidents, and the progress of ongoing serious adverse incident investigations. The second monthly meeting was held with the Acute Associate Medical Directors and the Assistant Directors. This meeting also discussed governance information but was particularly focused on learning from serious adverse incident investigations.

53. As Assistant Director for a number of surgical specialties, covering somewhere in the remit of 34 surgical consultants (the number varying over the years as services expanded), the management team – both operational and medical -was familiar with various concerns being raised at various times about various consultants across a number of teams. Such concerns were typically raised, discussed, and addressed. However, what was different in the case of Mr O'Brien was the ongoing challenge to address practices which, despite discussion at all levels within the organization and over a period of years, Mr O'Brien was either unwilling or unable to address consistently. However, it must be also noted that, throughout this period, Mr O'Brien did acknowledge and address some of the concerns. Some were addressed on a permanent basis and others intermittently.

54. Regarding concerns on Mr O'Brien's practice, the following (which are addressed in more detail below) were recurrent problems: (with the exception of that at paragraph e. below, management of inpatient Intravenous Antibiotics).

    a. From the beginning of my time in post October 2009 I was made aware of the extent of Mr O'Brien's review backlog.

    b. From the same time I was also made aware of the delays in Mr O'Brien returning completed consultant triage to the booking centre to enable them to book patients for appointment.

472. I believe Mr O'Brien should have been held to account for his clinical triaging practice by his Clinical Lead, Clinical Director, AMD, Director of Acute Services, and ultimately the Medical Director for patient safety. It was impossible to manage a consultant's practice outside of that medical Management structure.

[42] What support was provided by you and the Trust to Mr O'Brien given the concerns identified by him and others?

473. There were 2 issues identified by Mr O'Brien in relation to the concerns detailed above.

a. Time for triage.
b. His review backlog.

474. To the best of my knowledge he did not raise issues regarding patient notes at home.

475. In respect of triage, it was normal and accepted consultant practice that new GP referrals would be triaged by a consultant. It was accepted practice in all teams that this would be shared equally among each member of the consultant team on a rota basis.

476. To assist Mr O'Brien with this process, the following steps were taken:-

a. Only his own named referrals were sent to him for triage. These would have been the minority of new referrals as GPs were encouraged not to send named referrals.
b. On occasion he was totally relieved of triage by his consultant colleagues.
c. Mr O'Brien was encouraged to fully utilise the functions of his secretary, including theatre list management, to free up time for triage.
d. He was offered additional admin support by Mrs D Burns Director of Acute Services but, to the best of my knowledge, did not take up the offer.

documents. Please see attached for clarity, Final Report of the Stage 1 Grievance Mr A O'Brien O'Hare, Grievance Response Report Diamond and Young, and The report of Maintaining High Professional Standards Formal Investigation Case manager Determination Dr Khan report. *Attachments located at Section 21 2 of 2022, dr khan report, Grievance Response Report Diamond and Young.*

484. While they conclude that the practice of Mr O'Brien was not appropriate, they also raise the issue of "missed opportunities by managers to effectively and fully assess and address the deficiencies in practice of Mr O'Brien" and conclude that no one formally assessed the extent of the issues or properly identified the risk to patients". While I cannot comment from an informed position on the effectiveness of measures put in place post March 2016, I can conclude that, on reflection, there were missed opportunities by me and those operational and clinical managers that worked with me and to whom I reported during my tenure as Assistant Director from October 2009 to March 2016. I sincerely tried to ensure patient safety through all of my actions at that time as detailed in this statement, however I now know that I should have done more to better manage and monitor the triage process to ensure that no referral went untriaged and unreturned in the expected timeframe. I should not have relied on the clinical assurances given to me regarding Mr O'Brien's clinical excellence, but undertook a more robust objective investigation process. I sincerely regret that more was not done at the time. As my experience has developed, particularly in the last 4 years in a corporate role, I have learned and have grown in confidence and ability in speaking up against accepted practices which are not conducive to the best in quality care provision.

485. I am aware of a Review of Administration Process in Acute Services which was a recommendation of the Report of Dr Khan Maintaining High Professional Standards Formal Investigation, was completed on 10th May 2021. *Please see attached document Admin Review Process Nov 2021 1 - 6 located in Section 21 2 of 2022.*

staff required, to deliver the needs of our population. It was a service under pressure and that pressure included all members of the team including admin and management.

f. Knowing the clinical issues that we now know and, on reflection, I believe there was an over-reliance of trust in Mr O'Brien to manage patients clinically safely. While there was an acknowledgement at all levels of his different ways of managing administratively, there were no concerns raised regarding his clinical ability and therefore his admin management, although it differed from all his colleagues, was tolerated.

g. I believe that, while the patient safety concerns were identified relating to the deficiencies in admin management, the team were required to try to work around those deficiencies rather than have the support to require Mr O'Brien to address them effectively. On reflection, and while that was the culture of Acute Services during my tenure as Assistant Director, I take responsibility for not doing more to fully investigate and report on the effects of Mr O'Brien's administrative practice and ensure that action was taken to preserve the quality and safety of patient care in all its parts.

h. I also reflect that there was, potentially, an over reliance at the time on patient feedback. It was widely considered that, if you got access to the care of Mr O'Brien, then patient feedback indicated a super patient-centred service. The fact that Mr O'Brien phoned you himself to arrange your date for surgery was much appreciated by his patients. Patients reported him as attentive and considerate.

i. IT systems were not as well developed at this time, with most reliance still being on paper-based recording.

