



## Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB  
T: 02890 251005 | E: [info@usi.org.uk](mailto:info@usi.org.uk) | W: [www.urologyservicesinquiry.org.uk](http://www.urologyservicesinquiry.org.uk)

Mr. Eamon Mackle

Personal Information redacted by the USI

15 March 2022

BY EMAIL ONLY: Personal Information redacted by the USI

Dear Sir,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference. The Inquiry is of the view that in your roles you will have an in-depth knowledge of matters that fall within

our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you may be aware the Trust has responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or your legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make an application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

**Anne Donnelly**  
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO  
UROLOGY SERVICES IN THE  
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 4 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

**WARNING**

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Mr. Eamon Mackle**

Personal Information redacted by the  
USI



**IMPORTANT INFORMATION FOR THE RECIPIENT**

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

**WITNESS STATEMENT TO BE PRODUCED**

**TAKE NOTICE** that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon on **12<sup>th</sup> April 2022**.

**APPLICATION TO VARY OR REVOKE THE NOTICE**

**AND FURTHER TAKE NOTICE** that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon on **5<sup>th</sup> April 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 15<sup>th</sup> March 2022

Signed:

Personal Information redacted by the USI

Chair of Urology Services Inquiry

**SCHEDULE****[No 4 of 2022]****General**

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.
2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Please also provide or refer to any documentation, held by you or the SHSCT, which you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.
3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

**Your position(s) within the SHSCT**

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.
5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.
6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.
7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.
8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Assistant Director and Head of Urology Service or with any other role which had governance responsibility.

### **Urology services/Urology unit - staffing**

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?
11. Was the '*Integrated Elective Access Protocol*' published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?
12. How, if at all, did the '*Integrated Elective Access Protocol*' (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?
13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.
- I. What is your knowledge of and what was your involvement with this plan?
  - II. How was it implemented, reviewed and its effectiveness assessed?
  - III. What was your role in that process?
  - IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.
14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit during your tenure?
16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?
17. Were 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.
18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?
19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?
20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?
21. Did your role change in terms of governance during your tenure? If so, how?
22. Explain how the unit was supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.
23. Was there an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?
24. Were support staff concerns ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what you did in response.

25. Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.
26. What, if any role did you have in staff performance reviews?
27. Was your role as AMD subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role.

**Engagement with unit staff**

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.
29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit staff and how long those meetings typically lasted. Please provide any minutes of such meetings.
30. In your opinion during your tenure, did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

**Governance – generally**

31. What was your role regarding the consultants and clinicians in the unit, including in matters of clinical governance?
32. 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?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with that assurances regarding the quality of services?
34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this oversight?
35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?
36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?
37. Did those systems or processes change over time? If so, how, by whom and why?
38. How did you ensure that you were appraised of any concerns generally within the unit?
39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?
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.
41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?
42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?



43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.
44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?
45. The Inquiry is keen to learn the process, procedures and personnel involved when concerns regarding governance, which have the potential to impact on patient care and safety, arise. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might seek to see examples of concerns being dealt with in this way during your tenure.
46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

### **Concerns regarding the urology unit**

47. The Inquiry is keen to understand how, if at all, you, as AMD of Surgery, *liaised with, involved and had meetings with:*
- (i) The Chief Executive(s) (the inquiry understand these to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin)
  - (ii) The Medical Director(s) during your tenure (the inquiry understand these to have been Patrick Loughran, John Simpson, Richard Wright, Ahmed Khan and Maria O’Kane),

- (iii) The Director(s) of Acute Services (the inquiry understand these to have been Gillian Rankin, Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements)
- (iv) The Assistant Director(s), namely Heather Trouton and Ronan Carroll
- (v) The other Associate Medical Directors (the inquiry understand these to have been Mark Haynes, Stephen Hall, Charlie McAllister and Damian Scullion)
- (vi) The Clinical Director(s) (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)
- (vii) The Head of Service, namely Martina Corrigan, and
- (viii) The consultant urologists in post during your tenure.

In matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (i) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

- (a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.
- (b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

- (c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.
- (d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?
- (e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?
- (f) If you were given assurances by others, how did you test those assurances?
- (g) Were the systems and agreements put in place to rectify the problems within urology services successful?
- (h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

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

- (a) properly identified,
- (b) their extent and impact assessed,
- (c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff other than Mr. O'Brien by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss, seek to provide support, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q62 will ask about any support provided to Mr. O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

**Mr. O'Brien**

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What, if any, was your role and involvement in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? Do you now know how long these issues were in existence before coming to your or anyone else's attention?

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? You should include details of any discussions with named others regarding these concerns. Please provide dates and details of any discussions, including any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:
- (i) what risk assessment did you undertake, and
  - (ii) what steps did you take to mitigate against this? If none, please explain.
- If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.
58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified
59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?
60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and were working as anticipated? What methods of review were used? Against what standards were methods assessed?
61. Did any such agreements and systems- which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?
62. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss, seek to provide support, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.
63. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

**Learning**

64. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.
65. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?
66. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?
67. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.
68. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilized to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?
69. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

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

**NOTE:**

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

**UROLOGY SERVICES INQUIRY**

**USI Ref:** S21 No.4 of 2022

**Date of Notice:** 15<sup>th</sup> March 2022

---

**Witness Statement of: Edward (Eamon) John Mackle**

---

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

1. I currently occupy the role of Locum Consultant Surgeon within the Southern Health and Social Care Trust ('the Trust').
2. This statement is made in response to Section 21 Notice No.4 of 2022. It is made to the best of my recollection at this point in time and on the basis of the documents currently available to me. In the circumstances, I acknowledge that I may not have a complete view of all relevant matters.
3. In making this statement, I have had the benefit (with the express permission of the Inquiry) of assistance from the following persons in obtaining documents and information: Emma Stinson, Martina Corrigan and Heather Trouton.





## **Urology Services Inquiry**

**[1] Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

**[2] Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Please also provide or refer to any documentation, held by you or the SHSCT, which you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.**

**[3] Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.**

5. In this witness statement I have attempted to provide as detailed an answer as I can to each of the specific questions at numbers 4 to 70. I consider that, together, my answers to those questions provide a comprehensive and broadly chronological account of my involvement in the matters being investigated by the Inquiry. However, in light of the request made in Question 1, from paragraph 6 to 46 below I offer a narrative overview of my involvement in some of the issues being investigated by the Inquiry (referring, where appropriate, to my answers to other questions in this statement). This is not intended to replace, but rather to complement, the more detailed responses given at Questions 4 to 70.



## Urology Services Inquiry

6. Until my retirement from full time practice in February 2018 I was employed as consultant general surgeon in the Southern Trust, having been appointed to Craigavon Area Hospital in 1992. Following the establishment of the Southern Area Trust, I was additionally appointed Associate Medical Director for Surgery and Elective Care in 2008 and one of my responsibilities was for the urology service.
7. In November 2015, Personal Information redacted by the USI  
[REDACTED] it was suggested by Occupational Health that I should consider reducing my stress and come off on-call. In April 2016, I stepped down as Associate Medical Director and, in February 2018, I retired from full-time practice. At the time of my retirement from full-time practice, I had multiple box files in my office in the hospital as well as papers in the two filing cabinets. In these, I had kept relevant minutes and notes regarding each specialty. In 2018, I was unaware of any ongoing investigation into Aidan O'Brien so, during the month of February, I disposed of all papers and notes in my office. During March, I did the same in my study at home for any hospital-related correspondence or notes. I have therefore compiled this document principally from my recollection and what emails etc. I have been able to retrieve. As mentioned at paragraph 3 above, I have also had the benefit of being able to seek documents from the Trust where I believe there may be documents that might aid my recollection and/or relate to an issue I have to address in this statement.
8. Over the years, several performance issues have been raised regarding Aidan O'Brien's practice. Some of the issues have recurred over the years so, for clarity, I shall take them one at a time and deal with each issue chronologically.
9. Aidan O'Brien was appointed as the first full-time urologist to Craigavon Area Hospital in, I believe, 1993. Following the establishment of the urology service, he was joined by Michael Young in 1998 and then Mehmood Akhtar in 2007.



## Urology Services Inquiry

10. The review of urological services, completed in 2009, proposed a configuration model with three teams serving the province. The 'Team South' configuration had Craigavon Urology as the core service for the southern part of the province and included Enniskillen. As part of the case for implementation of the review, the Trust set up various groups to meet the expectations of the commissioner. At that time there was an extensive review backlog, the Trust had the worst 'new to review' out-patient ratio of the three proposed teams as well as long waiting lists for surgery. There were significant regional concerns about our ability to be able to deliver the activity to cope with the growing demand, and to modernise the service to make it fit for the proposed expanded service.
  
11. To enable the expansion of the service, multiple workstreams were set up to deliver an implementation plan. Initially Joy Youart and then Gillian Rankin chaired weekly meetings with the three urologists. These meetings were met with almost unanimous resistance by the urologists, and it involved a huge effort and dogged determination on our part to gradually achieve agreement on the issues needed to modernise the service. The changes in practice that were expected by the commissioners were many and included: management of red flag referrals, triage, pre-operative assessment, length of stay, number of patients per clinic (and thus length of appointment), transfer of radical pelvic surgery to Belfast, role of Nurse Specialists, and team job plans. Throughout these meetings it was obvious that the main resistance to embrace change came from Aidan O'Brien, although as stated above, he did get support from his two colleagues. Aidan O'Brien had quite fixed views on how he wished to practice and deliver a urological service and these did not match those of the commissioners. My main role at the meetings was to provide a clinical challenge function to the opinions re delivery of the service that were being expounded by the urologists so that Gillian Rankin could achieve the desired consensus and outcome.
  
12. While the weekly meetings were continuing we also had the issue of job plans, both individual as well as for the proposed 5-man urologist team. Despite productivity of the urology service being considered low, Aidan



## Urology Services Inquiry

O'Brien had been receiving from before the commencement of the trust 15 PAs, a figure which I was told was the highest in the Trust (one PA is equivalent to 4 hours work between 7am and 7pm or 3 hours spent working in hospital between 7pm and 7am). A contract for a newly appointed consultant in the England was expected to contain only 10 PAs and, in Northern Ireland, my understanding is that the average surgical contract was 11 to 12 PAs. Not surprisingly, there was a reluctance for Aidan O'Brien to constructively engage in the process. For years he had been paid for more administrative time SPAs (Supporting Professional Activity) than any other surgeon in the Trust. Eventually agreement was reached with Mehmood Akhtar and Michael Young but I found it impossible to agree a job plan with Aidan O'Brien. I therefore referred him to Medical Staffing for commencement of the facilitation process. This was chaired by Philip Murphy, Associate Medical Director Medicine, and the outcome was a reduction to 12.75 PAs from October 2011 and moving down to 12 PAs from March 2012. The 5-man team job plan process was an equally long-drawn-out process, but I acknowledge the difficulty was not solely due to Aidan O'Brien. Job planning is discussed in more detail below, in particular in my response to Question 18.

13. Staffing of the urology department was an issue from 2009 until 2014. There was a difficulty in recruiting and retaining consultant urologists and the unit was also relatively understaffed with non-consultant / training doctors, such that general surgery was ultimately needed to help provide out of hours cover. This shortage of staff did contribute to the difficulty in achieving activity targets set by the commissioners. Staffing is discussed in more detail below, in particular in my response to Questions 16-18
14. Over the years several performance and governance issues regarding Aidan O'Brien and his practice were recognised. For the sake of clarity, I will address them individually as, on a single timeline, they overlap.

### Triage

15. When GPs send in referral letters it is expected that a review of the letter will take place and the patient boarded for the out-patient clinic depending on their



## Urology Services Inquiry

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

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



## Urology Services Inquiry

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

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

### IV Fluids & IV Antibiotics

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

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

### Benign Cystectomies

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



## Urology Services Inquiry

Diane Corrigan, Consultant in Public Health Medicine, then conducted a province-wide review of the practice and this showed a higher than expected number were performed in Craigavon Area Hospital. I was instructed to review the last 12 cases performed. As a general surgeon I found myself unable to reassure the Trust re the indication for half of them. An Independent review was then conducted by Marcus Drake, Consultant Urologist in Bristol. We were unable to obtain all the information he required to produce a final report but, essentially, he felt that there were no gross errors or faults. However, a recommendation of the urology review had been that all major pelvic surgery was to be conducted in Belfast. In September 2011 the urologists were informed that no further elective cystectomies were to be performed in the trust.

21. The Benign cystectomies issue is also discussed in more detail below, in particular in my responses to Questions 54-57.

### Disposal of Patient Records

22. In June 2011 I was made aware that an auxiliary nurse in the urology ward had found a bundle of papers in one of the bins. The bundle consisted of fluid balance charts, TPN Fluid prescription forms, MEWs Charts and Prescription records belonging to 2 patients' charts. Human Resources were involved, and an investigation was undertaken. Aidan O'Brien accepted that he was wrong to have disposed of the records and he was issued with an informal warning in August 2011.
23. This issue is discussed in further detail below, in particular in my answers to Questions 54-57 & 61.

### Review of Results of Investigations

24. In 2009 a "never event" occurred whereby a swab was post-operatively left in a patient and was only discovered a year later when the patient was admitted as an emergency. A CT scan had been reported as abnormal three months later, but an investigation revealed that Aidan O'Brien had a policy of not reviewing results until patients attended out-patients. Aidan O'Brien raised





## Urology Services Inquiry

multiple objections when it was suggested that he should be reviewing all results therefore an instruction was issued to all consultants informing that it was their responsibility to review all the results of investigations on their patients once they are available.

25. This issue is addressed in more detail below, in particular in my answers to Questions 54-57.

### Patient Outcomes and Charts at Home

26. In 2013 Medical Records complained that an ongoing problem with Aidan O'Brien was patient hospital charts in his house and he was advised that this was not permitted. Following the expansion of the urology service to become Team South, outpatient clinics were provided in Enniskillen and patient records therefore needed to be transported to the clinic and back to Craigavon afterwards. The Trust transport was used for all other peripheral surgical clinics but for this service it had been arranged that, after the clinic, the consultant would bring the charts back to the Craigavon. Following dictation of the letter to the GP the outcome for the patient would be recorded (e.g., put on waiting list for surgery, discharged, or review arranged). Aidan O'Brien, however, was bringing the charts to his house after the clinic but not completing the dictation which also meant patient outcomes were not recorded. The Trust became aware in late 2015 of it as a problem but only discovered the extent of the problem, when following Heather Trouton's and my letter in March 2016, he returned the charts.

27. This issue is addressed in more detail below, in particular in my answers to Questions 58-61.

### Bullying and Harassment

28. In 2012 I was informed that Aidan O'Brien had spoken to Roberta Brownlee, then Chair of the Trust Board, complaining that I had been bullying and harassing him. I consider this to have been a false accusation and, on reflection, I believe it may have been malicious. Prior to 2012, I had acted as a major challenge to Aidan O'Brien's opinions and views regarding





## Urology Services Inquiry

development and modernisation of the urology service and I think he resented my input.

29. The modernisation of the service meant that I was expected to challenge traditional practice to bring it in line with the modern model, for example: admission on the day of surgery, utilisation of pre-operative assessment service, target for new patient to review ratio at outpatients, fixed length of consultations, number of patients at a clinic, etc. In addition, I hadn't accepted Aidan O'Brien's suggestions for a job plan and I referred him to the facilitation process which ultimately reduced his pay by 3 PAs. Furthermore, I helped organise the benign cystectomy review and I challenged him re breaches of the protocol for managing the IV fluids and IV antibiotics patients. I had also challenged him over failure to triage and had been involved in the discussion to refer him to HR re disposal of patient records in a bin. I also had actively supported Gillian Rankin regarding the necessity for Aidan O'Brien to review the results of patients' investigations once they are available.
30. While I was reassured that management did not believe the false accusation, on reflection it should have been investigated. The failure to investigate and exonerate me meant I had to be careful about acting in any sort of challenge role and my oversight of Aidan O'Brien's practice was reduced for fear that it could be misconstrued as evidence of harassment. On reflection, I now feel that he achieved his intended objective.
31. This issue too is addressed at various points in my answers below, particularly at Question 21.
32. Aidan O'Brien was considered by many to be old fashioned in his outlook and style of consultant practice. Once he saw a patient, he had a reputation for being very attentive and approachable. His patient feedback was excellent and many of his nursing and consultant colleagues held him in very high esteem. I was never informed of any issues or concerns arising from his appraisals. He had a reputation for being hard working and one who would



## Urology Services Inquiry

always strive to do the best for his patients. His style of practice, however, meant that he was slow to discharge a patient from his follow-up and was slow to embrace the use of specialist nurses for non-consultant outpatient review. He was known to take his time for outpatient consultations. This style of practice meant that clinics filled up with review patients, leading to a review backlog and a long waiting time for a new referral.

33. What I was not aware of (but have become aware of in the context of this Inquiry) was that he also did not routinely utilise named Keyworker/Specialist nurses in the cancer pathway. I believe the failure to engage with Keyworker/Specialist nurses reduced the ability to monitor adherence the MDM advice and identify delays in the management of cancer patients.
34. This issue is addressed in more detail below, in particular in my answers to Question 64.
35. At job planning he mentioned the amount of administration he had and how long it took. Much of this extra administration was Aidan O'Brien generated and, when steps were suggested on how to reduce the amount of administration, he would either ignore or object to the proposed process. His discharge summaries were extremely long and often over several pages. Following one GP speaking to me about the excessive length of a discharge summary, I asked Aidan if he could make them shorter and more geared for the GPs. However, he declined, saying that the long summary was for his benefit if he saw the patient again in the future.
36. Several times I suggested to him that triage need not be a large burden and that the majority of referrals can be triaged rapidly. He stated he did an "enhanced triage" and that it was significantly better than any method I suggested. Little did I know at the time that he had effectively stopped performing triage from about 2015.
37. He was slow to embrace technology, e.g., I recall that at one stage his secretary used to have print out emails as he didn't have a computer in his office. Rather than dictate a short note to his secretary he was known to write



## Urology Services Inquiry

long hand. When digital dictation was introduced for clinics, results, and discharge summaries he was slow to utilise it.

38. At various stages he was given support from his colleagues with triage. He was offered help by the Trust after his Job plan went to facilitation but didn't engage. He had twice as much secretarial support as his colleagues. Debbie Burns in 2014 asked him to say what support he needed to help his practice. That summer, he was given a month with no clinics to catch up on his administration. I don't know if it was arrogance or fear of losing face that stopped him from requesting more help / the help he needed to change his style of practice.
39. The failure to investigate the false accusation of bullying and harassment against me was, I believe, done for the best of reasons. I was aware at that time that Roberta Brownlee was very friendly with Aidan O'Brien and was a director of his charitable company 'CURE' from, I believe, 1997. Unfortunately, by not being investigated and exonerated I was told to be very careful in my dealings with Aidan O'Brien and as a result it reduced my ability to challenge him or his practice sufficiently.
40. The prevailing culture at the inception of the Trust was to maximise performance and to maintain financial stability. These main foci were also expected by HSCB. This drive for performance, while maintaining financial stability, may have distracted the Trust from quality issues. There was neither the time in the working day nor the support staff to undertake regular audits of outcomes and the patient pathway either solely within urology or when there was engagement with other departments like the cancer directorate, laboratories, radiology, theatres and outpatients.
41. The organisational structure for Medical Management of urology was Medical Director, Associate Medical Director, Clinical Director and then Lead Clinician. My role as AMD was extensive and demanding but at the same time, I was a full time General Surgeon with a special interest in Oesophagogastric as well as Colorectal Surgery. The nature of my general surgical post and the number of colleagues on the team meant that, if I was to free up extra time for the



## Urology Services Inquiry

AMD role, I would have had to stop my special interests. My PA allocation as a Consultant surgeon post AMD was equivalent to 12.5 which meant I technically was allocated 1.5 PAs to fulfil the AMD roles. I gather there are now three CDs in the Surgical Division to support the AMD Surgery while for part of the time I only had one CD and a maximum of two. Between the AMD and Medical Director is now a new tier of Assistant Medical Director. These new changes have, I expect, improved the governance structure and the Assistant Director tier has increased the support for both the Medical Director and the Associate Medical Directors.

42. On reflection, one can see where things went wrong and what should have been done. The post of AMD was difficult due to the pressures of clinical work, the time available to fulfil the role, and the fact that I was covering not only Urology but also all the other Surgical Specialties. Urology in total probably took up more time and effort than any other subspecialty despite being one of the smallest. Heather Trouton, the Acute Directors, and myself relied on the assurance of Michael Young and Robin Brown that there were no clinical concerns. The current system is such that an AMD has to rely on his CD and Lead Clinician to supply accurate assessments on the clinicians in their team.
43. The failure by Aidan O'Brien to complete timely triage should have triggered a greater scrutiny of his administrative processes. It also should have generated a discussion between the Acute Director and the Medical Director regarding a review of his practice.
44. At the time of the urology review, the service in Craigavon was under significant pressure with a demand that outweighed the capacity. This led to a concentration on provision of services for emergencies, cancer and urgent patients. To deal with the rising backlog of outpatients and operative cases, consultants from within the specialty were being asked to provide additional sessions on top of their recognised sessions. These extra sessions generated more review patients and more administrative tasks for the consultants. There was difficulty in attracting and retaining sufficient staff at consultant



## Urology Services Inquiry

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

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

46. On a personal level, I do not believe that I had sufficient support and time available to fulfil all the duties of the role. I accept there was a failure on my part not to have raised this as a concern. There were other factors outside of work affecting me. Personal information redacted by the USI

Personal information redacted by the USI

Personal information redacted by the USI The post was very stressful, although I didn't realise just how much until I stepped down from the role in April 2016. Personal information redacted by the USI

Personal information redacted by the USI



## Urology Services Inquiry

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

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

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

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

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

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



## Urology Services Inquiry

ensure completion of appraisals and to assist in the process of revalidation. Any issues with completion of Appraisals prior to establishment of the Medical Revalidation Office were communicated directly to the clinician but I would very occasionally have been asked to speak to an individual consultant on a case by case basis.

- (ii) Responsibility for Medical Education was undertaken by Mr Colin Weir, AMD for Postgraduate Medical Education while Research was the responsibility for Dr Peter Sharpe, AMD for Research and Development.

50. The Clinical Director Cancer Services Job Description reflects the duties and responsibilities of the post. *Document located in Section 21 4 of 2022, 20040323 Letter re Macmillan Lead Cancer Specialist CD wef 01.01.2004 + Job Description.*

51. I do not recall being issued with a job description for the Clinical Director Surgery post and Medical Staffing do not have a job description on file.

**[6] Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

52. As Lead Clinician for Out-patients, I worked with Hazel Neill, Out-patient Nurse Manager, and I provided clinical advice re Out-patients and Medical Records. I reported to the Clinical Director in Surgery, Mr Mulligan, and with Hazel Neill I also attended regular meetings with the Southern Health Board regarding Out-patient issues. I had no direct management role in Out-patients or Medical Records rather I provided clinical advice.

53. As Lead Clinician for General Surgery, I reported to the Clinical Director, Mr Stirling. I performed duties as requested by the Clinical Director and I also provided clinical advice. I liaised with fellow clinicians, ward and administrative





## Urology Services Inquiry

staff. My major task during this time was to assist Ivan Stirling with the integration of the surgeons from South Tyrone Hospital following the transfer of in-patient surgical services to Craigavon Area Hospital. As a result of the increased emergency surgical workload I proposed (with the support of Ivan Stirling) the introduction of the system of Surgeon of the Week for General Surgery in Craigavon Area Hospital.

54. As Clinical Director for Cancer Services, I assisted in overseeing the development of Cancer Services in the Southern Area from 2004 until 2007. I reported to the Medical Director (successively Caroline Humphrey, Ian Orr, Stephen Hall) as well as John Templeton, Chief Executive of CAHGT. I met weekly with Mrs Hazel Neill, the Cancer Nurse Manager, and took part in a regular Governance meeting with Dr Gerry Miller, GP Facilitator in Cancer and Palliative Care. We also regularly met staff from the SHSSB and the Service Delivery Unit to (i) help achieve Cancer Access Targets (ii) oversee the introduction of MDMs (Multi-Disciplinary Meeting to discuss all patients with a new cancer and to plan their treatment) (iii) oversee the development of a palliative care service and (iv) the tracking of patients through the cancer care pathway. The then solo Palliative Care Consultant, Osmond Morris, was employed by the Southern Area Hospice but reported to me in respect of his sessions in Craigavon Area Hospital.
55. As Clinical Director for Surgery, I liaised with the Assistant Director for Surgery, Simon Gibson, regarding operational management and provided advice on the application of new standards and guidelines as requested by the Associate Medical Director, Ivan Stirling. I was line manager for Michael Young, Lead Clinician Urology and Sam Hall Lead Clinician ENT.
56. As Associate Medical Director I had clinical leadership responsibility for ENT, General Surgery CAH and DHH, Urology, Trauma & Orthopaedics Service, Orthodontics and Ophthalmology. I was assisted initially by one Clinical Director, Mr Robin Brown (later joined by Ms Sam Sloan, followed by Sam Hall) as well as lead clinicians in ENT, Urology, T&O and Oral Dentistry. I worked closely with the Head of Service for each specialty and the Assistant





## Urology Services Inquiry

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

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

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

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



## Urology Services Inquiry

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

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

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

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



## Urology Services Inquiry

operational delivery and targets also lay with the Director and Heather Trouton, I was responsible for providing clinical support and advice to the Directorate Management Team to help meet the targets and to support Martina, Heather and/or the Director in any discussions with the urologists. I also was responsible for the provision of clinical advice towards development and modernisation of the service. I was responsible for the provision of clinical advice when screening DATIX (the Trust's electronic reporting system) or potential SAIs. When a Urology SAI was undertaken I was responsible for presenting the SAI at the Acute Governance Meeting and for disseminating any learning at the Morbidity & Mortality meeting.

61. The Medical Director (Paddy Loughran, John Simpson and Richard Wright) had overall responsibility for the Appraisal process. With Robin Brown being based in Newry, it was agreed it was more convenient for his appraisal to be performed by a Daisy Hill Consultant and it was performed Mr Geoff Blake. Robin Brown performed Michael Young's Appraisal and he in turn performed his consultant urological colleagues' appraisals. The completed appraisal form was forwarded directly by the individual consultants to the Medical Director. The Medical Director assumed oversight of Infection control, hence following the issue regarding IV Fluids/Antibiotics (see question 54 below) Paddy Loughran appointed Ms Sam Sloan, Clinical Director Surgery, and Dr Damani, Clinical Director of Infection Prevention and Control, (or his deputy) to chair a small committee to review the process for individual patients. My responsibility in the latter was to assist compliance.
62. Robin Brown was officially responsible for the initial meetings regarding job planning and I was responsible for review of the job plans. However, from 2009 to 2011 I had an active role in the negotiations with the urologists regarding their job plan and those of the extra consultants in the expanded urology department.

### Urology services/Urology unit - staffing



## Urology Services Inquiry

**[9] The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement in the establishment of the urology unit in the Southern Trust area.**

63. In November 2009, while preparing the case for development of 'Team South', it was noted, following discussions with commissioners and with the Urologists at the weekly meeting chaired by Gillian Rankin (initially chaired by Joy Youart) and attended by Heather Trouton, myself, Martina Corrigan and the three urologists, that there were significant issues with demand and capacity. Mairead McAlinden (Chief Executive) on 1 December 2009 chaired a meeting with Paddy Loughran, myself, Paula Clarke (Director of Performance and Reform), Debbie Burns (Assistant Director Performance), Heather Trouton and Gillian Rankin to agree a way forward. *Document located in Section 21 No 4 of 2022, 20091201 Uro Service Mtg Notes*. On 7 December 2009 Paddy Loughran chaired a meeting with Gillian Rankin, myself and Aidan O'Brien to discuss: listing patients for surgery by clinical urgency and chronology, pooling of lists, red flag referrals and triage as well as pre-operative assessment. *Document located in Section 21 No 4 of 2022, 20091207 Uro Services Mtg Minutes AOB*.

64. On 13 May 2010 a Steering Group was set up to manage the planning and implementation of the Urology Review. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100423 Email Steering Group Meeting*. The Steering Group was chaired by Gillian Rankin and, as AMD, I was a member. In order to develop the Team South Implementation Plan for both development of the service and operational delivery, the Director of Acute Services (initially Joy Youart and, after a few months, Gillian Rankin) chaired a weekly Monday evening meeting



## Urology Services Inquiry

with myself, Heather Trouton, Martina Corrigan and the three urologists. We would have a pre-meeting at 5pm to plan strategy and aims for the meeting. Then at 6pm we would be joined by the three Urologists: Aidan O'Brien, Michael Young and Mehmood Akhtar for up to an hour and a half. We would then have a debrief until approximately 8pm to discuss what was agreed and to plan the discussion points for the following week's meeting. Following some of the early meetings it was agreed by Gillian Rankin that I would act as a clinical challenge to the Urologists re their opinions and demands so that Dr Rankin could then obtain a reasonable, balanced consensus and agreement. This was a long, drawn-out process and we were met by the three urologists with a lot of suspicion, objection (see Aidan O'Brien's letter of 29 September 2010), obfuscation and obstruction to the process and aims of the project. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101004 Email Private and Confidential.* Frequently, we would find at one meeting that what we considered had been agreed at previous weeks' meetings the urologists would wish to renegotiate. I recall Gillian Rankin stating that she felt their aim was to talk us into submission.

65. Despite considerable progress being made in discussions with Michael Young and Mehmood Akhtar it was necessary for Gillian Rankin to write to Aidan O'Brien on 22 October 2010 regarding a refusal to amend clinical practice re length of time seeing out-patients, a reluctance to improve his 'new to review' ratio. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101022 Email Correspondence to Urologists.* At a meeting on 9 June 2011 Gillian Rankin outlined the requirement for job plans to be agreed, action to be taken on the review backlog, admission on the day of surgery and pooling of lists. *Document located at Section 21 4 of 2022, 20110627-email urology meetings.*

66. The MDM for Urological Cancers was organised by the Cancer Directorate and Mehmood Akhtar took a lead on developing this and worked with Ronan Carroll, Assistant Director Cancer & Clinical Services. My understanding is that the MDM commenced in 2010.



## Urology Services Inquiry

67. Robin Brown in 2012 took over negotiating the 5-man job plans with the urologists. Martina Corrigan on 6 June 2012 summarised the delays in obtaining agreement re the plans principally due to no response from the urologists to any proposals. *Document located in Section 21 4 of 2022, 20120606 E re Urology Job Plans and attachments A1 – A4.* On 27 February 2013 I wrote to thank Robin Brown for his efforts and advised him that despite Michael Young being keen to advertise we could not do so until we had agreed job plans. *Document located in Section 21 4 of 2022, 20130227 E re Urology Job Plans.* On 1 March 2013 I wrote to Robin Brown and Michael advising them that I had been informed by Kieran Donaghy, Director of Human Resources, of the requirement for any proposed job plans to meet the service-based agreement. *Document located in Section 21 4 of 2022, 20130301 E to MY and RB re Urology Job Plans.* In April 2013 the 5-man job plans were agreed and the fifth consultant commenced in December 2013.
68. I was also involved with Gillian Rankin and Heather Trouton in reviewing the progress of the draft implementation plans.

### **[10] What, if any, performance indicators were used within the urology unit at its inception?**

69. The performance indicators were set out by Hugh Mullen HSCB in a letter dated 27 April 2010 and were as follows:
- a. Introduction of one stop clinics for suspected urological cancers.
  - b. reduction in length of stay by use pre-op assessment clinics, admission on day of surgery and benchmarking with comparable units.
  - c. increase in percentage of day surgery cases.
  - d. Introduce Nurse led outpatient review.





## Urology Services Inquiry

- e. Introduce processes for booking of clinics, and management of DNAs and CNAs to maximise capacity (DNA did not attend, CNA cannot attend).

*Document located in Section 21 4 of 2022, 20100427 Ltr re Regional Uro Review.*

**[11] Was the 'Integrated Elective Access Protocol' published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?**

70. I did not personally provide the Integrated Elective Access Protocol to the Urologists and therefore I cannot say if the whole document was in fact shared. However, it formed the basis of the meetings which took place every Monday for approximately 18 months during 2009 and 2010 (see Question 9 above). I also note that, in the minutes of a Meeting that Paddy Loughran, Gillian Rankin and myself held 1/12/09 with Aidan O'Brien, the Protocol was mentioned and, in particular, the following items: treatment in chronological order, pooling of lists, red flag system and pre-op assessment. *Document located in Section 21 4 of 2022, 20091201 Uro Service Mtg Notes*

**[12] How, if at all, did the 'Integrated Elective Access Protocol' (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?**

71. The oversight of the time limits within the protocol were ultimately overseen by Heather Trouton and, through her, Gillian Rankin. Ronan Carroll, as Assistant Director for Cancer and Clinical Services, would have reported on the Cancer Access Targets to Gillian Rankin and Heather Trouton, likewise Anita Carroll as Assistant Director for Support Services who had responsibility for Out-patients and the booking centre. ICATs (Integrated Clinical And Treatment



## Urology Services Inquiry

Service), which ultimately came to be based in the urology out-patient department and was named the Thorndale Unit, came under the remit of Heather Trouton. The Trust Performance and Reform team led by Paula Clarke would have had direct conversations/meetings with Gillian Rankin regarding any significant breaches of targets. Breaches of targets would be discussed with me by Heather Trouton if there was an issue that could possibly be solved by a direct conversation / meeting between myself and a clinician. Martina Corrigan would have brought more minor issues directly to the consultant.

**[13] The implementation plan, Regional Review of Urology Services, Team South Implementation Plan, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.**

- I. What is your knowledge of and what was your involvement with this plan?**
- II. How was it implemented, reviewed and its effectiveness assessed?**
- III. What was your role in that process?**
- IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.**

**[I] What is your knowledge of and what was your involvement with this plan?**

72. At that time we had a major problem with a review backlog in Urology but also in nearly all surgical specialities; thus Urology was not alone. The Regional





## Urology Services Inquiry

Review of Urology Services 2009 showed that the Southern Trust had the worst new to review ratio 1:3.85 versus an average of 1:1.93 in the Province. Nationally, the new to review ratio was 1 to 2.1 and it was proposed the Trust should aim for an upper quartile ratio of 1:1.5. I was involved in the Monday evening meetings chaired by Gillian Rankin in 2009/10 where we had intensive discussion with the urologists regarding the plan.

### **[II] How was it implemented, reviewed and its effectiveness assessed?**

73. Clinic templates were drafted with a 20minute time for a new patient to be seen and a 10minute review time. Later the urologists pointed out that a Day 4 review of a newly diagnosed cancer patient needed more time to discuss the diagnosis so this particular review time was adjusted to 30minutes. Following repeated meetings by Gillian, Heather, myself with the urologists, Gillian Rankin wrote to Aidan O'Brian on 22 October 2010 asking him to agree to amend clinic templates. *Document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to Mr AOB re Reg Uro Implementation.* The urologists were also encouraged to select patients for follow up by the Urology Specialist nurses. The effectiveness was monitored by Heather Trouton as well as Gillian Rankin and the Performance team. Gillian Rankin, Heather Trouton and I held a meeting on 9 June 2011 with Michael Young and Mehmood Akhtar where methods of review triage and the input of Shirley Tedford Sister in Charge, Thorndale Unit to support the process were agreed. At the 9 June 2011 meeting with Aidan O'Brien it was agreed that Heather Trouton would further meet with him to discuss a way forward re managing the review backlog. *Document located at Section 21 4 of 2022, 20110627-email urology meetings.*

### **[III] What was your role in that process?**

74. I was involved in the negotiations with the urologists and, where necessary, I acted as a clinical challenge to their review practice and to that of the junior staff under their supervision. To try to reduce the number of patients requiring review Heather Trouton, myself and Martina Corrigan met with the AMD for



## Urology Services Inquiry

Primary Care, Dr Peter Beckett, along with the Urologists to discuss pathways for discharging patients to their GP for further follow-up. I also met with Michael Young to discuss a proposed service model with consultant expansion.

**[IV] Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.**

75. I don't believe the plan achieved its aims. My recollection is that a major contributor to the problem was that the HSCB had funded in-house additional waiting list clinics to reduce the length of time new patients waited for first appointment but no review clinics for these new patients were funded, hence the problem was made worse. A side effect of the alteration in clinic templates was that it made the new to review ratio look satisfactory but if a consultant didn't change their review practice the backlog increased (If clinics are booked with 1 new patient for every 1.5 review patients then unless the review backlog patients are individually counted the ratio may be worse). The plan also proposed an increase in the number of consultants in the unit but an increasing problem was and remains that young Northern Ireland consultants want to live in or near Belfast and also want to work in a unit which is well supported by junior staff and has sufficient consultants on the rota to improve work/life balance. All of these factors increased the difficulty in attracting new consultants.

**[14] Were the issues raised by the Implementation Plan reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.**



## Urology Services Inquiry

76. The issues raised in connection with the Implementation plan were widely known at senior level in the Directorate and by senior Trust management. The Surgical Division Risk Register was compiled by Heather Trouton and reviewed by me before being agreed by Gillian Rankin. The risks below were added to Risk Registers within the Acute Directorate. I have never had knowledge of the Corporate Risk Register contents. The Urology cancer pathway delays was added to the Surgery & Elective Care Risk Register ID 2943 on 7 April 2011. An increase in urology access waiting times was added to the Acute Directorate Risk Register ID 3166 on 25 June 2012. Increased waiting time for new outpatients and elective surgery was added to the Surgery & Elective Care Risk Register ID 3690 on 8 June 2015. *Documents located at Section 21 4 of 2022, SEC Risk Register 2011, SEC Risk Register 2015 and Acute Directorate Risk Register 2012.*

**[15] To your knowledge, were the issues noted in the Regional Review of Urology Services, Team South Implementation Plan resolved satisfactorily or did problems persist following the setting up of the urology unit during your tenure?**

77. Many of the issues noted in the Implementation Plan persisted following setting up the unit. There were delays with: clinic templates, consultant expansion, admission on day of surgery, use of pre-op assessment, nurse follow-up, GP follow-up, availability of a consultant oncology input to MDMs, provision of operating theatre time. Also, unlike other ICATS services, the Urology ICATS was not independent in that triage for ICATS was performed by consultants as well as the supervision of ICATS clinics.

