3. FW DATA QUALITY REPORTS 3C 3D IDENTIFYING MISSING OUTPATIENT ATTENDANCES AND DISPOSALS

4.Copy of 03D_-_OUTPATIENT_WITH_NO_ATTENDANCE_OUTCOME_-_DISPOSAL_RECORDED_(i.e._Added_to_Waiting_List)

5. Copy of 03B - OUTPATIENT APPOINTMENTS CANCELLED BY HOSPITAL WITH PATIENT TYPE CNC REASONS

6. Email 23.7.18 re - 03D - OUTPATIENT WITH NO ATTENDANCE OUTCOME - DISPOSAL RECORDED (i.e. Added to Waiting List)

7. Copy of 03C - OUTPATIENT APPOINTMENTS WITH NO ATTENDANCECODE RECORDED 20.4.17

8. 23.7.18 Copy of 03D - OUTPATIENT WITH NO ATTENDANCE OUTCOME - DISPOSAL RECORDED (i.e. Added to Waiting List)

9. Copy of Copy of 03A - OUTPATIENT APPOINTMENT CANCELLED BY PATIENT WITH HOSPITAL TYPE CNC REASONS

11.3 I cannot remember how often these reports were sent prior to the 2017 Investigation under the Maintaining High Professional Standards Framework regarding Mr O'Brien. I could only find the report as of the 14/4/16 in my records prior to 2017. Since the investigation, the reports are sent out monthly for validation.

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1 The SOP for Discharge Awaiting Results – Outpatient (DARO) indicates "If a patient is awaiting results prior to a decision regarding follow up treatment being made, they must be recorded as a discharge (DIS) and not added to the OP Waiting List for review".

12.2 I am aware that the SOP for DARO was not fully implemented while working for Mr O'Brien. This was at the request of Mr O'Brien. Mr O'Brien would have stated on his letters that he was booking an investigation (e.g., scan, blood results, etc., and review in a specific time – i.e., 3 months, 6

months, etc). In such cases, Mr O'Brien did not want me to DARO these patients and requested that they be put on the outpatient waiting list to be seen in the specified time. He was adamant that the patient was not to be discharged and should be on a waiting list for review as requested.

12.3 The DARO reports would have been sent out by the Service Administrator to the Secretaries on an ad hoc basis for the secretary to validate and return. I would have had approximately 60 patients on the DARO report (mainly from the Specialist Registrar/Staff Grade Doctors and some from Mr O'Brien). Other secretaries would have had considerably more patients on their DARO report. Therefore, I believe that management would have been aware that the SOP for DARO was not fully implemented by Mr O'Brien due to the vastly reduced numbers on Mr O'Brien's DARO report. Please see:

10. Daro 1409-311215

11. daro 01.04.10-11.05.16

12. DARO REPORT 11.5.16 OUTPATIENTS_DISCHARGED_WITH_REASON_CODE_DARO_(BASED_ON_DATE_OF_DISCHARGE) urology 11.05.16

13.Copy of 01_ _OUTPATIENTS_DISCHARGED_WITH_REASON_CODE_DARO_(BASED_ON_DATE_OF_DISCHARGE) Urology 04.01.16

13**. What systems of governance do you use in fulfilling your role?**

13.1 I adhered to the Trust Policies and Procedures in fulfilling my role. These are the General Policies and Procedures for all staff working in the Southern Trust which are found on the Trust Website.

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

From: Cunningham, Andrea
Sent: 11 May 2016 14:16
To: Hanvey, Leanne; Troughton, Elizabeth; Elliott, Noleen; Dignam, Paulette; Douglas, Teresa; Robinson, NicolaJ
Subject: daro 01.04.10-11.05.16
Attachments: 01_-_OUTPATIENTS_DISCHARGED_WITH_REASON_CODE_DARO_(BASED_ON_DATE_OF_DISCHARGE) urology 11.05.16.xls

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Please see attached DARO report updated today and filter as appropriate.

It is essential that this report is actioned upon receipt and validation confirmed by return email to me by the end of the month. If patients are no longer appropriate for DARO they must be reinstated or removed from DARO as per DARO SOP.

It is essential that responsibility is taken for all entries relevant to your Specialty **including General entries**.