487. In conclusion and on reflection, I believe that Mr O'Brien was able to practice independently and not adhere to accepted systems and processes as he saw fit, primarily due to his status within the department and the Trust. Knowing what we know now, there could have been more independent audit into the practice of all consultants, checking the effectiveness of all patient pathways, reviewing patient outcomes, patient experience, and patient safety. However,

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

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

New Gastroenterologist = 2
DHH " = 1 + 1
Nurse Endoscopists = 6 - Backfill
Staff Grade = 3.

Nurse End 48k
Staff Grade 71k.
119 k.

Leaves 138k.

11½ sessions over 42 wks.
includes Backfill

Urology

? Include Robin in data analysis.

Audit - what is actually happening.
Get Data on Tuc delay-- volumes
- How many of those referrals went red flags.
- How long has this delayed their pathway by.

↓
asap
↓
We bnet Eamon on data.
↓
Eamon meets Aidan
↓
Two resolving
↓
Dr Loughran. / Joy

Bnet Paula Clarke.
↓
P + R audit lead support.

- Not reassessed
- Triage Too long

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

Thanks

Martina

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

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

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Martina,
I really am so sorry that I have fallen so behind in triaging.
However, whilst on leave, I have arranged all outstanding letters of referral in chronological order, so that I can passed them to CAO via Monica in that order, beginning tomorrow.
I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me!
I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion,

Aidan

From: Corrigan, Martina
Sent: 24 November 2013 17:28
To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Importance: High

Dear Aidan,

Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and I know that this will need to be escalated early this week if not resolved.

I would be grateful for your action/update

Thanks

Martina

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

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

467. At a consultant's meeting on 18 July 2013, it was recorded that "*The current triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar system to that used in Wolverhampton and Guys hospital which we will take forward with our IT and booking centre colleagues"* [AOB-06748]. This demonstrates that others had concerns in relation to the triage system at that time, yet the Trust failed to address and change the system.

468. On 8 October 2013 Ms Trouton noted the serious delay in triage at that stage, whilst understanding the pressures within urology [AOB-06960 – AOB-06962]. I made the Trust aware in an email of 26 November 2013 that I was sorry I was behind in triage and had arranged to catch up on it during leave [TRU-01666-TRU-01672]. Surely the response to that should have been to provide adequate time to carry out the tasks within my job plan, rather than simply raise the issue, know the cause was overwork, yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave.

469. In early 2014 temporary measures to relieve me of triage commenced [AOB-00611] as Mr Young had agreed to help out at that time [AOB-00646]. That, however, was not only temporary but failed to address the underlying cause, which was progressively exacerbated by the additional burden of my roles with NICaN and with the Trust's Urology MDT and MDM at that time.

470. I was not the only consultant who struggled with the demands of triage whilst on call [see email 13 March 2014 AOB-70484 - AOB-70485].

471. I highlighted a number of issues in relation to red flag triage to colleagues on 16 March 2014 [see AOB-70487 - AOB-70488].

472. In March 2014 I again referred to pressure of work in the context of the referring to the triage backlog [see AOB-70605 - AOB-70606].

Corrigan, Martina

From: Burns, Deborah <[redacted]>
Sent: 21 February 2014 19:13
To: Mackle, Eamon; Young, Michael; Corrigan, Martina
Subject: Yesterday

I had a very helpful meeting with Mr O'Brien yesterday (Martina also attended). Mr O'Brien has agreed to not triage new referrals (with exception of those named to himself). He is also to think about if any additional admin support would assist him.

Michael I know this may place an additional burden on the rest of the team but appreciate you accommodating

Thanks for your help with this situation D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

Willis, Lisa

From: Trouton, Heather
Sent: 04 December 2013 18:40
To: Young, Michael; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Michael

I certainly didn't expect it to be sorted within a few days , and to be honest was surprised to be advised that triage was being taken over as I agree it is not fair to ask the other three surgeons to bear this workload. Robin and I had discussed just yesterday and were planning to meet with Aidan next week to fully discuss this issue. I'm sorry that I was given not totally correct information.

Thankyou for helping with the backlog. Happy to discuss further next week to try to come up with a sustainable solution.

Heather

From: Young, Michael
Sent: 03 December 2013 18:57
To: Trouton, Heather; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Not sure if the messages have transposed well
Also not sure 'if it is unlikely that Aidan will change' is correct. I do agree however with the chart issue.
I have offered to help out to get the backlog sorted. This should not have been interpreted as a complete take over of the triage. I do not think it acceptable to ask the other consultants to take up this task – this has not been talked about / discussed etc, yet decisions are being made. I do not find this acceptable. You have expected this issue to have been completely sorted within a matter of a few days. I said I would help sort this out and am doing so.

MY

From: Trouton, Heather
Sent: 03 December 2013 17:28
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

Michael, thank you for speaking with Aidan again.