**[16] Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?**



## Urology Services Inquiry

**[17] Were 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.**

**[18] Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?**

78. Given the overlap between Questions 16, 17 and 18, I have addressed them together below.

79. I do not think the unit was adequately staffed and properly resourced.

80. The initial consultant staffing plan was for 5 consultants although, due to increasing demand, it was eventually recognised that 6 would be required, particularly as Robin Brown on his retirement would not be replaced by a urologist in Daisy Hill Hospital.

81. On review of the list of Consultants and SAS Medical Grades October 2009-March 2016 I note that Consultant numbers fluctuated over the years as follows:

- a. From 2009 to 2011 there were 3 consultants, which rose to 4 in November 2011.
- b. In 2012 numbers went down to 3 in April and then back up to 4 from September.
- c. In 2013 numbers went down to 3 again in March and back up to 4 in November, and finally 5 in December.
- d. In 2014 numbers went back down to 4 in January and up to 5 in May, and finally 6 in August. The sixth post was an appointment that was made because we had two excellent candidates for one post and, after years of consultant understaffing, the Trust went at financial risk in the appointment.



## Urology Services Inquiry

e. In 2016 numbers went back down to 5 in October and I understand remained at that until at least 2018.

*Documents located at Section 21 4 of 2022, List of Consultants and SAS Medical Grades 2009-2016.*

82. Non consultant staffing was also a problem in that NIMDTA did not agree to provide core surgical trainees which meant there was only one tier of staff on-call below the consultant. The Unit had 2 registrar posts supplied by NIMDTA. There was supposed to be 2 trust grade doctors but these posts proved difficult to fill and frequently there would only be one at any time. The Urologists proposed that we appoint a clinical fellow (a trainee doing research but needing funding), thus they worked only 2 days per week in CAH and joined the registrars' on-call rota. In 2014 urology was down to only 2 registrar-level doctors and, due to annual leave requirements for the 2 registrars, urology was even more stretched. For approximately 6 weeks I organised General Surgery to provide trainees to assist the urologists in theatres. Also in 2014, because of the excessive number of hours Urology juniors were working to fill the rota, I organised the General Surgery middle grade staff to provide overnight cover from 11pm weekdays and 9 pm at weekends.

83. Due to expansion of Urology as well as other specialties (including General Surgery and ENT Surgery) there was a lack of operating theatre space to accommodate 5 to 6 urologists. The urologists therefore agreed to undertake a three-session theatre day. However, this produced other problems in that there was greater difficulty discharging the last couple of patients operated upon home that day and, for example, two three-session per day lists turned out not to be as efficient as three two-session per day lists.

84. The Day Surgery Unit in Craigavon Area Hospital is remote from the main hospital building with no connecting corridor and this restricted the selection of suitable day cases in case one needed admission post-operatively.



## Urology Services Inquiry

85. I was aware of the consultant issues. It took until March 2012 to get agreement from the three incumbents regarding how a 5-man unit would function while satisfying the demands of the commissioners re meeting the estimated workload. In the early stages of 2012, Mr Akhtar came and spoke to me to say he was leaving, although I had already been told of this by either Heather Trouton or Martina Corrigan. I believe either Martina or Heather were the first to inform me when David Connelly (approximately December 2012) and Ajay Pahuja (approximately October 2013) submitted their resignations. I was also informed of all the above resignations by Michael Young. We relied on Michael Young to advise us on the possibility of suitably trained candidates for a substantive consultant post being available to apply and, once he did, we acted on same. Hence, in 2014 we had two excellent candidates who applied for one post so the Trust appointed the second at financial risk (as mentioned above). The Consultants were not keen on appointing locum consultants as their clinical skills tended to be of a variable standard. The exception was that we appointed a previous registrar, K J Ho, as a locum consultant in October 2011, but he left in August 2012 following the full time appointment of Tony Glackin. I was aware of middle grade issues but this was managed directly by Michael Young and Martina/Heather as regards requesting locum appointments. When we had a short stay locum from an Agency, I would be shown their CVs by Heather for approval.

86. In my opinion the problems with Consultant and middle grade staffing meant that, while emergency activity continued, the availability of theatre time for elective patients was decreased and also the out-patient waiting list increased.

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

87. As detailed in Question 18 the emergency workload continued to be covered. It was policy that, if there was a capacity problem in any service, the red flag patients would take precedence over urgent and routine. A reduction from the



## Urology Services Inquiry

planned staffing levels meant that there was an increase in waiting times for an out-patient appointment and for surgery for the less urgent cases. It also increased the pressure on consultants.

88. A unit that has a significant shortage of staff is not as attractive to consultant applicants as one that is well resourced and has an attractive on-call rota. This would have contributed to the difficulty in recruitment and retention. When a unit has a full complement of junior staff there tends to be more Clinical Audit performed. This would include e.g., prescribing audits, outcome audits and reviews of patient management. The reduction in staffing reduced the ability to perform same.

**[20] Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?**

89. With the appointment of the sixth consultant in 2014, a formal subspecialisation was developed: Michael Young and John O'Donoghue developed a subspecialty interest in Stones, Mark Haynes and Tony Glackin specialised in Cancer, and Aidan O'Brien was Cancer and General Urology.
90. Following the arrival of the fifth and sixth consultant an agreement was reached with the commissioners for the introduction of a system of 'Consultant of the Week'. Prior to this Consultants had to fit emergency cases in around their normal working day and a consultant of the week model helped ensure that emergency cases were dealt as promptly as possible and without the consultant having to worry about the elective work he was meant to be performing at that time. Thus, for 4 hours each day a consultant was available to provide emergency care. A model like this can reduce elective activity but (a) it improves the treatment of emergency patients and can be safer and (b) because we had appointed an extra 6<sup>th</sup> consultant this compensated for the shortfall in activity.





## Urology Services Inquiry

91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

**[21] Did your role change in terms of governance during your tenure? If so, how?**

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.





## Urology Services Inquiry

**[22] Explain how the unit was supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.**

93. This question is outside my remit. Questions on nursing staff levels and allocation are best answered by Heather Trouton, while questions on administrative staff levels and allocations are best answered by Anita Carroll, AD Functional Support Services. The only item I do recall being discussed was that Aidan O'Brien had 1 WTE secretary allocated to him while the other urologists had 0.5 WTE secretarial support.

**[23] Was there an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?**

94. I am unable to answer this question and it is best answered by Anita Carroll, Assistant Director Functional Support.

**[24] Were support staff concerns ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what you did in response.**

95. I don't recall any support staff concerns being raised directly with me. I believe Aidan O'Brien asked at some point in time about having more than 1 WTE secretary (at this stage, all the others had a 0.5 WTE secretary) and that he was advised accordingly. In February 2014 Debbie Burns asked if he required any additional admin support. My recollection is that, following this, he asked to be excused during the month of July from all clinics to allow him to catch up on his administration and this was agreed.



## Urology Services Inquiry

**[25] Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.**

96. The day to day running of the Urology Unit at ward level was the responsibility of the ward sister, while in the Thorndale Unit it was Sister Shirley Tedford. The unit was overseen by Martina Corrigan, Heather Trouton and the Assistant Director of Nursing. Michael Young was the Lead Clinician and he reported to Robin Brown who reported to me.

**[26] What, if any role did you have in staff performance reviews?**

97. Robin Brown as CD performed the appraisal on Michael Young. Michael Young performed the appraisals on Aidan O'Brien and the remaining Consultants. The unit consultants were responsible for performance appraisals of the non-consultant doctors on their team. When Aidan O'Brien's appraisal was completed it was forwarded directly to the Medical Director. I cannot recall at any time concerns being raised with me as a result of the appraisals.

**[27] Was your role as AMD subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role.**

98. My appraisals were performed by the Medical Director. At my 2012 appraisal John Simpson noted my AMD oversight of the Morbidity and Mortality process and we discussed the monthly governance interface with Children and Young People Directorate and progress re management of children with head injuries and transfer of children to Belfast. *Document located at Section 21 4 of 2022, 2012 Appraisal EM.*



## Urology Services Inquiry

99. At my 2013 appraisal John Simpson noted that I had been leading on new developments in the Surgical Morbidity and Mortality reform. He also noted I played a leading role in governance in the Acute Directorate and that I regularly attended and contributed to the Acute Governance Forum and the AMD forum. *Document located at Section 21 4 of 2022, 2013 Appraisal EM.*
100. At my 2014/2015 appraisals Richard Wright noted that I was actively involved as AMD in the delivery of a safe service and that I had taken a number of initiatives in this role. He also noted that I had produced evidence of participation in the AMD team and Acute Governance Committees. In 2016, at my 2014/15 appraisals, Dr Richard Wright recommended that I consider undertaking a leadership module but, as I had stepped down as AMD in April 2016, this was never undertaken. *Document located at Section 21 4 of 2022, 2014-2015 Appraisal EM.*

### **Engagement with unit staff**

**[28] Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.**

**[29] Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit staff and how long those meetings typically lasted. Please provide any minutes of such meetings.**

101. I have answered Questions 28 and 29 together because of the overlap between them. I did not directly engage with all the staff in the urology unit as this role was the responsibility of the Lead Clinician and the Head of Service. The Clinical Director would have engaged with the Lead Clinician and it should be noted that, because of his urological interest, he attended the MDM. The engagement of other non-medical staff in the unit was the



## Urology Services Inquiry

responsibility of the Head of Service and the Assistant Director. Once a month, my weekly Governance meeting with Heather Trouton included Michael Young and Robin Brown. For the majority of these meetings no minutes were taken, rather Heather Trouton would make a note of any action points in her notebook. This joint portion of the meeting generally lasted about an hour and during this time any urology issues were discussed. As noted above, for approximately 18 months during 2009-10 I met with all three urologists for up to 90 minutes at the weekly meetings that Gillian Rankin held on a Monday evening regarding the implementation of Team South plan. I would also have met all the consultants at the monthly Morbidity and Mortality meetings, which lasted up to 2 hours.

**[30] In your opinion during your tenure, did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.**

102. During my tenure Martina Corrigan (Head of Service), Heather Trouton (Assistant Director) and Gillian Rankin, Debbie Burns and Esther Gishkori (Director of Acute Services) and myself worked very well together and had a common aim and purpose. Likewise, I feel that all of the above individuals established good working relationships with most of the urologists. Martina Corrigan, as Head of Service, had a very close relationship with them and would often act as an advocate on behalf of Urology. I have no reason to think that her relationship was not reciprocated. During the 18 months of Monday evening meetings it was obvious that the three Urologists, Michael Young, Mehmood Akhtar and Aidan O'Brien, were in agreement with each other regarding tactics and desired outcomes and, while the meetings were cordial, I felt that they had an underlying mistrust of the process. I feel I have been able, over the years, to maintain a good working relationship with Michael Young despite our differences in 2009-10. Mehmood Akhtar, when he was leaving in 2012, spoke to me and said that he had come to realise that I had urology's best interest at heart.



## Urology Services Inquiry

103. While Aidan O'Brien appeared to be friendly to me, I believe he had several issues with me built up over a couple of years. (i) I think he resented my role in challenging the urology proposals at the Monday meetings. (ii) I was at the meeting on 9<sup>th</sup> September 2010 when he was informed by Gillian Rankin and myself of the process that he had to follow if he wished to admit a patient for IV fluids & IV antibiotics. (iii) At the same meeting Aidan O'Brien was informed of the decision to investigate the issue of benign cystectomies and immediately objected to Mark Fordham (Consultant Urologist advisor to the Urology Review) conducting the review, I believe this was because Mark Fordham did not agree to major pelvic surgery being performed in Craigavon Area Hospital. (iv) I had informed him in the past that he had to complete triaging. (v) While I had no direct role with investigating the issue of him destroying patient records and had not personally referred him to HR, he knew that I had been involved in the discussion. Once I was told of Aidan O'Brien's complaint of bullying and harassment, I maintained polite interactions with him but I was no longer directly involved in supervising him. Michael Young I found to be very sympathetic and supportive towards Aidan as was Robin Brown and I cannot recall any concerns regarding Aidan O'Brien or his practice being raised with me by Robin Brown or Michael Young. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100910 Email Urgent*

### **Governance – generally**

**[31] What was your role regarding the consultants and clinicians in the unit, including in matters of clinical governance?**

104. My roles regarding the consultants and clinicians in the unit were as follows:

a. Professional leadership:



## Urology Services Inquiry

- I. To assist in the redesign, modernisation and improvement of service delivery
- II. To promote training and development
- III. To ensure highest standards of clinical effectiveness and medical practice including implementation of Guidelines and national recommendations.
- IV. Contribute to Directorate Governance Committee
- V. To place patient safety at the centre of Directorate activity

### b. Leading the Medical Team

- I. Be responsible for performance management for designated medical staff.
- II. Implement the consultant contract ensuring that the contract supports modernisation, quality improvement and achievement of access targets.
- III. Take part in the recruitment process.
- IV. Influence the modernisation of the workforce systems for delivering care change

### c. Quality and Information Management

- I. Support the development of clinical indicators and relevant outcome measures.
- II. Ensure a programme of multi-professional clinical audit is implemented.
- III. Support the Trust adverse incident reporting and complaints handling mechanisms.

### d. Collaborative Working



## Urology Services Inquiry

- I. Promote the development of clinical and professional networks across primary, secondary and social care.
- II. Promote and develop effective multi-professional team working and communication.

(See attached Job plan) *Document located at Section 21 4 of 2022, SHSCT Associate Medical Director JD.*

105. Re Professional leadership, I was supported by Robin Brown (CD) and Michael Young (Lead). Michael Young and the other urologists attended the Monday meetings re modernisation and development of the service. With Heather Trouton we formed a Directorate Governance Committee which met weekly and was attended by Martina Corrigan for matters relevant to Urology. On a monthly basis the Lead Clinicians and CDs attended. Relevant local and national guidelines were discussed as they arose.
106. Re leading the medical team, I knew that Robin Brown performed Michael Young's appraisal and he in turn was performing his consultant colleagues' appraisals. The completed appraisals went to the Medical Director and no issues were ever raised to me by either Robin or Michael. As part of the Revalidation process every five years consultants had to produce evidence of multi-source feedback of their performance as well as patient feedback. This was reviewed by their appraiser and the Revalidation Team and no issues were ever raised with me as a result of the revalidation process.
107. Re Modernisation, quality improvement and access targets, I was an active participant in the Monday evening meetings challenging the previous norms so as to help improve the service. Regarding recruitment, I assisted in the approval process for posts. I sat on nearly all the recruitment panels for Urology Consultants. When a short-term locum was employed to assist the service, Heather Trouton would beforehand have given me the CVs to review.
108. I introduced a combined monthly Morbidity and Mortality meeting across the two sites of DHH and CAH. Under the direction of John Simpson, I





## Urology Services Inquiry

actively supported the introduction of the multi-professional Patient Safety Meeting. Heather Trouton and myself, at our weekly governance meeting, screened DATIX, SAls and Significant complaints. National Safety alerts were reviewed as were any new relevant standards and guidelines. The Trust had invested in CHKS a system which allowed benchmarking with a group of other units/hospitals regarding quality and performance. The reports were reviewed both at directorate level as well as Trust. I attended the monthly Acute Governance meeting as well as the AMD governance meeting which was also held monthly.

109. Heather Trouton and I enlisted the assistance of Peter Beckett, AMD for Primary Care, and met with the urologists to promote collaboration between primary and secondary care in order to help reduce the large demand on Urology services. The Director of Nursing and Heather Trouton oversaw the Specialist nurses in the Thorndale Unit.

**[32] 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?**

**[33] How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with that assurances regarding the quality of services?**

110. Given the overlap between Questions 32 and 33 I have considered them together.

111. It is generally recognised that there are 7 pillars of Clinical Governance and each so-called pillar was overseen in a different manner:-

- i. Clinical Effectiveness: Clinical Standards, Guidelines and National Patient safety alerts were distributed by the Medical Director and the Director of Acute Services. Heather Trouton and I would check that relevant ones relating to Urology were forwarded or brought to them by





## Urology Services Inquiry

Martina Corrigan. Caroline Beattie, Standards & Guidelines Lead, would produce the Accountability report re implementation of the Standards and Guidelines for Corporate Governance and would flag up to Heather and myself if either of us needed to follow up with the team re implementation. Attendance at the MDM by the Clinicians treating Cancer patients helped to assure that correct treatment paths were being followed. Assurance of the effectiveness of the MDM process was provided to the Director of Acute Services, Heather Trouton, and myself by Ronan Carroll at the Acute Clinical Governance Meeting.

- ii. Risk Management: Heather Trouton would ensure that learning from previous issues was distributed to nursing staff while I would ensure it was presented at the Morbidity and Mortality Meeting and or our monthly Governance meeting with Robin Brown and Michael Young. Near misses were reported through DATIX and were screened by Heather Trouton and myself and, where we felt necessary, an SAI would be initiated and any learning disseminated as above.
- iii. Patient and Public Involvement: All consultants every 5 years undergo Revalidation and, as part of that process, have to have a 360 degree review by colleagues, both medical and non-medical. They also were required to have patients complete a feedback form. The reports are reviewed by their appraiser as well as the Medical Revalidation Team. Any significant issues regarding a consultant would be raised with either myself or the Medical Director. Patient complaints were screened by Heather Trouton and any clinical ones would be discussed with me and acted upon as we agreed necessary.
- iv. Audit: Clinical audits are traditionally performed by junior staff and presented at the Morbidity and Mortality meeting. However, with the small number of junior staff in Urology I recognise that this restricted the number of Audits performed. I further note that Northern Ireland and Wales did not participate in British Association of Urological Surgeons Surgical Outcomes Audits. Attendance at Morbidity and Mortality



## Urology Services Inquiry

meetings was recorded and reported to the Medical director's office and was expected to be >60% for all consultants. Infection Control performed regular audits on hand washing. The microbiologists also performed regular ward rounds to ensure compliance with antibiotic prescribing and reported back to Acute Clinical Governance and the Medical Director. Significant breaches would be reported to Michael Young, Heather Trouton and myself.

- v. Staff Management: As part of the appraisal process staff are expected to show evidence of compliance with Corporate staff mandatory training and, while failure with compliance should be noted by the Appraisal process, failure to complete mandatory training could prevent a recommendation for revalidation by the Medical Director.
- vi. Education and Training: Colin Weir as AMD for Postgraduate Medical Education was responsible for ensuring that opportunities for education existed. NIMDTA (Northern Ireland Medical & Dental Training Agency) were responsible for appointing trainees to the Unit and they received biannual feedback from the trainees on the quality of their teaching and training in the Unit. Issues would be raised with the Educational Supervisor who reported to Colin Weir. Colin Weir would inform myself if there were any deficiencies as well as the Medical Director at the AMD Governance Meeting. The consultants also had to produce evidence of internal and external education and continuing professional development as part of their appraisal process.
- vii. Information: A patient's information should always be up to date and correct on any systems used. It should be confidential through correct storage and management of data. Anita Carroll, as Assistant Director Functional Support Services, was responsible for the Booking & Contact Centre and Health Records.

112. At a clinical level the consultants oversaw the non-consultant grades. Michael Young worked clinically with the consultants and fed back to Robin Brown, who also had direct clinical interactions with the urologists. Michael



## Urology Services Inquiry

and Robin attended the Divisional Governance Meeting and provided assurance to Heather Trouton and myself. The urologists attended the Morbidity and Mortality meetings and later the Patient Safety Meetings. Prior to the introduction of the Patient Safety Meeting in 2014 and the formal appointment of a chair of same, Charlie McAllister AMD Anaesthetics, Theatres & Intensive Care and I would meet after the Morbidity & Mortality meeting to discuss if either of us identified any Governance issues which required further investigation or action. The urology MDM helped to standardise the treatment of urological cancers across the province. The cancer access targets and the cancer pathway of 31 and 62 days were the responsibility of Ronan Carroll, AD Cancer and Clinical Care, and he reported to the Acute Director who discussed relevant results with Heather Trouton and ultimately myself. In respect of achievement of the cancer targets, the Surgery & Elective Care Risk Register on 7 April 2011 documented delays in the urology pathways. On 22 June 2012 an increase in the urology access times were noted on the Directorate Risk Register. On 8 June 2015 the urology waiting time was 87 weeks and this was escalated to HSCB as there was a demand versus capacity mismatch. *Documents located in Section 21 4 of 2022, SEC Risk Register 2011, SEC Risk Register 2015 and Acute Directorate Risk Register 2012.*

**[34] How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this oversight?**

113. I did not have responsibility for performance metrics. Sharon Glenny, support lead, would have produced metrics including: New to R/V ratio, R/V backlog, Day of admission for surgery, Pre-op assessment, Outpatient waiting lists, in-patient waiting lists, etc. These would have been forwarded to Heather Trouton and, through her, reported to the Acute Director. Specific issues identified would have been discussed with me by Heather Trouton and/or the Acute Director. The Trust Performance and Reform Directorate were also responsible at a higher level.



## Urology Services Inquiry

**[35] How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?**

114. Managing patient risk and safety was a multipronged approach. Assurance was obtained from Appraisal and Revalidation process (Domain 2 of the appraisal was Safety and Quality).
115. I attended the Morbidity and Mortality meeting (later the Patient Safety Meeting). Jilly Redpath, Pharmacist, also attended the meeting and gave a detailed report on prescribing mishaps and errors that had occurred in the hospital. Any significant deaths or morbidity would be discussed at the Morbidity and Mortality meeting. Following the meeting, I would consult with Charlie McAllister, AMD for Anaesthetics, and discuss if there was anything presented that required further investigation or action. Learning from SAls was presented at the patient safety meeting.
116. The MDM process meant that cancer management was multiprofessional and the processes matched that of other urological units. Ronan Carroll as AD for Cancer reported any concerns to the Acute Director and the Acute Clinical Governance Meeting.
117. I assisted Heather Trouton in screening SAls and reviewed relevant DATIX and adverse incidents. If locums were to be employed from an agency I would assist in screening their CVs. With the help of Robin Brown and later Sam Hall I oversaw job planning. I liaised with front line teams. The Medical Director's office disseminated to all clinical staff any new Standards and Guidelines.

**[36] How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What**



## Urology Services Inquiry

**systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?**

118. All consultants in the Directorate knew that they could freely speak to me as AMD and, not infrequently, they did when they had a concern or issue in any part of the directorate. On a Tuesday, I operated in theatre 3 while a Urologist operated next door in theatre 4. The operating consultant was usually Michael Young and we would frequently have liaised with each other during the course of the day. I also would have liaised with Charlie McAllister during my theatre list and usually several other times during the week. I also would have spoken to Stephen Hall, AMD Radiology, at least once during the month on top of the Acute Governance meeting and the AMD Governance meeting.

119. I had frequent meetings with Heather Trouton and Martina Corrigan, including the weekly governance meeting, and would have been informed of any significant patient issues or concerns regarding the urology service. Martina Corrigan, by virtue of her role as Head of Service, worked closely with the senior staff in the unit and would be appraised of concerns as they arose. Minor concerns were usually dealt with verbally by speaking to the relevant urology consultant or Michael Young as Lead Clinician. A more serious concern, however, would be escalated. An example of such a concern was one raised on 16 June 2011 by the Shirley Tedford Ward Sister when a nursing Auxiliary had found in a bin part of a patient's records which Aidan O'Brien had dumped. This was escalated to Martina Corrigan who immediately discussed it with myself and Heather Trouton (see further Question 54 below). *Documents located in Relevant to HR, reference No 63 20110819 Ref 63 Issue of Informal Warning MrAOBrien and 20110600 Ref 63 Disciplinary Report Mr AOBrien*

120. DATIX allowed all staff both outside and inside the unit to flag any event that causes a loss, injury or a near miss to a patient, staff or others. The DATIX, as stated earlier, was reviewed by Heather Trouton and relevant issues discussed with me.



## Urology Services Inquiry

121. The Complaints Department received concerns from patients and relatives. A complaint would be sent out to the relevant team for completion, a reply would be drafted by, I believe, Heather Trouton and then ultimately signed by the Acute Director. Significant clinical complaints would be discussed at the Divisional and/or Acute Directorate governance meetings.
122. For the most part, the system worked. However, on reflection it is easy to see that, for example, our systems for monitoring triage were not sufficient. Because of repeated breaches, a system was introduced by Debbie Burns whereby the booking centre placed the patient on the out-patient list according to their GP's grading to ensure chronological booking. Following this, however, oversight of the triage compliance by Aidan O'Brien was not performed. The system for tracking of referrals has now been improved by the introduction of electronic triage using NIECR (Northern Ireland Electronic Care Record). Following the changes re booking of outpatient referrals I was not made aware of any delays in triage and it was only the raising of concerns by Aidan O'Brien's colleagues, while performing validation clinics in late 2015, that ultimately led to the investigation into his practice.

**[37] Did those systems or processes change over time? If so, how, by whom and why?**

123. I don't recall any significant changes in the systems with time.

**[38] How did you ensure that you were appraised of any concerns generally within the unit?**

124. I held regular meetings with the Head of Service, Assistant Director, Director and Lead Clinician. I had good working relations with nearly all staff including both medical and non-medical. With Heather Trouton and I reviewed any DATIX and any significant complaints received in the directorate.



## Urology Services Inquiry

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

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

125. The systems are as detailed in my answers above from Questions 33 to 38. At the time we thought the systems were effective and that concerns, as they arose, were being escalated and action taken. As such we did not have any significant governance concerns.
126. The issue regarding the number of benign cystectomies being performed was appropriately investigated, the practice was stopped and compliance monitored.
127. Likewise the issue regarding IV fluids & IV antibiotics was escalated and a protocol produced to change practice. Compliance was monitored and any breaches/ potential breaches followed up and stopped.
128. Regarding triage, this was an ongoing problem. The first time I became aware of it was approximately 1996. I spoke to Aidan O'Brien and he assured me that the "red flag" patients were being triaged and, in response to the intervention, he then completed his triage. Intermittently over the years it would be noted that he was behind on triage and, when challenged, would catch up. Heather Trouton and the Directors (Gillian Rankin, Debbie Burns) were aware that he was slow at performing triage but that, when he was challenged, he would do it. I did inform Paddy Loughran and John Simpson of the issue but I admit I didn't raise it as a serious governance concern and neither did they question it as being one. On reflection due the repeated failure to perform timely triage a thorough investigation should have been undertaken.





## Urology Services Inquiry

129. As mentioned above, in 2014, Debbie Burns introduced a new system into the booking office so that patients were placed on the waiting list according to GP grading and in chronological order. The patients would then be upgraded, if necessary, when triage was completed. I was not informed if there was ongoing monitoring of compliance, the results of any monitoring nor did I request any audit of his practice. On reflection, in light of his past history there should have been continuing audit. It was only at the end of 2015 that I was made aware that there appeared to be an issue. His delay in triaging allowed a significant governance risk to arise. The introduction of electronic triage using NIECR in approximately 2018 has increased the governance oversight of the process.
130. The issue re charts at home developed because of Aidan O'Brien's attendance at a urology clinic in Enniskillen. I don't recall being made aware that consultants were transporting the charts back from the clinic rather than the usual method of hospital transport.
131. To the best of my knowledge, pre the introduction of digital dictation, there was no mechanism to monitor that dictation was being done after the clinic other than a secretary flagging it to her line manager. The consultants were given in their job plan 30 minutes at the end of the clinic for dictation, we wrongly assumed the dictation was being performed and the clinic outcomes recorded. I believe that Aidan O'Brien attended the clinic in Enniskillen from 2011 but it was only from approximately 2015 that the issue non-dictation of clinic letters became apparent. Once his colleagues raised concerns with Martina Corrigan, the problem was escalated to Heather Trouton, Esther Gishkori and myself. Esther Gishkori recommended that Richard Wright should be notified. Richard, on having the issues detailed and the past history, advised the approach to be taken to investigate the extent of the issue and to manage it.

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





## Urology Services Inquiry

minutes or notes, or in the Risk Register? Please provide any documents referred to.

132. As detailed in Question 14 the following items relating to Urology were added to Risk Registers in the Acute Directorate. The Urology cancer pathway delays was added to the Surgery & Elective Care Risk Register ID 2943 on 7 April 2011. An increase in urology access waiting times was added to the Surgery & Elective Care Risk Register ID 3166 on 25 June 2012. Increased waiting time for new outpatients and elective surgery was added to the Surgery & Elective Care Risk Register ID 3690 on 8 June 2015. Concerns regarding Aidan O'Brien's triage were not added to the risk registers and to the best of my knowledge were not discussed or recorded in Governance meetings. This I believe was because, at the time, we didn't recognise the issues as a serious governance risk. *Documents located in Section 21 4 of 2022, SEC Risk Register 2011, SEC Risk Register 2015 and Acute Directorate Risk Register 2012.*

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

133. As detailed in the following paragraphs I know what sort of data was collected but I do not have knowledge of precisely how it was collected. The sort of data collected was as follows:
- a. New to Review ratios for out-patient clinics and the Review Backlog - This allowed bench-marking against targets set by the HSCB and, when combined with the change in review backlog, could show whether the ratio was improving or not.
  - b. Number / percentage of patients admitted on the day of surgery - Traditionally, patients were admitted the day before surgery and this was used to benchmark against targets set by HSCB and thus by decreasing the number of beds required free up beds for other patients.



## Urology Services Inquiry

- c. The length of stay - This shows how long a patient spent in hospital for a particular procedure and allowed benchmarking against other comparable units. An abnormally long length of stay may be due to one sick patient skewing the graph but multiple patients with long lengths of stay may demonstrate poor medical practice.
  - d. Theatre Utilisation - The time the list started and the time the list finished coupled with the number of cases treated per theatre list helped to show if there were inefficiencies in the system.
  - e. Cancer Access Targets - The length of time from referral of a patient with suspected cancer until they were seen and how long until investigation, then diagnosis, and finally commencing treatment, and matching against the 31/62 day access targets.
  - f. The Morbidity and Mortality meeting (M&M) discussed any significant and/or unexpected deaths and any unexpected major morbidity. The M&M meeting later became the Patient Safety meeting with screening of all deaths being performed by the Chairman.
  - g. Any learning from Serious Adverse Incidents (SAIs) reports reviewed.
  - h. Acute Directorate prescribing errors were collated by Pharmacy
  - i. The MDM process also collected data on all cancer patients and allowed tracking of patients through the system to identify any hold ups to diagnosis or treatment.
  - j. Triage was monitored by the booking centre and helped identify poor consultant practice.
134. The systems detailed above did demonstrate an issue with triaging as is detailed in Question 54 below. The M&M process however did not show any concerns with the unit. The Cancer Access Targets did show a failure to meet the targets, which was recognised to be in part due to demand and capacity. The theatre utilisation showed that the three-session theatre day as implemented to try to create extra theatre time for Urology was inefficient.



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

135. The systems detailed in Question 41 are good at measuring performance and, while you get some information towards quality of care, they are not principally geared to produce that type of information. The data produced was overseen by Martina Corrigan and Sharon Glenny, the Operational Support Lead. They then fed the information to the Assistant Director and Director.
136. Nationally, there is the Intensive Care National Audit and Research Centre which produces information on outcomes for patients in Intensive Care Units. Likewise nationally there outcomes data is produced for individual Cardiac Surgeons. BAUS (British Association of Urological Surgeons), for 7 years from 2012, collected outcomes data for six urological procedures in England and Scotland. Wales and Northern Ireland were not included in the Audit. Unfortunately, because we do not produce outcomes data for all individual surgeons in Northern Ireland, the current systems do not permit an accurate assessment of the standard an individual's medical practice.
137. One of the issues with delay in performing triage was that if patient A is referred before patient B and patient's A triage was late then he or she could end up being treated out of chronological order. As mentioned above, to help overcome this in 2014 Debbie Burns instructed the booking centre to place the patients on the system with the GP grade of urgency and then, if they were upgraded following triage, they were moved to the Red Flag or urgent lists. Also as mentioned above, my understanding is that a side effect of this was that it took the focus off Aidan O'Brien and his tardiness at triage.
138. Regarding the Morbidity and Mortality process, previously only the deceased patient's consultant decided which cases needed discussion Dr Simpson introduced changes to the M&M whereby the chair of the Patient Safety Meeting now screens all the deaths that occur in the Surgery Division



## Urology Services Inquiry

and decides which extra cases need a full discussion. This change in practice and extra scrutiny means that there is less chance of a death that should be discussed being missed. Every three months the Patient Safety Meeting is multi professional and across all surgical specialties including anaesthetics and intensive care. This permits a broader dissemination of learning and update on relevant patient safety information.

**[43] During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation**

139. The performance objectives for the service are as detailed in Question 10 above and were spelt out in the letter dated 27 April 2010 from Hugh Mullen HSCB. The objectives had been produced in March 2009 but not signed off by the Minister until April 2010. The objectives were principally set for the team, as differing subspecialisation by individual members can distort their apparent compliance. Joy Youart set up regular meetings to obtain agreement to meet the stated objectives. After the initial meeting the remaining ones were attended by Joy Youart (later replaced by Gillian Rankin), Heather Trouton, Martina Corrigan, myself and the three urologists. Gillian Rankin increased the frequency of the meetings to weekly. Mairead McAlinden would have occasionally called in at the meeting. At the meetings, all the individual performance objectives were spelt out to the three urologists and it took, I believe, approximately 18 months before we had agreement from the urologists. I also note that on 13 September 2013 Anita Carroll wrote to all Heads of Service, Clinical Directors and AMDs asking them to remind all clinical teams and clinicians of the IEAP rules re triage. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 Eamon Mackle, 20130913 Email Triage Process.*



## Urology Services Inquiry

140. I did not have responsibility for performance metrics. Sharon Glenny, support lead, would have produced metrics including: New to R/V ratio, R/V backlog, Day of admission for surgery, Pre-op assessment, Outpatient waiting lists, in-patient waiting lists, etc. These would have been forwarded to Heather Trouton and, through her, reported to the Acute Director. Overall monitoring of the objectives was the responsibility of the Director of Performance and Reform and Paula Clarke later Aldrina Magwood. I did not receive the metrics for urology and the question of how well they were achieved is best answered by either the Director of Performance and Reform or the Acute Director. In reference to the objectives set:

(a) One stop clinics were introduced as requested.

(b) Monitoring of admission on day of surgery was performed by the Ward Sisters and Martina Corrigan and the consultant spoken to. The pre-op assessment staff would let us know if patients weren't being referred and the consultant would be reminded.

(c) The percentage of day cases was recorded by Performance and Reform.

(d) Nurse led outpatient review was introduced.

(e) The booking centre managed the booking of clinics and the number of patients attending in a fixed clinic session. They also managed how appointments were offered to patients to reduce the number of DNAs and CNAs. Consultants and junior staff were reminded to be vigilant about organising a review. A DNA and CNA policy was introduced for Consultant staff regarding further review.

### **[44] How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?**

141. The job planning process was not straightforward. In 2010 Aidan O'Brien had a 15 PA contract and I am informed by Medical Staffing that Michael Young had a 14.75 PA contract. (one PA is one unit of professional



## Urology Services Inquiry

time spent actually working and is equal to 4 hours from 7am to 7pm or 3 hours from 7pm to 7 am). These two contracts were, I am also informed by Medical Staffing, the highest in the Trust. Thus there wasn't much enthusiasm from either consultant to progress the job planning process. At the same time, Gillian Rankin, Heather Trouton and myself were trying to reach agreement on the sessions a that 5-man team would have. The deliberations for same took almost 18 months of weekly meetings before we had agreement on the number of new and review patients at a clinic, cover for the Enniskillen sessions and theatre sessions. Finally, on 9 June 2011 Gillian Rankin, Heather Trouton and myself met individually with the urologists and amongst other items obtained an agreement to progress the job plans. Michael Young supplied a breakdown of activities on 16 June 2011 and job plans were drafted. I was unable to reach agreement with Aidan O'Brien so I referred the process for facilitation on 1 September 2011 and the outcome that he should be paid 12.75 PAs from October 2011, dropping to 12 PAs on 1 March 2012, is recorded in an email on 15 November 2011 from Malcolm Clegg, Assistant Manager Medical Staffing. When I stepped back from Urology in 2012 Robin Brown took over the Job planning negotiating role while I acted as second signoff. It took until approximately April 2013 to obtain agreement on the 5-man team model. *Documents located in Section 21 4 of 2022, 20110901 E to MC and HT re AOB Draft Job Plan and 20111115 E to Payroll re AOB.*

142. The appraisal process however was of no benefit at identifying any concerns with Aidan O'Brien's practice. The process at that stage meant that a consultant could choose their respective appraiser for the whole of the 5-year revalidation cycle and this potentially reduced the challenge function of the appraiser. One could also have the same appraiser for multiple years. Currently, the system is improved as one is assigned an appraiser and they are for, I believe, a maximum of three years, thus guaranteeing at least two different appraisers per revalidation cycle.