Regards
Andrea

Andrea Cunningham
Service Administrator
Ground Floor
Ramone Building
CAH

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

Hospital Code	Speciality Description (R)	Specialty Description	Consultant Name	Casenote Number	CHI Number	Referral Date Only	Date of Discharge only	Discharges	Discharge Code	Discharge Comment
BBH	UROLOGY	UROLOGY(C)	O'BRIEN A MR	Personal Information redacted by the USI		15/07/2009	20/02/2015	1	DARO	PSA MAY 2015
BBH	UROLOGY	UROLOGY(C)	O'BRIEN A MR	Personal Information redacted by the USI		26/10/2011	01/04/2015	1	DARO	USS KIDNEYS MARCH 16/WLIST KS
		UROLOGY(C)						2		
	UROLOGY							2		
BBH								2		

Hospital Code	Speciality Description (R)	Specialty Description	Consultant Name	Casenote Number	CHI Number	Referral Date Only	Date of Discharge only	Discharges	Discharge Code	Discharge Comment
CAH	UROLOGY	NURSE LED UROLOGY(N)	NURSE LED CLINIC	Personal Information redacted by the USI		14/08/2012	25/02/2016	1	DARO	USS FEB 2017
			NURSE LED CLINIC					1		
CAH	UROLOGY	NURSE LED UROLOGY(N)	NURSE LED HAEMATUR	Personal Information redacted by the USI		31/01/2014	05/11/2014	1	DARO	U&E/USS BY GP KS
			NURSE LED HAEMATURIA					1		
		NURSE LED UROLOGY(N)						2		
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST	Personal Information redacted by the USI		22/12/2015	07/01/2016	1	DARO	AWAIT MRI SCAN (MY) DARO
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			19/01/2016	25/01/2016	1	DARO	AWAIT CONTACT FROM PT RE: WL
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			19/01/2016	28/01/2016	1	DARO	AWAIT CT KUB RESULT (CMYREG)
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			29/01/2016	05/02/2016	1	DARO	USS PER AJG LTR PT/GP (NEW)
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			22/02/2016	26/02/2016	1	DARO	DISCUSS AT XRAY MEETING
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			31/03/2016	02/04/2016	1	DARO	DISCUSS AT MDT PER JOD
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			22/04/2016	25/04/2016	1	DARO	DMSA & WRITE *NEW AJG*
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			27/08/2015	25/04/2016	1	DARO	AWAIT KATHY TRAVERS REPORT
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			30/03/2016	25/04/2016	1	DARO	AWAIT USS
CAH	UROLOGY	UROLOGY(C)	GENERAL UROLOGIST			21/08/2015	25/04/2016	1	DARO	AWAIT GP RESPONSE

CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR	Personal Information redacted by the USI	17/06/2014	07/07/2014	1	DARO	AWAIT CT UROGRAM - MY
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		21/02/2014	11/12/2014	1	DARO	AWAITING CT SCAN - AOB
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		08/11/2012	22/12/2014	1	DARO	MRI SPINE
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		02/10/2014	09/02/2015	1	DARO	USS APRIL 15 THEN MDM MAY 15
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		13/06/2013	19/02/2015	1	DARO	PSA JULY 2015 AOB
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		18/02/2015	20/03/2015	1	DARO	MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		03/04/2015	03/04/2015	1	DARO	CT ABDOMEN AND PELVIS
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		07/10/2014	10/04/2015	1	DARO	FOR MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		11/04/2015	11/04/2015	1	DARO	CT UROGRAM - AOB
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		03/05/2013	22/05/2015	1	DARO	CT UROGRAM - AOB
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		15/05/2015	27/05/2015	1	DARO	USS PER AOB THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		30/04/2014	02/06/2015	1	DARO	MRI NOVEMBER 2016 KS
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		14/01/2014	03/06/2015	1	DARO	AWAIT SEMEN ANALYSIS - JOD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		18/07/2014	23/06/2015	1	DARO	USS TESTES - AOB
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		27/02/2013	29/06/2015	1	DARO	ULTRASOUND SCAN THEN TELE REV
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		03/04/2014	10/07/2015	1	DARO	FOR MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		19/11/2014	10/07/2015	1	DARO	FOR MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		04/04/2015	31/07/2015	1	DARO	FOR MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		14/08/2014	20/08/2015	1	DARO	AWAIT USS RESULTS - MY
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		10/09/2015	10/09/2015	1	DARO	DISCUSS AT MDT THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		24/08/2015	11/09/2015	1	DARO	FOR MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		10/10/2011	21/09/2015	1	DARO	CT UROGRAM KS
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		07/05/2014	22/09/2015	1	DARO	CT KUB - AOB

CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR	Personal Information redacted by the USI	25/04/2003	23/12/2015	1	DARO	CT DECEMBER 2017
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		14/12/2015	29/12/2015	1	DARO	FOR MDM DISCUSSION THEN OPD
CAH	UROLOGY	UROLOGY(C)	O'BRIEN A MR		16/04/2012	29/12/2015	1	DARO	PSA MARCH 16/USS KIDNEYS KS
			O'BRIEN A MR				73		
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		11/11/2014	14/01/2015	1	DARO	LIVER USS NOVEMBER 2015
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		11/09/2014	30/01/2015	1	DARO	USS NOVEMBER 2015
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		26/11/2014	09/02/2015	1	DARO	uss (january 2016) & review
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		26/02/2015	14/05/2015	1	DARO	DISCUSS AT XRAY MEETING
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		19/03/2015	15/06/2015	1	DARO	A/W INFO FROM DERMATOLOGY KS
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		23/07/2014	04/08/2015	1	DARO	USS TESTES JOD/REV AFTER
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		25/02/2015	10/08/2015	1	DARO	MRI JULY 2016
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		04/02/2015	01/09/2015	1	DARO	U&E IF NORMAL DISCHARGE
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		27/03/2015	04/09/2015	1	DARO	MRI THEN SEE AT OPD/FLOW RATE
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		27/05/2014	04/09/2015	1	DARO	CT RENAL THEN RE-DISCUSS XRAY
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		30/07/2015	11/09/2015	1	DARO	AWAIT PATIENT CONTACT RE CT
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		15/07/2015	11/09/2015	1	DARO	AWAIT PATIENT CONTACT RE CT
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		07/08/2014	15/09/2015	1	DARO	USS RENAL TRACT
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		17/10/2014	02/10/2015	1	DARO	AWAITING RESPONSE LONDON
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		06/05/2015	05/10/2015	1	DARO	AWAIT USS/DISCHARGE IF NORMAL
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		20/08/2015	05/10/2015	1	DARO	US TESTIS FEB 16/REV MARCH 16
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		30/04/2015	05/10/2015	1	DARO	CT UROGRAM
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		01/10/2015	06/10/2015	1	DARO	REV WITH PSA
CAH	UROLOGY	UROLOGY(C)	O'DONOGHUE J P MR		07/08/2015	14/10/2015	1	DARO	JOD TO RING WITH CTU

Backlog Information

Specialty: Urology

Secretary's Name : Noleen Elliott

Date of Completion : 08th JUNE 2015

Discharges Awaiting Dictation From Discharge Date	Clinics (no of charts) Awaiting Typing Oldest Clinic Date	Results Awaiting Dictation Oldest Result date	Daro: Validated	Filing – Give details of amount and type of filing, eg lab reports/consultant letters etc	Any Other Relevant Information
41 – Dating back to May 14 10 – FLEXI LIST 5/6/15	NIL	18	yes	Approximately 11 lever arch files	

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by USI

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a Personal Information redacted by the old lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for discharge tomorrow.
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

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: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; Personal Information redacted by USI; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Personal Information redacted by USI; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

Once this was raised with the Urology HOS, the HOS asked my team to monitor the dictation of Mr O'Brien's clinics. All Secretaries were reminded to report any issues on the Backlog Report. I have not been advised of any issues since.

28.3 The Trust's IT Department is currently trying to develop a report in conjunction with the supplier to show clinics that have taken place and no letters dictated against them.

28.4 The issues with the use of the DARO code were also frustrating and worrying. The secretary was spoken to on a least 2 occasions to say that she should be following instructions from her Line Manager and not her consultant re admin processes, although I have no log of these interactions. I do acknowledge this was difficult for her and the management of consultant secretaries is not easy due to their relationship and yet being managed by a different group of people. On this basis this issue was escalated to Mr M Haynes the Clinical Director and this was reinforced. The secretary then did comply.