Robin and I had a conversation about this this morning and the only solution we see if it is unlikely that Aidan will change practice is for triage to no longer go to him. I appreciate this will put an increased burden on yourself, Tony and Mr Surresh but it is just too critical to leave as it is.

I believe you have already agreed to do this for the general triage (Martina informs me) which is great and much appreciated.

Willis, Lisa

From: Carroll, Anita
Sent: 02 May 2014 16:52
To: Trouton, Heather
Subject: FW: Missing Triage

Follow Up Flag: Follow up
Flag Status: Flagged

Don't panic as you know we are going with gp triage anyway

From: Robinson, Katherine
Sent: 02 May 2014 16:19
To: Browne, Leanne; Carroll, Anita
Cc: Rankin, Christine
Subject: RE: Missing Triage

As you can see these have all been chased several times. Due to the lengthy target now these patients are not due appts yet. When they are we are going to be booking without triage result.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by USI
e: Personal Information redacted by USI

From: Browne, Leanne
Sent: 02 May 2014 16:11
To: Carroll, Anita
Cc: Robinson, Katherine; Rankin, Christine
Subject: Missing Triage

Hi Anita

Can you arrange for the following Urology referrals to be returned from triage as soon as possible please

Hosp

CHI Number

Casenote

Forenames

Surname

Age

Telephone

Telephone Work

Patient Notes

65. With regard to the concern of Mr O'Brien taking patient notes to his own home and retaining them there for long periods, this was a concern from a number of perspectives. In the first instance, patient notes contain personal and private information. From the perspective of information governance, all patient notes should be secure. Holding notes at home therefore was an information governance risk .Secondly, when a patient attends our emergency departments, access to patient notes are required to assist accurate clinical assessment. Not to have patient notes available in the hospital for this purpose was a risk to patient safety. It is important to say that, since the introduction of electronic methods of medical recording as in the Northern Ireland Electronic Care Record, this particular concern is now not so important from this perspective, but that was not the case before the introduction of NIECR. Finally, patients attend many different services and specialties in the Trust. The Medical Records department prepared for outpatient clinics by ensuring that all patients' notes were available for the medical team at each clinic. On a number of occasions, they would not be able to find patient notes as they were at Mr O'Brien's home. Again, not only was this frustrating for the clinical team attempting to see a patient without notes but again had a direct impact on patient safety and care. However, the NIECR system has assisted in this regard.

66. Mr O'Brien did return notes on request, and we had no way of knowing how many charts were in his home. However, despite many conversations regarding the need to keep patient notes on the hospital premises or return them immediately if it was necessary to take them home, concerns were still raised periodically by the medical records team. (This issue is also addressed in my response to Questions 24, 34, 35, 37, and 39-41 below)

No Record of Care, Treatment, or Diagnosis

67. In 2015 a new concern emerged with regard to the practice of Mr O'Brien. By that time the additional consultants had started as members of the urology team. They had experience working in England and were working both to develop the Urology service and assist in reducing the waiting times for patients and in

Willis, Lisa

From: Corrigan, Martina
Sent: 08 October 2013 09:52
To: Trouton, Heather
Cc: Carroll, Anita
Subject: RE: UPDATE ON CHART WITH AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Heather

Best time is probably is a Thursday between xray meeting over at 9:30ish and grand ward round at 10ish, or else on a Friday in Thorndale, between patients.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Trouton, Heather
Sent: 08 October 2013 08:28
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: UPDATE ON CHART WITH AOB

Martina

I need to talk to Aidan re this when would be the best time?

heather

From: Carroll, Anita
Sent: 07 October 2013 10:58
To: Trouton, Heather
Subject: FW: UPDATE ON CHART WITH AOB

Sorry to keep going on re this but is there anything Eamon could do to assist ?
A

From: Forde, Helen
Sent: 04 October 2013 14:24
To: Carroll, Anita
Subject: FW: UPDATE ON CHART WITH AOB

Here's an example of the extra work that is associated with Mr O'Brien having charts at home.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by USI
Personal Information redacted by USI

From: Lawson, Pamela
Sent: 04 October 2013 14:12
To: Forde, Helen
Subject: FW: UPDATE ON CHART WITH AOB

fyi

From: Mills, Barbara
Sent: 24 September 2013 11:18
To: Lawson, Pamela
Subject: UPDATE ON CHART WITH AOB

Personal Information redacted by USI - AOB due to return from Wales to-morrow and Monica will text him in am. He is off all week but will hopefully bring in this chart in am. Patients apt. to-morrow 15:15 hrs.

-----Original Message-----
From: Carroll, Anita [redacted]
Sent: 11 August 2014 09:12
To: Trouton, Heather <[redacted]>; Gibson, Simon <[redacted]>
Cc: Lappin, Aideen <[redacted]>; Burns, Deborah <[redacted]>; Stinson, Emma M <[redacted]>
Subject: RE: New complaint - [redacted]

Yes we have a temporary file and all tracking of it is recorded as “pages and labels” so we know that the chart wasn’t there – and then when the actual chart comes back the “pages and labels” are interfiled to have all documentation in the one place.