## Urology Services Inquiry

**[45] The Inquiry is keen to learn the process, procedures and personnel involved when concerns regarding governance, which have the potential to impact on patient care and safety, arise. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might seek to see examples of concerns being dealt with in this way during your tenure.**

143. Once a governance concern arose which could have an impact on patient care and safety, it was discussed by Heather Trouton and myself. We would also inform the Director (Gillian Rankin, Debbie Burns, Esther Gishkori) of the issue and discuss a plan to deal with the issue. If there were significant patient care and safety issues the Director would make the decision to escalate to Human Resources for investigation utilising the Disciplinary Procedure and or the Medical Director regarding utilising the framework described in Maintaining High Professional Standards or referral to the General Medical Council. Where the clinician's health is considered to be a risk then referral to Occupational Health. More minor issues would be dealt with by Martina Corrigan, Heather Trouton, Michael Young, Robin Brown and myself. Examples of more significant issues that were escalated are as follows.

144. The discovery of destruction of patient documents (mentioned at Question 36 above) was escalated to HR. An investigation team was appointed and an investigation using the Trust's disciplinary procedure performed. On 19 August 2011 Aidan O'Brien was issued with an informal warning and a copy of the disciplinary procedure.

145. The issue with IV Fluids and IV antibiotics (mentioned in detail at Question 54 below) was escalated to Paddy Loughran. An investigation into the extent of the problem was performed and a protocol was introduced re managing the issue. Monitoring was performed by Shirley Tedford and assurance re compliance provided to Heather Trouton, myself, Gillian Rankin and Paddy Loughran. Any potential breaches were dealt with directly.





## Urology Services Inquiry

146. The issue re the number of benign cystectomies (mentioned in detail at Question 54 below) being performed was identified through the urology review. Dr Diane Corrigan (Public Health Medicine Consultant) informed me that she would undertake a benchmarking exercise against the numbers performed by other consultants and units in the province. Following her investigation she wrote to Paddy Loughran 1 Sept 2010 and copied Gillian Rankin and myself. Following discussion with Gillian Rankin, Heather Trouton, and Paddy Loughran, I was instructed to perform a review of 12 cases. I was unable to satisfy myself regarding the indication in 6 cases so I was instructed to contact Mark Fordham (Consultant Urologist Advisor to the Urology Review) for advice on a suitable expert. I then organised an independent expert to review the cases and reported back to Paddy Loughran and ultimately Diane Corrigan. It was recommended in the review and agreed by Gillian Rankin and Paddy Loughran in consultation with Diane Corrigan that the procedure stop in CAH and the compliance was monitored by Martina Corrigan.

*Document located in Relevant to MDO, Evidence after 4 November MDO, Reference No 77, Correspondence Patrick Loughran, 20100901 Re Urology ATTACHMENT 2*

147. I admit that at no time prior to December 2015 can I recall any of the Acute Directors or Medical Directors discussing with me about utilising the framework described in "Maintaining High Professional Standards in the Modern HPSS" or referral to the GMC.

*Document located in Relevant to HR, reference no 67, TC8 6.2005 MPHS Handbook.*

**[46] Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.**





## Urology Services Inquiry

148. I felt supported by Paddy Loughran and he was proactive regarding the issues of benign cystectomies and regarding IV fluids and IV antibiotics. I did inform John Simpson that I had been accused of bullying and harassment by Aidan O'Brien and that I had been advised by Gillian Rankin to have Robin Brown more directly manage urology and, in particular, Aidan O'Brien. He didn't suggest any different path to that recommended by Gillian Rankin. At my regular one-on-one meetings with him I informed him of issues as they arose in Urology including triage and staffing. I did not however express that I had any serious concerns regarding Aidan O'Brien, largely because we did not feel that patients were being put at significant risk by Aidan O'Brien's practice. Equally John Simpson did not indicate to me that he considered issues concerning Aidan O'Brien to be serious. Indeed, Aidan O'Brien was held in high regard by many nursing and Medical Colleagues including Michael Young and Robin Brown and this, I believe, influenced our thinking. I felt supported by Richard Wright who, when informed of the issues in Urology, took an active role and met with Heather Trouton and myself in the Acute Director's meeting room (I believe early in January 2016) to discuss a plan of action re Aidan O'Brien.

### Concerns regarding the urology unit

**[47] The Inquiry is keen to understand how, if at all, you, as AMD of Surgery, liaised with, involved and had meetings with:**

- i. The Chief Executive(s) (the inquiry understand these to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin)**
- ii. The Medical Director(s) during your tenure (the inquiry understand these to have been Patrick Loughran, John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane),**



## **Urology Services Inquiry**

- iii. **The Director(s) of Acute Services (the inquiry understand these to have been Gillian Rankin, Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements)**
- iv. **The Assistant Director(s), namely Heather Trouton and Ronan Carroll**
- v. **The other Associate Medical Directors (the inquiry understand these to have been Mark Haynes, Stephen Hall, Charlie McAllister and Damian Scullion)**
- vi. **The Clinical Director(s) (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)**
- vii. **The Head of Service, namely Martina Corrigan, and**
- viii. **The consultant urologists in post during your tenure.**

**in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (i) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.**

**[i] The Chief Executive(s) (the inquiry understand these to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin)**

149. Mairead McAlinden was different from all subsequent Chief Executives in that she had a very visible presence in the hospital and my recollection is that, late afternoon, she frequently would appear in the main hospital, usually for a meeting with Gillian Rankin or Debbie Burns. I had many discussions with her in the corridor, over coffee, or in Gillian or Debbie's office during her term. We would discuss all the surgical specialties and in particular any new issues that she had become aware of. During those conversations I would, for



## Urology Services Inquiry

example, have updated her on the IV fluids & IV antibiotic issue and the benign cystectomy issue. I can't recall if I specifically talked about the issue of notes in a bin. For general governance issues regarding urology, like new to review ratio and waiting lists, she was already well informed. I discussed staffing issues with her and she was aware that Aidan O'Brien was tardy at triage but, as stated earlier, we didn't at that time think that it could lead to a serious governance risk. Mairead McAlinden also attended at least one (and possibly more) of Gillian Rankin's Monday evening meetings with the urologists.

150. Paula Clarke was in post from April 2015 and I would not have had the same amount of direct contact with her. I don't recall specifically talking to her about any urological governance issue.

151. Particularly during Mairead McAlinden's time there was a major push from the commissioners regarding waiting lists and targets. There was a huge performance drive within the Trust and while quality was not ignored it didn't always seem to be the prime driver.

152. I did not work as AMD with Francis Rice, Stephen McNally or Shane Devlin.

**[ii] The Medical Director(s) during your tenure (the inquiry understand these to have been Patrick Loughran, John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane),**

153. Paddy Loughran, John Simpson and Richard Wright all had a monthly AMD Governance meeting and also a monthly on-on-one (I think Paddy's may have been every two months). During the one-on-ones we would discuss issues in each specialty and any staffing issues or governance issues and would at those meetings have discussed named individuals and, as detailed above, the issues of benign cystectomies, notes in bin, IV fluids and IV antibiotics. Generally, I found that the Medical Directors provided advice on



## Urology Services Inquiry

how to manage issues. There were no formal minutes produced from the one-on-one meetings.

**[iii] The Director(s) of Acute Services (the inquiry understand these to have been Gillian Rankin, Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements)**

154. Joy Youart, Gillian Rankin, Debbie Burns and Esther Gishkori all were very supportive and involved in the Surgical Division and held regular meetings. I can't recall if I had a regular one-on-one with Joy Youart (although we had many informal meetings) but I did have a regular monthly meeting with the other three. During the meetings we discussed all the aforementioned issues in Urology and would have discussed Aidan O'Brien's foibles, although as stated earlier, until late 2015 we did not have any serious governance concerns regarding him. A monthly Acute Governance meeting was also held and included ADs and AMDs. Once Esther Gishkori was made aware that we did have serious concerns about Aidan O'Brien, she immediately suggested the involvement of Richard Wright. I did not work as AMD with Anita Carroll or Melanie McClements. However, as stated in (i) above, there was a huge drive from the commissioners regarding performance and maximising activity. Gillian Rankin kept box files relating to my one-on-ones as well as the other AMDs but I am not aware if they still exist or their contents.

**[iv] The Assistant Director(s), namely Heather Trouton and Ronan Carroll**

155. Ronan Carroll was made AD in April 2016, so I didn't work directly with him. Heather Trouton and I met every week to discuss governance issues. Where governance was concerned, we would jointly agree a plan of action in respect of any issue raised. We also attended the Acute Clinical Governance meeting chaired by the Director. Heather Trouton kept a notebook for action points from meetings but we did not keep formal minutes.

**[v] The other Associate Medical Directors (the inquiry understand these to have been Mark Haynes, Stephen Hall, Charlie McAllister and Damian Scullion)**



## Urology Services Inquiry

156. Stephen Hall and Charlie McAllister attended the Acute Clinical Governance meetings as well as the Medical Directors Governance meeting. When we were expanding urology from a 3 to a 5-person team there was a shortage of available theatre space. Charlie McAllister was involved in helping to arrange a three-session day for urology. At one stage there was an issue of timely access to radiology for urology service patients and Stephen Hall helped solve that issue. Both Stephen and Charlie were aware of Aidan O'Brien's foibles but I am unaware of them having serious governance concerns. Mark Haynes and Damian Scullion were made AMDs after my tenure.

**[vi] The Clinical Director(s) (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)**

157. Robin Brown, upon appointment, was given responsibility for Daisy Hill and for Urology. Robin did not take part in the Monday evening meetings held by Gillian Rankin regarding implementation of the urology review. Robin did, however, attend the monthly governance meeting chaired by Heather Trouton and myself and would bring the perspective of a general surgeon with an interest in urology. Following the false 2012 accusation that I bullied and harassed Aidan O'Brien, any issues requiring direct intervention with Aidan O'Brien were dealt with by Robin Brown. Ms Sam Sloan was appointed Clinical Director in approximately 2010 to help look after General Surgery, ENT and T&O. If Aidan O'Brien was considering admitting a patient for IV fluids & IV antibiotics he had to present the case to Sam Sloan and Dr Damani for approval or other microbiological instructions regarding management. When Sam Sloan left in December 2011, Sam Hall took on this role. Other than IV fluids and IV Antibiotics, I cannot recall either Sam Sloan or Sam Hall raising a governance issue regarding urology.

158. Colin Weir and Ted McNaboe each took up post after my term.

**[vii] The Head of Service, namely Martina Corrigan, and**

159. I met with Martina Corrigan at least weekly on an informal basis and she also attended the Weekly Governance Meeting chaired by Heather



## Urology Services Inquiry

Trouton and myself. Martina was instrumental in bringing many of the governance issues to us and played a huge role in checking on compliance with previously identified issues. For example, Martina would not infrequently meet with Aidan O'Brien regarding triage and would generally persuade him to complete it.

### **[viii] The consultant urologists in post during your tenure.**

160. I would have met all three urologists at the monthly Morbidity and Mortality Meeting.
161. As mentioned already, during 2009 and 2010 I met with the three urologists: Aidan O'Brien, Michael Young and Mehmood Akhtar at the weekly Monday evening meeting chaired by Gillian Rankin. While the meetings were focussed on the implementation of Team South, they also involved governance as the purpose was to streamline the process for managing urology patients, improve throughput, maximise resources and standardise the service.
162. Gillian Rankin, Heather Trouton and I held a meeting on the 9<sup>th</sup> June 2011 with Mehmood Akhtar to agree pooling of lists, management of review backlog and triaging of Red Flag referrals.
163. Michael Young attended the monthly governance meeting chaired by Heather Trouton and myself.
164. As Michael Young's Theatre list coincided with my main theatre list day we would not infrequently liaise at some point of the day and any pressing issues could be raised.
165. I also have notes of a meeting held on 9<sup>th</sup> June 2011 by Gillian Rankin, Heather Trouton and myself with Michael Young which involved discussion on review backlog and the assistance of Sr. Shirley Tedford with triage of them. Pooled day lists were also agreed and nurse endoscopy discussed.
166. Regarding Aidan O'Brien, as with Michael and Mehmood he attended the Monday evening meetings and Gillian Rankin, Heather Trouton and myself met with him on 9<sup>th</sup> June 2011 and discussed Review backlog and Heather was to meet with him after that to discuss processes regarding same.



## Urology Services Inquiry

Aidan O'Brien also agreed to have pooled days surgery lists and to admit patients on day of surgery.

167. After the accusation of bullying and harassment, I had no significant meetings with Aidan O'Brien that I can recall until 31<sup>st</sup> March 2016, when I met him with Martina Corrigan to give him the letter from Heather Trouton and myself regarding our concerns about his practice.
168. I do not recall any formal meetings with Mark Haynes, John O'Donoghue, Ajay Pahuja or Tony Glackin apart from the Morbidity and Mortality meetings.
169. Ram Suresh was appointed a Consultant Urologist in December 2013. In December 2015 I was made aware that he was not very comfortable at performing open surgical procedures and that his decision-making was suspect. This raised a governance concern re his ability to provide on-call cover at night and to make patient management decisions on ward rounds. I met with the rest of the urology team in December to discuss a way forward and for them to consider options regarding cover. I informed Richard Wright of the issue and what process was being considered. I met again with Michael Young, Tony Glackin, John O'Donoghue and Martina Corrigan on 4 March 2016 to finalise how this issue would be managed: cover, support and mentorship would be provided: second on-call cover by colleagues for open surgery cases; a consultant colleague accompanying him on his ward rounds; he also was to be advised to provide details of suitable courses for training which would then be funded by the Trust. I met with him on 23 March 2016 and spelt out the required actions. As I stepped down as AMD the following month I had no further involvement in the issue.

*Documents located in Section 21 4 of 2022, 20160304 E re Actions from AMD and Uro Consultant Mtg and 20160323 Ltr to AOB from EM and HT.*

**[48] Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of**





## **Urology Services Inquiry**

urology services? Without prejudice to the generality of this request, please address the following specific matters: -

- a. What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.
- b. What steps were taken (if any) to risk assess the potential impact of the concerns once known?
- c. Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.
- d. If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?
- e. How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?
- f. If you were given assurances by others, how did you test those assurances?
- g. Were the systems and agreements put in place to rectify the problems within urology services successful?
- h. If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

170. I will attempt below to address, together, each of the matters raised at paragraphs (a) to (h) under the heading of each of the main problems that I encountered or that were brought to my attention.





## Urology Services Inquiry

### Medical Staffing

171. Medical staffing for the unit was recognised as an issue from the beginning. The Team South plan proposed five consultants, two registrars and two trust grade doctors. The small support staff meant that it was more difficult to recruit consultants, the majority of whom seem to want to live in or close to Belfast and have a good on-call rota with supporting junior staff, thus improving work/life balance. It took until May 2014 before the fifth consultant was appointed and then, because we had interviewed two excellent candidates and because urology had been understaffed for years, the trust went at financial risk and appointed a sixth consultant from August 2014.
172. The two registrars were appointed by NIMDTA but the Trust grades need to be appointed locally. This proved to be difficult and, often, one or two of the posts would not be filled. Michael Young then requested that we appoint a clinical fellow (a person who was doing research but in an unfunded post). The clinical fellow was expected to work 2 days per week, at least one session of which was flexible cystoscopies to help with the waiting list. The clinical fellow also took part in the night rota. This post likewise proved difficult to fill from one year to the next. Two of the trust grade doctors were found to be unsuitable for the posts and their contracts terminated, one in July 2012 after 8 months and the other in August 2013 after 8 months. My recollection is that, in 2014, there only were 2 registrars and for six weeks in June and July, while they took their annual leave, there were insufficient junior assistants to safely run theatres. I therefore had General Surgery supply surgical assistants for urology theatres. Also from 2014, because of the excessive number of hours the Registrars were working to provide on-call cover, I organised for General Surgery Registrars to cover from 11pm on weekdays and from 9pm at weekends.
173. A GP with special interest (GPWSI) worked in Urology ICATs but, unfortunately, in approximately 2012 I was informed that Occupational Health had placed him on sick leave and he ultimately retired on medical grounds. The Urology ICATs was not a true ICATS in that the consultants performed



## Urology Services Inquiry

the triage and supervised the Thorndale Unit. After the GPWSI retired, the Thorndale Unit was integrated completely into urology.

174. The net effect of all of the above was that there was a difficulty in meeting the demand. Emergency work was always covered and red flags were prioritised but this led to an increase in waiting times for out-patients and elective surgery. I was not party to the discussions with the commissioners regarding the above issue and the problem remained when I ceased to be AMD.

### Facilities

175. The original Thorndale building was a prefab unit and housed urology ICATs and out-patients in the early years. However, it was not perfect, the entrance was remote from the main building and the space was not adequate. In 2012 plans were produced for redesign of part of the out-patient department of the main hospital and the new purpose built Thorndale Unit opened in September 2014. This allowed Flexible cystoscopies to be performed in the unit and freed up a theatre session in the Day Surgery Unit. It also facilitated supervision by the consultants. The new department didn't affect patient safety but helped with the overall running of the urology service.

### Review Backlog

176. A problem with review backlog existed in Urology from before the Urology Review and was recognised by both the Trust and the Commissioners. Previously, waiting list initiatives were only funded for new patients and did not including funding for their review, thus exacerbating the problem. While it was not unique to urology, it was compounded by urology in the Southern Trust having the worst new to review ratio in the province. Joy Youart and subsequently Gillian Rankin embarked on an 18-month series of meetings to change consultant practice to improve the ratio and reduce the review backlog. A series of measures were introduced: Clinic templates were drafted with a 20 minute time for a new patient to be seen and a 10 minute review time (later this was amended to allow 30 minutes for a Day 4 review



## Urology Services Inquiry

consultation of a newly diagnosed cancer patient to discuss the diagnosis). It took repeated meetings by Gillian Rankin, Heather Trouton, myself and the urologists to agree to amend clinic templates. The urologists were also encouraged to select patients for review follow up by the Urology Specialist nurses. We held a meeting on 9 June 2011 with Michael Young and Mehmood Akhtar where methods of review triage and the input of Shirley Tedford to support the process were agreed. At the 9 June 2011 meeting with Aidan O'Brien it was agreed that Heather Trouton would further meet with him to discuss a way forward re managing the review backlog. To try to reduce the number of patients requiring review Heather Trouton, myself and Martina Corrigan met with the AMD for Primary Care, Dr Peter Beckett, along with the Urologists to discuss pathways for discharging patients to their GP for further follow-up. The decision by the trust to appoint an additional sixth consultant at financial risk was to help reduce the effect of the backlog on patient safety. The consultants were funded from waiting list initiatives to validate the reviews and to provide extra clinics for waiting list patients. On 4 January 2012 Gillian Rankin met all the AMDs and ADs to inform us of the early work of Primary Care Partnerships. I understand that Michael Young was involved in producing guidelines for General Practitioners on managing conditions like haematuria and Urinary Tract Infections. *Document located in Section 21 4 of 2022 20120323 Ltr to AOB from EM and HT.*

177. The combined effectiveness of all the above measured was monitored by Heather Trouton as well as Gillian Rankin, Debbie Burns and the Performance Team. Overall, I understand it produced a reduction in the number of patients waiting and in the length of time spent waiting but was not sufficient to meet recommended targets.

### Other Issues

178. The issues of Triage, Benign Cystectomies and IV Fluids/IV Antibiotics, Review of Results of Investigations are all discussed in Questions 54-56.



## Urology Services Inquiry

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

- a. properly identified,**
- b. their extent and impact assessed,**
- c. and the potential risk to patients properly considered?**

### Medical Staffing

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

### Review Backlog

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

### Triage

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

### Benign Cystectomies



## Urology Services Inquiry

182. I believe the issue was properly identified and managed. All major pelvic surgery in Craigavon Area Hospital was cancelled and patients were to be referred to Belfast.

### IV fluids & IV antibiotics

183. This issue was properly identified and assessed. The risk to patients was considered and a process introduced to ensure safe practice.

**[50] What, if any, support was provided to urology staff other than Mr. O'Brien by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss, seek to provide support, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q62 will ask about any support provided to Mr. O'Brien).**

184. A full time consultant, Ram Suresh, was appointed on 11 December 2013. In approximately December 2015 Mark Haynes (my recollection is that it was he who spoke to Martina Corrigan/ Heather Trouton) raised concerns regarding Mr Suresh's decision-making skills and operative skills for open surgery. As mentioned at Question 47 above, the issue was discussed with Richard Wright, I had discussions with the other urology consultants and they agreed to provide second on call cover for his on-call and to support him on ward rounds. Ram Suresh was to advise us of courses to improve his skills. Funding was provided to compensate the other surgeons for the extra work involved in providing cover. Michael Young wrote to Richard Wright in June 2016 confirming the above and providing governance assurance. *Document located in Section 21 4 of 2022 201606 Ltr to MD re Ram Suresh Uro Cover.*

185. In view of the small number of registrar-level staff that the unit had, and the excessive hours that their juniors were working, in 2013 I organised for the general surgical registrars to cover the unit at night.

186. In 2014 there was a shortage of junior doctors in urology to assist in theatre to enable major surgery to be performed. For six weeks in June and



## Urology Services Inquiry

July I organised for general surgery trainees to assist the urologists when performing open surgery.

### **[51] Was the urology department offered any support for quality improvement initiatives during your tenure?**

187. There was a proposal from the Urology team to introduce one-stop clinics for investigating haematuria and for investigating possible prostatic cancer. These were supported and I believe they won a Trust award for same.

### **Mr. O'Brien**

### **[52] Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?**

188. The Medical Directorate structure was that Aidan O'Brien would liaise with his Lead Clinician, Michael Young, who in turn would report to his Clinical Director, Robin Brown, who in turn would report to me. However, any clinician was able to skip one or two stages and speak to me directly. Michael Young also attended the monthly meeting with Heather Trouton and myself. For the approximately 18 months of Monday night meetings I would have met with Aidan O'Brien for up to 90 minutes. We would have met monthly at the Morbidity and Mortality meeting and I believe this lasted about two hours. Outside of those two processes my contact would probably have been a maximum of 1% of my time. Once I was accused of bullying and asked to step back, I had very little contact with him until March 2016, when I delivered the letter to him summarising the concerns regarding him. I cannot recall having a conversation with Aidan O'Brien since March 2016.



## Urology Services Inquiry

**[53] What, if any, was your role and involvement in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.**

189. The job planning process was difficult. Aidan O'Brien had a 15PA contract which was the highest amongst the surgical division (as mentioned above, one PA is one unit of professional time spent actually working and is equal to 4 hours from 7am to 7pm or 3 hours from 7pm to 7 am). The amount of time dedicated to administration in his job plan was in excess of the average surgeon. In comparison to his 15 PA contract, a newly appointed surgeon in England was generally offered a 10PA contract. His colleague Mehmood Akhtar was receiving 12.25 PAs (I understand that, due to his resignation in 2012, the relevant records have been deleted but Medical Staffing have checked with payroll and believe this is an accurate figure). My recollection (albeit I have been unable to locate any evidence) is that there was a reluctance on the part of Aidan O'Brien to engage in the job planning process. On 9 June 2011, Gillian Rankin, Heather Trouton and myself met with Aidan O'Brien and the minutes record he was informed that Michael Young would submit a current breakdown of activities (submitted on 16 June 2011) to permit a draft Job plan to be constructed for discussion. I submitted a draft 10.5 PA job plan dated 1 July 2011 based on the sessions that I understood he was working. Document located in Section 21 4 of 2022, 2011 – 2012 Job Plan AOB. He rejected this and sent an email on 22 July 2011 outlining why. I redrafted the job plan and sent it to him on 10 August 2011. He rejected that draft on 24 August 2011 and at that stage requested an extra 1 PA as he was planning to conduct Audit in the coming year. On 26 August 2011 I redrafted his job plan allowing 12 PAs considering the points he made and said he would receive the standard 1.5 PAs for Supporting Professional Activities. I informed him that the requested extra PA for Audit would be considered on provision of further details including Audit Tool, benefits and measurable outcomes. On 1 September 2011 he rejected the proposed job plan so I referred the process to HR for facilitation. *Document located in Section 21 4 of 2022 20110901 E to MC and HT re AOB Draft Job Plan.* On 15 November 2011 Malcolm Clegg, Assistant Medical Staffing Manager,





## Urology Services Inquiry

wrote to Oonagh Gannon, Payroll Team Manager, informing her that Aidan O'Brien would reduce from 15PAs to 12.75PAs from October 2011 and then, on 1<sup>st</sup> March 2012, reduce to 12PAs.

190. Subsequent job planning meetings with Aidan O'Brien were to be performed by Robin Brown. On 1 February 2013 Gillian Rankin met with Michael Young and Heather Trouton to discuss team job plans. On 27 February 2013 Martina Corrigan documented how she and Michael Young had been matching the job plans versus activity required. Also on 27 February 2013 I wrote to Robin Brown stating that I wanted to check the job plans before sending to the urologists for signing. On 1 March 2013, I wrote to Michael Young and Robin Brown detailing a meeting with Kieran Donaghy where he informed me that urology was not meeting the Service Based Agreement and I was instructed to state that the decisions made and agreed at the Monday evening meetings had to be included in job planning.

*Document located in Section 21 4 of 2022, 20130301 E to MY and RB re Urology Job Plans.* On 5 March 2013 Martina Corrigan wrote stating a meeting was arranged with the urologists, Robin Brown, and Heather Trouton on 6 March to discuss proposed job plans and activity. Finally the job plans were agreed and approval for the 5<sup>th</sup> post was obtained from the Specialty advisor on 11 April 2014. I do not recall any further involvement in Aidan O'Brien's job planning. *Document located in Section 21 4 of 2022, 20130305 E re Uro Team Job Plans*

**54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? Do you now know how long these issues were in existence before coming to your or anyone else's attention?**

**55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.**





## Urology Services Inquiry

**56. What actions did you or others take or direct to be taken as a result of these concerns? You should include details of any discussions with named others regarding these concerns. Please provide dates and details of any discussions, including any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate**

**57. Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:**

- i. **what risk assessment did you undertake, and**
- ii. **what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.**

191. I have addressed Questions 54 to 57 (inclusive) together because of the clear overlap of the issues raised by them.

192. I shall attempt to deal with those issues together under headings corresponding to each concern about Mr O'Brien of which I was aware.

### IV Fluids/IV Antibiotics

193. At approximately the end of March 2009, the Trust became aware of the practice of IV fluids and IV antibiotic therapy being used for recurrent UTIs. My understanding is that there were a couple of patients who had been receiving the treatment from early 2000s. There was a risk that repeated IV injections could lead to a loss of peripheral veins and serious consequences if emergency IV access was ever needed.

194. Paddy Loughran was informed and he sought expert advice from Mr Mark Fordham (Urologist) and Dr Jean O'Driscoll (Consultant Microbiologist). Responsibility for infection control was the remit of the Medical Director. Following several meetings and correspondence with Aidan O'Brien and Michael Young, Paddy Loughran on 4<sup>th</sup> August 2009 obtained agreement from the urologists that a list of patients would be compiled, that each surgeon would review the treatment regime, and a multi-disciplinary team would be



## Urology Services Inquiry

convened to look at the treatment plan for each patient with a view to converting from IV administration to oral administration if required (in memo 2 Sept 2010). *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100902 Email Urology Services.*

195. On 19 July 2010 with the Head of Service having made me aware that the consultants were not adhering to the guidance. Paddy Loughran, Heather Trouton and Dr Rankin were all informed of this ongoing practice. With the assistance of Martina Corrigan, I discovered 13 patients were still getting IV treatment and that two of the patients had recently been admitted for insertion of a central line. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100719-email IV antibiotics in Urology*
196. On 1 September 2010 a meeting was organised with Gillian Rankin, Paddy Loughran and myself to discuss a way forward. It was decided that Gillian Rankin, accompanied by myself, should meet Aidan O'Brien and Michael Young to discuss an immediate cessation of this form of treatment. Paddy Loughran also stated that he would organise a formal independent review of the practice. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100825 Email IV antibiotics fluids.*
197. On 9 September 2010 I accompanied Gillian Rankin to a meeting with Aidan O'Brien where he was informed of the discussions on 1 September. Gillian Rankin tabled a protocol of the case review process involving Ms Sam Sloan, Clinical Director Surgery, and Dr Damani, Consultant Microbiologist, and the pathway that the two urologists had to follow. The protocol also detailed that, in future cases when this IV fluids and IV Antibiotics treatment was being considered, then a multidisciplinary case review had to take place as detailed above. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100910-email urgent*



## Urology Services Inquiry

198. Correspondence was received on 6 December 2010 from a patient and her MLA complaining about the change of practice. I suggested that, as Aidan O'Brien was the patient's consultant, he should discuss the change in management plan with the patient. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101216 Email private and confidential.*
199. On 9<sup>th</sup> June 2011 Gillian Rankin, Heather Trouton and myself met with Aidan O'Brien and once more informed him that, if he wanted to admit a patient for pre-operative antibiotics or IV fluids and antibiotics, then a meeting had to be held with Sam Sloan and a microbiologist (my recollection is that this was in response to a breach of protocol but I have not located any evidence to confirm same). *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110627-email urology meetings.*
200. Subsequent to the meeting on 9 June 2011, I was made aware that, despite meeting the previous week, Aidan O'Brien planned to admit one such patient. When challenged by Martina Corrigan he only consulted Dr Rajendran, Consultant Microbiologist.
201. I wrote to him on 15 June 2011 and copied Gillian Rankin, Heather Trouton and Helen Walker (Human Resources), informing him that the prerequisite was non-negotiable. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle , 20110615 Email Antibiotics and urology patients.* A further memo of the meeting from 9 June 2011 was sent to Aidan O'Brien on 20 June 2011 by Heather Trouton. Shirley Tedford (Urology Coordinator) was tasked with ensuring that patients were not being admitted for IV fluid/IV antibiotics without the approval of Sam Sloan and Microbiology and she provided assurance to Martina Corrigan and, through her, ultimately Paddy Loughran.
202. On 13 December 2011 I wrote to Aidan O'Brien and Michael Young informing them that as Mr Sam Hall had been appointed as CD and that he would chair any meeting regarding patients who they felt needed IV treatment.



## Urology Services Inquiry

I am not aware of any further instances of violation of the protocol after this.

*Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20111218 Email IV Fluids and antibiotics in urological patients.*

### Benign Cystectomies

203. Dr Diane Corrigan, Consultant in Public Health Medicine, on 1 September 2010 wrote to Paddy Loughran and copied in Gillian Rankin and myself, noting that, when she read the review of the IV Fluid and IV antibiotic therapies, that there was a comment re major bladder surgery. She had recently informed me that she was going to conduct an N.I.-wide audit of the number of procedures being performed. This she reported as showing a higher than expected number of cystectomy and/or ileal conduit procedures for benign disease than would be expected. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100901 – email urology.*
204. On 9 September 2010, at a meeting held by Gillian Rankin and myself and attended by Aidan O'Brien and Michael Young, a statement regarding the screening process the Trust was planning to undertake was tabled. Aidan O'Brien at this point said that, if Mark Fordham was appointed to carry out a review, then under no circumstances was he prepared to meet with him. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100910-email urgent.*
205. On instruction the most recent 12 cystectomies for benign disease, dating back to 2006, were collated with the assistance of Martina Corrigan and reviewed by myself. I was unable to reassure the Trust on at least 6 of the cases. A decision was made by the Trust that an independent reviewer should be sought. I therefore drove to Aldergrove Airport hotel one evening to meet with Mark Fordham who was staying there for the night prior to a flight early the next morning, following a visit to NI in respect of the Urology Review. He advised on how he thought any review should be performed and said he would get back to me with a suggested expert. On 9 February 2011 I wrote to



## Urology Services Inquiry

Mr Marcus Drake, Consultant Urologist at the Bristol Urological Institute, and asked him to conduct the review. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110210 Email Governance Issue.*

206. Mr Drake attended the Trust on 25 March 2011 and I supplied him with my summary of the cases and the available hospital notes for his review. On 3 May 2011 we received a draft report from Mr Drake. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110503-email NI SouthernTrust review of cystectomy cases.* In it he concluded as follows: (i) That the majority of cases appear to have been managed with compassion and consideration; (ii) The cases in general appear to have supportable clinical grounds; (iii) He did, however, feel the documentation was insufficiently comprehensive and felt that there should have been a clear description of severe pathology, substantive functional impairment and impact on quality of life, attempts to undertake conservative measures and discussion of risks involved; (iv) He did request a check to see if any more notes were available; (v) He was critical of a lack of a plan for one patient receiving botulinum injections; and (vi) He recommended the process that the trust had already instituted re management of infection.
207. A check was made to see if any of the further information he requested was available and, when it wasn't, the draft report was accepted. Paddy Loughran wrote to Dr Corrigan on 28 July 2011 summarising the above and assured her that there would be no further cystectomies performed in the Trust. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110728, Email Urology Review.* I sent Dr Corrigan a copy of the conclusions on 5 August 2011. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle 20110805 Email Cystectomies in the Southern Trust.*



## Urology Services Inquiry

208. On 7 September 2011 Gillian Rankin wrote to the three urologists informing them that no elective cystectomies were to be performed in the Southern Trust. Martina Corrigan, as Head of Service, monitored the in-patient admissions and theatre lists to ensure that no further elective cystectomies were performed. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110907 Email for Comment Correspondence to Urologists.*

### Triage

209. Triage was an issue which was raised with me at various times.

210. When I was Lead Clinician for Out-patients, Mr O'Brien had a folder in his office with referral letters in it. The issue was raised with me by Mrs Hazel Neill, Nurse Manager for Out-patients, at a regular meeting we had. I spoke to Mr O'Brien at the time (I can't recall when exactly, but it was approximately 1996) pointing out that this practice was not acceptable. He informed me that he had checked the letters and had selected any high risk ("Red flag") letters to be seen quickly. He did however assure me that he would clear the backlog. I also informed the CD, Mr Osmond Mulligan, of the practice and of my actions, as well as the General Manager of the Trust Mr John Templeton. My recollection is that Hazel Neill informed me that the triaging was then completed. Prior to the booking centre, my recollection is that the out-patient staff were responsible for booking appointments and kept a check on the return of letters sent for triage.

211. During the period 2007 to 2009 my recollection is that on (I think) 2 occasions I was asked to speak to Aidan O'Brien to complete the triaging process. I can't recall who asked me to do so.

212. On 30 March 2010 Heather Trouton wrote to Aidan O'Brien and Michael Young pointing out that there were 60 referrals untriaged. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20100310 Email Triage.* It turned out that the delay was with Aidan O'Brien's referrals. On (again, I think) 19<sup>th</sup>





## Urology Services Inquiry

April 2010 (it was the period of the Icelandic Ash Cloud), Gillian Rankin and myself were made aware by either Heather Trouton and/or Martina Corrigan that Aidan O'Brien had a significant number of untriaged letters. Aidan O'Brien was also planning to go to a European conference the following day and thus the letters would not be triaged for at least a further week. It was agreed with Gillian Rankin that I would inform him that his study leave would be cancelled if the letters weren't triaged. I note that, by the following morning, all the letters had been triaged.

213. On 27 September 2010 Aidan O'Brien wrote to Gillian Rankin regarding the Regional Review and in his letter confirmed that all red flag referrals were being triaged within one week and that by 1 November 2010 all triaging would be performed within one week, as long as there was a maintenance of three consultants in the unit. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101004 Email Private and Confidential.* My recollection is that, by this stage, the booking centre were keeping a check on letters sent for triage and number being triaged.
214. However, by the end of March 2011, it was found that Aidan O'Brien had a backlog of 129. On 1 April 2011 Michael Young triaged 14 and Mehmood Akhtar triaged 53 of them. On 4 April 2011 62 letters remained to be triaged, the oldest of which was from 1 February. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110406 Email Urology Triage.* A meeting on 7 April 2011 was held by Gillian Rankin, myself, Heather Trouton with Aidan O'Brien to discuss same. I don't have minutes of the meeting but I believe that, soon after it, Mr Akhtar took responsibility for the triage of red flag referrals. My understanding is that any named red flag referrals to Aidan O'Brien were followed up by the Cancer trackers.
215. The issue regarding triaging was an intermittent problem and, when Martina Corrigan would raise it, then Aidan O'Brien would comply and then after a period relapse again. I have, when gathering information to aid with



## Urology Services Inquiry

this response, sought information from Heather Trouton who has shared an email of 4 December 2013 showing that Robin Brown spoke to him in July 2013 and again in November 2013 regarding triage and that Michael Young had offered to help with the backlog. Document located in Section 21 4 of 2022, 20131204 E re Missing Triage.

216. On 21 February 2014 Mrs Debbie Burns wrote to me to say that Martina Corrigan and herself had a meeting with Aidan O'Brien on 20 February 2014 and it is recorded that Aidan O'Brien would only triage named referrals (i.e., referrals that have been sent specifically to him). *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20140221 Email Yesterday.* Debbie Burns also asked Aidan O'Brien to consider if he required any additional administration support. My recollection is that he requested to have no clinics in July to allow him to catch up on his administration.
217. I have, when gathering information to aid with this response, sought information from Martina Corrigan in respect of some matters relating to triage and I understand that Michael Young performed Aidan O'Brien's triage for approximately 6 months in 2014.
218. As it was felt that there was a potential risk to patient safety of delayed triage (albeit that the significance of that risk was not, in my view, properly appreciated at the time), and to mitigate the risk, Debbie Burns in (I believe) 2014 instructed the booking centre to initially record all referrals as per the GP grading pending a completed triage. If referrals were upgraded by the consultant, then they would adjust the waiting lists. My recollection is that at the end of 2015 we became aware of the issue of non-recording of patient outcomes and this triggered further investigation into his practice and the continued issue with triage was identified.
219. On reflection, it is apparent that following this change in practice monitoring of compliance should have continued but no outcomes of any checks were reported to me.