29. **What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

29.1 Once a concern was known, eg. non-triage issue, I was advised by the HOS to put in place the 'GP default' position. I have no idea if this was risk assessed. In relation to the non-dictation of clinics, when this came to light steps were taken to remedy this. I have no idea if this was risk assessed. With regard to the DARO issue I engaged with Mr M Haynes, CD who reinforced the reasoning behind the use of this code etc. I probably should have risk assessed this issue formally at that time as this risk sat with us. At our monthly HOS meetings with our AD we do address any issues of risk.

Notes of Meeting with N.Elliott, Anita Carroll & Katherine Robinson via desktop

3/9/20

Anita introduced herself and explained that KR had raised the issue of Noelene's stress with her. Anita advised that these concerns had led her to ask to meet to discuss. Anita asked her how long she had worked for AOB and NE advised 5 years, Anita recognised that the relationship between consultant and secretary but said they needed to discuss admin arrangements and get a clear position on paperwork / admin functions and how things worked in particular as to get a feel for what was stressing Noelene and also the fact that she had advised KR the previous day that AOB had asked her to change some things When asked about this at this meeting, she denied that she changed things but advised she didn't use all admin processes in particular the DARO function.

- **DARO-** Noelene advised that AOB hated using this function so Noelene had only approx. 50 on her Daro list because she only used it when Regs sent patients for results. For AOB's pts she used the outpatient waiting list as per AOB. This method was felt by them to be their safety net. EG

  CT scan requested, 6 mths, this was put on the review w/l to be seen within 7 mths time.

- **Results** – on receipt of paper form of results, these would be passed to AOB and the chart would be tracked to CAOBS – Result for AOB to see (*Awaiting results)*. This was proof that AOB had been passed the actual result. These charts remained in the sec office until a result was returned to Noelene for further action. Routine results never made their way back to Noelene, only urgent ones. Periodically Noelene went through the charts in the Awaiting results section of her office to chase up anything outstanding. It was explained to Noelene that this was not foolproof and this is why DARO was introduced some years ago.

- **Outstanding paperwork for AOB –** Mr Fell was working his way through things and Noelene was using the function DARO per admin policy.

- **Backlog Reports – delays in dictation etc,** Noelene advised that AOB didn't get to tidy everything up due to the way he retired. She advised that there were approx. 100 charts in the Awaiting Results section of her office that need checked. Martina to be informed.

- **Oncology Letters from Belfast –** These letters were passed to AOB and because now they are on NIECR they were not always (never were) passed back to Noelene.

Following discussion Noeleen did advise that she was unhappy with how changes were communicated with her recently (following AOB retirement) she said she was asked to work for Ms Salaman in Breast surgery and then this offer was withdrawn , Anita and Katherine agreed the communication had been poor and then discussed the current role in urology, Noeleen expressed that she would prefer to work in another specialty as

5.0 DESCRIPTION OF INCIDENT/CASE
than surveillance with PSA monitoring.

6.0 FINDINGS

Diagnosis and Staging

- 5 of the 9 patients in this review experienced significant delay in diagnosis of their cancer. This was related to patients with prostate cancer and reflected variable adherence to regionally agreed prostate cancer diagnostic pathways, NIACN Urology Cancer Clinical Guidelines (2016).
- Service User B had a delay of over 15 months from presentation.
- The review team could not find evidence of a Digital Rectal Examination in the notes of Service User D - potentially missing an opportunity to detect his high grade cancer earlier in his pathway.
- Service User F had a slow initial diagnostic pathway which was outside expected cancer care time-frames.
- Service User C had a delayed diagnosis of a metastatic prostate cancer following successful treatment of Renal Cancer. This was due to non-action on a follow-up CT scan report.
- Patient I had a delayed diagnosis of Prostate cancer due to non-action on a histopathology report at TURP.
- Patient H with penile cancer had a 5 week wait between referral and first appointment. Subsequent time to diagnosis and MDM were appropriate. He had a 17 week wait for a CT scan for staging.
- Service User G was on a renal mass surveillance programme - a recommendation at MDM to discuss his case with the regional small renal lesion team was not actioned and it is not known if they would have suggested earlier intervention.