From: Trouton, Heather
Sent: 07 August 2014 17:22
To: Carroll, Anita; Gibson, Simon
Cc: Lappin, Aideen; Burns, Deborah; Stinson, Emma M
Subject: RE: New complaint - [redacted]

Anita

What chart did Mr Young and all the other appointments use if his chart was at Mr O’Briens home since 2011 heather

From: Carroll, Anita
Sent: 06 August 2014 14:50
To: Gibson, Simon; Trouton, Heather
Cc: Lappin, Aideen; Burns, Deborah; Stinson, Emma M
Subject: RE: New complaint - [redacted]

Heather and Simon
I will be responding to this complaint however I think it is useful to share information I have received from Helen Forde regarding this.

Helen has advised [redacted] attended Mr O’Brien on 11 October 2011 and was put on the WL – he was then cancelled from Mr O’Brien’s WL on 28 Jan 2012. In the interim this patient has attended Mr Young and is back on Mr Young’s Waiting List. He has also attended several other clinics. So between [redacted] being cancelled from Mr O’Brien’s list and now, [redacted] has attended several other areas.

One of the Health Records members was doing another search and asked Mr O’Brien as [redacted] had attended him 3 years ago and he was able to confirm that he chart was at his home and he would bring it in the following day.

As a result of this Health Records staff have spent several hours looking for this chart, and a patient and their relative have felt concerned enough to write in a complaint to Mr Poots and Mairead McAlinden about Health Records inability to provide a chart.

I have raised issues like this before and I am not sure what we can do but this looks like health records have been careless with a chart when this is not the case Anita

From: Truesdale, Pamela
Sent: 04 August 2014 16:39
To: Carroll, Anita; Gibson, Simon
Cc: Lappin, Aideen; Conlon, Noeleen; Kerr, Vivienne
Subject: New complaint - Personal Information redacted by USI

Anita & Simon

Please see attached new complaint for advice and risk rating.

Thanks
Pamela

Pamela Truesdale
Governance Office, Acute Services
The Maples
Craigavon Area Hospital
68 Lurgan Road
Craigavon
BT63 5QQ

Tel Personal Information redacted by USI

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:	20th June 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 Young 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 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: Personal Information redacted by USI Telephone: Personal Information redacted by USI

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 Ms Sloan and Dr Damani/Raj.
   - All patients 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 Young 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 and be a reasonable time allocation for the more complex patients.

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

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

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,

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: Personal Information redacted by 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: Personal Information redacted by USI Personal Information redacted by 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)

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.

From: Rankin, Gillian <[redacted]>
Sent: 30 December 2011 16:23
To: Stinson, Emma M
Subject: FW: review of investigations processes
Attachments: PROCESS USED FOR DEALING WITH RESULTS.docx

From: Trouton, Heather
Sent: Friday, December 30, 2011 4:22:30 PM
To: Marshall, Margaret
Cc: Burns, Deborah; Rankin, Gillian
Subject: review of investigations processes Auto forwarded by a Rule

Margaret

With reference to the letter from Diane Corrigan asking the process by which we ensure that all investigation results are reviewed as soon as they become available and the letter responding which was sent by Debbie indicating that we were looking at same in light of PACS, Ordercoms etc, I undertook to scope the process currently in place by all secretaries for all specialities.

Please see attached the responses received so far. I am still waiting on MUSC but Phylis has assured me they will be with us soon.

Could you and I get together at some point to go through the various processes (after MUSC's come in) and get a sense of if there is a problem or are we well sorted from a governance perspective.?

I think both Debbie and Dr Rankin wanted us to work on this together.

Are you ok with this approach?

Heather

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

Mackle, MR E

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

Personal Information redacted by USI

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

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

394. The systems and agreements were successful to an extent, in that the patient's diagnosis journey was closely tracked and patients were prioritised for access to assessment and diagnostics. However, due to a lack of sufficient capacity within the Urology team, radiology, and oncology, it was not possible to completely rectify the situation and totally prevent pathway breaches. It is my understanding that the problem remains today but the current Urology team would have the specific data and be better able to address the current position.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

395. The primary metric used was the number of patients that breached the 31 or 62 day pathway standard. The aim was to have no patients breach the standard.

(i) Is it your view that the extent of the issues within urology services and the deficiencies in practice were:

(a) Properly identified

396. I think the issues relating to the patient journey up to diagnosis and first definitive treatment were identified with a focus on early diagnosis, MDM discussion on clinical management, and decision on treatment.

397. However, knowing what we know now regarding the practice, on occasions, of Mr O'Brien not referring patients on for treatment post-diagnosis nor referring patients with a cancer diagnosis to the specialist cancer nurse for support and follow up, I would have to say that the extent of the issues in this regard were not properly identified at that time. Again, it was expected that the consultant would have accessed all relevant support for their patients and

SECTION 3: PATIENT EXPERIENCE

3.1 Key Worker (14-2G-113)

The identification of the Key Worker(s) will be the responsibility of the designated MDT Core Nurse member.

It is the joint responsibility of the MDT Clinical Lead and of the MDT Core Nurse Member to ensure that each Urology cancer patient has an identified Key Worker and that this is documented in the agreed Record of Patient Management. In the majority of cases, the Key Worker will be a Urology Clinical Nurse Specialist (Band 7) or Practitioner (Band 6). It is the intent that all Key Workers will have attended the Advanced Communications Skills Course.