## Urology Services Inquiry

### Disposal of Patient Records

220. On 15 June 2011 it was reported to Shirley Tedford that an auxiliary had found a bundle of two patients' records in the bin. The bundle consisted of fluid balance charts, TPN Fluid prescription forms, MEWs Charts and Prescription records. Aidan O'Brien admitted to Shirley Tedford that he had been responsible. The issue was escalated to Heather Trouton. Following discussion it was escalated to HR and an investigation utilising the Trust Disciplinary Procedures was undertaken by Robin Brown and Zoe Parks, Medical Staffing Manager. Aidan O'Brien accepted that he was wrong and he was issued with an informal warning on 19 August 2011. *Document located in Relevant to HR, reference no 63, 20110819 Ref 63 Issue of Informal Warning MrAOBrien and 20110600 Ref 63 Disciplinary Report Mr AOBrien.*

### Review of Results of Investigations

221. In 2011 an SAI was performed in respect of a "never event" of a retained abdominal swab post-operatively. Despite the surgery being in July 2009 and a CT scan three months later showing an abnormality, the diagnosis was only made when the patient was admitted 12 months later as an emergency.
222. The investigation showed Aidan O'Brien had a policy of not reviewing results until the patient attended for review.
223. Upon being informed that there was an expectation that results should be reviewed as soon as they are available, he replied raising several objections to adopting what would be considered good medical practice. I copied his email to Gillian Rankin on 26 August 2011 as a governance issue. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20110826 E re Results and Reports of Investigations.*
224. My recollection is that there was a difficulty in Gillian Rankin organising a meeting. A check was performed by Heather Trouton of the practice in other specialities. My recollection is that, while the majority of consultants in



## Urology Services Inquiry

the Directorate did review results of investigations on a regular basis, we could not be certain they all complied.

225. Following further discussions with Gillian Rankin my recollection is that an instruction was then issued to all the consultants in the Directorate reminding / informing them that it was their responsibility to review the results of investigations on their patients once they are available. Secretaries were informed that results of investigations were not to be filed in the chart unless they had been reviewed and signed / initialled by a consultant.

### Patient Outcomes

226. My recollection is that at the end of 2015 we started to become increasingly aware of an issue regarding patient centre letters and outcomes. Some of the urologists were undertaking waiting list work / validation and found that, in many of Aidan O'Brien's patients, their clinic outcomes and letters were not recorded and there was no record in the chart. It was also noted that many of the hospital charts were not available for clinics.

### Charts at Home

227. A recurring issue since I came to the trust was consultants at times taking charts home. On request from Medical records they would be returned to the hospital. Aidan O'Brien was not unique in this respect and from time to time all consultants would be reminded not to bring them home. In September 2013 Helen Forde, Head of Health Records flagged the issue with Heather Trouton and Anita Carroll and through Anita Carroll to Debbie Burns. *Document located in Section 21 4 of 2022, 20130905 E re Charts to Consultants Home.* Debbie Burns identified it as a governance issue and Robin Brown was instructed to discuss with Aidan O'Brien and if not did it need escalated. 22 September 2013 Robin Brown emailed to say he would deal with it. *Document located in Section 21 4 of 2022, 20130922 E re Datix Incident Report.* I do not recall the issue of charts at home being discussed with me until the end of 2015. At the end of 2015 / early 2016 as part of an overall investigation Heather Trouton made me aware that it had started to



## Urology Services Inquiry

become a significant problem (Aidan O'Brien was taking them home after his Enniskillen clinic to dictate on them). The urologists at that time were performing a validation of the review backlog but there was a significant number of Aidan O'Brien's that could not be validated. This issue formed part of the concerns raised with Richard Wright and is discussed further in the next paragraph.

228. My recollection is that, as a result of our increasing governance concerns regarding Aidan O'Brien's performance and following discussions with Esther Gishkori and Heather Trouton, I reported our concerns to Richard Wright for advice. In (I believe) January 2016 Richard Wright attended a meeting with us in the Administration floor of CAH and recommended that we should check all the facts, document them on a letter to Aidan O'Brien, and ensure we had detailed records as he expected we may need to involve HR. On the 23 March 2016, in the presence of Martina Corrigan, I met with Aidan O'Brien and gave him the letter which Heather Touton and myself had drafted regarding:

- a. Untriaged letters - It was noted that, during the course of 2015, Aidan O'Brien had built up a backlog of 253 untriaged referral letters. (While this list did not contain red flag referrals, we could not be sure that none of them needed upgrading to red flag.)
- b. Review Backlog - Mr O'Brien had 679 patients and had not agreed a plan or accepted any proposals regarding a review of same. (It had been agreed with urology that revalidation of the review backlog would take place with the time needed for review was being funded as extra sessions).
- c. Patient Centre Letters and recorded outcomes from Clinics - (It had been reported to Martina Corrigan and Heather Trouton that there was often no record of consultations/discharges on Patient Centre or in the patient records.)



## Urology Services Inquiry

d. Patient Notes at home - (We were aware that Aidan O'Brien had some hospital records in his house but were unsure of how many.) *Document located in Section 21 4 of 2022, 20160323 Ltr to AOB from EM and HT.*

229. Prior to December 2015 the Medical Directors (Paddy Loughran & John Simpson), Acute Directors (Gillian Rankin, Debbie Burns and Esther Gishkori), Assistant Director Heather Trouton, Clinical Director Robin Brown, Lead Clinician Michael Young and I did not appreciate that Aidan O'Brien's failings would put patients at significant risk. On reflection I appreciate that his repeated non-compliance with administrative tasks like triage should have signposted us to the possibility of failure to complete other significant stages of the patient pathway like clinic dictation, recording of patient outcomes from a clinic or MDM.

**[58] If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified**

**[59] What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?**

**[60] How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and were working as anticipated? What methods of review were used? Against what standards were methods assessed?**

**[61] Did any such agreements and systems- which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you**



## Urology Services Inquiry

**think that was the case? What in your view could have been done differently?**

230. Again, because of the overlap in these questions, I have provided a single answer seeking to address all issues.
231. In respect of benign cystectomies, as the commissioner didn't support the procedure being performed outside of the Belfast Trust, the procedure was no longer permitted to be performed in the Southern Trust. Martina Corrigan attended the urology weekly scheduling meeting and was able to monitor compliance and thus she was able to assure myself and the Director.
232. Regarding disposal of patient records, Aidan O'Brien gave an undertaking that he would cease and desist from the practice. The ward staff and ward clerks were asked to be alert to a repetition of the problem and to report it.
233. Regarding IV fluids and IV Antibiotics, as detailed above at Questions 54-57 Aidan O'Brien was expected to have a multidisciplinary meeting to discuss any patients who he felt would need the treatment. Shirley Tedford monitored cases to ensure compliance and thus assured the Acute Director and Medical Director.
234. Following the issue of failing to review results of investigations, my recollection is that Gillian Rankin could not be assured that all consultants regularly reviewed results of investigations. As a result, all consultants were reminded / informed that it was their responsibility to review results and secretaries were instructed not to file results unless they were signed by a consultant.
235. Triage was an ongoing issue which was repeatedly addressed with Aidan O'Brien. At various times he was spoken to by myself, Robin Brown, Michael Young, Martina Corrigan, Heather Trouton and, I believe, Gillian Rankin. He would then comply but would gradually slip back again. Debbie Burns was concerned that patients referred to Aidan O'Brien could miss out on chronological booking and that patients identified by their GP as Red Flags



## Urology Services Inquiry

could wait longer. Therefore, during 2014 all patients were put on the out-patient waiting lists according to the GP grading and then would be upgraded if he regraded them. It was assumed that this would mitigate the risks from a delay in triage. Since that time the introduction of electronic triage to the Trust has led to a more robust system of monitoring triage and ensuring consultants complete it in a timely fashion. On reflection, it is apparent that the monitoring of compliance by Aidan O'Brien should have continued. I do not recall requesting any checks to be performed nor was I informed of any checks performed nor do I recall being informed of any issues with compliance by Aidan O'Brien. Also on reflection, the repeated offences should have triggered engagement at Acute Director level and Medical Director level with HR to investigate why triage was such a problem for Aidan O'Brien. I and others noted that he was slow and deliberate in nearly everything he did but we did not recognise that failure to triage was a potential sign of an inability to cope. The accusation of bullying by me is I believe, why Debbie Burns asked Robin to speak to him regarding notes at home.

236. In 2013 it was highlighted by medical records that there was an ongoing problem with Aidan O'Brien having charts at home. It was escalated to Anita Carroll who escalated it to Debbie Burns who requested Robin Brown to speak to him. On 5 September 2013 Martina Corrigan confirmed she would speak to him that day and Robin was to follow up with him. *Document located in Section 21 4 of 2022, 20130905 E re Charts to Consultants Home.* On 22 September 2013, following another 2 DATIX regarding notes at home, Robin stated he had been on sick leave but said he would speak to him. *Document located in Section 21 4 of 2022, 20130922 E re Datix Incident Report.* I admit I did not follow up on the issue as I knew Robin had been requested to deal with it. I also cannot recall being informed of any further problems in this respect until the end of 2015 / early 2016. The clinic in Enniskillen, however, changed dramatically the scope of the problem. What usually happened when a consultant performed an out-patient clinic on a remote site e.g., Banbridge, Armagh or Dungannon, is that the Trust transport would bring the charts to the clinic and, afterwards, back to Craigavon. I do not recall being aware that the consultants were transporting the charts back after the clinic in



## Urology Services Inquiry

Enniskillen. When waiting list work and validation was being performed by some of his colleagues in 2015, this showed that there was an issue with missing charts as well as the recording of clinic outcomes and discharges.

237. I was made aware of the issue of failing to dictate clinic letters and of recording clinic outcomes at the end of 2015. The initial investigation in January 2016 by Martina Corrigan indicated a significant governance concern. Following advice from Richard Wright and Esther Gishkori a letter was drafted and on 23 March 2016 I handed him the letter listing our concerns. Document located in *Section 21 4 of 2022, 20160323 Ltr to AOB from EM and HT*. I stepped down as Associate Medical Director in April 2016 and had no further involvement thus I am unaware of what agreements were made to address concerns. I am also unaware of what systems were put in place and this question could best be addressed by Anita Carroll.

238. On 23 March 2016 I handed a letter to Aidan O'Brien, drafted by Heather Trouton and myself, outlining our concerns re: untriaged outpatient referral letters, failing to agree a plan to address validation of the review backlog, the lack of patient centre outcomes and notes at home. A few weeks later I stepped down as AMD and had no further involvement.

**[62] What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss, seek to provide support, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.**

239. The support that I was aware of is set out below.

240. The urologists were each given 0.5 WTE secretarial support, however, Aidan O'Brien was given twice as much at 1 WTE secretarial support. Mehmood Akhtar in June 2010 took over triage of all red flags and in April 2011 assisted with Aidan O'Brien's backlog. Michael Young at various times assisted by completing his triage and I believe, following a request from





## Urology Services Inquiry

Debbie Burns in February 2014, performed Aidan O'Brien's triage. In gathering in information to assist in my response I sought information from Martina Corrigan in respect of some matters relating to triage and I understand that Michael Young performed Aidan O'Brien's triage for approximately 6 months in 2014. 2014 Debbie Burns asked if he needed any extra support and I believe that, in July 2014, at his request, he was excused from all clinics for a month to allow him to catch up on his administration. At no time in 2015 did Aidan O'Brien state that he had difficulty completing his triage. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20140221 Email Yesterday.*

241. Aidan O'Brien was held in very high esteem by his patients, other hospital consultants as well as by Michael Young and Robin Brown. He was considered to be a hard working individual and someone who would always strive to do the best for his patients. I believe it was this perceived dedication to his patients that contributed to a failure to consider involving HR.. I believe that the accusation in 2012 of bullying and harassment reduced my ability to manage Aidan O'Brien and therefore the Acute Directors (Gillian Rankin, Debbie Burns and Esther Gishkori) and myself relied on Robin Brown. At that time I felt Aidan O'Brien's behaviour was that he resented challenge and, as a result, I and others failed to consider that perhaps he was not capable of coping. If we had considered the latter to be the reason then the Acute Director and the Medical Director would have engaged HR for advice regarding support.

**[63] How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not**





## Urology Services Inquiry

242. At my governance meetings with Heather Trouton we would review the risk register and could add items as required. Likewise, the Directorate risk register was reviewed at the Acute Governance meeting. I have to admit that items such as triage and charts at home were not added as we all failed to appreciate the risk and/or its significance. As detailed in my response to Question 14 above, the following items relating to Urology were added to Risk Registers in the Acute Directorate. The urology cancer pathway delays was added to the Acute Directorate Risk Register ID 2943 on 7 April 2011. An increase in urology access waiting times was added to the Surgery & Elective Care Risk Register ID 3166 on 25 June 2012. Increased waiting time for new outpatients and elective surgery was added to the Surgery & Elective Care Risk Register ID 3690 on 8 June 2015. *Documents located in S21 4 of 2022, SEC Risk Register 2011, SEC Risk Register 2015 and Acute Directorate Risk Register 2012.*

### Learning

**[64] Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.**

243. I ceased being Associate Medical Director in April 2016. I was unaware of the indication or outcome of the SAIs until recently. Reviewing them shows governance issues regarding the management of urological cancers within the trust including: the MDM structure and quorum, a lack of support for the MDM, failure to track the cancer patients' whole pathway, failure to utilise Keyworker/Cancer nurse specialist, failure to adhere to MDM advice and delays in management of cancer patients.

244. Oversight of the Cancer Service was the responsibility of the Associate Medical Director, Stephen Hall, and of the Assistant Director, Ronan Carroll. At no time did either of them raise concerns regarding Aidan O'Brien, either



## Urology Services Inquiry

directly with me or at the Acute Governance meeting. There was a collective failure within the surgical division to appreciate that Aidan O'Brien posed a serious governance risk, thus, apart from the issue regarding failing to review the results of investigations, I don't recall any other governance issues regarding Aidan O'Brien being raised with Stephen Hall or Ronan Carroll. The cancer division were tasked with overseeing the MDMs and auditing the cancer pathways. On 7 April 2011 the prostate cancer and the haematuria pathways were identified as a risk due to delays and, upon the commencement of one stop clinics for both conditions, they were then recorded on the Surgery & Elective Care Risk Register as being resolved. *Documents located in S21 4 of 2022, SEC Risk Register 2011.* I was not made aware of any audits of the cancer pathway demonstrating concerns with Aidan O'Brien. I am unsure if the cancer division should have been tracking the cancer patient's whole pathway and this would need to be considered by Ronan Carroll. I believe they should have been aware of the failure by Aidan O'Brien to utilise Keyworker/Cancer Nurse Specialists. I believe a result of the failing to utilise Keyworker/ Cancer Nurse Specialists was that it reduced the ability to monitor adherence to MDM advice and identify delays in management of cancer patients. I believe that, with greater coordination between the surgery and cancer divisions, the problems may have been identified and acted upon sooner.

**[65] Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?**

245. On reflection, I think that there was a combination of factors which contributed to what went wrong.

246. During at least the first half of my tenure there was a huge push from the commissioners to maximise performance and I feel the major focus was on this plus financial stability. I am not saying quality was ignored but, on reflection, we all overly relied on individual consultants, including Aidan O'Brien, to be safe clinicians. There was a large demand for the service but



## Urology Services Inquiry

capacity was not sufficient to meet it. For several years, we did not have a full consultant complement. The level of junior staffing was too low and there were problems in recruiting and retaining suitable candidates for the Trust grade roles.

247. Aidan O'Brien was liked by consultants and nurses throughout the hospital and he had the active support of both Michael Young and Robin Brown. Patient feedback was excellent and he was seen as a very caring and considerate surgeon.
248. The 18 months of meetings held every Monday evening by Gillian Rankin showed the commitment by management to bring about a change in practice, not just from Aidan O'Brien, but his colleagues as well. The urologists', almost universal, reluctance to accept change meant that Aidan was not perceived as being the sole outlier.
249. Two clinical issues with Aidan O'Brien's practice were identified in 2009 and 2010, i.e., that of benign cystectomies and IV fluids & IV antibiotics. While Aidan O'Brien was involved in the majority of the relevant cases, Michael Young was also treating patients with IV fluids & IV antibiotics. Paddy Loughran reviewed the report from Marcus Drake on benign cystectomies and felt that the review was indeterminate. Paddy Loughran was also actively involved in managing the IV fluids & IV antibiotic cases. I believe those two concerns were managed appropriately by (a) transferring of all major pelvic surgery to Belfast and (b) by the protocol for independent clinician and microbiologist review of each case. In 2011 I raised the issue of Aidan O'Brien not reviewing the results of investigations. This was resolved by Gillian Rankin writing to all consultants advising them of the requirement to review results of investigations and sign them. The secretaries were instructed not to file results unsigned by consultants. Apart from these clinical issues we didn't think that there were any significant clinical concerns nor were any raised with us.
250. Aidan O'Brien's repeated failure to complete timely triage should have triggered a greater scrutiny of his administrative process. When challenged



## Urology Services Inquiry

(he had told me that he did select the high risk “red flag” referrals) he would complete the process. At no time did he say he wasn’t going to undertake triage nor that he wasn’t capable of same. I believe his repeated procrastination led to fatigue on the part of management and, ultimately, a failure to resolve the issues completely.

251. He was very possessive of his patients and, when challenged, would say that his practice of very personal attention enabled the highest standard of care. It was in this context that we judged his failure to fully embrace delegation of routine outpatient review of selected groups of patients by the specialist nurses. I am informed that the urology MDM was one of the last to be setup (I believe about 2010) but I was not made aware that Aidan O’Brien did not involve a key worker / specialist nurse with his cancer patients.
252. At the time of the urology review the service in Craigavon was under significant pressure with a demand that outweighed the capacity. This led to a concentration of services for emergencies, cancer and urgent patients. To deal with the rising backlog of outpatients and operative cases consultants from within the specialty were being asked to provide additional sessions. These extra sessions generated more review patients and more administrative tasks for the consultant. As detailed above at Question 16, there was difficulty in attracting and retaining sufficient staff at consultant level and a stable 5-man consultant team wasn’t achieved until 2014. It was also difficult to attract sufficient, good quality trust grade level doctors.
253. In 2012 I was informed that Aidan O’Brien had spoken to Roberta Brownlee, Chair of the Trust, and claimed that I was bullying and harassing him. This false accusation, however, did not lead to any human resources investigation or determination. Rather, I was told to be very careful in what I would say or do regarding him and to ask Robin Brown to assume management of him. I accept that it was considered a false accusation by management but the net outcome, of protecting me by not investigating and exonerating me, was that my ability to challenge him was significantly reduced. If his complaint had been formally found to be baseless and/or



## Urology Services Inquiry

malicious, then he should have been subject to the relevant disciplinary procedures.

254. During my tenure as AMD there was a trend for the Trust to be reacting to problems rather than anticipating them. On reflection I realise that the repeated issues should have raised concerns among the senior managers in the Acute Directorate regarding Aidan O'Brien's performance and triggered a fuller investigation .

**[66] What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?**

255. The tendency to base judgements on Aidan O'Brien's clinical ability and reputation led to a failure to fully assess Aidan O'Brien's administrative shortcomings and their potential governance risks. I think a major learning point is that, no matter the seniority or reputation of a clinician, repeated failures to complete administrative tasks should lead to a fuller investigation and there should have been a proper assessment of the risk to patient care and safety. The changes in the booking system, introduced in 2014, to attempt to mitigate the delay in triage should have been coupled with ongoing review and assurance of Aidan O'Brien's triaging.
256. Likewise, having good clinical skills doesn't automatically translate to management skills. The training of medical managers (lead clinician, clinical director and associate medical director) in leadership should be ongoing with regular updates provided on e.g., effective committee meetings, leadership and team dynamics, resolving conflict and self-awareness. The first time as Associate Medical Director I can recall a suggestion that I should consider leadership training was at my last appraisal as AMD.



## Urology Services Inquiry

257. Regular governance training should also be provided, in particular on risk assessment and management.
258. The decision regarding referral to human resources of a consultant is generally considered to be at director level i.e., between Acute Director and Medical Director. Awareness training of the support Human Resources can provide should be provided to both clinical and non-clinical managers.
259. Fully resourced local and national clinical audit of patient pathways and outcomes needs to be embedded in all specialties and not just urology.
260. Once an accusation of bullying or harassment is received about a manager then it should be investigated, otherwise unresolved false accusations inhibit the manager's ability to manage.

**[67] Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.**

261. As detailed above in Question 9, multiple meetings at regional, Trust and hospital level were conducted to support the development of the urology service. At the Acute Directorate level for 18 months in 2009-10 we held a weekly meeting with the urologists to meet the requirements of the commissioners and the needs of the patients.
262. Questions 16 to 18 above show the efforts to support the staffing issue and Question 53 above shows the efforts to attain reasonable job plans that would be supported by the commissioners. Following agreement on the 5-man job the Trust, in 2014, went at financial risk to appoint a sixth consultant.
263. Questions 54 to 57 above demonstrates the amount of effort that went into managing the problems encountered in urology: IV fluids & IV antibiotics,



## Urology Services Inquiry

benign cystectomies, triage, disposal of patient records, review of results of investigations,

264. Monitoring of triage and notes at home would not be considered the responsibility of clinical managers and would be considered an operational issue. The Acute Director and Assistant Director may, however, require the assistance of Associate Medical Director with managing the issue. I accept that there was a failure on my part and also, in my opinion, on the part of Heather Trouton, Gillian Rankin, Debbie Burns and Esther Gishkori to fully recognise the problems with triage and notes at home. This failure meant that, at best, we contained the problems but didn't sort them out. Debbie Burns, in order to mitigate the risk of delay in triage, introduced a system whereby the booking centre placed patients on the list according to GP grading. There was a failure following this for either the booking centre to monitor delays in triage or if they did for breaches to be acted upon. On reflection, I believe the repeated triaging breaches, despite multiple requests, should have led to a discussion by the Acute Director and the Medical Director regarding action.

**[68] Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilized to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

265. As stated above in Question 67, I believe mistakes were made by myself, Heather Trouton, Gillian Rankin, Debbie Burns and Esther Gishkori in recognising the risks of the concerns identified. We failed to fully grasp that the repeated infringements regarding triage and notes at home could be an indication of a potentially serious risk to patient safety.





## Urology Services Inquiry

266. Apart from the issues regarding notes in the bin, IV fluids & IV antibiotics and benign cystectomies (which, in my view, were properly addressed), I believe that, in light of repeated infractions at triaging, the Acute Director should have engaged with the Medical Director regarding handling the problem. On reflection, in 2014 when urology had appointed a sixth consultant, I believe, rather than just change the booking centre system, Debbie Burns should have considered engaging with John Simpson.
267. I think Roberta Brownlee, in her governance role, should have requested investigation of the bullying and harassment complaint.

**[69] Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

268. One of the biggest issues I had as AMD was the amount of time that the post required. I also had a full time General Surgical post and subspecialised in Colorectal surgery as well as Oesophagogastric surgery. For the first approximately two years I was supported by only one clinical director. This increased to two when Sam Sloan became clinical director but, due to family commitments for her last year in the role, I believe she was unable to devote the necessary time. I admit I did not raise these concerns with the Acute Director or Medical Director.
269. I understand that, since then, there has been a new medical management structure put in place with the Medical Director being supported by a new tier of Assistant Medical Directors who are in turn supported by the Associate Medical Directors and Clinical Directors. I further understand there are now three clinical directors in the surgery division. I also understand that more time is allocated to medical managers to carry out their tasks.





## Urology Services Inquiry

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

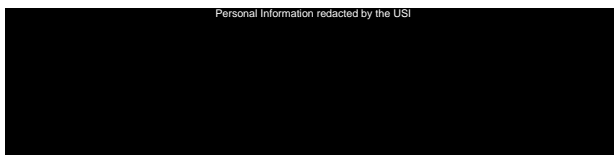
**70. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?**

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

### Statement of Truth

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

Signed: \_\_\_\_



Date: 12 April 2022

**S21 4 of 2022****Witness statement of: Edward (Eamon) John Mackle****Table of Attachments**

<b>Attachment</b>	<b>Document Name</b>
1	SHSCT Associate Medical Director JD
2	20040323 Letter re Macmillan Lead Cancer Specialist CD wef 01.01.2004 + Job Description
3	20091201 Uro Service Mtg Notes
4	20091207 Uro Services Mtg Minutes AOB
5	20110627-email urology meetings
6	20120606 E re Urology Job
7	20120606 E re Urology Job Plans A1
8	20120606 E re Urology Job Plans A2
9	20120606 E re Urology Job Plans A3
10	20120606 E re Urology Job Plans A4
11	20130227 E re Urology Job Plans
12	20130301 E to MY and RB re Urology Job Plans
13	20100427 Ltr re Regional Uro Review
14	SEC Risk Register 2011
15	SEC Risk Register 2015
16	Acute Directorate Risk Register 2012
17	List of Consultants and SAS Medical Grades 2009-2016
18	2012 Appraisal EM
19	2013 Appraisal EM
20	2014-2015 Appraisal EM
21	20110901 E to MC and HT re AOB Draft Job Plan
22	20111115 E to Payroll re AOB
23	20160304 E re Actions from AMD Uro Consultant Mtg
24	20160323 Ltr to AOB from EM and HT
25	201606 Ltr to MD re Ram Suresh Uro Cover
26	20130305 E re Uro Team Job Plans
27	20131204 E re Missing Triage
28	20130905 E re Charts to Consultants Home
29	20130922 E re Datix Incident Report
30	2011 - 2012 Job Plan AOB

**Reference Number:**

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

**JOB SUMMARY**

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

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

**KEY RESULT AREAS:**

**Strategy Development:**

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

**Service Delivery**

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

**Professional Leadership**

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

**Medical Education and Research**

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

**Leading the Medical Team**

- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff and to ensure that personal and professional development plans are in line with corporate objectives
- Implement the consultant contract, within the Directorate, ensuring the contract supports modernisation, quality improvement and achievement of access targets
- Provide leadership in the effective implementation and monitoring of Modernising Medical Careers and The New Deal for Junior Doctors.
- Ensure that doctors within the Directorate comply with arrangements for the assessment of fitness for clinical work and be responsible within the directorate for professional standards and regulation of doctors
- Ensure that a process is in place within the directorate for proper appraisal of all grades of doctors, including locum tenens, in line with regional guidance.
- Take part in the recruitment process for new doctors or ensure that other colleagues do so effectively
- Influence the modernisation of the workforce as systems for delivering care change
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

**Quality & Information Management**

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

- Ensure a programme of multi-professional clinical audit is implemented within the Directorate that supports the Trust integrated governance strategy and support the development of benchmarking activities within the Directorate
- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the Directorate

### **Collaborative Working**

- Actively promote the development of clinical and professional networks across primary, secondary and social care.
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated
- Promote and develop effective multi-professional team working and communication.

### **Corporate Responsibilities**

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

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

appropriate to the grade may be assigned from time to time by the Medical Director/ Director of Acute Services.

## **GENERAL RESPONSIBILITIES**

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

**July 2007**

# **Southern Health and Social Care Trust**

## **Associate Medical Director – Surgery/Elective Care**

### **Personnel Specification:**

**Title of Post:** Associate Medical Director – Surgery/Elective Care

***Knowledge, skills and experience required:***

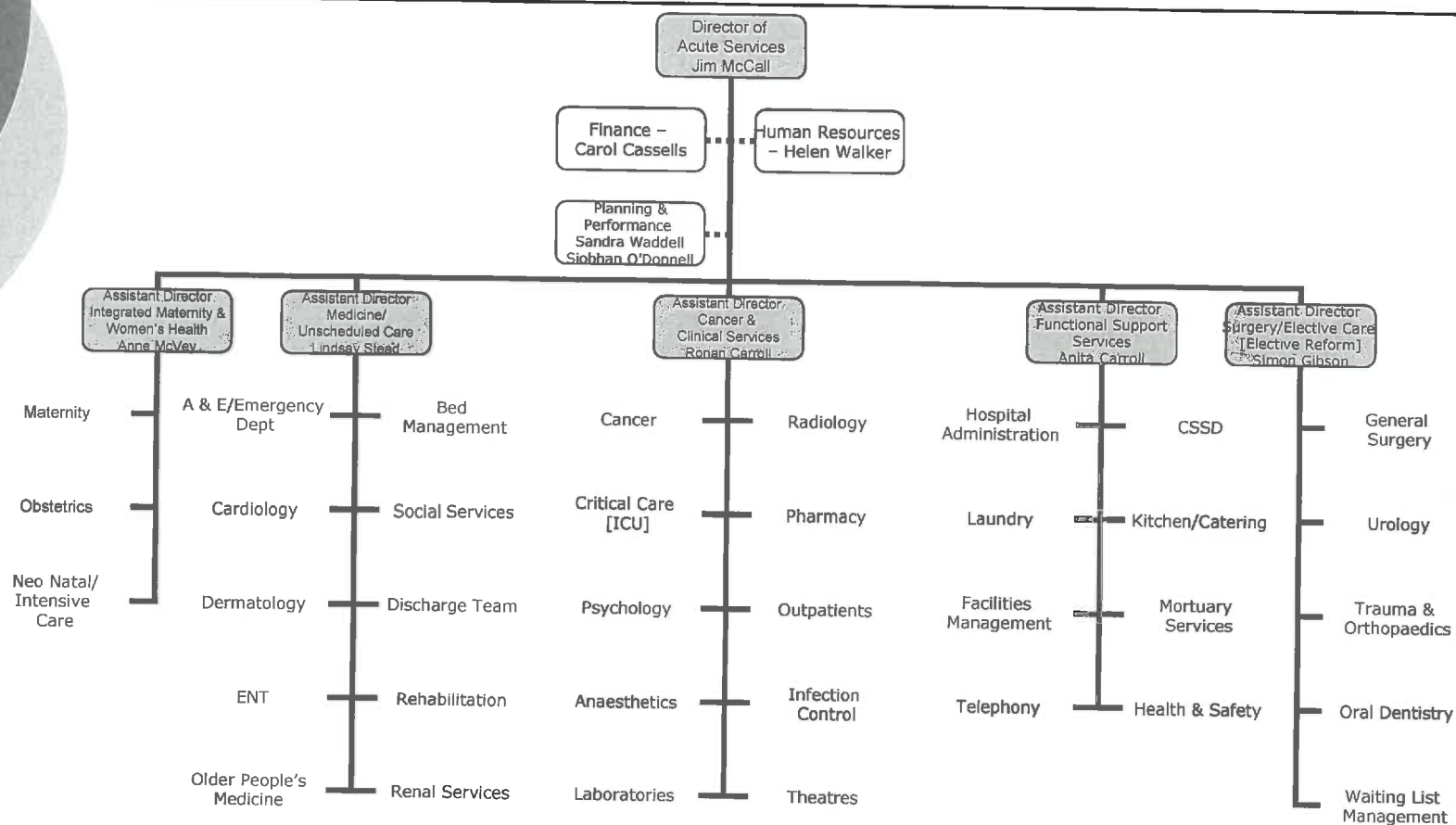
- Hold a medical or dental qualification, GMC registration and specialist accreditation.
- Demonstrate evidence of leadership within a team that led to successful service development and/or quality improvement.
- Demonstrate evidence of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.
- Have excellent communication skills, both orally and in writing.
- Be prepared to undertake clinical management development.

### **SHORTLISTING**

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified



# Directorate of Acute Services



*Medical Management/Structures will be confirmed following appointment of Medical Director*



G ref MR/BW/hm-c

23 March 2004

**STRICTLY PRIVATE & CONFIDENTIAL**

Mr E Mackle  
Macmillan Lead Cancer Specialist/Clinical Director – Cancer Services  
Macmillan Building  
Craigavon Area Hospital

Dear Mr Mackle

I have pleasure in formally confirming your appointment as Macmillan Lead Cancer Specialist/Clinical Director – Cancer Services (Southern Health and Social Services Board).

This appointment will take effect from 1<sup>st</sup> January 2004 and will be for a 3-year period in the first instance. The sessional commitment will be 2 sessions per week which will be recognised through the payment of 2 additional temporary sessions. You will, of course, be involved in agreeing a new job plan in the context of the new Consultant Contract and at that stage you will be in a position to review the implications of this additional workload with your Clinical Director and with the Medical Director.

In the meantime, however, I am pleased to be able to confirm that arrangements for payment have been made with the Finance Department, with adjustment and arrears being paid in your April salary.

May I take this opportunity to wish you every success in this important and demanding post. If you have any queries, please do not hesitate to contact me on extension Personal information redacted by USI

Yours sincerely

cc: Dr C Humphrey  
Salaries & Wages  
File

Personal information redacted by the USI

---

**BETTY WILLIAMSON (Mrs)**  
**Medical Staffing Officer**

**CRAIGAVON AREA HOSPITAL GROUP TRUST****JOB DESCRIPTION**

**POST:** Macmillan Lead Cancer Specialist/Clinical Director – Cancer Services (Southern Health & Social Services Board)

The Post is a Consultant appointment based at Craigavon Area Hospital (as designated Cancer Unit for the SHSSB area). The postholder will provide clinical leadership in the development of cancer services for the SHSSSB population in accordance with the recommendations of the Campbell Report "Cancer Services – Investing for the Future" and the recommendations of the SHSSB Cancer Services Steering Group.

**RESPONSIBLE TO:** Chief Executive, Craigavon Area Hospital Group Trust

**REPORTS TO:** Medical Director, Craigavon Area Hospital Group Trust

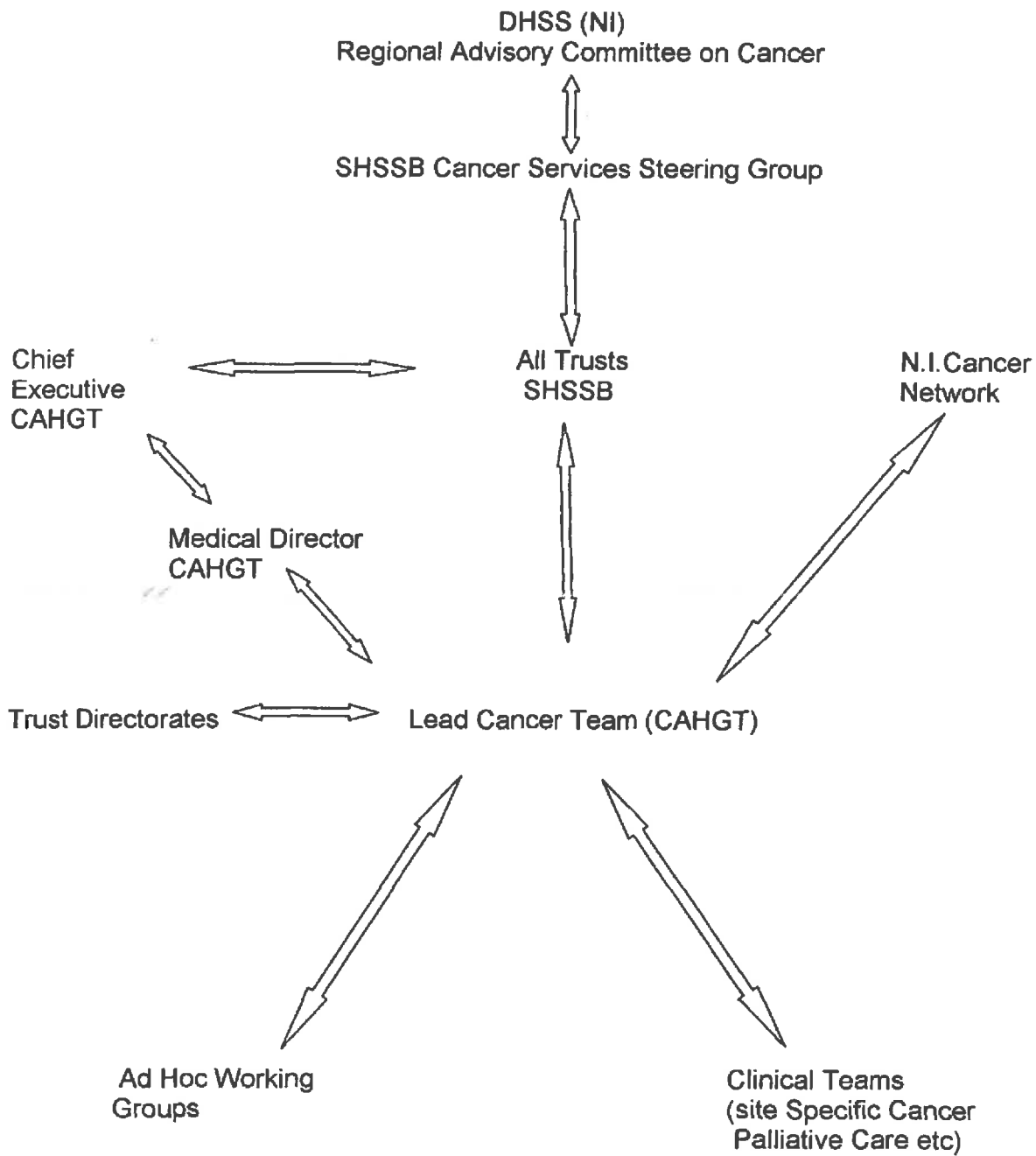
**SESSIONAL COMMITMENT:** 2 Sessions per week

**TENURE OF THE POST:** 3 years in the first instance, subject to review

The postholder will provide professional leadership to the lead cancer team based at Craigavon Area Hospital Group Trust.