Targets

- Three of the nine patients were said to have met one of their 31 / 62 day targets.
- Service User I was said to have met his diagnostic target for 31 days despite his tissue cancer diagnosis being missed and the patient suffering an 8 month delay.
- Service User H was said to have met his 62 day (1st treatment) target but had been referred down a pathway that did not meet the NICAN Urology Cancer Guidelines 2016. A regional Penile Cancer Pathway was agreed in January 2020.
- Service User B was said to have met his diagnostic target of 31 days despite having a delay from initial presentation of 15 months.

SUC had CT scanning performed on 17 December 2019. It was reported on 11 January 2020. There was no evidence of any recurrence or progression of renal cell carcinoma on CT scanning. However, it was reported that a new area of ill-defined sclerosis was present within the left side of the first lumbar vertebra, and slightly extending into the pedicle. This was not evident on previous CT scans, and sclerotic metastasis was within the differential diagnosis. A dedicated radioisotope bone scan was advised for further evaluation.

My secretary had retained SUC's hospital chart in her office to await the report of the CT scan performed on 17 December 2019, so that his chart would be available for his intended review in January 2020. She transferred the chart with the report of the CT scan to my office on some unspecified date following receipt of the report. As she did not track the transfer of the chart from her office to mine, it has not been possible to determine when it occurred. It is probable that it was during February 2020 due, once again, to my not being able to review SUC during January 2020 due to the inadequacy of outpatient review capacity. In fact, he still remained on the list for review at my oncology review clinic in June 2019.

I always returned to my office each evening of every working day in the hospital. On doing so, I could find that my secretary had left a hierarchy of administrative tasks requiring attention. The most urgent could be positioned on my chair so that I could not sit down without being aware of it. I would find a number of hospital charts would be left on my desk, some which I had requested, others accompanied by the reports of investigations which had been requested. In addition, there would be a much greater number of hard copy reports of investigations without hospital charts, particularly the large numbers of reports of investigations requested during triage of referrals, as well as messages, queries and requests to contact patients or their relatives etc. I would firstly review the reports accompanied by hospital charts as that released most desk top space at which to begin working. I would then place the hospital charts on a shelf in my office to deal with at a later time when available. This was a necessity so that I could log on to my computer to address those tasks sent by email, and all this after attending firstly to those administrative tasks involved in arranging future admissions etc.

While I do not have a record of the date, I believe that it was either in late February 2020 or early March 2020 when I reviewed the report of the CT scan and the recommendation of a radioisotope bone scan. I do so as my dominant concern was with regard to exposing SUC to the risk of Covid by having him attend Craigavon Area Hospital for scanning. I called with the radiographers in the Department of Nuclear Medicine to enquire whether they were continuing to arrange radioisotope

(v) **Prescription of drugs**

24(v) -1 I had no involvement in the prescription of drugs.

(vi) **Administration of drugs**

24(vi)-1 I had no involvement in the administration of drugs.

(vii) **Private patient booking**

24 (vii)-1 I had no input into any Consultant's private practice. I would have received phone calls from patients/relatives enquiring into private appointments and these were re-directed to the Consultant's private telephone number.

24(vii)-2 Mr O'Brien was the first consultant I had worked for who also had a private practice. He had a private consultation practice in his home. These patients would have been then transferred to the NHS for their surgery.

24(vii)-3 Mr O'Brien would have given me a list of patients for his Wednesday theatre list. On receipt of this list of patients I would have pre-admitted the patients accordingly. However, the patient(s) Mr O'Brien had seen privately were not on the Trust Patient Administrative System Waiting List (PAS). I was able to check the "Chart Tracker" on PAS to see when the patient's chart was tracked to "Mr O'Brien's PP Filing Cabinet" by Leanne Hanvey (who did all Mr O'Brien's Private Patient typing) and this was the date I used to put the patient, originally seen as a private

TRU-294353

Reply all | Delete Junk |

Request for private appointment

Elliott, Noleen [redacted]
Tue 19/05/2015, 10:39
[redacted] O'Brien, Aidan [redacted]

SKMBT_2231505121108...
142 KB

Download

[redacted],

Re: [redacted]
DOB [redacted]
Contact Number: [redacted]

The above patient has requested a private appointment with Mr O'Brien. He has attended Mr O'Brien's clinic in SWAH on 13/19/14. See e-mail below.