Patients and families should be informed of the role of the Key Worker. Contact details are given with written information, and in the Record of Patient Management.

As patients progress along the care pathway, the Key Worker may change. Where possible, these changes should be kept to a minimum. It is the responsibility of the Key Worker to identify the most appropriate healthcare professional to be the patient's next Key Worker. Any changes should be negotiated with the patient and carer prior to implementation, and a clear handover provided to the next Key Worker.

Urology Clinical Nurse Specialists and Practitioners should be present or available at all patient consultations where the patient is informed of a diagnosis of cancer, and should be available for the patient to have a further period of discussion and support following consultation with the clinician, if required or requested. They may also be present, and should be available, when patients attend for further consultations along their pathway.

Key responsibilities of the Key Worker:

- Act as the main contact person for the patient and carer at a specific point in the pathway
- Should be present when the cancer diagnosis is discussed and any other key points in the patients journey
- Offer support, advice and provide information for the patient and their carers, referring to Macmillan Information and Support Service as appropriate to enable access to services
- Ensure continuity of care along the patients pathway and that all relevant plans are communicated to all members of the MDT involved in the patients care
- Ensure that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patients care

relevant to PIT, Evidence after 4 November 2021 PIT. Reference 77, Reference 77 – Heather Trouton document Sept 2009 notebook.

412. I believe that I can take from the note the following: it referred to delays in referral triage, with a medical audit on the volumes involved requested. Mr Brown (CD) was to be involved in the data analysis, a report to Mr Mackle AMD of the data outcome was to be made, with a plan for Mr Mackle to meet to address with Mr O'Brien (as this was a clinical practice issue), with a further plan to escalate to the Director (Mrs Joy Youart) and Medical Director (Dr Patrick Loughran) if the issue could not be successfully resolved.

413. I am afraid I cannot see a note of the outcome of this particular planned approach nor can I recall the outcome.

414. The primary concerns regarding Mr O'Brien that were brought to my attention were as follows. These particular concerns came to my attention when I took up post as Assistant Director for Surgery and Elective Care.

a. Taking patient notes home and not returning them in a timely fashion.
b. Not returning patient referrals following consultant triage in the required timeframe.
c. Large number of patients awaiting his review.
d. Proactive prescription of IV antibiotics for management of Urinary Tract Infection.

415. There were other more singular issues brought to my attention over the period September 2009 to March 2016 but those noted above were recurrent concerns. The 4th concern was resolved, the first 2 concerns resolved intermittently but recurred, and the 3rd concern did not resolve, primarily due to general capacity issues.

416. Singular issues noted included the following:-

a. Not referring patients for pre-operative assessment in a timely fashion or at all. This was brought to my attention in November 2015 for the first time .Please see email denoting issue with pre op assessment. *I refer you to document DSU list 05.11.2015 email Urology DSU List located in Relevant to PIT, Evidence after 4th November PIT, Reference 77, Reference 77 – Heather Trouton.*

b. Periodic concerns regarding listing patients he had seen privately as outpatients but referring to NHS for surgical treatment and listing these patients in a short timeframe. When noted and asked re short waiting time for surgery, Mr O'Brien would always have had clinical justification for the short wait. This concern arose at various times throughout my tenure as AD.

c. Towards the end of my tenure as AD for Surgery and Elective Care, in 2015, a new concern was raised to me and Mr Mackle by the Head of Urology and ENT as to Mr O'Brien not recording patient outcomes on the electronic patient centre administration system or often in patient notes. This issue came to light with the expansion of the Urology team. The new consultants were undertaking a review of Mr O'Brien's patients in the review backlog as one of the measures introduced to reduce same. As they were relatively new consultants they had not at that point generated a review backlog of their own. While reviewing the patients, they noticed they could not find any record of the outcome of the last review by Mr O'Brien on the patient centre record and escalated same to Mrs Corrigan. This was in turn escalated through medical management lines.

417. I do not know how long these particular concerns were known about prior me taking up post but I am aware that while Mr O'Brien was a highly esteemed Urologist and it was known he had his own way of managing patients from an administrative perspective.

418. It is important to note that, throughout my time as Assistant Director for Surgery and Elective Care, while there were concerns regarding Mr O'Brien's

Willis, Lisa

From: Trouton, Heather
Sent: 02 November 2015 15:33
To: Corrigan, Martina; Mackle, Eamon
Subject: FW: UROLOGY DSU LIST 03/11/15
Attachments: MR O'BRIEN IN PATIENT THEATRE LIST 04/11/15.eml

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dear martina

Have you the lists for this week?

Heather

From: McGeough, Mary
Sent: 02 November 2015 13:51
To: Donnelly, Rachel; Kelly, Brigeen; Corrigan, Martina
Cc: Trouton, Heather; Carroll, Ronan
Subject: RE: UROLOGY DSU LIST 03/11/15
Importance: High

Martina

Please see email below regarding Mr O'Brien's patients for his day surgery list tomorrow. As you will see 3 out of the 5 patients have not been to pre-op. Could you please investigate and advise why these patients were never sent to pre-op as to get this level of notification of their surgery is as I am sure you will agree unacceptable. We are now in a position where we are unable to get these 3 patients pre-assessed due to the extremely tight timeframe before their surgery. I have also attached a second email from Rachel with regard to Mr O'Brien's inpatient list on 4th November and again there are a couple of patients on this list who have not been to pre-op. Have all of these patients been seen somewhere other than at his outpatient clinic? If yes then a system will need to be put in place ASAP in order to ensure that these patients are pre-assessed well in advance of their surgery being scheduled.