*1 January 2004 for 3 years in first inst.*

## ORGANISATIONAL RELATIONSHIPS



## Organisational Relationships Continued

- Responsibility for determining the broad strategic framework for local cancer services remains within the SHSSB working through its Cancer Services Steering Group. The Steering Group will continue to use existing collaborative structures such as the Implementation Groups for site specific cancers.
- Responsibility for the financial framework for the development of local cancer services remains within the SHSSB working in collaboration with all Trusts in the SHSSB area but principally through the structures identified in the organisational framework.
- The Lead Cancer Team will consist of :
  - Macmillan Lead Cancer Specialist )
  - Macmillan GP Facilitator ) with administrative duties
  - Macmillan Lead Cancer Nurse )

The Lead Cancer Team will be responsible for implementing the cancer services development plans for the SHSSB area and will be responsible to the Chief Executive, Craigavon Area Hospital Group Trust and through the Lead Cancer Specialist to the SHSSB Cancer Services Steering Group.

- The Macmillan Lead Cancer Specialist will provide the professional lead to the Cancer Team and will be involved in the appointment of other team members.
- The Lead Cancer Team will have an overview of all issues in relation to cancer in the SHSSB area. The remit of the Lead Cancer Team will cover the following key areas:
  - participation in N.I. Cancer Network;
  - liaison with the Cancer Centre;
  - liaison with other Cancer Units;
  - assessment of progress towards implementation of cancer service redevelopment/organisation;
  - development of constructive implementation proposals;
  - development and dissemination of guidelines for good clinical practice;
  - development of plans for collaborative audit and other quality assurance mechanisms for all aspects of cancer services;
  - facilitation of multidisciplinary team working;
  - development of training recommendations for all staff groups based on assessment of present expertise and training needs;
  - development of SHSSB Cancer Services Directory;
  - co-ordination of production of monitoring reports for the Cancer Service;
  - contribution to the continuing development strategy for cancer services in SHSSB area;
  - contribution to increased understanding of health needs of patients with cancer.

**RESPONSIBILITIES OF THE POST**

- To lead the Craigavon Area Hospital Group Trust Lead Cancer Team
- To join in the work of the N.I. Cancer Network
- To work with the site specific cancer implementation groups to facilitate clinical integration of services for cancer care provided in all SHSSB Trusts in line with agreed plans.
- To enhance links between GPs and the Cancer Unit, the Cancer Centre in Belfast and all Trusts in the SHSSB area.
- To facilitate the provision and development of non-surgical Oncology services to the Cancer Unit.
- To oversee the development and audit of protocols between primary care, the Cancer Unit services and the Cancer Centre to ensure an effective network of high quality care.
- To meet regularly with colleagues from other Cancer Units, the Cancer Centre and General Practice to ensure equity of access to care and equity of standard of care.
- To liaise with the Macmillan network of Medical Advisers and Lead Cancer Clinicians.
- To supervise arrangements for audit and monitoring of standards in cancer care.
- To supervise arrangements for continuing medical education in cancer care.

**ASSIGNMENT AND REVIEW OF WORK**

The SHSSB Cancer Services' Steering Group will set broad objective in terms of the development of cancer services within its area.

The postholder will determine the most effective way of achieving appropriate service development through the Lead Cancer Team in liaison with local clinicians and the SHSSB.

Performance will be reviewed periodically throughout the year.

**COMMUNICATION AND WORKING RELATIONSHIPS**

- Other members of the Lead Cancer Team.

Senior/Lead Clinicians and Clinical Directors within SHSSB Trusts and Primary Care.

- Members of the SHSSB Steering Group.
- Senior clinician in palliative care
- Department of Public Health Medicine, SHSSB.
- GP locality advisers.
- Area Medical Advisory Committee.
- Lead Clinicians and project managers, Cancer Centre, Belfast.
- Local Postgraduate Tutors.
- N.I. Cancer Network

**QUALIFICATIONS/EXPERIENCE REQUIRED FOR POST**

The postholder will be a registered medical practitioner practising at Consultant grade. He/she should have:

- an understanding of the provision of cancer services to the population of the SHSSB;
- a well established interest in cancer care;
- an understanding of the organisational change required to effect high quality cancer care;
- proven clinical management skills;
- proven high level team working skills;
- an understanding of the complexities of cancer care;
- professional credibility amongst clinicians in the SHSSB area.





## **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. Quality & Safety**

##### **Key Issues:-**

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



## **Meeting re Urology Service**

**Monday 7 December 2009**

### **Action Notes**

#### **Present:**

Dr Patrick Loughran, Medical Director  
Mr Eamon Mackle, AMD – Surgery & Elective Care  
Dr Gillian Rankin, Interim Director of Acute Services  
Mr Aiden O'Brien – Consultant Urologist

#### **Key points of discussion:**

1. The Trust expects in line with the N I Integrated Elective Access Protocol, that all patients will be treated by clinical priority and chronological order. Those patients on Mr O'Brien's list as clinically urgent may not be clinically urgent. No agreed process in place with Consultants and junior staff on what is urgent or routine. If juniors designate as urgent wrongly, the patient status is not amended to routine. Agreement to review whether urgent or not by Monday 14<sup>th</sup> December. **ACTION: Mr O'Brien.**
2. Agreed to put all urgent patients on to immediate lists. **ACTION: Mr O'Brien**
3. Current problems perceived in system:
  - Patients are getting letters of offer from IS even though they have already received an in-house appointment.
  - Clinical management plans are not accurately put on PAS eg. Flex. Cystoscopy planned for annual review is booked for 3 months.
  - Suggestion of separation of dictation and onward management/booking. **ACTION: Review and process mapping of systems – Heather Trouton.**
4. Pooling of lists is acceptable if patient consents, and is aware that may be treated more quickly by another surgeon. Need to agree who has clinical responsibility post operatively (original surgeon or operating surgeon). **ACTION: Mr Mackle and Urologists.**

The Urologists need to agree which patients/conditions can be put on a pooled list.

**ACTION: Urologists and Heather Trouton.**

**5. Red Flag System**

The N I Standard is that patients with potential cancer are tracked by the red flag system to ensure they are seen within designated timescales. This system is not used at all at present, mainly on principle because the system is blunt and does not grade the degree of clinical priority across all red flags; nor does it reconcile with non-cancer clinically urgent.

The use of red flags is mandatory and reflects clinical evidence. (NICE and NICE).

Agreement to develop a sub-division of red flags for use in specialty. **ACTION: Mr Mackle and Urologists.**

- 6.** Need to clarify what POA hold signifies against a patient on waiting list; and whether if a patient is not medically fit for a procedure the clock stops. **ACTION – Heather Trouton**

**7. Pre-Op Assessment**

Needs review as patients can be called unnecessarily.

- 8.** Confidence in Trust destroyed due to ward reconfiguration.

**Corrigan, Martina**

---

**From:** Trouton, Heather [Personal Information redacted by the USI]  
**Sent:** 27 June 2011 18:43  
**To:** Stinson, Emma M; Mackle, Eamon; Rankin, Gillian  
[Personal Information redacted by the USI]  
**Subject:** RE: Urology meetings  
**Attachments:** 200611 Memo Mr Akhtar (3).docx; 200611 Memo Mr Young.docx; 200611 Memo Mr O'Brien.docx

Sorry

From: Stinson, Emma M  
Sent: 27 June 2011 14:10  
To: Trouton, Heather  
Subject: Urology meetings

Heather

Sorry, no attachment.

Emma

Emma Stinson  
PA to Dr Gillian Rankin  
Director of Acute Services  
Admin Floor  
Craigavon Area Hospital  
Tel: [Personal Information redacted by the USI]  
Fax: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]  
P Please consider the environment before printing this email

From: Rankin, Gillian  
Sent: 27 June 2011 12:44  
To: Stinson, Emma M  
Subject: FW: Urology meetings

-----  
From: Trouton, Heather  
Sent: Monday, June 27, 2011 12:43:50 PM  
To: Rankin, Gillian; Mackle, Eamon  
Subject: Urology meetings  
Auto forwarded by a Rule

Gillian and Eamon

Can you please see details of discussions had with the three Urologists.

Can you please read through and make any amendments you wish/ feel necessary before I send to on to the three guys.

Thanks  
Heather

## Memorandum **By E-Mail**

**To:** Mr Michael Young, Consultant Urologist  
**From:** Mrs Heather Trouton, Assistant Director of Acute Services –  
Surgery and Elective Care  
**Date:** 20<sup>th</sup> June 2011  
**Subject:** **Issues and Actions from Meeting held on 9<sup>th</sup> June 2011**

---

Following our meeting on Thursday 9<sup>th</sup> June 2011 please see a summary of issues discussed and actions agreed.

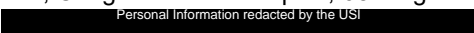
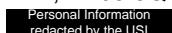
1. Dr Rankin outlined the Trust requirement for updated Job Plans to be complete prior to end of June 2011. Dr Rankin also placed the meeting in the context of the Regional Urology Review and the necessity of demonstrating the provision of an effective, efficient and productive Urology Service if further 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 16<sup>th</sup> June 2011. Draft Job Plan constructed for discussion.

### **3. Review Backlog**

- Discussion around length of Review Backlog and potential to triage more effectively with the input of Sr Tedford to support Mr Young with the supply of patient centre letters etc and the use of the Standard Discharge Template
- Agreed we would supply a selection of letters which under another speciality permission would be given to discharge using agreed standard discharge letter by Senior Nurse for Mr Young's assessment.
- Heather Trouton to meet with Mr Young to work through a process of review, agreeable to all which will see a more satisfactory management of the Review Backlog than we have currently.

Surgery and Elective Care Division, Acute Services Directorate,  
Admin Floor, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ  
E-mail:  Telephone: 

**4. Ramone Ward – Potential Relocation**

- Mr Young to present rationale for space requirements
- This occurred on Wednesday 15<sup>th</sup> June 2011.
- Outcome – Mr Young to send to Heather Trouton the list of essential rooms required for Heather Trouton to liaise with Estates to see if this can be accommodated within the available space.

**5. Trust Grade Appointments**

Interview for Urology Trust Grade 23<sup>rd</sup> June 2011. Mr Young requested to employ two Trust Grades. Heather Trouton to contact Finance re available funding for 2<sup>nd</sup> Trust Grade and advise.

**6. Pooled Day Case Lists**

Agreed that this would be acceptable for all patients with the exception of those that Mr Young specifically requests to do himself. Otherwise both Mr O'Brien and Mr Akhtar will incorporate Mr Young's long waiter day case patients onto their lists to equalise waiting times.

**7. Urodynamics**

Consultant input – it was agreed following discussion that Mr Young would require 20minutes 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.

**8. Nurse Provided Flexible Cystoscopy**

Discussion was had around the possibility of Sr McMahon refreshing her skills in undertaking flexible cystoscopies. There would be no issue with this once Sr McMahon had some supervised sessions and felt competent to undertake this procedure.

**9. Cancer Pathway**

Discussion was had around Specialist Interest within Urology. It was agreed that although Mr Young may favour specialising in Stone Treatment, that he would wish to retain in the meantime an interest in cancer work.

With regard to Outpatient time required to see Day 4 Cancer patient it was agreed that a 30minutes slot would be required and be a reasonable time allocation for the more complex patients.

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**



## 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:** 20<sup>th</sup> June 2011  
**Subject:** **Issues and Actions from Meeting held on 9<sup>th</sup> June 2011**

---

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

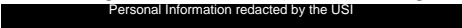
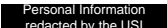
1. Dr Rankin outlined the Trust requirement for updated Job Plans to be complete prior to end of June 2011. Dr Rankin also placed the meeting in the context of the Regional Urology Review and the necessity of demonstrating the provision of an effective, efficient and productive Urology Service if further 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 16<sup>th</sup> 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:  Telephone: 

**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**

## Memorandum **By E-Mail**

**To:** Mr Mehmood Akhtar, Consultant Urologist  
**From:** Mrs Heather Trouton, Assistant Director of Acute Services –  
Surgery and Elective Care  
**Date:** 20<sup>th</sup> June 2011  
**Subject:** **Issues and Actions from Meeting held on 9<sup>th</sup> June 2011**

---

Following our meeting on Thursday 16<sup>th</sup> June 2011 please see a summary of issues discussed and actions agreed.

1. Mrs H Trouton outlined the Trust requirement for updated Job Plans to be complete prior to end of June 2011. Mrs Trouton 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 Akhtar presented current Job Plan to Mr Mackle. Discussion took place regarding essential elements, particularly the outpatient capacity, required new/review general clinic appointments and the requirement for a Specialist Clinic to see Day 4 Cancer patients.
- It was agreed that the new Job Plan would try to accommodate:
  - 1 specialist Cancer Clinic with 8-10 slots.
  - 1 General Urology Clinic with 16-17 slots in 3½hour clinic i.e. 1:30pm – 5pm
  - 1 Prostate Assessment Clinic with 8 prostate patients and 4 Red Flag patients.
- Mr Mackle has on Friday 17<sup>th</sup> June 2011 drafted a suggested updated Job Plan for Mr Akhtar's review.

### **3. Review Backlog**

- Mr Akhtar has no backlog for patients seen at South Tyrone Hospital clinic but does have a backlog of patients seen at Craigavon Area Hospital clinic.
- Discussion was had regarding the review/triage process used successfully in General Surgery and other specialties.

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 the USI Telephone: Personal Information redacted by the USI

- Heather Trouton to provide Mr Akhtar with details of the Nurse Supported process and provision of example letters which may be able to be discharged via the agreed discharge letter template as decided by the Speciality Senior Nurse.
- It was agreed that management of the Review Backlog is a priority for the Urology Team and the Trust.

**4. Flexible Cytoscopy Provision**

- It was agreed, following discussion that Mr Akhtar would support flexible cystoscopies being performed by Sr McMahon, initially for planned and surveillance patients after refresher training and medical supervision to build up confidence and competence in this procedure once more. Mr Akhtar would like to lead on this initiative.
- Martina Corrigan to liaise with Sr McMahon to establish training requirements.

**5. Pooled Lists**

- Mr Akhtar outlined his current scheduling process for day cases which currently involves him sitting with his secretary and chronologically scheduling his patients every 6 weeks. It was agreed that the Speciality Administrator for Urology, Mrs Andrea Cunningham would provide Mr Akhtar with the day case waiting list of all urology patients from which he will schedule the longest waiters from any Urology Consultants list to ensure equality of access to surgery.
- Andrea Cunningham to make contact with Mr Akhtar regarding this process.

**6. Urodynamics**

Mr Akhtar stated that Urodynamics was something he did not wish to participate in as he wished to focus on Cancer work.

**7. Triaging of Red Flag Referrals**

It was agreed that Mr Akhtar will continue to provide this service in the meantime as part of his specialist interest in cancer.

**8. One Stop Prostate Assessment/Biopsy Clinic – all day Wednesday**

Please see Job Plan – 8 patients and 4 RF in morning session. Biopsy's in afternoon session.

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**

**Mackle, Eamon**

---

**From:** Corrigan, Martina  
**Sent:** 06 June 2012 16:08  
**To:** Trouton, Heather; Brown, Robin  
**Cc:** Mackle, Eamon; Reid, Trudy  
**Subject:** RE: Urology Job plans  
**Attachments:** UROLOGY CONSULTANT JOB PLAN - POST 5 - FOR JD.doc; UROLOGY CONSULTANT JOB PLAN - POST 3 - FOR JD.doc; UROLOGY CONSULTANT JOB PLAN - POST 4- FOR JD.doc; Urology Job Plans Jan 12 v4.xls

**Importance:** High

Dear Mr Brown

Please see attached as discussed earlier with Heather.

Just to advise that the first draft of these was sent to the Urologists for comments in October 2010. Mehmood was the only person to comment and his comments were mainly about the cancer work and MDT which were addressed in the next draft done in December 2010 and again this was forwarded to the Consultants for comments but we never received any. When we had received confirmation from the Board that we could advertise the 2 new consultant posts in October 2011 we revisited all of these job plans and resent them to the Urologists inviting comments back. Again we received none at this stage.

We then resent them in January 2012 as we needed to get consultant 4 & 5 put into a job plan for the job descriptions along with Mr Akhtar's replacement post. I have attached these as well to this email. Michael came back with a proposal which after discussion with Eamon was not feasible in respect of theatres as it meant changing teams and consultants each week. This was fed back to Michael at the time. In the meantime we sent the job description to Specialty Advisor Mr Patrick Keane who came back with comments only in respect to the SPA's and all this information was fed back to Michael.

I am happy to discuss if you need any further information.

Many thanks

Martina

Martina Corrigan  
Head of ENT and Urology  
Craigavon Area Hospital

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

From: Trouton, Heather  
Sent: 06 June 2012 15:21  
To: Brown, Robin  
Cc: Mackle, Eamon; Reid, Trudy; Corrigan, Martina  
Subject: Urology Job plans

Robin

Following our discussion this am, I have asked Martina to send you a copy of all 5 job plans in the team job plan for Urology Team South.

I have spoken to Eamon this afternoon re the issues that Aidan and Michael have raised re changing their minds about evening theatre sessions.

Would it be possible for you to review the job plans as is and see if you think they are reasonable, And secondly see if there is any way that Aidan and Michael could be facilitated with 9-5pm sessions so that they would not have to do evening sessions. None of us have any wish to impose something that they would not be comfortable with, albeit that when first raised they were very happy with the evening sessions and it was only Mehmood that did not want to move to evening theatre work.

I am conscious that we are interviewing next week based on the job plans advertised but would be really grateful if you could have a look.

Thanks  
Heather

## CONSULTANT JOB PLAN (POST 5) - INTEREST IN STONES (Replacement Post)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	8.30am – 9.00am 9.00am – 1.00pm 9.00am – 1.00pm 1.00pm – 1.30pm	Travel CAH to ACH (week 2) OPD – ACH (week 2) SPA (week 1, 3 & 5) Travel ACH to CAH (week 2)	ACH CAH	0.125 1.00  0.125	3.00			7.25	
	2.00pm – 5.00pm 2.00pm – 5.00pm	Stone Treatment clinic (Weeks 2 & 4) Admin (weeks 1, 3 & 5)	CAH CAH	1.50 1.50					
Tues	9.00am – 1.00pm 9.00am – 1.00pm	Day surgery unit (weeks 1, 3 & 5) Admin (weeks 2 & 4)	CAH CAH	2.00 2.00				8.00	
	1.00pm – 5.00pm 1.00pm – 5.00pm	Emergency Urologist (weeks 1, 3 & 5) SPA (weeks 2 & 4)	CAH	2.00	2.00				
Wed	8.00am – 12.00	Theatres (weeks 2 & 4)	CAH	2.00				6.50	
	12.00 – 7.00pm 1.00pm – 5.00pm	Theatres CAH (weeks 1, 3 & 5) SPA (week 2)	CAH CAH	3.50	1.00				
Thurs	9.00am – 1.00pm 2.00pm – 5.00pm	Stone Treatment D/Cs (weeks 1, 3 & 5) OPD – weekly	CAH CAH	2.00 3.00				5.00	
Fri	9.00am – 1.00pm 1.00pm – 5.00pm 1.30pm – 5.30pm	Flexible Cystoscopies Emergency Urologist (weeks 1, 3 & 5) Theatres (weeks 2 & 4)	CAH CAH CAH	4.00 2.00 2.00				8.00	
TOTAL HOURS				28.75	6			34.75	
TOTAL PROGRAMMED ACTIVITIES				7.18	1.50			8.68	

- Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly**

## 1. EMERGENCY WORKLOAD

On-call availability Supplement	
On-call Category:	A
Agreed on-call Rota Frequency:	1 in 5 (Medium Frequency)
On-Call Availability Supplement:	5%

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	1.00
TOTAL PA's for ON-CALL:			1.00

## 2. SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	8.18 (includes 1 PA for Ward rounds)	
Supporting Professional Activities:	1.50	Specific Role:
On-Call Allocation:	<i>Total including Predictable &amp; Unpredictable</i>	
	1.00	
Any Additional HCS Responsibilities:		Reason:
Any External Duties:		Reason:
Any Annualised Activity & Reason		Reason:
<b>TOTAL PA's:</b>	<b>10.75</b>	



## CONSULTANT JOB PLAN (POST 3) - INTEREST IN ONCOLOGY (Replacement Post)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	9.00am – 1.00pm	Admin	CAH	4.00				7.50	
	1.00pm – 5.00pm 2.00pm – 5.00pm	Emergency Urologist (Weeks 2 & 4) OPD – CAH (weeks 1, 3 & 5)	CAH	2.00 1.50					
Tues	8.30am – 9.00am 9.00am – 1.00pm	Travel to STH (weeks 2 & 4) Day Surgery Unit – (weeks 2 & 4)	STH	0.25 2.00				4.00	
	2.00pm – 5.00pm 5.00pm – 5.30pm	OPD – STH (weeks 2 & 4) Travel from STH (weeks 2 & 4)	STH	1.50 0.25					
Wed	9.00am – 1.00pm 9.00am – 1.00pm	SPA (weeks 1, 3 & 5) OPD – CAH (weeks 2 & 4)	CAH	2.00	2.00			7.50	
	1.00pm – 5.00pm 2.00pm – 5.00pm	Emergency Urologist (weeks 2 & 4) Prostate Biopsy (weeks 1, 3 & 5)	CAH	2.00 1.50					
Thurs	9.00am – 1.00pm	SPA	CAH		4.00			7.00	
	2.00pm – 5.00pm	MDT – weekly	CAH	3.00					
Fri	9.00am – 1.00pm	Theatres	CAH	4.00				8.00	
	1.30pm – 5.30pm	Theatres	CAH	4.00					
TOTAL HOURS				28	6.00			34	
TOTAL PROGRAMMED ACTIVITIES				7	1.50			8.5	

- Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly

## 1. EMERGENCY WORKLOAD

On-call availability Supplement	
On-call Category:	A
Agreed on-call Rota Frequency:	1 in 5 (Medium Frequency)
On-Call Availability Supplement:	5%

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	1.00
TOTAL PA's for ON-CALL:			1.00

## 2. SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	8.00 (includes 1 PA for Ward rounds)	
Supporting Professional Activities:	1.50	Specific Role:
On-Call Allocation:	<i>Total including Predictable &amp; Unpredictable</i>	
	1.00	
Any Additional HCS Responsibilities:		Reason:
Any External Duties:		Reason:
Any Annualised Activity & Reason		Reason:
<b>TOTAL PA's:</b>	<b>10.5</b>	

## CONSULTANT JOB PLAN (POST 4) – SPECIAL INTEREST IN ONCOLOGY (New Post)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	9.00 – 1.00pm	SPA (weeks 1, 3, & 5)	CAH		2.00			7.56	
	9.00 – 1.00pm 7.45 – 9.00am 9.00 – 1.00pm	OPD (week 2) Travel from CAH to Erne (week 4) Day surgery unit (week 4)	CAH CAH EKN	1.00 0.31 1.00					
	2.00 – 5.00pm 2.00 – 5.00pm 5.00 – 6.15pm	Admin (weeks 1, 2, 3 & 5) OPD – Erne (week 4) Travel EKN to CAH (week 4)	CAH EKN	2.25 0.75 0.25					
Tues	8.00 – 12.00	Theatre – (weeks 2 & 4)	CAH	2.00				7.50	
	12.00 – 7.00pm	Theatre – (weeks 1,3 & 5)	CAH	3.50					
	1.00 – 5.00pm	Emergency Urologist - (weeks 2 & 4)		2.00					
Wed	9.00 – 1.00pm	SPA	CAH		4.00			7.50	
	1.00 – 5.00pm	Emergency Urologist (weeks 1,3 & 5)		2.00					
	2.00 – 5.00pm	Prostate Biopsy (weeks 2 & 4)	CAH	1.50					
Thurs	9.00 – 1.00pm	OPD (weeks 1, 3 & 5)	CAH	2.00				5.00	
	2.00 – 5.00pm	MDT weekly	CAH	3.00					
Fri	9.00 – 1.00pm	Admin (weeks 1, 3 & 5)	CAH	2.00				6.83	
	9.00 – 1.00pm	Theatres – (weeks 2 & 4)	DHH	2.00					
	2.00 – 5.00pm	OPD – DHH (weeks 2 & 4)	DHH	1.50					
	5.00 – 5.40pm	Return travel from DHH (weeks 2 & 4)		1.33					
TOTAL HOURS				28.39	6			34.39	
TOTAL PROGRAMMED ACTIVITIES				7.09	1.5			8.59	

- **Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly**

## 1. EMERGENCY WORKLOAD

On-call availability Supplement	
On-call Category:	A
Agreed on-call Rota Frequency:	1 in 5 (Medium Frequency)
On-Call Availability Supplement:	5%

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	1.00
<b>TOTAL PA's for ON-CALL:</b>			1.00

## 2. SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	<b>8.09 (includes 1 PA for Ward rounds)</b>	
Supporting Professional Activities:	<b>1.50</b>	Specific Role:
On-Call Allocation:	<i>Total including Predictable &amp; Unpredictable</i> <b>1.00</b>	
Any Additional HCS Responsibilities:		Reason:
Any External Duties:		Reason:
Any Annualised Activity & Reason		Reason:
<b>TOTAL PA's:</b>	<b>10.5</b>	

## Proposed Urology Job Plans - 5 Consultant Model

v0.4 Jan 12

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
MY	OPD - Banbridge 2/month 2,4 OPD CAH 1, 3, 5	Stone Treatment Clinic 2/month 1, 3, 5 Emergency Urologist 2:4	Theatre CAH 8am - 12pm 2/month 1, 3 & 5	Theatre CAH 12pm - 7pm 2/month 2 & 4	Stone Treatment DCs 2/month	Free	DSU STH 1, 3, 5	MDT	OPD CAH 2/month 1 & 3, 5	Theatre CAH 1, 3, 5 Emergency Urologist 2/month
AOB	Day Surgery Enniskillen 1/month ACH 1/month	OPD Enniskillen 1/month	DSU CAH 2/month	OPD CAH weekly	Theatre CAH 8am - 12pm 2/month 1, 3 & 5	Theatre CAH 12pm - 7pm 2/month 2 & 4	DSU STH 2, 4	Emergency Urologist 4:4 weeks	OPD CAH 2, 4	
MA		OPD CAH /month 1 & 3, 5 Emergency Urologist 2:4 weeks	DSU STH 2/month	OPD STH 2/month	OPD CAH 2,4	Prostate Biopsy 2/month 1, 3, 5 Emergency Urologist 2:4 weeks		MDT	Theatre CAH weekly	Theatre CAH weekly
Cons 4	Day Surgery Enniskillen 1/month CAH 1/month	OPD Enniskillen 1/month	Theatre CAH 8am - 12pm 2/month 2 & 4	Theatre CAH 12pm - 7pm 2/month 1, 3 & 5 Emergency Urologist 2:4		Prostate Biopsy 2/month Emergency Urologist 2:4 weeks	OPC CAH 1, 3, 5	MDT	DSU DHH 2/months	OPD DHH 2 & 4
Cons 5	OPD ACH 1/month week 2	Stone Treatment Clinic 2/month 2 & 4	DSU CAH 2/month	Emergency Urologist 2/month	Theatre CAH 8am - 12pm 2/month 2 & 4	Theatre CAH 12pm - 7pm 2/month 1 & 3	Stone Treatment DCs 1, 3, 5	OPD CAH weekly		Theatre CAH 2 & 4 Emergency Urologist 2/month  Flexible Cystoscopies

**Mackle, Eamon**

---

**From:** Mackle, Eamon  
**Sent:** 27 February 2013 17:30  
**To:** Corrigan, Martina; Brown, Robin  
**Cc:** Trouton, Heather  
**Subject:** RE: Urology job plans

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Hi Robin

Thanks for all the work you have done in respect of the Urology Job plans. I know Michael is very keen to advertise the post but until the job plans are agreed it will not be possible to do so. I am conscious therefore that the steps as laid out in your summary could introduce a further delay if the principles discussed and agreed with the Urologists, over almost 2 years of Monday evening meetings, have not been followed in the proposed job plans. Therefore, to avoid any unnecessary delays, could you forward them to me to check before they go to the urologists for signing.

Many thanks

Eamon

From: Corrigan, Martina  
Sent: 27 February 2013 11:08  
To: Brown, Robin  
Cc: Trouton, Heather; Mackle, Eamon  
Subject: RE: Urology job plans

Dear Robin,

As you will be aware Michael and I have been working through the figures in respect to the activity required to be delivered by the Urology Team through their job plans. There has been a few tweaks and these have now been made with Zoe and Malcolm. I know from Michael that there has been some verbal discussions with the other urologists about the job plans but I was wondering if there is full sign off from them on what is now the nearly completed version. Heather has advised that you were going to speak with the rest of the team in respect to this and I was wondering if you have had the opportunity to do this as I will need to send out the assumptions of what the clinics etc. will look like once these have been signed off as I think this is important that the urologists know what they are signing up to in terms of volumes expected from them in their clinics. I don't want to send these assumptions to the rest of the team until I know that you have talked to them. (I have included these assumptions below).

I also know that Michael is anxious to get the 5th post to the specialty advisor over the next day or so as Patrick Keane is going on 2 weeks annual leave. I also know that Michael has spoken to him and that he has said that he will not pass the job if it is over 10 PA's and that it has 2 SPA's included in it, so Michael has asked Zoe/Malcolm to take out a few clinics to show this, whilst Michael has said that it is only temporary and once we would appoint we could negotiate to have this added back in I am not happy about this in case whoever we appoint won't agree to the clinics being added back in and this will mean we will definitely not meet the required activity agreed with the Board, to me it may make more sense to take out e.g. grand ward round or MDT which would be easier to put back in.?

ASSUMPTIONS ON WHAT NEEDS TO BE INCLUDED IN CLINICS IN ORDER TO DELIVER THE AGREED ACTIVITY

Stone Treatment clinics will be setup to see 6 New and 11 Review – there will be 1.5 clinics per week Outreach (SWAH/STH/DHH/BAN/ARM) will be set up to see 5 New and 7 Review - there will be 2 outreach clinics per week General at CAH will be set up to see 6 New and 8 Review which will mean PM clinic starting at 1:30pm - there will be 3 general clinic per week.

Oncology will be set up to see 3 red Flag and 4 Protective Review and 4 uro-oncology review – there will be 3.75 of these per week

D4 Clinics will be set up to see 4 patients (review) – there will be 1 of these per week Prostate D1 will be set up to see 8 red flags and 2 News and there will be 1 of these per week

Urodynamics is nurse-led and cannot be counted in Consultant activity

Also note that the above does NOT include the ICATS activity which is set at 1620 NEW and 1724 REVIEW and this needs to be taken into account for the support clinics and the consultants need to consider this in the future of these 'Thorndale' clinics which will be nurse and GPSWI led.

I would be grateful if you could come back to me as soon as possible so that we can progress this and I am happy to discuss if required.

Many thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)

Mobile: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

From: Brown, Robin

Sent: 12 February 2013 08:09

To: Young, Michael

Cc: Clegg, Malcolm; Parks, Zoe; Corrigan, Martina; Trouton, Heather; Mackle, Eamon; Rankin, Gillian

Subject: RE: Urology job plans

Michael – you will by now have received the job-plans.

Malcolm and Zoe have literally invested hours translating them from English to Zircadian.

The order of events from now is:

1. You get the first viewing, considering that you really put a lot of work into these job plans
2. If you think they are OK or could be OK after a tweak or two, then:
3. Send to Heather and Martina and perhaps together we could calculate the “quantities” to reassure ourselves that the SBA can be met
4. Offer to the urologists (and hopefully signed off)
5. Send to Eamon (and me) for signing.
6. Present to Gillian
7. Progress “Job 5”
8. Execute the actual job plans particularly in respect of outreach lists and clinics.
9. Review the job-plans at, perhaps 3 – 6 months and modify according to our experience of the job-plans in practice.

Robin

Subject: FW: Urology job plans

From: Mackle, Eamon

To: Young, Michael <

Personal Information redacted by the USI

Personal Information redacted by the USI

Brown, Robin

Personal Information redacted by the USI

Cc: Martina Corrigan

Personal Information redacted by the USI

Personal Information redacted by the USI

Sent: 3/1/2013, 12:16:24 PM

1 MARCH 13

Dear Michael and Robin

I have reviewed the 5 consultant job plans and I have also had discussions with Martina regarding SBA activity. As you are only too aware we have to supply a decreed minimum level of activity in each OPC, in - patient and day cases. At present we are not achieving the minimum activity and also are not meeting the red flag targets. I had a meeting with Kieran Donaghy today and discussed job planning across the whole of SEC. One of the issues for the Trust is if we don't meet SBA activity it puts the Trust at serious financial risk due to the costs incurred with sending patients to the independent sector. Kieran was concerned as well at the financial cost of WLI activity and how we can't justify it to the auditors if the SBA activity is not being met. As a result for sub-specialities where there is a serious risk of underperforming we are going to have to include a minimum prescribed activity in the job plans. Kieran also is seriously concerned if consultants are carrying out WLI if they haven't got a signed job plan.

I haven't been able to speak to Dr Rankin today as she is in Antrim. I have been instructed that the decisions, which were made over 18 months of Monday evening meetings, have to be included in job planning. Martina has detailed this below. The two other issues which Robin needs to include in the job plans is that the Grand Rounds are to be considered as SPA and the 2 stone consultants are not expected to be Core Members of the MDT and thus are not expected to attend the MDTs.

Eamon

From: Corrigan, Martina

Sent: 27 February 2013 11:08

To: Brown, Robin

Cc: Trouton, Heather; Mackle, Eamon

Subject: RE: Urology job plans

Dear Robin,

As you will be aware Michael and I have been working through the figures in respect to the activity required to be delivered by the Urology Team through their job plans. There has been a few tweaks and these have now been made with Zoe and Malcolm. I know from Michael that there has been some verbal discussions with the other urologists about the job plans but I was wondering if there is full sign off from them on what is now the nearly completed version. Heather has advised that you were going to speak with the rest of the team in respect to this and I was wondering if you have had the opportunity to do this as I will need to send out the assumptions of what the clinics etc. will look like once these have been signed off as I think this is important that the urologists know what they are signing up to in terms of volumes expected from them in their clinics. I don't want to send these assumptions to the rest of the team until I know that you have talked to them. (I have included these assumptions below).

I also know that Michael is anxious to get the 5th post to the specialty advisor over the next day or so as Patrick Keane is going on 2 weeks annual leave. I also know that Michael has spoken to him and that he has said that he will not pass the job if it is over 10 PA's and that it has 2 SPA's included in it, so Michael has asked Zoe/Malcolm to take out a few clinics to show this, whilst Michael has said that it is only temporary and once we would appoint we could negotiate to have this added back in I am not happy about this in case whoever we appoint won't agree to the clinics being added back in and this will mean we will definitely not meet the required activity agreed with the Board, to me it may make more sense to take out e.g. grand ward round or MDT which would be easier to put back in.?

ASSUMPTIONS ON WHAT NEEDS TO BE INCLUDED IN CLINICS IN ORDER TO DELIVER THE



**AGREED ACTIVITY**

Stone Treatment clinics will be setup to see 6 New and 11 Review – there will be 1.5 clinics per week  
Outreach (SWAH/STH/DHH/BAN/ARM) will be set up to see 5 New and 7 Review - there will be 2  
outreach clinics per week

General at CAH will be set up to see 6 New and 8 Review which will mean PM clinic starting at 1:30pm -  
there will be 3 general clinic per week.

Oncology will be set up to see 3 red Flag and 4 Protective Review and 4 uro-oncology review – there will be  
3.75 of these per week

D4 Clinics will be set up to see 4 patients (review) – there will be 1 of these per week

Prostate D1 will be set up to see 8 red flags and 2 News and there will be 1 of these per week

Urodynamics is nurse-led and cannot be counted in Consultant activity

Also note that the above does NOT include the ICATS activity which is set at 1620 NEW and 1724  
REVIEW and this needs to be taken into account for the support clinics and the consultants need to consider  
this in the future of these 'Thorndale' clinics which will be nurse and GPSWI led.

I would be grateful if you could come back to me as soon as possible so that we can progress this and I am  
happy to discuss if required.

Many thanks

Martina

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

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

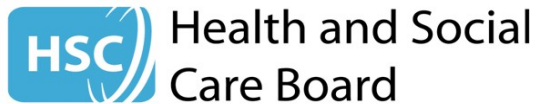
From: Brown, Robin  
Sent: 12 February 2013 08:09  
To: Young, Michael  
Cc: Clegg, Malcolm; Parks, Zoe; Corrigan, Martina; Trouton, Heather; Mackle, Eamon; Rankin, Gillian  
Subject: RE: Urology job plans

Michael – you will by now have received the job-plans.  
Malcolm and Zoe have literally invested hours translating them from English to Zircadian.

The order of events from now is:

1. You get the first viewing, considering that you really put a lot of work into these job plans
2. If you think they are OK or could be OK after a tweak or two, then:
3. Send to Heather and Martina and perhaps together we could calculate the “quantities” to reassure ourselves that the SBA can be met
4. Offer to the urologists (and hopefully signed off)
5. Send to Eamon (and me) for signing.
6. Present to Gillian
7. Progress “Job 5”
8. Execute the actual job plans particularly in respect of outreach lists and clinics.
9. Review the job-plans at, perhaps 3 – 6 months and modify according to our experience of the job-plans in practice.

Robin



*Performance Management and Service  
Improvement Directorate*

Trust Directors of Acute Services

*HSC Board Headquarters  
12-22 Linenhall Street  
Belfast  
BT2 8BS*

*Tel :* [Personal Information redacted by the USI]  
*Fax :* [Personal Information redacted by the USI]  
*Email:* [Personal Information redacted by the USI]

Our Ref: HM670  
Date: 27 April 2010

Dear Colleagues

## **REGIONAL UROLOGY REVIEW**

As you are aware, the Trust was represented on the Regional Urology Review which was completed in March 2009. The final report was presented to the Department in April 2009 and was endorsed by the Minister on 31 March 2010. I am aware an initial meeting of team East was held on 22 March and team North on the 1 April 2010 and team South is planned for the 13 May 2010.