Many thanks.

Noleen

From: Elliott, Noleen
Sent: 12 May 2015 12:03
To: O'Brien, Aidan
Subject: Re: [redacted] - [redacted]

Aidan,

The above patient was ringing regarding his review appointment. He attended your SWAH clinic on 13/10/14 and was told you would review him in early 2015. There is no outcome logged on PAS. I have attached his PSA results for your information. Can you please advise.

Many thanks.

Noleen

Corrigan, Martina

From: Elliott, Noleen [redacted]
Sent: 24 September 2018 13:21
To: O'Brien, Aidan
Subject: Private Patient typing
Attachments: Document in PatientCentre.doc

Aidan,

I have attached letters which were on G2. I note that you actually saw this patient privately and wonder if these should be on your private patient letterhead paper instead. There were no recent episodes on PAS for me to link this to. Can you please advise.

Many thanks.

Noleen

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: Personal Information redacted by USI
Secretary: Personal Information redacted by USI

Personal Information redacted by the USI

Dear DR Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.: Personal Information redacted by USI
Address: Personal Information redacted by USI
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

I write to you regarding this Personal Information redacted by the USI old man who first attended our department in June 2011 for assessment of lower urinary tract symptoms which were predominantly of a voiding nature, and which he had had for some 10 years previously. In 2011, he reported having hesitancy of micturition, a slow urinary flow and a sensation of unsatisfactory voiding in addition to post micturitional incontinence and mild nocturia, having to rise once each night to pass urine. On ultrasound scanning, he was found to have minimal prostatic enlargement and was found to have inadequate bladder voiding with a post micturitional, residual urine volume of 289mls. His lower urinary tract appeared to be endoscopically normal on flexible cystoscopy in July 2012. Urodynamic studies performed in June 2013 indicated that he definitely did have bladder outlet obstruction, for which he had a bladder neck incision performed in April 2015. At review 3 months later in July 2015, Personal Information redacted by USI reported that bladder neck incision had resulted in a significant improvement in his urinary symptoms.

Personal Information redacted by USI came to see me privately in September 2016, reporting recurrent of all of his former symptoms. In addition, he reported pain referred to his right hemiscrotal contents, and quite severe pain on ejaculation. On clinical examination then, I found him to have right epididymal tenderness. I advised Personal Information redacted by USI that he probably had right genital tract infection, and for which I requested that he be prescribed Ciprofloxacin 250mgs to be taken twice daily for a period of 3 months.

With regard to recurrence of his lower urinary tract symptoms, I advised Personal information redacted by USI that he would be better served by having his prostate resected. When I reviewed him by telephone recently, he reported that his lower urinary tract symptoms

remained unchanged, and are predominantly of an obstructive nature. He also reported persistent. He also reported persistent pain on ejaculation. He no longer localised pain to his right epididymis.

Personal Information redacted by USI is keen to proceed with surgical intervention in the hope that so doing will permanently relieve him of these longstanding urinary symptoms. Mindful of his relatively young age, I have advised him that I would prefer to reassess his lower urinary tract dysfunction by repeating flexible cystoscopy and urodynamic studies prior to arranging bladder outlet surgery. I have arranged for him to attend for flexible cystoscopy and urodynamic studies on Friday the 5th of October 2018.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 22/09/18	**Date Typed:** 24/09/18

23.2 I was aware that there were targets set for cancer pathways, however, it was not in my job remit to monitor these. Rather, it was the responsibility of the Cancer Tracker to monitor this.

24. **Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:**

(i) **Waiting times**

24(i)-1 I was responsible for putting patients on the waiting list for surgery and pre-admitting patients when requested by the consultant.

(ii) **Triage/GP referral letters**

24(ii)-1 When I joined the Urology Service in 2013 triage letters were forwarded to the Consultant through the Secretary from the booking office, I ensured these were passed to the Consultant for completion. The Booking Office would have sent reminders via e-mail to me to chase up any outstanding triage letters. I would have received an e-mail with a list of patients with missing triage and would have forwarded this e-mail unto Mr O'Brien for action (*see attached example 21. Missing Triage; and 22. MISSING TRIAGE (2)).* I am not sure how often I received these reminders and I did not do anything with them other than pass them to Mr O'Brien for action.