Happy to discuss

Mary

Mary McGeough
Head of Anaesthetics, Theatres and ICU
Craigavon area Hospital
Tel: Personal Information redacted by USI

From: Donnelly, Rachel
Sent: 02 November 2015 12:42
To: Kelly, Brigeen; McGeough, Mary
Subject: UROLOGY DSU LIST 03/11/15

Dear Brigeen and Mary

Linda came to me this morning with the attached list – Mr O'Brien DSU AM list for 03/11/15.

The list was sent to her on Friday PM.
Out of the 5 patients – 3 have not been pre-op'd.
These 3 patient are all urgent added to the WL 9th and 12th October 2015.
They were all pre-admitted on Wednesday 28th October 2015.

I have not been able to contact:
Personal Information redacted by USI - phoned at 1135hrs unable to leave a message Personal Information redacted by USI – phoned 1140hrs, message left to call me on mobile voice mail.
At this late stage on the day before surgery these 2 ladies will not be pre-op'd.

I have made telephone contact with Personal Information redacted by USI. I completed her HSQ over the phone, but she needs an ECG (due to her age and h/o murmur some years ago) and FBC and U&E. Personal Information redacted by USI is unable to attend today to have these investigations carried out. Personal Information redacted by USI did confirm to me that she seen Mr O'Brien privately at his house on 10/10/15.

I will let Ursula know about these 3 patients.
Please would you advise what I should do next regarding these patients?

Many thanks

Regards

Rachel

Rachel Donnelly
Pre-operative Assessment Manager
Main Out Patient Department
Craigavon Area Hospital
Ext Personal Information redacted by USI

Tel: Personal Information redacted by USI

Tracking Code: Personal Information redacted by USI

From: Personal Information redacted by USI
Sent: 02 November 2015 12:40
To: Donnelly, Rachel
Subject: Message from KMBT_283

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private patients being brought onto NHS lists having significantly jumped the Waiting List. As I have been through our inpatients in preparation for taking over the on-call today I have once again come across examples of this behaviour continuing. Specific patient details are;

[redacted] AOB
Referred Sept 2015, Seen OP ([redacted]) Sat 10/10/15, Urodynamics @thorndale unit 6/11/15, Cystodistension 25/11/15.

[redacted] AOB
Referred 28/10/15, Seen OP ([redacted]) Sat 7/11/15, GA cystoscopy 25/11/15 (?recurrent stricture)

I have expressed my view on many occasions. This is Immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means, who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in. The HSC board can see it when they look at our service and any of our good work is undone by this.

Can you advise me what action has been taken since I raised this?

Mark

Willis, Lisa

From: Carroll, Anita
Sent: 27 January 2015 12:54
To: Trouton, Heather
Subject: RE: Aob and charts at home

Follow Up Flag: Follow up
Flag Status: Flagged

I know A

-----Original Message-----
From: Trouton, Heather
Sent: 27 January 2015 12:28
To: Carroll, Anita
Subject: RE: Aob and charts at home

I spoke to Mr Young about this last week and he is going to speak to Aidan again.

I will consider the Risk register although with that you are supposed to address the risk and eliminate it. This is down to a personal way of working which seems impossible to stop.

Heather

-----Original Message-----
From: Carroll, Anita
Sent: 27 January 2015 11:55
To: Trouton, Heather; Corrigan, Martina
Cc: Forde, Helen
Subject: Aob and charts at home

Heather

Do you think you ? Should have something on risk register in relation to this

Anita

particular the review backlog. At that time they began to see patients of Mr O'Brien who were in the review backlog. It is my understanding, through escalation by the new consultants to the Head of Urology and ENT, to myself, and to the Associate Medical Director, that after undertaking a number of clinics, they found that there was often little or no record on the patient centre electronic patient notes recording system of the care, treatment or diagnosis of patients that Mr O'Brien had seen at his previous clinics. In effect, there was often no record of clinic activity or outcomes. It is my understanding that, when Mr O'Brien was asked about this, he conceded that he would undertake his record keeping at a later time rather than most consultants' practice which was to dictate notes after each patient seen at clinic. As this was an emerging issue just prior to my change of role, it is my recollection that, on taking advice on required action, the advice was to address it in writing with Mr O'Brien as per the letter issued to him in March. However, as it was a new issue, I am not able to provide the same detail in respect of it (e.g., in respect of actions taken to address it) as I am regarding other issues such as triage, notes at home, and so on.

68. Following this discovery at the end of 2015 / January 2016, Mr Mackle and myself spoke with the then Medical Director, Dr Richard Wright, regarding our concerns with Mr O'Brien's practice, not only with regard to this latest discovery but also with regard to the other recurrent concerns we had not been able to fully address.

69. Dr Wright advised that he thought it was time to put all the concerns in writing to Mr O'Brien and request a plan from Mr O'Brien to address these concerns.