Now that the Minister has endorsed the recommendations from the Review, it is imperative that the Trusts with lead responsibility for the development of the Business Case/Implementation Plan move quickly to develop the team model and agree the activity to be provided from the additional investment.

The Teams should base their implementation plan on each of the relevant Review recommendations; a full list of the recommendations is included in Appendix 1. I am aware that each of the teams has established project management arrangements to develop and agree the implementation plan for each team. It is also anticipated that these teams will agree the patient pathways, complete a baseline assessment of the current service, their current location and the activity available from the existing service model. The teams should aim to have completed the first draft of the Implementation Plan and submit this to the Board by Friday 11 June 2010.

It is planned that an overarching Implementation Project Board will be established comprising the Chair and Clinical Advisor from each of these project Teams, and key HSCB staff; to oversee the implementation of the Review. The first meeting of the Urology Project Implementation Board will be held on Thursday 1 July 2010 at 2.00pm in the Conference Room, Templeton House. The Project Team chair should send the team nominated representatives to [Personal Information redacted by the USI] by Friday 7 May 2010. I have asked Beth Malloy, Assistant Director, Scheduled Services, Performance Management and Service Improvement, to chair the Project Implementation Board.

The Review estimated the cost of implementing the recommendations to be £3.5m, of this £637k has already been allocated to Belfast Trust, and the remaining balance of £2.9m is

available. Please see Appendix 2 which has notionally allocated this budget to each of the teams, and it is on this basis the Teams should work collectively across Trusts to develop the Implementation Plans. The plan should also include a proposal for the use of the non-recurrent 'slippage' funding available from the teams share of the recurring £2.9m, this should include what additional in-house sessions will be provide to maintain the waiting times as at 31 March 2010 and to deal with any backlog of patients waiting for urological diagnostic investigations or outpatient review.

As per the details outlined in the Review, the initial assumption regarding the activity associated with each of the additional Consultant appointments is included in Appendix 3. To assist the teams in the further discussion, the figures outlined in the Urology Review have been updated and are attached in Appendix 4.

The Implementation plan, proposed patient pathways and the non-recurrent funding proposal should be sent to Beth Malloy Personal Information redacted by the USI by Friday 11 June 2010.

Yours sincerely

Personal Information redacted by the USI

**HUGH MULLEN**

**Director of Performance Management and Service Improvement**

Enc

cc     Trust Directors of Performance  
       John Compton  
       Paul Cummings  
       Beth Malloy  
       Michael Bloomfield  
       Iain Deboys  
       Lyn Donnelly  
       Paul Cavanagh  
       Paul Turley  
       Bride Harkin

## **Appendix 1**

### **1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS**

#### **Section 2 – Introduction and Context**

1. Unless Urological procedures (particularly operative ‘M’ code) constitute a substantial proportion of a surgeon’s practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.
2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of “N” Code work and the associated resources to the Urology Team.
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

#### **Section 3 – Current Service Profile**

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.
5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.
6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.
7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.
9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.
10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

**Section 4 – Capacity, Demand and Activity**

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

**Section 5 – Performance Measures**

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.
13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.
14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.
15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.
16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.
17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

**Section 7 – Urological Cancers**

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.
19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.
20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

**Section 8 – Clinical Workforce Requirements**

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.
22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.
23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

**Section 9 – Service Configuration Model**

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.
25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.
26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

## Appendix 2

### Estimated Team Costs for the Implementation of Adult Urology Review Recommendations.

	Team South	Team North	Team East	Total	No	Unit Cost	Total
<b>Staffing Costs</b>							
Consultant Urologist – additional wte team allocation	2 wte	1 wte	3 wte	6	6		
Consultant Urologists wte	£208,000	£104,000	£312,000	£624,000		£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	£124,800	£62,400	£187,200	£374,400	3.6	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	£62,400	£31,200	£93,600	£187,200	1.8	£104,000	£187,200
Band 5 Radiographer @ 6 per wte Con Radiologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 3 Nursing @ 0.46 wte per Con. Urologist	£17,870	£8,935	£26,805	£53,610	2.7	£19,856	£53,611
Band 7 Specialist Nursing *1	£103,605	£0	£103,605	£207,210	5	£41,442	£207,210
Band 5 Nursing @ 0.64 wte (day surgery)	£5,972	£2,986	£8,958	£17,916	0.64	£27,995	£17,917
Band 4 Personal Secretary @ 0.5 wte per consultant urologists	£23,265	£11,633	£34,897	£69,795	3	£23,265	£69,795

Band 3 Admin support to radiologists at 0.5 wte per Radiologist	6,618	3,309	9,927	£19,854	1	£19,856	£19,856
Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2	£31,438	£0	£28,129	£59,567	3	£19,856	£59,568
Band 4 Medical Records support 0.5 per unit *3	£11,632	£23,265	£23,265	£58,162	2.5	£23,265	£58,162
Band 7 MLSO – Bio-medical Science *4			£41,442	£41,442	1	£41,442	£41,442
<b>Staffing Costs Sub Total</b>	<b>£797,164</b>	<b>£348,510</b>	<b>£1,172,174</b>	<b>£2,317,848</b>			<b>£2,317,853</b>
<b>Support Costs</b>							
Surgical G&S @ £94,500 per Con. Urologist	189,000	94,500	283,500	£567,000	X 6	£94,500	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	100,000	50,000	150,000	£300,000	X 6	£50,000	£300,000
Radiology G&S per Con. Urologist	5,000	2,500	7,500	£15,000	X 6	£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	64,000	32,000	96,000	£192,000	X 6	£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	40,000	20,000	60,000	£120,000	X 12	£10,000	£120,000
<b>Support Costs Sub Total</b>	<b>£398,000</b>	<b>£199,000</b>	<b>£597,000</b>	<b>£1,194,000</b>			
<b>Sub Total</b>	<b>£1,195,164</b>	<b>£547,510</b>	<b>£1,769,174</b>	<b>£3,511,848</b>			<b>£3,511,853</b>
<b>Less funding in 2008/09</b>			<b>£637,076</b>	<b>£637,076</b>			<b>-£637,076</b>
<b>FINAL TOTAL</b>	<b>£1,195,164</b>	<b>£547,510</b>	<b>£1,132,098</b>	<b>£2,874,772</b>			<b>£2,874,777</b>

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

\*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.



	Existing Establishment	Number of consultants with a sub-specialty interest	Additional CNS
Team South	0	2	2
Team North	2	2	0.5
Team East	2	4	2.5

\*2 – 0.5 allocated to each Team as per the Specialist Nurse

\*3 – 0.5 allocated to each Trust Unit within each Team

\*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

## **Appendix 3**

The exact details of the additional activity associate with the additional Consultant appointments will require agreement with the Board Commissioning teams. As outlined in the Review, it is assumed that the additional activity will be as follows:

Ref: Review Page 40-41

Outpatients: 1176 – 1680 per Consultant

Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post

Outpatients 19,992 to 28,560

IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments

Outpatients 7,056 to 10,080

IP/DC FCEs – 6,000 to 7,500

Regional Total

Outpatients 27,048 to 38,640

IP/DC FCEs – 23,000 to 28,750

Please note:

This analysis does not take into account the improvements expected from the introduction and full implementation of the ICATS for urology, as outlined on page 19 of the Review. The additional activity from the CNS has still to be quantified. In addition, the quantification of the service improvements, to be gained from the implementation of the Review recommendations, still to be agreed with the each Trust (for each of the team) and the Board are not included.

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
2898	01/02/2011	Provide safe, high quality care	Outpatients Dept	No screens surrounding the examination couches in the Consultation rooms	Staff are unable to secure privacy and dignity of patient without adequate resources. Patient does not have any dignity or privacy to change for an examination. Potential for litigation to Trust secondary to inadequate changing facilities and potential for violation of patient privacy during an examination/consultation.	Clinician leaves the room to allow patient for privacy Changing cubicles are in use, and patients then walk in front of waiting are in hospital gown	23.01.12 - Screens have been ordered, awaiting delivery. 11/11/11 <b>Personal</b> has been contacted and measurements have been taken. No cost estimate as yet. 10.11.11 Screens ordered from Jan 2011, awaiting delivery of same to progress with <b>Personal</b>	LOW	DIV
2899	01/02/2011	Provide safe, high quality careBe a great place to work	Outpatients Dept	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose ro	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose room. Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	25.10.11 Reviewed and closed by Connie Connolly	MOD	HOS
2943	07/04/2011	Provide safe, high quality careMake the best use of resources	Urology Clinic	Urology cancer pathway delays (also on CCS Divisional Risk Register ID 2942)	Patients on haematuria and prostate cancer pathways. Delays in first appointments, investigations and treatments. Patients with cancer being delayed in diagnostics and treatment pathways. Patients may be late diagnosed and have further advanced disease leading to poorer outcome. This may mean that a patient changes from potentially curative to palliative during the waiting period.	Identification of patients at risk ongoing. Detailing of capacity and demand ongoing to identify needed capacity and resources. Further reconfiguring of services required to support the change required in the service to reduce delays. Further resources required to support the volume of work within both cancer and non cancer urology work.	23.01.12 - one stop prostrate clinic is fully operational, hence no delays at present. See Risk 2942 10.11.11 We will update figures early December 2011 01.10.11 One stop prostate clinic commences 1 October 2011 and One stop Haematuria clinic commences 6 October 2011.	LOW	DIV
2968	21/04/2011	Provide safe, high quality care	4 South Surgical	Risk to staff and patients of the spread of HCAI due to condemned Bedpan Washer Ward 4 South	Condemned Bedpan Washer Ward 4 South. Risk of the spread of Health Care associated Infections [HCAI] to staff and patients. The Bedpan washer is broken and has been condemned on the Male side sluice room of Ward 4 South. This poses significant risk to the patient and the staff re: the spread of HCAI.	At present staff are using the Bedpan Washer on the Female side of the ward to decontaminate bedpans and urinals	A visit is taking place to another facility to view an HTM compliant bedpan washer in April 2011. As an interim measure a temporary Bedpan washer is being installed week commencing 13th June 2011	MOD	DIV
2990	19/05/2011	Provide safe, high quality care	Outpatients Dept	No hand washing facility in clinical Outpatient consultation rooms Room 63 and room adjacent	This risk assessment is being measured on the basis that currently these clinical rooms are being used by Speech and Language only. This specialty by its nature is non-invasive and does not traditionally create a high decontamination risks. If these rooms were to be allocated in the future to other specialties, the risk to the Trust would be substantially higher.** Staff and patients do not have access to any hand washing facilities in the clinical consultation room. Risk to Health and Safety- Risk of infection, cross infection and hospital acquired infection to patients. Risk to Health and Safety Risk of infection and cross infection to staff utilising this clinical area. Environment will not have access to timely cleaning as there is no water or washing/cleaning facilities available. Risk to Health and Safety - infection to staff, and patients. Risk of Litigation, secondary to hospital acquired infection. Risk of Loss of Reputation to Trust with hospital acquired infection rate. Risk of non compliance with RQIA <del>recommendations</del>	Cleansing wipes and alcohol jells are used in between patients and to wipe equipment Equipment cleansed at the end of clinics with soap and water from other clinical area.		LOW	DIV
2989	19/05/2011	Provide safe, high quality care	Outpatients Dept	Inappropriate flooring Consultation rooms not compliant with Health and Safety/Infection Control	Carpet flooring will need replaced with a washable surface. Risk of infection/injury to staff, patients and Clinicians. Risk of litigation to Trust secondary to Hospital Acquired Infection Unable to achieve waiting time targets regarding Outpatient Capacity. Risk of financial penalty for not meeting Outpatient Capacity and Demand.	Daily cleaning of carpet by domestic staff.	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work Remains a risk. 14.11.11 Note link with Risk 2823	MOD	HOS
2998	31/05/2011	Provide safe, high quality care	Outpatients Dept	Unable to safely store sterile ENT equipment	Patients will not have access to a sterile nasopharyngeal scope, and appointment for examination will have to be rescheduled. This will directly result in a delay in diagnoses and an increased review backlog. Patients will not have timely access to sterile ENT nasopharyngeal scoped during ENT consultation. Patient at risk of delayed diagnoses. Risk of Hospital Acquired Infection. Risk of Litigation. Risk of Loss of Reputation secondary to RQIA non compliance. Risk of Loss of Reputation secondary to increased Review Backlog	Staff are currently supporting the Outpatient clinic and decontaminating equipment.		HIGH	DIV
3006	21/06/2011	Provide safe, high quality careBe a great place to work		Environmental works at 4 North, 4 South & 3 South wards pose threat to management of HCAI;compliance with fire and disability	Outstanding Environmental works at 4 North, 4 South and 3 South wards pose threat to management of HCAI;compliance with fire and disability regulations. Each of the wards have the following areas which need a minor works programme to include: Toilet facilities upgraded; Bathroom / shower facilities upgraded; Installation of sinks in bays; Painting and plastering; Various Ceiling tiles replaced; Nurses station to be upgraded; The facilitation of a waste room in 4N; Floor tiles.	All reasonable measures are in place at present; cleaning schedules; decluttering; good housekeeping practices.	01.08.12 - Programmed of works completed in 4 North and 4 South. Awaiting funding to commence 3 south.  19.06.12 - Programme of works completed 4 south, programme of works near completion 4 North, awaiting funding to commence 3 south. 17.04.12 - Programme of works has commenced in Wards 4 North and 4 South. 3 South no date as yet - awaiting funding. 23.01.12 - Funding has been approved and refurbishment programme commencing February 2012. 10.11.11 Funding has now been allocated and a workable program for dates is being progressed. 01.10.11 Awaiting costing from Estates for refurbishment have walked the wards. Awaiting feedback. Review July 2011	MOD	DIV
3027	08/09/2011	Safe, High Quality and Effective Care	Pre-Operative Assessment Clinic	PRE OP BAND 6 STAFFING	Patients are at risk of not receiving timely Pre-Operative Assessment by Band 6 POA Nurses Staff are at risk of overlooking patient management issues secondary to dramatic increase in workload Patients are at risk of delay in immediate pre-operative management re medicines management secondary to decrease in workforce.  Decreased capacity to Pre Operatively assess patients 6 weeks in advance of surgery Increased risk of day of surgery cancellation or late cancellation secondary to insufficient pre-operative assessment Potential risk for theatre under-utilisation Potential for unnecessary use of staff resource on ward/unit due to unnecessary admission Potential for delay in patient treatment, patient distress, and disruption to patient work/home arrangements Potential for litigation to Trust re potential for delay in patient recovery due to insufficient pre-operative preparation	Patients with dates for admission have been made immediate priority All patients with dates for admission, needing Warfarin management, has been delegated to POA Project Leader Clinic templates have been adjusted to only include patients with dates for admission, and additional time has been allocated for processing results and managing queries Clinical Sister in CAH OPD has been supporting the Band 5/6 triage issues, and has been managing same All long term staff are being actively managed via Occupational Health Temporary replacement of Band 6 Sister has been provided with immediate effect .73 Wte All associated specialties and staff have been notified of temporary staffing issue	25.10.11 Reviewed and closed by Connie Connolly. 01.10.11 Situation should be resolved when full staffing in place by November 2011.	MOD	TEAM
3048	23/11/2011		Outpatients Dept	Portable suction within CAH ENT OPD now obsolete, and no longer fit for purpose	Patients are at risk of not receiving high quality examination secondary to poor visibility for the Clinician. Potential for increase in waiting times for patients secondary to the extended period of time being needed for examination-may result in delay in diagnoses. Clinician at risk of overlooking clinical finding due to poor visibility. Patient at risk of auditory damage if suction control is inadequate during examination. Potential for inconclusive examination secondary to poor visibility during examination. Potential for patient harm secondary to inadequate suction-may result in needing additional treatment.	Patient examinations have been prolonged to allow for inadequate suction.	22.11.11 Direct Nursing support during every examination during ENT Clinics.	MOD	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3690	08/06/2015			Increased waiting time for New out-patients and Elective Surgery	Surgery & Elective Care: Breast Surgery, General Surgery, Endoscopy, ENT, Urology, Orthopaedics Urgent Out-Patients: Waiting times have been growing across the specialties, in some cases exceeding clinically accepted waiting times for urgent appointments. Current urgent waiting times for new out-patients are: General Surgery - 21 weeks, ENT - 28 weeks, Urology - 30 weeks, Orthopaedics - 43 weeks Current urgent waiting times for elective surgery are: Breast Surgery - 33 weeks, General Surgery - 54 weeks, Endoscopy - 12 weeks, ENT - 13 weeks, Urology - 87 weeks, Orthopaedics - 56 weeks Delay in treatment plan and diagnosis. Increased waiting time for Routine patients may result on patients being reprioritised as urgent putting increased pressure on existing capacity and bottle-necking available urgent slots	Monitoring measures are being put in place to ensure that patients triaged/categorised as urgent are being seen within the clinically accepted waiting time. Patients exceeding this waiting time will be escalated to management and clinical teams for further advice. Active plans to reduce urgent waits within specialties are on-going Increasing urgent waiting times have been escalated to HSCB and they are aware of limited control due to demand vs capacity mismatch.		LOW	DIV
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	19/11/2021- no change 28/06/2021- remains unchanged no funding. 15/02/2021- remains unchanged still no capital funding 11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV
3726	01/09/2015	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Registered nurses assisting during operative procedures	It has come to light that currently there are registered nurses assisted during operative procedures who have not completed nationally recognised training and this role has never been agreed or approved by the Trust. Risk of potential injury to the patient, risk to staff member in undertaking duties out with their role and job description as registered practitioners.	It has been discussed with Interim Director of Acute Services we cannot cease the practice immediately as this would impact adversely on operating lists, thereby resulting in patient cancellations. In order to reduce the risk we have stopped nurses undertaking assisting duties that would be considered a surgical in nature ie tapping on a chisel in ENT and uterine manipulation for gynae patients not having a hysterectomy. The need has been identified for surgical first assistant role, currently the Trust is working to secure funding for these roles. We are also looking at a dual role for a scrub practitioner for very minor cases only. An interim holding position has been discussed and agreed with gynae, with regards to the duties that the nursing staff can undertake until surgical first assistants are in post.	08/04/2019 - closed following further review by SEC. 6/2/19 - as below MOVE to departmental RR 20/11/18 - ongoing risk, MOVE TO Departmental ATICS risk register. Job plan is being finalised for possible advertisement in the near year. Discussion to take place with Mr Carroll re progression banding. 4/10/18 Ongoing keep on RR until recruited. 8.8.18 Research completed meeting arranged to discuss findings with BK and plan to move forward with recruitment. 10.4.18 Ongoing research 28.02.18 Risk remains the same 7.11.17 Funding to be transferred from SEC to ATICS. To research posts before recruitment commenced. 30/5/17 - Money identified for 2 x surgical practitioners. For follow up and recruitment once processes agreed 7.3.17 Unchanged	HIGH	HOS
3734	24/09/2015	Accessible and Responsive Care		At intervals, the Trust does not have the capacity to meet the demands of the outpatient and inpatient trauma and orthopaedic se	Poor patient outcomes.	Discussions ongoing with HSCB regarding additional resources. Additional outpatient clinic and theatre lists organised where possible.	12.5.16 - Ongoing 'at risk' additional fracture sessions being undertaking from April 16 onwards to meet demand. Additional funding received for orthopaedic IP long waiters to reduce waiting time, Orthopaedic NOP and ROP. In process of securing dates. 23.02.16 - Additional clinics and operating lists organised to meet trauma demand as required to meet patient safety standards. HSCB aware of capacity gap. Work ongoing with ED to implement elements of the Glasgow model to meet demand.	MOD	DIV
3745	30/11/2015	Safe, High Quality and Effective Care	High Dependency Unit DHH	NIV Equipment in DHH HDU is becomming difficult to repairr and 2 of the 4 have recently been condemned.	Risk of being unable to provide non invasive ventilation to patients who require this, adversely affecting patient outcome, e.g., morbidity and mortality.	New NIV 60 ordered on 26 November 2015 and request for additional capital funding requested for further machines. Request sent to finance for approval to lease new equipment until receipt of new order.	29.11.16 New NIV equipment has been replaced. CAH have ordered more, they are both elf contained. 23/10/16 - As below, still outstanding. RC to advise if actioned. 05.08.16 - Still outstanding. Ronan Carroll to advise if actioned. 26/5/16 - Need to communicate with the appropriate staff that this medical device needs to be standardised between both sites. Ronan Carroll to action. 23.02.16 - NIV equipment ordered and will be delivered before 31st March 2016.	MOD	DIV
3746	30/11/2015	Safe, High Quality and Effective Care	3 South ENT	Paediatric Patients treated in 3 South ENT treatment room - cannot guarantee nurses with up to date paediatric training.	Limited paediatric trained staff includes - paediatric trained nurse may not be with patient in the treatment room - clinical outcomes if patient needs specific paediatric nursing care including resuscitation - poor patient experience and safeguarding issues.	Meeting held with Paediatric Head of Service to discuss issues on 27 November to scope the problem. Data has been requested. Further meetings planned with the aim to have a paediatric nurse with paediatric patients or inform paediatric ward of admissions.	10/8/2020 - take off RR, paeds go to Blossom Unit and  18.09.19 part of rapid access clinic when this moves will resolve the issue 26.06.19, 28/3/19 06/02/19- no change.	LOW	DIV

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3064	ACUTE	09/01/2012		Faulty Lifts in DHH outside labour ward	Lifts outside Delivery Suite which service the maternity ward, frequently breaking down. Health and Safety Issue for transferring mothers in labour or in an emergency situation.	Plan in place for Estates works to commence early 2012. Currently using second lift. Exploration of possible use of Evacuation Chairs.	29-08-12 one lift replaced and one refurbished. No further issues. 28.05.12 Fire evacuation chairs now purchased. Parts for 2nd lift currently being replaced. 26.04.12 Work completed on back lift.	MOD
3165	ACUTE	22/06/2012	Provide safe, high quality care	Inadequate Speech and Language Therapist	Inadequate Speech & Language Therapist. Stroke patients waiting up to 3 days to be seen by Speech and Language Therapist. No Speech and Language Therapist allocated to MAU resulting in inappropriate management of patients care/treatment.	Staff trained in swallow assessment	25.09.13 - 80% staff in stroke ward CAH and XX% stroke ward DHH now trained in swallow awareness. Ongoing training for other ward areas.	HIGH
3166	ACUTE	25/06/2012	Provide safe, high quality care	Urology Access Waiting Times	Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.	3/3/15 - TO BE TAKEN AS PER AD CCS/ATICS 10.12.14 - Cancer targets are being met, i.e., 31 and 62 day pathway. While red flag and urgent appointment times are being met this is utilising all outpatient capacity leaving routine patients with longer waiting times. A new service model is being trialled which may improve the totality of waiting times in the long term. Inpatient/Day Case waiting times for routine patients remain challengin with the focus on treating cancer patients within the standards. 12.5.14 - with respect to the urology performance against the 62-day cancer target, there are 21 patients over 62+days of which 11 pts waiting over 85+days. With respect to haematuria 1st appointment now sitting at D16 which is an improvement on the previous positions due to a combination of drop in demand and extra capacity on a Saturday. 12.02.14 Urology waiting times are extended throughout the Province due to demand and capacity issues. The HSCB have commissioned a further Regional review of Urology Services . The SHSCT will partake in this Regional review. In the meantime, Team South will focus its resources on meeting the cancer waiting times within this specialty	MOD
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals across multiple tumour sites continues, leading to	HIGH

Southern Health & Social Care Trust

CONFIDENTIAL

List of Consultants and SAS Medical Grades aligned to Urology from 1 October 2009 - 31 March 2016

Prepared by/HR Contact: Ciara Rafferty, Senior HR Data Analyst

Prepared for: Andrea McNeice and Zoe Parks, Medical HR

Ref: AD/2022/117

Date: 25 March 2022

*Note: Employees with multiple posts have been highlighted in green*Staff in Post from 31 October 2009 - 30 November 2013*Note: This information was taken from staff in post reports, during the above reporting period, extracted from HRMS at time of reporting.*

Surname	Forename1	Fac/Bk/Staff No	Date Commenced Post	Employment Status	Grade Description	Cost Centre Code	Cost Centre Description	Location of Post Description	WTE	Date Appointed to Trust	Date Left Trust	Current SHSCT Employees
O'BRIEN	AIDAN	Personal Information redacted by the USI	01/04/1993	PERMANENT	CONSULTANT (NC)	Inevant information redacted by the USI	CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	01/04/1993	17/07/2020	N
CONNOLLY	DAVID JAMES		03/09/2012	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	03/09/2012	31/03/2013	N
GLACKIN	ANTHONY JUDE		01/08/2012	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	01/08/2012		Y
HO	KUO JONG		01/10/2011	TEMPORARY	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	06/04/2011	01/08/2012	N
			01/10/2011	TEMPORARY	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	06/04/2011	01/08/2012	N
PAHUJA	AJAY		01/11/2012	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	01/11/2012	05/01/2014	N
FERNANDO	MAURICE JAYANTH		12/11/2012	PERMANENT	SPECIALTY DOCTOR (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	12/11/2012	09/08/2013	N
AKHTAR	MEHMOOD		03/09/2007	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	03/09/2007	08/04/2012	N
YOUNG	MICHAEL		01/05/1998	PERMANENT	CONSULTANT (NC)		CAH CAH - UROLOGY	CAH - MAIN BUILDING	1.00	14/04/1998		Y

Staff in Post from 1 December 2013 - 31 March 2016*Note: This information was taken from HRPTS, detailing all staff aligned to Urology Organisational Units during the above reporting period*

Last name	First name	Pers.No.	HRMS Staff No	Org Assignment Start Date	Org Assignment End Date	Work Contract	Job Description	Organizational Unit	Cost Ctr	Cost Center	location	WTE	Date Appointed to Trust	Date Left Trust	Current SHSCT Employees
Hall	Samuel	Personal Information redacted by the USI	Personal Information redacted by the USI	01/01/2015	15/03/2016	Permanent	Consultant (NC)	Clinical Director ENT Urology T&O	Inevant information redacted by the USI	CAH E.N.T. - CAH	Craigavon Area Hosp-Main Building	1.00	01/04/1993	15/03/2016	N
				17/03/2016	31/12/2016	Temporary	Consultant (NC)	Clinical Director ENT Urology T&O		CAH E.N.T. - CAH	Craigavon Area Hosp-Main Building	0.40	17/03/2016	31/12/2016	N
O'Brien	Aidan			01/04/1993	17/07/2020	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	01/04/1993	17/07/2020	N
Haynes	Mark			12/05/2014	31/12/9999	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	12/05/2014		Y
O'Donoghue	John			04/08/2014	31/12/9999	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	04/08/2014		Y
Martin	Jennifer			20/10/2014	26/08/2016	Temporary	Specialty Doctor (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	20/10/2014	26/08/2016	N
Glackin	Anthony Jude			01/08/2012	31/12/9999	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	01/08/2012		Y
Suresh	Kothandaraman			11/12/2013	26/10/2016	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	11/12/2013	26/10/2016	N
Pahuja	Ajay			01/11/2012	05/01/2014	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	01/11/2012	05/01/2014	N
Young	Michael			14/04/1998	27/05/2022	Permanent	Consultant (NC)	CAH Urology Medical		CAH - UROLOGY	Craigavon Area Hosp-Main Building	1.00	14/04/1998	27/05/2022	Y

**Confidentiality & Data Protection** - This report has been compiled and is intended for use only by the official recipient. Please remember your responsibilities under data protection legislation, for example, by ensuring personal information is kept secure and not left in view of unauthorised staff or visitors, is only used for the purpose intended, and is not shared with anyone who should not have access to it. Also, once personal information has been used for its intended purpose it should be appropriately destroyed, or kept in a secure location if it is required for future use.

**Timeliness Issues & HRPTS Recording** - In order to ensure that information is reported correctly from HRPTS, it is essential that on line processes or off line forms are actioned or forwarded for action on HRPTS as soon as possible. Delays will result in reported information not being up to date.

**Data Quality** - If you believe the information in this report does not accurately reflect the current position, please contact the HR Analytics & Governance Team.

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



## APPRAISAL DOCUMENTS

## CONTENTS

Form 1	Background Details
Form 2	Current Medical Activities
Form 3	Supporting Information for Appraisal & Summary of Appraisal Discussion
Form 4	Personal Development Plan
Form 5	Health & Probity Statements
Form 6	Sign Off
Form 7	Revalidation Progress
Appendix 1	Appraiser Feedback Form
Appendix 2	Appraisee Feedback form
Appendix 3	Aide Memoire and Quality Assurance Audit Tool

## FORM 1 - BACKGROUND DETAILS

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.
- The form includes an optional section for any additional information.

1.1	Full name	Edward John Mackle
1.2	GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3	Main employer	Southern Trust
1.4	Main place of work	Craigavon Area Hospital
1.5	Other employers/ places of work	Hillsborough Private Clinic Ulster Independent Clinic
1.6	Date of primary medical qualification	July 1980
1.7	GMC registration number and type	Personal Information redacted by the USI
1.8	Start date of first substantive appointment in HSC as a trained doctor	August 1981
1.8	GMC Registration date and specialties	10 August General Surgery Specialist Register
1.9	Title of current post and date appointed	Consultant Surgeon from Feb 1992 Associate Medical Director for Surgery and Elective Care from October 2007
1.10	For any specialist registration / qualification outside UK, please give date and specialty	
1.11	Please list any other specialties or sub-specialties in which you are registered	Coloproctology, Upper GI Surgery
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	

Name: Edward John Mackle

GMC Number:

Personal Information redacted by the USI

Appraisal Period : 2012

**HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**

1.14 Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	Honorary Lecturer Queen's University Belfast - 2011
--	---

**ANY ADDITIONAL INFORMATION**

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2012



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 2 - CURRENT MEDICAL ACTIVITIES**

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.
- Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.
- You may wish to comment in addition on factors which affect the provision of good health care.

2.1 Please give a short description of your work, including the different types of activity you undertake	General Surgery Outpatient and in-patient On-call for surgical emergencies
2.2 List your main sub-specialist skills and commitments / special interests	Colorectal Surgery: Cancer, benign diseases, pelvic floor dysfunction Oesophagogastric surgery: Cancer and benign
2.3 Please give details of any emergency, on-call and out of hours responsibilities	SOW weekends 1 in 8 On-call 1 in 8
2.4 Please give details of out-patient work if applicable	Outpatient Clinic: Monday am CAH Outpatient clinic: Thursday pm 2 <sup>nd</sup> and 4 <sup>th</sup> CAH
2.5 Details of any other clinical work	In-patient Theatre: 2 sessions (Tuesday) per week CAH Day Surgery Theatre: 2 sessions per month CAH Endoscopy list: 1 session per week CAH
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: <ul style="list-style-type: none"> <li>▪ Number and type of cases.</li> <li>▪ Any audit or outcome data for the private practice.</li> <li>▪ Details of any adverse events, critical incidents.</li> <li>▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues</li> </ul>	Ulster Independent Clinic: Full admitting rights Hillsborough Private Clinic: Outpatient clinic, endoscopy and minor operations
2.7 List any non-clinical work that you undertake which relates to teaching	Examiner Final MB QUB Undergraduate Examiner RCSI Convenor and Tutor Basic Surgical Skills Courses RCSI Senior Examiner IMRCS RCSI

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2012

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.7.1 List any non-clinical work that you undertake which relates to management	Associate Medical Director, Surgery & Elective Care, Southern Trust
2.7.2 List any non-clinical work that you undertake which relates to research	
2.7.3 List any work you undertake for regional, national or international organisations.	<p>Member of the Paper Panel Intercollegiate Committee for Basic Surgical Examinations 2008 – present</p> <p>Member of the OSCE Subgroup Intercollegiate Committee for Basic Surgical Examinations 2008 – present</p> <p>Royal College of Surgeons of England Assessor Consultant Advisory Appointment Committees 2002 –</p> <p>Member RCSI Post-graduate Surgical Examination Operation Group 2010 –</p> <p>Member of the Intercollegiate Committee for Basic Surgical Examinations</p> <p>Member NICAN Colorectal Group</p> <p>Member NICAN Upper GI Group</p> <p>President of the Ulster Medical Society 2013-14</p> <p>President of the Ulster Society of Gastroenterology 2013-15</p> <p>Chair of the Examiner Development Group RCSI 2013 -</p>
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	I provide medical expert reports on behalf of the Directorate of Legal Services

**CURRENT JOB PLAN**

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

**ADDITIONAL INFORMATION**

Please use to record issues which impact upon delivery of patient care.

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION****DOMAIN 1 - Knowledge, Skills and Performance**

Attribute: 1.1 Maintain your professional performance

Attribute: 1.2 Apply knowledge and experience to practice

Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Supporting Information	Applicable Date
1	Job Plan	
2	Workload data CHKS	
3	CPD Summary 2012	
4	PDP Template for 2012	
5	CPD Evidence	
6	UIC Surgery performed	
7	GMC Registration	
8		
9		
10		

**Discussion**

CHKS data still unreliable at matching activity to an individual consultant

Attended Association of Coloproctology which was a 3 day meeting.

CPD total for the year: Internal &gt;25, external &gt;50.

**Actions Agreed**

Plan to discuss CHKS data inaccuracies with senior medical managers

Will be undertaking preparatory work for Presidency of the Ulster Medical Society ie producing programme and the inaugural lecture.

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2012

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**DOMAIN 2 - Safety and Quality**

Attribute: 2.1 Contribute to and comply with systems to protect patients

Attribute: 2.2 Respond to risks to safety

Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1	M&M Attendance 2012	
2	Safety and Quality summary	
3	Agenda Acute Clinical Governance	
4	Agenda Acute/CYP Meeting	
5	Agenda VTE Meeting	
6	Details of GP	
7	Hepatitis and Vaccination Record	
8	DVA Clearance	
9	Reflection on Practice	
10	Teaching and Training Summary	

**Discussion**

M&M attendance noted.  
 As AMD has oversight of the process  
 Monthly governance interface with CYP noted and discussed  
 Health update including Flu vaccine noted

**Actions Agreed**

Progress made with CYP and transfer of patients to Belfast, also regarding management of head injury.  
 New Chair of M&M appointed.  
 Structured reflective template on practice – support to a colleague taking into account his psychological state.

Name: Edward John Mackle

GMC Number:

Personal Information redacted  
by the USI

Appraisal Period : 2012

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**DOMAIN 4 - Maintaining Trust**

Attribute:4.1 Show respect for patients

Attribute:4.2 Treat patients and colleagues fairly and without discrimination

Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	Statement of Probity and Health	
2	Complaint and Reflection on same	
3	Compliments	
4	Patient Feedback (see above)	
5	Colleague Feedback (see above)	
6	UIC statement	
7	HPC Statement	
8		
9		
10		

**Discussion**

Complaint re anastomotic leak discussed. Consent practice discussed.  
Statement on Health and Probity noted.

**Actions Agreed**

To complete a reflective template on GMC and Patient Feedback surveys.

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2012

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 4 - PERSONAL DEVELOPMENT PLAN**

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

**Review of last year's Personal Development Plan**

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
Feedback from Colleagues	GMC Colleague Feedback Report	Fully achieved
Feedback from patients	Patient Feedback Survey	Fully achieved

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2012

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	Actions agreed	Target dates
Presidential Lecture Ulster Medical Society	Prepare Lecture and Programme	Sept 2013
Gastroenterology	Prepare Programme for the British Irish Gastroenterology Meeting in Belfast	April 2013

Name: Edward John Mackle

GMC Number: Personal Information redacted by the USI

Appraisal Period : 2012

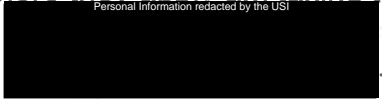
## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 5- HEALTH AND PROBITY STATEMENTS****HEALTH DECLARATION****Professional Obligations**

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.
78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.
79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: .....  ..... Date: 15/11/13

Name in capitals ..... EAMON MACKLE

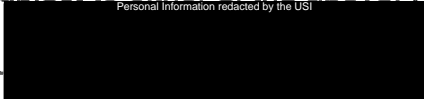
**Regulatory and Voluntary Proceedings**

Since my last appraisal/revalidation I have not, in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: .....  ..... Date: 15/11/13

Name in capitals ..... EAMON MACKLE



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## PROBITY DECLARATION

## Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice* (2013)

Signature.....

Date ..... 10/11/13

Name in Capitals..... E. S. MACKLE

*Convictions, findings against you and disciplinary action*

Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

If I have been subject to any of the above, I have discussed this with my appraiser.

Signature.....