24(ii)-2 In November 2014 there was a change in this process when the Booking Office left the triage letters in the Thorndale Unit for the Consultant of the Week to complete and the Secretary had no involvement in this process. Then again in

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 77 of 2022

Date of Notice: 23rd September 2022

Addendum Witness Statement of: Noleen Elliott

I, Noleen Elliot, will say as follows:-

I wish to make the following amendments to my existing response, dated 28th October 2022, to Section 21 Notice number 8 of 2022.

1. At paragraph 18.3 (WIT-76337), I have stated '*Regarding extra hours worked, Michelle McClenaghan took over as Service Administrator for a short period of time.*' This should state '*Regarding extra hours worked,* ***Michelle McClelland*** *took over as Service Administrator for a short period of time.'*

2. At paragraph 24(vii)-3 (WIT-76345), I have stated '*However, the patient(s) Mr O'Brien had seen privately were not on the Trust Patient Administrative System Waiting List (PAS). I was able to check the "Chart Tracker" on PAS to see when the patient's chart was tracked to "Mr O'Brien's PP Filing Cabinet" by Leanne Hanvey (who did all Mr O'Brien's Private Patient typing) and this was the date I used to put the patient, originally seen as a private patient by Mr O'Brien, on the NHS waiting list.*' This should state '*However,* ***if the patient(s) Mr O'Brien had seen privately were not on the Trust Patient Administrative System Waiting List (PAS),*** *I was able to check the "Chart Tracker" on PAS to see when the patient's chart was tracked to "Mr O'Brien's PP Filing Cabinet" by Leanne Hanvey (who did all Mr O'Brien's Private Patient typing) and this was the date I used to put the patient, originally seen as a private patient by Mr O'Brien, on the NHS waiting list.*'

3. At paragraph 24(vii)-4 (WIT-76346), I have stated '*Then there was the instruction of the Transfer Status Form (not sure of the date).* This should state '*Then there was the* ***introduction*** *of the Transfer Status Form (not sure of the date).'*

Southern Health and Social Care Trust

Quality Care - for you, with you

Paying Patients

A Guide for Southern Trust Administrative Staff

What is a private patient?

Private patients are patients who give an undertaking [or for whom one is given] to pay charges for accommodation and services.

All income generated from private patients is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

What do you need to do?

- Ensure the status of private patients is recorded on the PAS system.
- For booked patients with Republic of Ireland address, ensure that patient is recorded as Private on PAS [unless the are a known cross border worker]
- For emergency patients, admitted via the Emergency Department please record as NHS and advise the Paying Patients Office of their admission.
- For any patient with a UK address but with a Republic of Ireland GP please notify the Paying Patient Office on their admission.

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DAISY HILL HOSPITAL
Paying Patients Office
Personal Information redacted by USI
Personal Information redacted by USI

CRAIGAVON AREA HOSPITAL
Paying Patients
Personal Information redacted by USI
Personal Information redacted by USI

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE | [redacted] Personal information redacted by the USI

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.**

38.1 I have since left the Urology Service and therefore cannot comment in that regard. However, since moving to the Breast Service, I am aware that the new technologies (NIECR and e-triage), adequate capacity, and my attendance at Multidisciplinary Meetings all play a part in running a more effective service. The waiting times in the Breast Service for surgery and outpatient appointments are considerably shorter than those of Urology and therefore I feel the Breast Service, which has adequate capacity to care for their patients, is more effective and therefore does not present the same risk or potential for concern.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 I feel there wasn't adequate capacity in the Urology Service which led to long waiting times for both outpatients and elective waiting lists. Patients were having to wait too long to be treated in Urology.

39.2 While working in the Urology Service staff were not actively completing Incident Reporting forms (IR1) for any concerns they may have. Instead, staff raised their concerns through the Service Administrator. I am not aware if IR1 forms were completed by the Service Administrator. I feel the reporting of concerns/incidents should all be reported through Incident Reporting on DATIX.

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services**