70. The resulting letter was delivered to Mr O'Brien by Mr Mackle and Martina Corrigan in March 2016.

71. At the end of March 2016, due to a general reshuffle of Assistant Directors in Acute Services by the then Director of Acute Services, Mrs Esther Gishkori, I was transferred to the post of AD for Integrated Maternity and Womens Health and Cancer and Clinical Services. Mr Mackle and Mrs Corrigan remained in post and Mr Ronan Carroll was transferred into my outgoing post. He was aware of the

Stinson, Emma M

From: Young, Michael
Sent: 15 December 2021 09:48
To: Stinson, Emma M
Subject: FW: Personal Information redacted by USI

Section 21

-----Original Message-----
From: Young, Michael
Sent: 03 December 2015 22:29
To: Corrigan, Martina
Subject: RE: Personal Information redacted by USI

Appears to have been seen
No letter
Us request notes clinically benign prostate and not emptying bladder Psa is really much the same as in 2011

I would suggest that this is not serious but pt and gp are not in the loop Two options - put on to AOB review clinic (as this is probably what AOB thinking when is note benign feeling gland) or send email to AOB asking for his outcome of the consult and if no response gained then pt will be added to one of his clinics

From: Corrigan, Martina
Sent: 02 December 2015 19:36
To: Young, Michael
Subject: FW: Personal Information redacted by USI
Importance: High

Can we discuss please?

Martina

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

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

From: Cunningham, Andrea
Sent: 02 December 2015 13:56
To: Corrigan, Martina
Subject: FW: Personal Information redacted by USI
Importance: High

Martina,

See below -Consultant does not use clinic outcome sheets. Clinical decision outstanding.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by USI
T: Personal Information redacted by USI

From: Browne, Leanne
Sent: 27 November 2015 11:58
To: Elliott, Noleen
Cc: Cunningham, Andrea; Coleman, Alana
Subject: FW: Personal Information redacted by USI
Importance: High

Hi Noleen

Personal Information redacted by USI attended EUROAOB 22nd June, no follow-up has been arranged. Can you check the outcome sheet to see if he needs reviewed or discharged please.

Thanks

Leanne

From: Coleman, Alana
Sent: 24 November 2015 12:05
To: Browne, Leanne
Subject: FW: Personal Information redacted by USI
Importance: High

Hey,

No response to below queries.

Thanks
Alana

From: Coleman, Alana
Sent: 14 October 2015 16:03
To: Elliott, Noleen

Cc: Browne, Leanne; Robinson, Katherine
Subject: FW: Personal Information redacted by USI
Importance: High

Hi Noleen,

This patient was seen in June at SWAH, patient has not been discharged or reinstated for a review following last attendance. Please advise of Mr O'Brien's decision on attached referral. Is the referral for Info or Urgent/Routine review?

Thanks
Alana

From: Coleman, Alana
Sent: 21 August 2015 12:29
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: FW: Personal Information redacted by USI
Importance: High

Hi Noleen,

Please see below email, please advise of triage. Does this patient require a review or is this just info?

Thanks
Alana

From: Coleman, Alana
Sent: 14 July 2015 17:53
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: Personal Information redacted by USI
Importance: High

HI Noleen,

Please see attached referral – please forward to Mr O'Brien and advise of outcome.

Many Thanks
Alana Coleman
Registration and Booking Clerk
Referral and Booking Centre
Ramone Building
CAH

(moved from AHP office to main office)
Tracking Code: Personal Information redacted by USI
Tel : Personal Information redacted by USI

1:1 Esther 21/12/15.

- Surgical Workshop - Plan 2016.

- Urology - AOB
  - Charts
  - No PR conte letters.
  - Triage.

  } Plan letter - 1 month improve.

- Emergency surgeon - Interviews 8th Jan
- Breast Surgeon - .. Feb.
- General Surgeons x 2 OHH - In progress advert.
- ENT Mr Hall replacement -

Additional mobile theatre - Ronan advises he will arrange visit Musgrave Jan 2016 - Trudy Mr McKeown + I will attend.

- Need to advertise internally 2 Clinical Directors EOI. Jan 2016.

- Finance 677k underspent to date - that will be eroded with Optham retraction + Agency Spend - Still should break even.

- Review + clear policy on core staff moving wards. - Way forward. - Bank staff too great a role at present - my opinion.

- Staffing - Still no additional staff until Feb - limited. - try to firm up with bank + agency.

for specific drilling down into the Urology data, however, it would have been expected for any significant variance from expected norms to have been highlighted in the regular reports produced.

39.4. In retrospect I believe the issues of concern that related to Mr O'Brien had been managed for too long exclusively within the directorate on an informal basis. Once it became clear that the measures put in place were not proving as effective as they might have been I would have expected that this would have been shared more forcibly at an earlier stage.

40. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

40.1. The concerns were discussed in detail at the Oversight Committee meetings, the minutes of which are provided. As these were issues affecting predominantly the Acute Services Directorate, any governance concerns would normally be escalated through the Directorate governance pathway in the first instance. The Corporate Risk Register reveals some concerns around staff grade medical recruitment. Although there were temporary consultant vacancies they did not reach the threshold to be placed on the Corporate Risk Register during my time (July 2015 until February 2018).