Date ..... 10/11/13

Name in Capitals..... E. S. MACKLE

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2012

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 6 - SIGN OFF

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE
N/A	Personal Information redacted by the USI	20/12/13

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			✓
Quality improvement activity			✓
Significant events review			✓
Review of complaints and compliments			✓
Feedback from colleagues	Year undertaken OR Planned Year:	12	✓
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	13	✓

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	✓
Ensure the previous year's Personal Development Plan has been reviewed.	✓
Forward required Forms according to the organisation's appraisal policy.	✓

## APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

## APPRAISEE

Signature of Appraisee: \_\_\_\_\_ Date: \_\_\_\_\_

## APPRAISER

Signature of Appraiser: \_\_\_\_\_ Name of Appraiser: \_\_\_\_\_  
 GMC Number: \_\_\_\_\_ Date: 20/12/13

## CO-APPRAISER (if applicable)

Signature of Co-Appraiser: \_\_\_\_\_ Name of Co-Appraiser: \_\_\_\_\_  
 GMC Number: \_\_\_\_\_ Organisation: \_\_\_\_\_

Name: Edward John Mackle

GMC Number: \_\_\_\_\_

Personal Information redacted by the USI

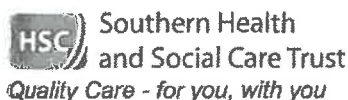
Appraisal Period : 2012

## PERSONAL DEVELOPMENT TEMPLATE

*This should be used to inform discussion on development provided for on **Form 4**. It should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified.*

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
<i>Explain the need.</i>	<i>Explain how you will take action, and what resources you will need?</i>	<i>The date agreed with your appraiser for achieving the development goal.</i>	<i>How will your practice change as a result of the development activity?</i>	<i>Agreement from your appraiser that the development need has been met.</i>
<b>1.Feedback from Colleagues</b>	<b>GMC Colleague Feedback Report</b>	<b>For 2012 Appraisal</b>		Personal Information redacted by the USI 2013
<b>2.Feedback from Patients</b>	<b>Patient Feedback Survey</b>	<b>For 2012 Appraisal</b>		Personal Information redacted by the USI 2013
<b>3.</b>				
<b>4. etc</b>				

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



## APPRAISAL DOCUMENTS 2013

CONTENTS

Form 1	Background Details
Form 2	Current Medical Activities
Form 3	Supporting Information for Appraisal & Summary of Appraisal Discussion
Form 4	Personal Development Plan
Form 5	Health & Probity Statements
Form 6	Sign Off
Form 7	Revalidation Progress
Appendix 1	Appraiser Feedback Form
Appendix 2	Appraisee Feedback form
Appendix 3	Aide Memoire and Quality Assurance Audit Tool

FORM 1 - BACKGROUND DETAILS

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.
- The form includes an optional section for any additional information.

1.1 Full name	Edward John Mackle
1.2 GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3 Main employer	Southern Trust
1.4 Main place of work	Craigavon Area Hospital
1.5 Other employers/ places of work	Hillsborough Private Clinic Ulster Independent Clinic
1.6 Date of primary medical qualification	July 1980
1.7 GMC registration number and type	Personal Information redacted by the USI
1.8 Start date of first substantive appointment in HSC as a trained doctor	August 1981
1.8 GMC Registration date and specialties	10 August General Surgery Specialist Register
1.9 Title of current post and date appointed	Consultant Surgeon from Feb 1992 Associate Medical Director for Surgery and Elective Care from October 2007
1.10 For any specialist registration / qualification outside UK, please give date and specialty	
1.11 Please list any other specialties or sub-specialties in which you are registered	Coloproctology, Upper GI Surgery
1.12 Is your registration currently in question?	No
1.13 Date of last revalidation (if applicable)	

Name: Edward John Mackle

GMC Number:

Personal Information redacted by the USI

Appraisal Period : 2013

**HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**

1.14 Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	Honorary Lecturer Queen's University Belfast - 2011
--	---

**ANY ADDITIONAL INFORMATION**

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 2 - CURRENT MEDICAL ACTIVITIES**

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.
- Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.
- You may wish to comment in addition on factors which affect the provision of good health care.

2.1 Please give a short description of your work, including the different types of activity you undertake	General Surgery Outpatient and in-patient On-call for surgical emergencies
2.2 List your main sub-specialist skills and commitments / special interests	Colorectal Surgery: Cancer, benign diseases, pelvic floor dysfunction Oesophagogastric surgery: Cancer and benign
2.3 Please give details of any emergency, on-call and out of hours responsibilities	SOW weekends 1 in 8 On-call 1 in 8
2.4 Please give details of out-patient work if applicable	Outpatient Clinic: Monday am CAH Outpatient clinic: Thursday pm 2 <sup>nd</sup> and 4 <sup>th</sup> CAH
2.5 Details of any other clinical work	In-patient Theatre: 2 sessions (Tuesday) per week CAH Day Surgery Theatre: 2 sessions per month CAH Endoscopy list: 1 session per week CAH
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: <ul style="list-style-type: none"> <li>• Number and type of cases.</li> <li>• Any audit or outcome data for the private practice.</li> <li>• Details of any adverse events, critical incidents.</li> <li>• Details of any investigations into the conduct of your clinical practice or working relationships with colleagues</li> </ul>	Ulster Independent Clinic: Full admitting rights Hillsborough Private Clinic: Outpatient clinic, endoscopy and minor operations
2.7 List any non-clinical work that you undertake which relates to teaching	Examiner Final MB QUB Undergraduate Examiner RCSI Convenor and Tutor Basic Surgical Skills Courses RCSI Senior Examiner IMRCS RCSI External Examiner Undergraduate Medical University of Bahrain

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013

**HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**

2.7.1 List any non-clinical work that you undertake which relates to management	Associate Medical Director, Surgery & Elective Care, Southern Trust
2.7.2 List any non-clinical work that you undertake which relates to research	
2.7.3 List any work you undertake for regional, national or international organisations.	<p>Member of the Paper Panel Intercollegiate Committee for Basic Surgical Examinations 2008 – present</p> <p>Member of the OSCE Subgroup Intercollegiate Committee for Basic Surgical Examinations 2008 – present</p> <p>Royal College of Surgeons of England Assessor Consultant Advisory Appointment Committees 2002 –</p> <p>Member RCSI Post-graduate Surgical Examination Operation Group 2010 –</p> <p>Member of the Intercollegiate Committee for Basic Surgical Examinations</p> <p>Member NICAN Colorectal Group</p> <p>Member NICAN Upper GI Group</p> <p>President of the Ulster Medical Society 2013-14</p> <p>President of the Ulster Society of Gastroenterology 2013-17</p> <p>Chair of the Examiner Development Group RCSI 2013 -</p>
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	I provide medical expert reports on behalf of the Directorate of Legal Services

**CURRENT JOB PLAN**

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

**ADDITIONAL INFORMATION**

Please use to record issues which impact upon delivery of patient care.



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION**

<b>DOMAIN 1 - Knowledge, Skills and Performance</b>		
Attribute: 1.1 Maintain your professional performance		
Attribute: 1.2 Apply knowledge and experience to practice		
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.		
	List of Supporting Information	Applicable Date
1	Job Plan	
2	Workload data CHKS	
3	CPD Summary 2013	
4	PDP Template for 2013	
5	CPD Evidence	
6	GMC Registration	
7		
8		
9		
10		
<b>Discussion</b>  <p>Eamon agrees that the CHKS workload data has improved to the degree that it is a reasonable reflection of his activity and now provides a more useful source when comparing his activity with peers. He is satisfied with his performance therein, he compares well with his peers considering his other commitments. He reports no difficulties in balancing his clinical and managerial workload over the past year.</p> <p>He has presented evidence of CPD activity to satisfy his RCS requirements. There are no gaps.</p>		
<b>Actions Agreed</b>  <p>His intention is to continue with the same job plan and is confident he will maintain his CPD.</p>		

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**DOMAIN 2 - Safety and Quality**

Attribute: 2.1 Contribute to and comply with systems to protect patients

Attribute: 2.2 Respond to risks to safety

Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1	M&M Attendance 2012/13	
2	Safety and Quality summary	
3	Details of GP	
4	Reflection on Practice	
5	Teaching and Training Summary	
6		
7		
8		
9		
10		

**Discussion**

Eamon has been leading on new developments in the surgical M&M as part of the trust's overall reform. A new M&M chair is to be recruited formally in 2014/15, the first in this format. It is proposed to divide the M&M into subspecialty groups alongside ATICS.

His reflective practice centers on acute kidney injury in surgery. The issues around this were discussed at M&M and the learning thereof disseminated. This has resulted in changes in practice in his division.

**Actions Agreed**

Reorganisation of Surgical/ATICS M&M. Appointment of new chair of M&M.  
Follow up on changes in practice re acute kidney injury.

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**DOMAIN 3 - Communication, Partnership and Teamwork**

Attribute: 3.1 Communicate effectively

Attribute: 3.2 Work constructively with colleagues and delegate effectively

Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1	Teamwork Summary	
2	Sample MDT Minutes	
3	Sample AMD Meeting Minutes	
4	Sample Acute Governance Minutes	
5		
6		
7		
8		
9		
10		

**Discussion**

Eamon is a leading participant in his colorectal MD team, evidence of such is noted. He is satisfied that he makes an important contribution and that the MD team is functioning well.

He plays a leading role in governance in the Acute directorate. As AMD for surgery he regularly attends and contributes to the Acute Governance forum, evidence as noted above. He also attends the trust wide AMD forum.

**Actions Agreed**

He doesn't foresee any need to make any changes to the above.

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**DOMAIN 4 - Maintaining Trust**

Attribute:4.1 Show respect for patients

Attribute:4.2 Treat patients and colleagues fairly and without discrimination

Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	Statement of Probity and Health	
2	Complaint and Reflection on same	
3	Compliments	
4	UIC statement	
5	HPC statement	
6		
7		
8		
9		
10		

**Discussion**

Eamon has provided statements of probity and good health.

He provides evidence of reflection on a patient complaint and has discussed re same. He believes the learning from that has helped improve his clinical practice.

He provides letters of good standing from the two private clinics where he works in the spirit of whole practice appraisal. No difficulties are reported however the letters might provide more detailed evidence?

**Actions Agreed**

He will explore with the UIC and HPC re providing more detailed letters of good standing.

Name: Edward John Mackle

GMC Number

Personal Information redacted by the USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 4 - PERSONAL DEVELOPMENT PLAN**

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

**Review of last year's Personal Development Plan**

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
Presidential Lecture Ulster Medical Society and prepare programme for same	Prepare Lecture and Programme	Fully achieved
Gastroenterology	Prepare programme for the British Irish Gastroenterology Meeting	Fully achieved

Name: Edward John Mackle

GMC Number:

Personal Information redacted by the  
USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	Actions agreed	Target dates
Coloproctology	Attend Association of Coloproctology of GB&I	July 2014
Gastroenterology	Prepare Programme for Ulster Society of Gastroenterology including full teaching day.	October 14
Independent Sector practice	Discuss with UIC and HPC re evidence etc in letters of good standing	2014/15

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 7- REVALIDATION PROGRESS****Year 1**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2013 has been satisfactorily completed.

**Current Outstanding Issues:****Action Required****Resolution**

none

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: John Simpson \_\_\_\_\_

GMC Number: \_\_\_\_\_

2703824

Date : Dec2014 \_\_\_\_\_

**Year 2**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:****Action Required****Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Year 3**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:****Action Required****Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

Name: Edward John Mackle

GMC Number: \_\_\_\_\_

Personal Information redacted  
by the USI

Appraisal Period : 2013

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 6 - SIGN OFF

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			X
Quality improvement activity			X
Significant events review			X
Review of complaints and compliments			X
Feedback from colleagues	Year undertaken OR Planned Year:	2016/17	
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	2016/17	

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	X
Ensure the previous year's Personal Development Plan has been reviewed.	X
Forward required Forms according to the organisation's appraisal policy.	X

**APPRAISAL COMPLETION**

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

**APPRAISEE**

Signature of Appraisee: :

Personal Information redacted by the USI

Date:

10/3/15

**APPRAISER**Signature of Appraiser:  
Simpson

Name of Appraiser: John

GMC Number:

Personal Information redacted by the USI

Date : Dec 2014

**CO-APPRAISER (if applicable)**

Signature of Co-Appraiser: \_\_\_\_\_

Name of Co-Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Organisation: \_\_\_\_\_

Name: Edward John Mackle

GMC Number:

Personal Information redacted by the USI

Appraisal Period : 2013



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**Year 4**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____	Name of Appraiser: _____
GMC Number: _____	Date: _____

**Year 5**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____	Name of Appraiser: _____
GMC Number: _____	Date: _____

**Year**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____	Name of Appraiser: _____
GMC Number: _____	Date: _____

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years			
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Name: Edward John Mackle

GMC Number

Personal Information redacted  
by the USI

Appraisal Period : 2013



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



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

Appendix 1

## APPRAISER FEEDBACK FORM

Appraiser:  
John  
Simpson

Appraisee:  
Eamon  
Mackle

Date of Appraisal:  
Dec 2014

## Before the Appraisal

How challenging did you find it to review the paperwork for this appraisal?

1 ☐2 ☐3 ☐4 ☐5 ☒

Very difficult

Quite simple

How much time did you spend preparing for this appraisal?

Over 5 hours ☐Between 2 and 5  
hours ☐Between 1 and 2  
hours ☐Less than 1 hour ☒

Overall, how would you say you were feeling towards this impending appraisal?

1 ☐2 ☐3 ☐4 ☐5 ☒

Very negative

Very positive

## During the Appraisal

Did you begin the appraisal feeling clear about what was going to be discussed?

1 ☐2 ☐3 ☐4 ☐5 ☒

Not at all

We agreed this at the  
beginning

Did you feel that the confidentiality of the process was understood?

1 ☐2 ☐3 ☐4 ☐5 ☒

No

Completely clear

Did you feel at ease during this appraisal?

1 ☐2 ☐3 ☐4 ☐5 ☒I felt ill at ease  
throughoutI felt completely at ease from  
the start

Did you feel that the appraisee was familiar with the paperwork?

1 ☐2 ☐3 ☐4 ☐5 ☒They did not appear  
to have read itHad clearly taken time to  
read and think about it

Did you feel that the appraisal addressed all the issues that needed to be addressed?

1 ☐2 ☐3 ☐4 ☐5 ☒

Not at all

Completely

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period : 2013

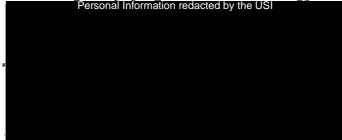
## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

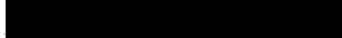
**FORM 5- HEALTH AND PROBITY STATEMENTS****HEALTH DECLARATION****Professional Obligations**

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.
78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.
79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: .....  ..... Date: ..... 10-3-14 .....

Name in capitals .....  ..... *S. Mackle* .....

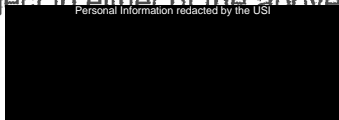
**Regulatory and Voluntary Proceedings**

Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

**OR**

If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: .....  ..... Date: ..... 10/3/14 .....

Name in capitals .....  ..... *S. Mackle* .....

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## PROBITY DECLARATION

## Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006)*.

Signature.....

Personal Information redacted by the USI

Date ..... 10.13.15

Name in Capitals..... E. J. Mackle

*Convictions, findings against you and disciplinary action*

Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

If I have been subject to any of the above, I have discussed this with my appraiser.

Signature .....

Personal Information redacted by the USI

Date ..... 10.3.15

Name in Capitals ..... E. J. Mackle

Name: Edward John Mackle

GMC Number

Personal Information redacted by the USI

Appraisal Period : 2013



Southern Health  
and Social Care Trust

Medical Directorate

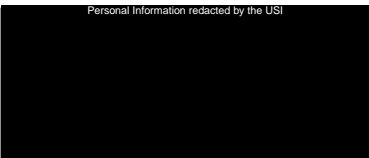
## Memorandum

<b>Our Ref</b>	RW/LM
<b>To:</b>	Dr E Mackle
<b>Cc:</b>	Dr R Wright
<b>From:</b>	Dr Richard Wright, Medical Director
<b>Date:</b>	9 <sup>TH</sup> June 2016
<b>Subject</b>	<b>APPRAISAL</b>

Thank you for forwarding a copy of your Appraisal Documentation from your 2014 - 2015 appraisal.

This document has been stored electronically in my office and I return the original for your files.

Personal Information redacted by the USI

A large black rectangular redaction box covering several lines of text in the memorandum.

**DR RICHARD WRIGHT**  
Medical Director  
Enc.



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

# **MEDICAL APPRAISAL DOCUMENTS & CHECKLIST**

**PLEASE USE THESE FORMS FOR CALENDAR YEAR  
JANUARY TO DECEMBER 2015 ONWARDS**

<b>Remember to include:-</b> <i>[Please ensure all boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]</i>	<input checked="" type="checkbox"/>
Your name, GMC No, and the appraisal period covered in the footer of the forms. Simply double-click on the relevant section at the bottom of the document.	<input checked="" type="checkbox"/>
Evidence of Reflection on Practice and use of Structured Reflective Templates – click <a href="#">here</a>	<input checked="" type="checkbox"/>
Evidence of Research Activity (if applicable)	<input type="checkbox"/>
Evidence of at Least 66% Attendance at M&M Meetings	<input checked="" type="checkbox"/>
Use of M&M SBAR Template with Appropriate Detail of Involvement – click <a href="#">here</a>	<input checked="" type="checkbox"/>
Evidence of Regular Participation in Clinical Audit	<input checked="" type="checkbox"/>
<b>Remember to send:-</b> <i>[Please ensure all boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]</i>	<input checked="" type="checkbox"/>
FRONT PAGE CHECKLIST – with <u>all</u> boxes ticked	<input checked="" type="checkbox"/>
FORM 1 – all parts completed by Appraisee	<input checked="" type="checkbox"/>
FORM 2 – all parts completed by Appraisee to include <u>whole practice</u> i.e. Private / Medico Legal Work etc.	<input checked="" type="checkbox"/>
FORM 3 – All four GMP Domains completed jointly by Appraisee and Appraiser to include list of supporting information and evidence of the discussion that took place during the appraisal meeting – click <a href="#">here</a>	<input checked="" type="checkbox"/>
FORM 3 – Inclusion of agreed actions against <u>all four</u> GMP domains – click <a href="#">here</a>	<input checked="" type="checkbox"/>
FORM 4 – Review of Last Year's PDP	<input checked="" type="checkbox"/>
FORM 4 – PDP for the Year Ahead Developed from the Discussions Around the Four GMP Domains – click <a href="#">here</a>	<input checked="" type="checkbox"/>
FORM 5 – all parts completed with FIVE signatures, one for each section	<input checked="" type="checkbox"/>
FORM 6 – completed, signed and dated by both Appraisee & Appraiser	<input checked="" type="checkbox"/>
FORM 7 – Completed in respect of where the appraisee is in their forthcoming Revalidation Cycle i.e. Year 1, 2, 3 etc. Please ensure last section also completed in relation to whether the Revalidation Requirements have been met or when they are proposed to be met.	<input checked="" type="checkbox"/>
APPENDIX 1 – all parts completed, signed and dated by Appraisee & Appraiser	<input checked="" type="checkbox"/>
APPENDIX 2 – completed fully by Appraiser	<input checked="" type="checkbox"/>
APPENDIX 3 – completed fully by Appraisee	<input checked="" type="checkbox"/>
APPENDIX 4 – NOT REQUIRED / KEEP FOR YOUR OWN RECORDS	<input type="checkbox"/>

**PLEASE DO NOT SUBMIT THESE FORMS UNLESS ALL OF THE ABOVE BOXES HAVE BEEN TICKED AS THEY WILL NOT BE ACCEPTED FOR PROCESSING.**

You can submit the documentation by scanning and emailing the original signed copies to:-

Personal Information redacted by the USI

Or send the signed originals by internal mail to the Revalidation Support Team at the address below where they will be scanned in, saved and returned to you:- (Copies will not be accepted).

Revalidation Support Team, Medical Directorate, Clanrye House, DHH.

For further guidance and FAQ's – click [here](#)



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



## APPRAISAL DOCUMENTS

CONTENTS

Form 1	Background Details
Form 2	Current Medical Activities
Form 3	Supporting Information for Appraisal & Summary of Appraisal Discussion
Form 4	Personal Development Plan
Form 5	Health & Probity Statements
Form 6	Sign Off -
Form 7	Revalidation Progress
Appendix 1	Education and Training Competencies Available for Medical Staff
Appendix 2	Appraiser Feedback Form
Appendix 3	Appraisee Feedback form
Appendix 4	Aide Memoire and Quality Assurance Audit Tool

FORM 1 - BACKGROUND DETAILS

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.
- The form includes an optional section for any additional information – click [here](#) to navigate to the relevant guidance in Appendix 4 of these forms.

1.1 Full name	Edward John Mackle
1.2 GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3 Main employer	Southern Trust
1.4 Main place of work	Craigavon Area Hospital
1.5 Other employers/ places of work	Hillsborough Private Clinic Ulster Independent Clinic
1.6 Date of primary medical qualification	July 1980
1.7 GMC registration number and type	Personal Information redacted by the USI
1.8 Start date of first substantive appointment in HSC as a trained doctor	August 1981
1.8 GMC Registration date and specialties	10 August General Surgery Specialist Register
1.9 Title of current post and date appointed	Consultant Surgeon from Feb 1992 Associate Medical Director for Surgery and Elective Care from October 2007
1.10 For any specialist registration / qualification outside UK, please give date and specialty	
1.11 Please list any other specialties or sub-specialties in which you are registered	Coloproctology, Upper GI Surgery
1.12 Is your registration currently in question?	No
1.13 Date of last revalidation (if applicable)	21/03/2014
1.14 Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any	Honorary Lecturer Queen's University Belfast - 2011

Name: Edward John Mackle

GMC Number:

Personal Information redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 2

**HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**

honorary and/or part-time posts)	
----------------------------------	--

<b>ANY ADDITIONAL INFORMATION</b>

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 2 - CURRENT MEDICAL ACTIVITIES**

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.
- Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.
- You may wish to comment in addition on factors which affect the provision of good health care.

Click [here](#) to navigate to the relevant guidance in Appendix 4.

2.1 Please give a short description of your work, including the different types of activity you undertake	General Surgery Outpatient and in-patient On-call for surgical emergencies Associate Medical Director Surgery and Elective Care
2.2 List your main sub-specialist skills and commitments / special interests	Colorectal Surgery: Cancer, benign diseases, pelvic floor dysfunction Oesophagogastric surgery: Cancer and benign
2.3 Please give details of any emergency, on-call and out of hours responsibilities	On-Call 1 in 8
2.4 Please give details of out-patient work if applicable	Outpatient Clinic: Monday am CAH Outpatient clinic: Thursday pm 2 <sup>nd</sup> and 4 <sup>th</sup> CAH
2.5 Details of any other clinical work	In-patient Theatre: 2 sessions (Tuesday) per week CAH Day Surgery Theatre: 2 sessions per month CAH Endoscopy list: 1 session per week CAH
2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? Please give details including: <ul style="list-style-type: none"> <li><input type="checkbox"/> Number and type of cases.</li> <li><input type="checkbox"/> Any audit or outcome data for the private practice.</li> <li><input type="checkbox"/> Details of any adverse events, critical incidents.</li> <li><input type="checkbox"/> Details of any investigations into the conduct of your clinical practice or working relationships with colleagues</li> </ul>	Ulster Independent Clinic: Full admitting rights Hillsborough Private Clinic: Outpatient clinic, endoscopy and minor operations  I have approximately 10 sessions of operating per year in the UIC. This contains a combination of endoscopy and general surgery. I perform approximately 40 to 50 endoscopies per year in Hillsborough Private Clinic There have been no critical incidents and no investigations into my clinical practice.
2.7 List any non-clinical work that you undertake which relates to teaching	Undergraduate Examiner RCSI Senior Examiner IMRCS RCSI External Examiner Undergraduate Medical University of Bahrain Lecturer RCSI OSCE Course



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.7.1 List any non-clinical work that you undertake which relates to management	Associate Medical Director, Surgery & Elective Care, Southern Trust
2.7.2 List any non-clinical work that you undertake which relates to research	
2.7.3 List any work you undertake for regional, national or international organisations.	Member of the Paper Panel Intercollegiate Committee for Basic Surgical Examinations 2008 – present. Vice Chair 2015 – Member of the OSCE Subgroup Intercollegiate Committee for Basic Surgical Examinations 2008 – present Royal College of Surgeons of England Assessor Consultant Advisory Appointment Committees 2002 – Member RCSI Post-graduate Surgical Examination Operation Group 2010 – Member of the Executive Committee of the Court of Examiners RCSI 2014 – present Member of the Intercollegiate Committee for Basic Surgical Examinations President of the Ulster Medical Society 2013-14, Member of Council 2014 – present President of the Ulster Society of Gastroenterology 2013-17 Chair of the Examiner Development Group RCSI 2013 –
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	I provide medical expert reports on behalf of the Directorate of Legal Services

**CURRENT JOB PLAN**

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

--

**ADDITIONAL INFORMATION**

Please use to record issues which impact upon delivery of patient care.

--

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## FORM 3 - SUPPORTING INFORMATION &amp; SUMMARY OF APPRAISAL DISCUSSION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

**DOMAIN 1 - Knowledge, Skills and Performance**

Attribute: 1.1 Maintain your professional performance

Attribute: 1.2 Apply knowledge and experience to practice

Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Supporting Information	Applicable Date
1	Job Plan	
2	CHKS CLIP Report 2014	
3	CHKS CLIP Report 2015	
4	Reflective Template on CLIP Report 2014	
5	Reflective Template on CLIP Report 2015	
6	CPD Summary 2014 + ANNUAL LEAVE SUMMARY	
7	CPD Evidence 2014	
8	CPD Summary 2015 + ANNUAL LEAVE SUMMARY	
9	CPD Evidence 2015	
10	GMC Registration	
11	Personal Study Reflective Template	
12	Other roles structured Reflective template	

**Discussion**

Mr Mackle has demonstrated an appropriate level of CPD for his clinical practice over this extended appraisal period. He is very active as a college examiner, appreciation from the RCSI has been evidenced for this. His CLIP report reveals an appropriate case mix and volume. There is a lack of evidence re attribute 1.3 which should be addressed next year.

**Actions Agreed**

- Provide evidence of good practice re 1.3 attribute.
- Consider appropriate CPD related to his managerial role.

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 2 - Safety and Quality		
Attribute: 2.1 Contribute to and comply with systems to protect patients		
Attribute: 2.2 Respond to risks to safety		
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health		
	List of Supporting Information	Applicable Date
1	M&M Attendance 2014	
2	M&M Attendance 2015	
3	Safety and Quality Summary 2014 & 2015	
4	Details of GP + VERIN M&M RECORDS	
5	Teaching And Training Summary 2014 & 2015	
6	AUDIT OF OBSTETRIC SURGERY	
7	GMB + MBS.	
8		
9		
10		
<p><b>Discussion</b></p> <p>Mr Mackle has demonstrated reasonable attendance at M&amp;M meeting. He is actively involved as AOD in delivery of safe service and has taken a number of initiatives in this role to ensure the general surgical service is provided safely.</p> <p>- There is a lack of evidence of participation in ongoing clinical audit which needs to be addressed this year. This has already been addressed with presentation 2016.</p> <p><b>Actions Agreed</b></p> <ul style="list-style-type: none"> <li>- Develop + lead a significant clinical audit, resulting in service improvement.</li> <li>- Provide evidence of up to date appropriate vaccination</li> <li>- Appropriate reflection related to learning from safety issues.</li> <li>- Statement re complaints + incidents with examples to be provided (addressed in section 314).</li> </ul>		

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

**DOMAIN 3 - Communication, Partnership and Teamwork**

Attribute: 3.1 Communicate effectively

Attribute: 3.2 Work constructively with colleagues and delegate effectively

Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1	Teamwork Summary	
2	Sample Acute Thrombosis Meeting Agenda	
3	Sample Acute Clinical Governance Minutes	
4	Sample AMD Meeting Agenda	
5	Reflection re complaint from colleague	
6	re patient complaint	
7		
8		
9		
10		

**Discussion**

- Mr Mackle has produced evidence of participation in the A.M.D team & Acute Governance committee
- There is no evidence of appropriate reflection re teamwork
- 

**Actions Agreed**

- 360 feedback from colleagues consider Leadership module
- Evidence communication structure + style re C.Ds.
- Reflection required re dispute with anaesthetist and learning (already produced in 4)
- Evidence of annual & study leave

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 4 - Maintaining Trust		
Attribute:4.1 Show respect for patients		
Attribute:4.2 Treat patients and colleagues fairly and without discrimination		
Attribute:4.3 Act with honesty and integrity		
	List of Supporting Information	Applicable Date
1	Signed Statements re Probity, Health and Indemnity	
2	HPC Statement + VIC Statement	
3	Complaints and Reflections on same	
4	Reflection on Compliments	
5	Compliments 2014	
6	Compliments 2015	
7	VIC Statement	
8		
9		
10		
<b>Discussion</b> <p>Mr Mackle has demonstrated evidence of the appreciation of large numbers of patients via thank you letters etcetera. He is clearly held in high esteem by them for his clinical practice.</p>		
<b>Actions Agreed</b> <ul style="list-style-type: none"> <li>- Equality &amp; Diversity update.</li> <li>- Statement &amp; Reflection re consent.</li> <li>- 360° feedback.</li> <li>- VIC Clinic statement.</li> </ul>		

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

Name: Edward John Mackle

GMC Number

Personal Information  
redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 9

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 4 - PERSONAL DEVELOPMENT PLAN**

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

**Review of last year's Personal Development Plan**

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
Coloproctology	Attend Association of Coloproctology Meeting 2014	Achieved
Gastroenterology	Prepare Programme for USG 2014 & 2015	Acheived
Colorproctology	Attend ECCP Annual Meeting 2015	Acheived

[CLICK HERE](#) for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

Name: Edward John Mackle

GMC Number: Personal Information  
redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 10

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	Actions agreed	Target dates
Gastroenterology	Prepare Programme for USG Spring and Autumn meeting 2016	October 2016
General Surgery	Attend Meeting of Association of Surgeons of GB & I	May 2016
Mandatory Training	Update several modules re same	2016

[CLICK HERE](#) for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 11

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 5- HEALTH AND PROBITY STATEMENTS****HEALTH DECLARATION**

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

**Professional Obligations**

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.
78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.
79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

20.3.16

Name in Capitals: \_\_\_\_\_

S. WATKINS

**NB:** Additional Health and Probity forms are on the Southern Docs website – click [here](#)

**Regulatory and Voluntary Proceedings** [Please check relevant box by clicking on it and then sign below]

☒ Since my last appraisal/revalidation I have not, in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

☐ If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

20.3.16

Name in Capitals: \_\_\_\_\_

F. S. WATKINS

Name: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Appraisal Period : \_\_\_\_\_

Page 12



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## PROBITY DECLARATION

## Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006)*.

Signature: \_\_\_\_\_ Date: 20.3.16

Name in Capitals: EDWARD JOHN MACKLE

**Convictions, findings against you and disciplinary action** [Please check relevant box by clicking on it and then sign below]

☒ Since my last appraisal/revalidation I have not, in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

☐ If I have been subject to any of the above, I have discussed this with my appraiser.

Signature: \_\_\_\_\_ Date: 20.3.16

Name in Capitals: EDWARD JOHN MACKLE

## INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click [here](#)

Signature: \_\_\_\_\_ Date: 20.3.16

Name in Capitals: EDWARD JOHN MACKLE

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 6 - SIGN OFF**

Please ensure this section is fully completed, signed and dated by both Appraiser and Appraisee.

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION		PRESENT	
Continuing professional development			
Quality improvement activity			
Significant events review			
Review of complaints and compliments			
Feedback from colleagues	Year undertaken OR Planned Year:		
Feedback from patients (where applicable)	Year undertaken OR Planned Year:		

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	
Ensure the previous year's Personal Development Plan has been reviewed.	
Forward required Forms according to the organisation's appraisal policy.	

APPRAISAL COMPLETION	
We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:	
APPRAISEE	Personal Information redacted by the USI
Signature of Appraiser:	Date: 01/06/16
APPRAISER	Personal Information redacted by the USI
Signature of Appraiser:	Date: 01/06/16
GMC Number:	Personal Information redacted by the USI
CO-APPRAISER (if applicable)	
Signature of Co-Appraiser:	Name of Co-Appraiser:
GMC Number:	Organisation:

Name: Edward John Mackle

GMC Number:

Personal Information redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 14

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**FORM 7- REVALIDATION PROGRESS**

Ensure these sections are fully completed to indicate where the appraisee is in their 5 Year Revalidation Cycle.

**Year 1**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:****Action Required****Resolution**

N/A

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

01/05/16

**Year 2**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:****Action Required****Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Year 3**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:****Action Required****Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**Year 4**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:**

**Action Required**

**Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Year 5**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:**

**Action Required**

**Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Year**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year \_\_\_\_\_ has been satisfactorily completed.

**Current Outstanding Issues:**

**Action Required**

**Resolution**

Signature of Appraiser: \_\_\_\_\_

Name of Appraiser: \_\_\_\_\_

GMC Number: \_\_\_\_\_

Date: \_\_\_\_\_

*Please ensure the section below is fully completed.*

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years			
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Name: Edward John Mackle

GMC Number: \_\_\_\_\_

Personal Information  
redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 16



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

## Appendix 1. Education and Training Competencies Available for Medical Staff

Right Patient, Right Blood	Method	Core / Optional	Date Completed
RPRB Theory (18 month refresher required)	Elearning Blood Transfusion Module <a href="#">Click Here</a>	Core	
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff Contact Patricia Watt on <small>Personal Information redacted by the USI</small>	Core	

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face. Part of the Trust mandatory training day – <a href="#">click here for dates and program</a> . Email <small>Personal Information redacted by the USI</small> to <small>Personal Information redacted by the USI</small> to book a place.	Core	
2 Yearly Updates	Method	Core / Optional	Date Completed
Infection Prevention and Control	SHSCT E-Learning Module <a href="#">Click Here</a>	Core	
Resuscitation	Face to Face. CAH - Helen Cullen <small>Personal Information redacted by the USI</small> Bleep: <small>Personal Information redacted by the USI</small> DHH - Bernie O'Connor <small>Personal Information redacted by the USI</small> Ext: <small>Personal Information redacted by the USI</small> Bleep: <small>Personal Information redacted by the USI</small>	Optional	December 2015
Safeguarding Children & Vulnerable Adults	Face to Face. Part of the Trust mandatory training day – <a href="#">click here for dates and program</a> . Email <small>Personal Information redacted by the USI</small> to <small>Personal Information redacted by the USI</small> to book a place.	Core	
3 Yearly Updates	Method	Core / Optional	Date Completed
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module <a href="#">Click Here</a>	Core	
Moving and Handling	SHSCT E-Learning Module <a href="#">Click Here</a>	Core	
Health & Safety / Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module <a href="#">Click Here</a>	Core	
Discovering Diversity	HSC E-Learning Module <a href="#">Click Here</a>	Optional	
Recruitment & Selection	HSC E-Learning Module <a href="#">Click Here</a>	Optional	Jan 2016
Sickness & Absenteeism Training	Face to Face. Contact ELD on <small>Personal Information redacted by the USI</small> or email <small>Personal Information redacted by the USI</small>	Optional	
Hyponatraemia	BMJ E-Learning Module <a href="#">Click here</a>	Optional	
Management of Actual or Potential Aggression	Face to Face. Contact ELD on <small>Personal Information redacted by the USI</small> or email <small>Personal Information redacted by the USI</small>	Optional	
Fraud Awareness	HSC E-Learning Module <a href="#">Click here</a>	Optional	
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module <a href="#">Click here</a>	Optional	

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Once off Training	Method	Comp / Optional	Date Completed
National Early Warning System	National NEWS e-learning <a href="#">Click here</a>	Optional	
Obstetrics Early Warning System	Online Module <a href="#">Click here</a>	Optional	
Paediatrics Early Warning System	Face to Face. Contact CAH Dr S Shah <small>Personal Information redacted by the USI</small> Contact DHH Dr B Aliarad <small>Personal Information redacted by the USI</small>	Optional	
Consent	In House E-Learning Module <a href="#">Click here</a>	Optional	
Blood Culture	In House E-Learning Module <a href="#">Click here</a>	Optional	
Peripheral Line	In House E-Learning Module <a href="#">Click here</a>	Optional	
Oral Anticoagulants	MHRA Module <a href="#">Click here</a> Once on the site choose the Anticoagulant Module. On completion of the module, complete the assessment and print a completion certificate. Takes 24 hours for registration.	Optional	
Naso Gastric Tube Placement	In House E-Learning module <a href="#">Click here</a>	Optional	
Protocol following death of patient	In House E-Learning module <a href="#">Click here</a>	Optional	
Guide to Prescribing in SHSCT	In House E-Learning module <a href="#">Click here</a>	Optional	
Research and Development - Good Clinical Practice Training	Elearning Module <a href="#">Click here</a>	Optional	
VTE	King's Thrombosis Centre E-learning <a href="#">Click here</a>	Optional	
Safe Sedation [Module 1,2 & 3]	In House Elearning Modules <a href="#">Click here (Part 1)</a> <a href="#">Click here (Part 2)</a> <a href="#">Click here (Part 3)</a>	Optional	
Gastrointestinal endoscopy	Face to Face Contact Dr A Murdock <small>Personal Information redacted by the USI</small>	Optional	
Chest Drain Insertion	Face to Face Contact Dr A Ferguson <small>Personal Information redacted by the USI</small>	Optional	
Blood Gas Instrument	Face to Face Contact Derek McKillan <small>Personal Information redacted by the USI</small> Face to face	Optional	
Appraiser Training	Face to face <a href="#">Dates available here</a>	Optional	
Appraisee Training	Face to face <a href="#">Dates available here</a>	Optional	
Insertion and Management of Indwelling Urinary Catheters	Online Module <a href="#">Click here</a>	Optional	
Coroner's Investigations and Inquests Programme	Online Module <a href="#">Click here</a>	Optional	
HIV Awareness Training	Face to Face Contact Lyndsey Hasson Tel: <small>Personal Information redacted by the USI</small>	Optional	
Patients enrolled in Clinical Trials	In House E-Learning module <a href="#">Click here</a>	Optional	

Name: Edward John Mackle

GMC Number

Personal Information redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 18

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Waste Management	SHSCT E-Learning Module <a href="#">Click Here</a>	Optional	
Modules proposed for E-Learning	Method	Core / Optional	Date Completed
Better Communication/Complaint Handling	Face to face	Optional	
Incident Reporting	Face to face	Optional	
Clinical Negligence	Not currently available	Optional	

Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, Personal Information redacted by the USI

Please note that when you complete a training module either face-to-face or via elearning, you need to email the Revalidation Support Team in order that your training passport can be updated as the Team are not automatically informed.