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

41.1. Patient data collection would have been the responsibility of the Acute Services Directorate operational team. As Medical Director I would not normally be involved at this level and therefore am not the best placed person to answer this question. Over the time period of my involvement (July 2015 - February

2018) data gleaned by the Head of Service (Mrs Corrigan) and her team highlighted the difficulties around patient triage. The Datix IR1 incident reporting system was in place across the Trust. It seems that it is through this mechanism the incident (MH) which subsequently became was upgraded to the first SAI (Serious Adverse Incident) was identified.

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

42.1. The Acute Services Governance Manager, Dr Tracey Boyce, or the central Governance Lead at the time, Margaret Marshall, may be in a better position to comment on this. I have no detailed knowledge of the data collection systems within urology at the time. My involvement ceased in February 2018 when I went initially on sick leave and then retired. However, I note that the central data governance team in the Trust won the UK award for best data governance team within the UK among 200 trusts from the CHKS peer comparator system 2017.

42.2. In my opinion, and with hindsight, it seems there was significant data available regarding many of the key issues. As I see the issue, the main factor was a reluctance to formally address the issues identified, rather than a lack of data.

42.3. Incident reporting moved from a paper-based system to an online system (Datix). This allowed for more timely collection of statistics and analysis but was dependent to some degree upon access to input terminals and appropriate training to use the system.

42.4. During this period the central governance team were piloting a new system of understanding complaints data with the London School of Economics. This eventually provided much more useful information around relevant themes rather than simple response time information.

Willis, Lisa

From: Trouton, Heather
Sent: 16 March 2016 15:28
To: Corrigan, Martina
Subject: RE: Confidential letter to AOB - January 2016

Sensitivity: Confidential

Martina

Eamon went through this today,

Would it be possible just to refresh the latest figures so that we can send?

Thanks
Heather

From: Corrigan, Martina
Sent: 18 January 2016 15:22
To: Trouton, Heather; Mackle, Eamon
Subject: Confidential letter to AOB - January 2016
Importance: High
Sensitivity: Confidential

Dear both,

Apologies for not getting this to you sooner but I wanted to rerun and update the information before including this in this correspondence. I wasn't sure if this was a joint letter but I have put it from a plural perspective, so this may need changed.

Hope it is ok and if there is anything else needed please do not hesitate to give me a shout….

Regards

Martina

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

Telephone: Personal Information redacted by USI (direct dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

21/9/16 1:1 Esther + Eamon.

→ Flexing of Beds 4N, 3S, Fem Surgical post 31/3/16 ??
Financial agreed.

→ 3 applicants for the CD post in Surgery.

→ Issues DHH → D. McCoy - Colorectal - issue - D/W Eamon

→ Heads of Service - nervous.

→ OSL → Shaun - with me.

→ Surgical Strategy paper.

→ Need to get letter to POB this week.

→ Do an independant review to decide if any colorectal surgery should be done on the DHH site. - Eamon to find Someone.

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. **Patient Notes at home**

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle
Associate Medical Director

Heather Trouton
Assistant Director

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

Witness Statement

NAME OF WITNESS	**Mrs Heather Trouton**
OCCUPATION	Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 5 June 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 Mrs Heather Trouton. I am employed by the Southern Health and Social Care Trust as Assistant Director of Acute, Integrated maternity women's health, cancer and clinical services. I was appointed to this role in April 2016. I previously worked as Assistant Director of Surgery and Elective Care between September 2009 and 31 March 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 a new Director had taken up post within Acute Services in August 2015 and she decided to change the structure at a senior level within the Directorate. She wanted to have 3 clinical staff to operationally manage the Directorate. This resulted in an internal move and reduced Assistant Director roles from 7 to 5. Tracey Boyce and Anita Carroll remained in their roles. Simon Gibson went to the Medical Director's office and Barry Conway took up a role dealing with strategic reform. Anne McVey went to Medicine, I got women's services and Ronan Carroll got Surgery.

5. In respect of TOR 1, I advised that I wouldn't know the detail about un-triaged referrals but I am aware that MR O'Brien did not agree with triage and he made it clear that he didn't agree with

61. On reflection and now that I am aware of this Framework (and as mentioned above), I believe it could have been used much earlier on in attempting to deal with the admin concerns raised. I therefore consider that Operational Managers, at all levels, not just Director level need to be trained in the content of this framework. I believe this would strengthen the governance processes around maintaining high professional standards for doctors and dentists. While I fully understand the expertise of the medical profession in deciding the appropriateness for use in particular cases and circumstances, this should not preclude a much more open and transparent opportunity for staff at all levels and professions to be aware of this framework.

62. I consider a level of independence outside of medicine to be useful in challenging constructively practice or behaviours that are not conducive to effective teamwork or patient experience. I think that, while medical expertise is valuable and essential, there is a real role for other perspectives to be included in the process. I believe that the MHPS process would be enhanced if appropriate staff outside of medicine had a role. It is interesting that, across the UK and even in Collective leadership teams, the management of medical staff from a clinical practice perspective continues to be managed solely within the medical management structure. I am very mindful of my position as Assistant Director at that time and it is with regret that I was not successful in effecting this challenge more successfully.

14. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr O'Brien.

63. Having appraised myself of the MHPS process and how it was used in this case my views are as follows-