**TRAINING DECLARATION**

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

**APPRAISEE**Signature of Appraiser: Personal Information redacted by the USIName of Appraiser: E J MackleGMC Number: Personal Information redacted by the USIDate: 01/06/16**APPRAISER**Signature of Appraiser: Personal Information redacted by the USIName of Appraiser: E J MackleGMC Number: Personal Information redacted by the USIDate: 01/06/16

## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

**HSC** Southern Health  
and Social Care Trust  
Quality Care – for you, with you

Appendix 2

## APPRAISER FEEDBACK FORM

Appraiser:		Appraisee:		Date of Appraisal:	
------------	--	------------	--	--------------------	--

## Before the Appraisal

1. How challenging did you find it to review the paperwork for this appraisal? *(Click in the relevant box)*

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Very Difficult	Difficult	Neither Difficult / Easy	Easy	Quite Simple

2. How much time did you spend preparing for this appraisal?

Over 5 hours <input type="checkbox"/>	Between 2 and 5 hours <input type="checkbox"/>	Between 1 and 2 hours <input checked="" type="checkbox"/>	Less than 1 hour <input type="checkbox"/>
---------------------------------------	--	---	---

3. Overall, how would you say you were feeling towards this impending appraisal?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Very Negative	Negative	Neither Negative / Positive	Positive	Very Positive

## During the Appraisal

4. Did you begin the appraisal feeling clear about what was going to be discussed?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Not at all	A Little Unclear	Fairly Clear	Very Clear	We agreed this at the beginning

5. Did you feel that the confidentiality of the process was understood?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Not at all	A Little	Fairly Understood	Well Understood	Completely Understood

6. Did you feel at ease during this appraisal?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
I felt ill at ease throughout	I felt a little uneasy	I felt neither easy / uneasy	I felt fairly at ease	I felt completely at ease from the start

7. Did you feel that the appraisee was familiar with the paperwork?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
They did not appear to have read it	May have read it briefly	Was fairly familiar	Was very familiar	Had clearly taken time to read and think about it

8. Did you feel that the appraisal addressed all the issues that needed to be addressed?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Not at all	A Little	Could have been addressed better	Almost	Completely

9. Did you feel that the feedback you gave was constructive?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Not at all	A Little Unconstructive and Unfair	A Little Constructive and Fair	Fairly Constructive and Fair	Very constructive and fair

10. To what extent did this appraisal help reflect on and identify development needs?

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input checked="" type="checkbox"/>	5 <input type="checkbox"/>
Not at all	A little	Fairly Good Extent	Very Good Extent	Totally

Name: Edward John Mackle

GMC Number:

Personal Information  
redacted by the USI

Appraisal Period Jan 14 – Dec 15 Page 20



## HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

11. To what extent are you confident that enough evidence was gathered for revalidation as a doctor in HSC?

1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐  
 Not at all A little Moderately Confident Fairly Confident Very Confident

12a. Did you discuss other roles in addition to the clinical role?

Yes ☐ No ☐ Role discussed: \_\_\_\_\_

12b. If yes, to what extent are you confident that enough revalidation evidence was gathered for this other role?

1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐  
 Not at all A little Moderately Confident Fairly Confident Very Confident

13. Did you feel that a fair and appropriate personal development plan was identified by the end of the interview?

1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐  
 Not at all A little Could have been better More or Less Very Much So

14. Overall, how did you feel by the end of appraisal interview?

1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐  
 Very negative Negative Neither Positive/  
 Negative Positive Very Positive

## After the Appraisal

15. How long did the appraisal interview last?

Over 2 hours ☐ Between 1.5 and 2 hours ☐ Between 1 and 1.5 hours ☒ Less than 1 hour ☐

16. Did it feel the right length?

Too long ☐ Too short ☐ Just about right ☒

17. Please rate the venue of the appraisal in terms of convenience to get to, comfort and freedom from interruption:

1 ☐ 2 ☐ 3 ☐ 4 ☒ 5 ☐  
 Very Unsuitable Unsuitable Neither Unsuitable / Suitable Suitable Very Suitable

18. How soon after the meeting did you complete the paperwork?

Not yet complete ☐ within 2 weeks ☐ within 1 week ☐ We completed it together straight after the interview ☐ *FEW WEEKS.*

19. How many hours did it take to complete the paperwork?

4 hours or more ☐ Between 2 - 3 hours ☐ Between 1 - 2 hours ☐ Less than 1 hour ☒

20. Did you feel the completed paperwork reflected a fair and accurate account of your discussion?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☒  
 Not at all A Little Reasonably Fair & Accurate Very Fair & Accurate Completely Fair & Accurate

Name: Edward John Mackle

GMC Number

Personal Information redacted by the USI

Appraisal Period Jan 14 - Dec 15 Page 21



Southern Health  
and Social Care Trust

Medical Directorate

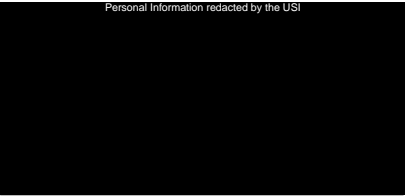
## Memorandum

<b>Our Ref</b>	RW/LM
<b>To:</b>	Dr E Mackle
<b>Cc:</b>	Dr J Simpson
<b>From:</b>	Dr Richard Wright, Medical Director
<b>Date:</b>	9 <sup>TH</sup> June 2016
<b>Subject</b>	<b>APPRAISAL</b>

Thank you for forwarding a copy of your Appraisal Documentation from your 2013 appraisal.

This document has been stored electronically in my office and I return the original for your files.

Personal Information redacted by the USI

A large black rectangular box redacts the content of the memorandum. The text 'Personal Information redacted by the USI' is printed in small font above the box.

**DR RICHARD WRIGHT**  
**Medical Director**  
**Enc.**

## Mackle, Eamon

---

**From:** Mackle, Eamon  
**Sent:** 01 September 2011 10:20  
**To:** Corrigan, Martina; Trouton, Heather  
**Subject:** Fw: O'Brien Aidan DRAFT job plan Jun 2011

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

**Categories:** AD of the Week

FYI

Eamon

---

**From:** Mackle, Eamon  
**To:** Clegg, Malcolm  
**Sent:** Thu Sep 01 10:16:33 2011  
**Subject:** Fw: O'Brien Aidan DRAFT job plan Jun 2011

Malcolm

Will you start the facilitation process please.

Eamon

---

**From:** aidanpobrien [REDACTED] Personal Information redacted by the USI  
**To:** Mackle, Eamon  
**Sent:** Thu Sep 01 09:23:00 2011  
**Subject:** Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

I am unable to agree to revised Job Plan proposal of 26 August 2011 as it is even less workable that previous proposal.

Aidan.

-----Original Message-----

**From:** Mackle, Eamon [REDACTED] Personal Information redacted by the USI  
**To:** aidanpobrien [REDACTED] Personal Information redacted by the USI  
**CC:** Corrigan, Martina [REDACTED] Personal Information redacted by the USI  
**Sent:** Fri, 26 Aug 2011 13:13  
**Subject:** RE: O'Brien Aidan DRAFT job plan Jun 2011

Aidan

Thank-you for your email

Re the points raised.

· The fifth Monday occurs X4 per year equally bank holiday Mondays also equal X4 per year

· The specialist clinic is in Thorndale on a Friday so I cannot understand your point

· I have swopped your ward round on a Tuesday for the occasional patient who needs admitted the day before. You have a total of 4 hours for in-patient ward round per week.

· I note the comment re administration time and following reassessment of the admin time allocated to your colleagues I have reduced your allocation to 4.25 hours per week which is now similar to your colleagues.

· SPA time as I have stated at our meeting is a core of 1.5 SPAs. Any requests for increased SPA will be considered in the future on provision of further detail including Audit Tool, benefits and measureable outcomes.

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

Eamon

From: [aidanpobrien](#) Personal Information redacted by the USI  
Sent: 24 August 2011 11:05  
To: Mackle, Eamon  
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

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

\* I find it unacceptable the proposal to travel to Banbridge on the morning of the fifth Monday of the month, to conduct a clinic, lasting four hours, without credit in a Job Plan. If it cannot be accredited, I would prefer that it would not be included in a Job Plan.

\* I believe that it was both important and reasonable to have time allocated to addressing patient management issues arising in Thorndale Unit. Last Friday, I spent one hour doing so. That included contacting the GP of a patient whose serum PSA had increased from 8 ng/ml to 803 ng/ml in less than one year. I had proposed the inclusion of a nominal time allocation of 30 minutes per week (on Tuesdays 1.00 to 1.30 pm). I believe that Urology ICATS cannot function safely without consultant urologists providing advisory input, and I believe time allocated to that function should be included in Job Plans.

\* I believe that it remains a necessity to allocate time to conduct a ward round on Tuesday evening. Irrespective of practices in other specialties, I would anticipate that we will continue to have some patients undergoing surgery, and who will not have been admitted electively on the day of surgery. In any case, all patients admitted electively will have given prior consent. Even if that prior consent is in written form, I believe that it would be better practice to review the patient following admission, and that it would be inappropriate to defer that review to the morning of surgery. Moreover, this round is not solely for the purpose of obtaining written consent from patients undergoing surgery

the following day, but for all inpatients.

\* The time allocated to administration remains inadequate. I note a recent expectation that the results of all investigations (presumably of outpatients) be read by consultants as soon as the results are available. How much administrative time will this consume? How much time will be allocated in Job Plan?

\* Lastly, I would propose to increase SPA time by one PA per month to conduct audit in urological oncology. I have included this in Professional Development in appraisal for coming year, and as stated previously, I believe that audit must begin in order to satisfy MDT peer review. It will not begin with current SPA allocation.

Aidan

-----Original Message-----

From: Mackle, Eamon [Personal Information redacted by the USI]  
To: aidanpobrien [Personal Information redacted by the USI]  
Sent: Wed, 10 Aug 2011 12:54  
Subject: RE: O'Brien Aidan DRAFT job plan Jun 2011

Aidan

I have written comments in red below and am attaching a revised job plan. If you are in agreement will you let either myself or Martina know and we can get the document printed for signature

Eamon

From: [aidanpobrien](#) [Personal Information redacted by the USI]  
Sent: 22 July 2011 10:38  
To: Mackle, Eamon  
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

Thank you for amended job plan proposal. I appreciate the attention that has been given to previously submitted comments. I am left with a few issues to be clarified or resolved:

1. Going to Banbridge on Fifth Monday of month. I am confused as to how one calculates recognition of that, both with regard to travelling time and clinic time. I have not been allocated any travelling or clinic time in the proposal. Is it difficult to do so for Fifth 'Anything' in the month? Would it be better or easier not to do clinic on Fifth Monday? I talked to HR and to date it has been taken as swings and roundabouts.

2. I go to Thorndale Clinic on Tuesdays between Day Surgery and Outpatients

Clinic, to address any issues there. These are to decide management of patients who have attended Nurse Led Clinics. So it would be impractical to do Ward Round

between 1pm and 1.30 pm. In fact, it would be good to have that half hour built into every Tuesday, irrespective of whether I am in Day Surgery on Tuesday mornings, or doing Admin, and to have instead half hour for ward round from 5.30

to 6.00, which will enable be to visit and consent any patients who are admitted on Tuesday for surgery on Wednesday, and who would not have been admitted at the earlier time in any case. We have moved in colorectal to admission on the day of

surgery so consents are either done in the OPD or during the preop ward round.

3. It is my view that it would be better to have Inpatient Theatre session extended to 5.30 on Wednesday, followed by allocation of one hour for Ward Round. I do believe that doing so will enable theatre utilisation to be maximised. I believe that terminating the theatre allocation time at 5.00 will certainly result in a drift to have operating actually finishing at 4.30 to 4.45, reducing theatre utilisation and productivity. I believe that would be a negative and short-sighted development. Theatre staff are already annoyed at overruns and I am constantly reminded by Ronan Carroll that the all day list is from 9 until 5.

4. I believe that we three have accepted the split between DCC and SPA on Thursday mornings, but strongly believe that 'Grand' should be restored to 'Ward Round'. Grand has been inserted. When we become five, we would intend to split the team into two firms, in some way, to ensure that Grand Rounds can still be conducted, as we believe that it is a vital component of clinical governance, and wish to retain it.

5. I would prefer to have Admin and Ward Round on Friday switched around, so that Admin can be done from 1.00 - 2.00, so as to complete all Admin arising from Thorndale whilst in Thorndale, followed by Ward Round at 2pm.

6. I believe all of the above can be readily addressed and resolved, leaving one more substantive issue, which is the totality of Administrative time, which currently stands at 4.25 hours. As I have related previously, and in discussion with my colleagues, there is absolutely no doubt that such an allocation is inadequate. It is just simply impossible to do the proposed work with one PA allocated to Admin. Upon your request, I have given consideration to the amount of time required. I am entirely cognisant of the presumed requirement to be perceived to be as productive and as efficient as is possible. Taking that into consideration, I believe that 2 PAs are required to be allocated to Administration. If allocated a total of 2 PAs, I would be committed to continuing to provide, to the best of my ability, all of the administration arising from the proposed Job Plan, knowing that I would be doing unremunerated work. I would propose that one additional hour be allocated to Administration at

the end of each of the four days, Monday to Thursday. I have increased it by a further hour per week.

I do hope that these proposed amendments are received as being helpful and constructive, as they are sincerely intended to be. I would hope that they can be considered in that light, as I would much prefer to avoid facilitation etc,

Aidan.

The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material.

Any review, transmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from any computer.

Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department

Personal Information redacted  
by the USI

**Clegg, Malcolm**

---

**From:** Clegg, Malcolm  
**Sent:** 15 November 2011 12:30  
**To:** Gannon, Oonagh  
**Cc:** Porter, Pamela  
**Subject:** Mr Aidan O'Brien - change of PAs  
**Attachments:** O'Brien. Aidan - 12.75 PAs from 1.10.11 - 28.2.12.pdf

Oonagh,

Please find attached notification of change to PAs for Mr Aidan O'Brien

Personal Information redacted by  
the USI

Mr O'Brien's PAs should reduce from 15 PAs to 12.75 PAs from 1<sup>st</sup> October 2011 until 28 February 2012. On 1<sup>st</sup> March 2012 he should further reduce to 12 PAs.

He should continue to receive his 8% on call supplement and clinical excellence award.

If you require any additional information please let me know.

Sorry that this is so late, but I have just returned to work today following a family bereavement.

Regards

Malcolm

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

Tel: Personal Information redacted by  
the USI



**Mackle, Eamon**

---

**From:** Corrigan, Martina  
**Sent:** 04 March 2016 13:40  
**To:** Mackle, Eamon; Haynes, Mark; Glackin, Anthony; O'Brien, Aidan; Young, Michael; ODonoghue, JohnP  
**Subject:** Actions from AMD and Urology Consultant Meeting  
**Importance:** High  
**Sensitivity:** Confidential

Dear all,

To formalise, please see the notes/actions arising from today's meeting.

Present: Mr Mackle, Mr Young, Mr Glackin, Mr O'Donoghue, M Corrigan. Apologies : Mr O'Brien, Mr Haynes

Mr Mackle advised that the purpose of the meeting today was to follow on from the last meeting which was held on 17 December 2015 as he has a meeting with Medical Director at end of March and he will need to update him on what has been put in place.

Actions agreed:

1. Mr Young to meet with Mr Suresh this week/early next week and explain what processes are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him. (Mr Young to update when this happens)
2. Mr Mackle to meet with Mr Suresh on Wednesday 16 March 2016 at 2:30pm in AMD office, M Corrigan to organise
3. Mr Mackle and Mr Young to advise him that he should be seeking appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
4. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh
5. Formalise evening cover and the purpose of this will be explained to Mr Suresh in his meeting with Mr Mackle and Mr Young.  
Mr Young to formalise after discussions with the rest of the Team and that this should be shared with all the Team, Mr Mackle and M Corrigan. Mr Suresh is going back oncall on Thursday 17 March (Bank Holiday), Mr Young has agreed that he will do the handover Ward Round and cover Mr Suresh on this day.
6. Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and M Corrigan.
7. The Consultants involved in the 'second on call' and Ward Rounds will be remunerated by ½ PA – M Corrigan to organise.

A further meeting in 3 months to be organised in order to update on progress – M Corrigan to confirm date.

Regards

Martina

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

Telephone: [Personal Information redacted by the USI]

Mobile: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

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: 

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: Personal Information redacted by the USI

Re : Ram Suresh Urology cover

June 2016

Dear Medical Director

Although you will be aware of this issue, I write to keep you up to date of meetings and progress in relation to urology emergency cover for our colleague Mr Ram Suresh. Due to circumstances arising last autumn, it was felt that additional senior cover was required in the event that emergency 'open' urological procedures would be needed. Mr Mackle has discussed this with you already but further clarification was to be defined.

The consultants in the department have had two meetings with Mr Mackle, (Dec15 and in March 16) to discuss arrangements. All consultants have been present at either or both the meetings. Two areas of cover were deemed necessary to cover. These were for emergency theatre cover for open urological procedures and day time supervision of ward work.

A rota was to be put in place so that these two areas were covered. Although it was clear what cover emergency theatre meant, it was up to each consultant to provide daytime cover as they felt to be required. Some consultants felt uneasy about too high a profile cover but they were there for advice. Support, cover and mentorship were in essence the backbone of our approach. Mr Young and Mr Mackle had separate meetings with Mr Suresh to outline and reaffirm the needs and expectations for progress. These included surgical skills training courses and attend other consultants theatre lists where appropriate.

Mr Suresh has fully engaged with the process. He has recognised the areas that require attention and has added additional ideas for training opportunities. He has recognised that the patients under his 'wing' of on-call are his responsibility yet other consultants are available for consultation. During the last six months he has appropriately availed of this facility.

There has been a formalized evening rota arrangement for cover within the department for the past six months. Formalized daytime joint consultant ward rounds have been conducted but on a more ad hoc basis, but to an adequate level to assess the situation. A Multi-disciplinary feedback questionnaire is planned to be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan will be organising and collating responses. This will be used as constructive feedback for Mr Suresh. Mr Mackle regarded that the cover arrangement for second on-call would be remunerated by a ½ PA.

A further meeting was to be held over the summer to assess progress and the next step. This will be planned soon but it is clearly evident that distinct progress has been made from comments made from senior colleagues.

M Young

Lead Clinician Urology

**Mackle, Eamon**

---

**From:** Corrigan, Martina  
**Sent:** 05 March 2013 14:51  
**To:** (Aidanpobrien [Personal Information redacted by the USI]) [Personal Information redacted by the USI] AJay Pahuja  
[Personal Information redacted by the USI] Glackin, Anthony; Young, Michael; O'Brien, Aidan; Tony Glackin [Personal Information redacted by the USI])  
**Cc:** Brown, Robin; Trouton, Heather; Mackle, Eamon  
**Subject:** Urology team Job Plans  
**Importance:** High

Dear all

I have spoken with Robin this morning and in order to finalise and get sign-off for the job plans, I have included below the clinic templates as agreed with the Health and Social Care Board (HSCB) in order to meet the activity that is required to meet our Service Budget Agreements (SBA).

We have organised a meeting tomorrow on the Admin Floor with Robin, Michael, Heather and I to discuss these job plans and it would be good if any of the rest of you are available if you can attend, although I do appreciate your other clinical commitments.

I would be grateful if you could look at the assumptions below and advise me of any comments that you may have before tomorrow as it is important that once we sign off the job plans I will be setting up the clinics to see these volumes of patients.

#### ASSUMPTIONS ON WHAT NEEDS TO BE INCLUDED IN CLINICS IN ORDER TO DELIVER THE AGREED ACTIVITY

Stone Treatment clinics will be setup to see 6 New and 11 Review – there will be 1.5 clinics per week

Outreach (SWAH/STH/DHH/BAN/ARM) will be set up to see 5 New and 7 Review - there will be 2 outreach clinics per week

General at CAH will be set up to see 6 New and 8 Review which will mean PM clinic starting at 1:30pm - there will be 3 general clinic per week.

Oncology will be set up to see 3 red Flag and 4 Protective Review and 4 uro-oncology review – there will be 3.75 of these per week

D4 Clinics will be set up to see 4 patients (protective review) – there will be 1 of these per week

Prostate D1 will be set up to see 8 red flags and 2 News and there will be 1 of these per week

Inpatients – it is assumed that there will be 3 on a four hour session

Daycases – we have agreed 10 flexible cystoscopies on a list and 5 patients on a daycase list.

Thanks

Martina

Martina Corrigan  
Head of ENT, Urology and Outpatients

Southern Health and Social Care Trust

Telephone: Personal Information  
redacted by the USI (Direct Dial)

Mobile: Personal Information  
redacted by the USI

Email: Personal Information redacted by the USI



is, 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:**  
**Flag Status:** Follow up  
 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.

We will have to closely monitor the returns of the named referrals though and Anita can you please ask Katherine to let us know early if there are any problems arising?

Re charts at home, I think we all agree this is just not acceptable.

Thankyou all for your help

Heather

---

**From:** Young, Michael  
**Sent:** 02 December 2013 15:28  
**To:** Brown, Robin; Trouton, Heather  
**Subject:** RE: \*\*URGENT NEEDING A RESPONSE\*\*\*\* MISSING TRIAGE

Have spoken and offered help with the triage issue – will reinforce again this week

---

**From:** Brown, Robin  
**Sent:** 30 November 2013 14:00  
**To:** Young, Michael; Trouton, Heather  
**Cc:** Corrigan, Martina; Carroll, Anita  
**Subject:** RE: \*\*URGENT NEEDING A RESPONSE\*\*\*\* MISSING TRIAGE

Heather

I wonder if could you call me on the phone to discuss this  
I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.  
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.  
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward  
Aidan is an excellent surgeon and I'd be more than happy to be his patient [REDACTED], so I would prefer the approach to be "How can we help".

Robin

---

**From:** Young, Michael  
**Sent:** 26 November 2013 12:35  
**To:** Trouton, Heather; Brown, Robin  
**Cc:** Corrigan, Martina; Carroll, Anita  
**Subject:** RE: \*\*URGENT NEEDING A RESPONSE\*\*\*\* MISSING TRIAGE

Understand  
I will speak

---

**From:** Trouton, Heather  
**Sent:** 26 November 2013 11:40  
**To:** Young, Michael; Brown, Robin  
**Cc:** Corrigan, Martina; Carroll, Anita  
**Subject:** FW: \*\*URGENT NEEDING A RESPONSE\*\*\*\* MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August, he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

---

**From:** Corrigan, Martina  
**Sent:** 26 November 2013 08:02  
**To:** Robinson, Katherine; Glenny, Sharon  
**Cc:** Trouton, Heather  
**Subject:** FW: \*\*URGENT NEEDING A RESPONSE\*\*\*\* MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Thanks

Martina

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

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

---

**From:** Robinson, Katherine  
**Sent:** 21 November 2013 14:31  
**To:** Corrigan, Martina  
**Subject:** FW: MISSING TRIAGE

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

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

---

**From:** Browne, Leanne  
**Sent:** 21 November 2013 14:12

**To:** McCorry, Monica  
**Cc:** Cunningham, Andrea; Robinson, Katherine  
**Subject:** MISSING TRIAGE

Monica

Here is list of missing triage as requested

CAH	Personal Information redacted by the USI				URO	AOB	ROUTINE	03/09/2013
CAH					URO	GURO	ROUTINE	23/08/2013
CAH					URO	GURO	ROUTINE	27/08/2013
CAH					URO	GURO	ROUTINE	28/08/2013
CAH					URO	GURO	ROUTINE	28/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	GURO	ROUTINE	29/08/2013
CAH					URO	AOB	ROUTINE	03/09/2013

CAH	Personal Information redacted by the USI				URO	GURO	ROUTINE	04/09/2013	64	EM. MO 091
CAH					URO	AOB	ROUTINE	09/09/2013	59	EM. MO 091
CAH					URO	AOB	URGENT	10/09/2013	58	EM. MO 091
CAH					URO	AOB	ROUTINE	10/09/2013	58	EM. MO 091
CAH					URO	AOB	ROUTINE	10/09/2013	58	EM. MO 091
CAH					URO	AOB	ROUTINE	11/09/2013	57	EM. MO 091
CAH					URO	GURO	ROUTINE	27/08/2013	72	EM. MO 091
CAH					URO	GURO	ROUTINE	28/08/2013	71	EM. MO 091
CAH					URO	GURO	ROUTINE	29/08/2013	70	EM. MO 091

CAH	Personal Information redacted by the USI				URO	GURO	ROUTINE	03/09/2013	65	Personal Information redacted by USI
-----	--	--	--	--	-----	------	---------	------------	----	--------------------------------------

## Urology

Host	CHI Number	Caserote	Forenames	Surname	Age	Telephone	Telephone Work	Spec Code	Cons Code	Priority	Referral Date Only	Days From Ref Date	No
CAH	Personal Information redacted by the USI							RO	AOB	ROUTINE	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	URGENT	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	13/09/2013	55	EM
CAH								RO	GURO	URGENT	13/09/2013	55	EM
CAH								RO	GURO	URGENT	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	13/09/2013	55	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	ROUTINE	15/09/2013	52	EM
CAH								RO	GURO	URGENT	15/09/2013	52	EM
CAH								URO	GURO	ROUTINE	15/09/2013	52	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	AOB	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	URGENT	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	URGENT	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	17/09/2013	51	EM
CAH								URO	GURO	ROUTINE	18/09/2013	50	EM
CAH								URO	GURO	ROUTINE	18/09/2013	50	EM
CAH								URO	GURO	ROUTINE	18/09/2013	50	EM
CAH								URO	GURO	ROUTINE	18/09/2013	50	EM

CAH	Personal Information redacted by the USI				URO	GURO	ROUTINE	19/09/2013	49	EM. MO
CAH					URO	GURO	URGENT	19/09/2013	49	EM. MO
CAH					URO	AOB	ROUTINE	20/09/2013	48	EM. MO

CAH	Personal Information redacted by the USI				URO	AOB	ROUTINE	26/09/2013	42	e 1
CAH					URO	AOB	ROUTINE	27/09/2013	41	e 1
CAH					URO	AOB	URGENT	30/09/2013	38	e 1
CAH					URO	GURO	ROUTINE	02/10/2013	36	e 1
CAH					URO	AOB	ROUTINE	02/10/2013	35	e 1

CAH	Personal Information redacted by the USI				URO	GURO	URGENT
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	URGENT
CAH					URO	GURO	URGENT
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	URGENT
CAH					URO	GURO	URGENT
CAH					URO	GURO	ROUTINE
CAH					URO	GURO	ROUTINE

[illegible]

CAH	Personal Information redacted by the USI	URO	GURO	ROUTINE	17/10/2013	21	ema
CAH		URO	GURO	URGENT	17/10/2013	21	ema
CAH		URO	AOB	URGENT	17/10/2013	21	ema
CAH		URO	GURO	URGENT	17/10/2013	21	ema
CAH		URO	GURO	ROUTINE	17/10/2013	21	ema
CAH		URO	GURO	URGENT	17/10/2013	21	ema



CAH	Personal Information redacted by the USI				URO	GURO	ROUTINE	17/10/2013	21	en
CAH					URO	GURO	ROUTINE	17/10/2013	21	err
CAH					URO	GURO	ROUTINE	17/10/2013	21	err
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em
CAH					URO	GURO	ROUTINE	17/10/2013	21	em

Leanne

Leanne Browne  
Acting Supervisor  
Referral & Booking Centre  
Ramone Building  
Craigavon Area Hospital

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

## Mackle, Eamon

---

**From:** Corrigan, Martina  
**Sent:** 05 September 2013 07:24  
**To:** Burns, Deborah; Mackle, Eamon  
**Subject:** RE: CHARTS TO CONSULTANT'S HOME

Debbie

I will speak with him again today and then let Robin follow up on this?

One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for, I will let you both know how I get on

Thanks

Martina

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

From: Burns, Deborah  
Sent: 05 September 2013 06:38  
To: Mackle, Eamon; Corrigan, Martina  
Subject: FW: CHARTS TO CONSULTANT'S HOME

? We need this addressed  
D

Debbie Burns  
Interim Director of Acute Services  
SHSCT  
Tel: Personal Information redacted by the USI  
Email: Personal Information redacted by the USI

From: Brown, Robin  
Sent: 04 September 2013 21:17  
To: Burns, Deborah  
Subject: RE: CHARTS TO CONSULTANT'S HOME

I will try to get to meet Aidan week after next. I am Sow next week.

Robin

From: Burns, Deborah  
Sent: 03 September 2013 15:11  
To: Corrigan, Martina; Mackle, Eamon; Brown, Robin  
Subject: FW: CHARTS TO CONSULTANT'S HOME

I know you have tried before – this is a governance issue – Robin can you discuss again with Mr O'Brien - or do we need to escalate?

D

Debbie Burns

Interim Director of Acute Services

SHSCT

Tel: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

From: Carroll, Anita

Sent: 03 September 2013 10:11

To: Burns, Deborah

Cc: Corrigan, Martina; Forde, Helen

Subject: FW: CHARTS TO CONSULTANT'S HOME

Debbie how do you think its best to deal with this , should the HOS discuss with mr o brien can they arrange to get charts back or do we need to discuss at governance as part of the problem is they aren't even tracked out Happy to discuss Anita

From: Forde, Helen

Sent: 27 August 2013 18:15

To: Trouton, Heather; Corrigan, Martina

Cc: Carroll, Anita

Subject: FW: CHARTS TO CONSULTANT'S HOME

Please see below – Mr O'Brien continues to have charts at home. This is causing problems for records as per Pamela's e-mail. What can be done to resolve this?

Helen Forde

Head of Health Records

Operations Office, Admin Floor, CAH

Direct Line : [Personal Information redacted by the USI]

Mobile : [Personal Information redacted by the USI]

From: Lawson, Pamela

Sent: 27 August 2013 11:06

To: Forde, Helen

Subject: CHARTS TO CONSULTANT'S HOME

Helen – can you please raise this issue with the appropriate person? I have been submitting IR1 forms regarding this but the problem is getting worse instead of better.

We are wasting a lot of valuable time searching for charts that are not tracked properly and we are falling behind. Last week was particularly bad and we are short-staffed which doesn't help matters.

Please see list of IR1 forms to date

27/08/13	AOB	3 charts
23/08/13	AOB	2 charts
22/08/13	AOB	3 charts
14/06/13	AOB	1 chart
31/05/13	AOB	2 charts
20/05/13	AOB	1 chart
16/05/13	AOB	1 chart

08/05/13      AOB      1 chart

Many thanks  
Pamela

Pamela Lawson  
Health Records Manager (HRM)  
CAH, BBPC and STH  
Tel [REDACTED]  
Mob [REDACTED]

Personal Information  
redacted by the USI

Personal Information  
redacted by the USI

## Mackle, Eamon

---

**From:** Brown, Robin  
**Sent:** 22 September 2013 12:40  
**To:** Corrigan, Martina  
**Cc:** Mackle, Eamon; Trouton, Heather; Nelson, Amie  
**Subject:** RE: Datix Incident Report Number W19270

Personal Information redacted by the USI

Debbie emailed me about this a couple of weeks before I went off [Personal Information redacted by the USI].

I texted Aidan but he didn't reply

Last time there was a problem like this I drove over to CAH and waited for him to finish a clinic in Thorndale

It did look a bit like an ambush and might have been a bit counter-productive

I think it might be better if I could catch him at the beginning or end of an MDM.

I have an OPD appt on Tuesday morning - What does Aidan do on Tuesdays - Is that his list day?

Irrelevant Information Redacted by the USI

What about the Thursday lunchtime meetings?

I don't know if they are still happening [Irrelevant Information Redacted by the USI]

Robin

-----Original Message-----

From: Corrigan, Martina

Sent: 21 September 2013 22:05

To: Brown, Robin

Cc: Mackle, Eamon

Subject: FW: Datix Incident Report Number [Personal Information redacted by the USI]

Robin

Personal Information redacted by the USI

Below is another DATIX received in respect to charts being in Aidan's home. This was the second one last week and I am receiving at least one of these each week as Health Records are continuing to spend time looking for charts that they discover are in Aidan's house.

I would be grateful if you could speak with him as it has now been escalated to Debbie.

Many thanks

Martina

Martina Corrigan

Head of ENT, Urology and Outpatients

Southern Health and Social Care Trust

Telephone: [Personal Information redacted by the USI] (Direct Dial)

Mobile: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]

-----Original Message-----

From: Nelson, Amie

Sent: 19 September 2013 16:37

To: Corrigan, Martina

Subject: FW: Datix Incident Report Number [Personal Information redacted by the USI]

-----Original Message-----

From: datix [Personal Information redacted by the USI] [[mailto:\[Personal Information redacted by the USI\]](#)]

Sent: 19 September 2013 15:52

To: Nelson, Amie

Subject: Datix Incident Report Number [Personal Information redacted by the USI]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [Personal Information redacted by the USI]

Description:

chart not found where tracked to. Health Records staff checked all of urology. A lot of Health Records time is wasted looking for these charts that are held in the consultant's home.

Please go to [Personal Information redacted by the USI] to view and approve it.

DRAFT



## CONSULTANT JOB PLAN REVIEW TEMPLATE

### Job Plan Dates

This job plan is effective from: **1<sup>st</sup> July 2011**

Next Job Plan Review Due on/before: **1<sup>st</sup> July 2012**

### Personal details:

Name of doctor: **Mr Aidan O'Brien**

Contract Type:

Directorate/Division & Location: **Urology/ Surgery and Elective Care Division**

**Whole Time**

### On-call rotas only - On-call availability supplement:

Rota Frequency – i.e. Number of doctors on rota: **1 : 3**

Rota Category: **Category A**

*For info:* More frequent than or equal to 1 in 4 = Category A: 8% Category B: 3% of basic salary  
 Less frequent than 1 in 4 or equal to 1 in 8 = Category A: 5% Category B: 2% of basic salary  
 1 in 9 or Less frequent = Category A: 3% Category B: 1% of basic salary

### Summary of Programmed Activities:

Direct Patient Care excluding on-call: **7.31 PA's**

Supporting Professional Activities: **1.50 PA's**

**Specific Roles:**

On-Call Allocation: **Predictable**

**Unpredictable**

PA's

**1.57 PA's**

Any Annualised Activity & Reason

PA's

**Reason:**

Any Additional HCS Responsibilities:

PA's

**Reason:**

Any External Duties:

PA's

**Reason:**

**TOTAL PA's: 10.5 PA's**

## CONSULTANT JOB PLAN REVIEW TEMPLATE

### 1. OBJECTIVES: Refer to Section 3 in Regional Job Planning Guidance.

Objectives should be specific, measurable, achievable, reasonable and time bound. They may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these should be reasonable and agreement should be sought.

#### Service Developments & Objectives

- Service developments and key targets which will impact on PAs

#### Personal Objectives

- Objectives against which PA's will be allocated [both DCC and all SPA's]
- E.g. Activity targets specifying an indicative activity for outpatient clinics, theatre lists.
- E.g. Quality objectives incorporating attainment of standards of quality of care.

#### Team Objectives

- As appropriate to the team job plan e.g. to guarantee to provide a fixed number of clinics or operating lists for the whole team over a year when achievable.

### SUPPORTING RESOURCES

Facilities and resources required for delivery of duties and objectives	
1. Staffing support	
2. Accommodation	
3. Equipment	
4. Any other identified resources	





## CONSULTANT JOB PLAN REVIEW TEMPLATE

### 2. DIRECT CLINICAL CARE (Section 8 in Regional Job Planning Guidance.)

Emergency duties, including work during or arising from on-call, Operating Sessions including preoperative and postoperative care, Ward Rounds, Outpatient activities, Clinical diagnostic work, Other patient treatment, Public health duties, Multidisciplinary meeting about direct patient care, Any administration related to any of the above, including referrals & notes.

### 3. JOB PLAN TEMPLATE

This job plan is subject to review at least once per year by you and your Clinical manager. In the case of a new employee a review of the job plan will take place 3 months after commencement and annually thereafter.

*(If appropriate cut and paste your job plan into this space set out in the following format.)*

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total Hours	Prem
				DCC	SPA	APA	EPA		
Mon	9.00 - 2.00	Week 1 – B'bridge OPC (+ 1 hr return travel)	BPC	2.5				9.00	
		Week 2 – Armagh OPC (+ 1 hr return travel)	ACH						
		Week 3 – SPA	CAH		2.5				
		Week 4 – SPA	CAH						
	2.00 – 6.00	Admin (2 weeks from 4) SPA (2 weeks from 4)	CAH	2.0	2.0				
Tues	9.00 – 1.00	Day Surgery (2 weeks per month)	CAH	2.0				7.00	
		Admin (2 weeks per month)	CAH	2.0					
	2.00 – 5.00	Outpatients clinic	CAH	3.0					
Wed	8.30 - 9.00	Pre op ward round	CAH	0.5				8.50	
	9.00 – 1.00	Theatre	CAH	4.0					
	1.00 – 5.00	Theatre	CAH	4.0					
Thurs	8.30 – 9.30	Radiology meeting	CAH	1.0				7.75	
	9.30 – 12.00	Grand Ward Round	CAH	1.0	1.5				
	12.00 – 1.30	Departmental Meeting	CAH	1.5					
	2.15 – 5.00	MDM	CAH	2.75					
Fri	9.00 – 12.00	Specialist clinic	CAH	3.0				4.00	



## CONSULTANT JOB PLAN REVIEW TEMPLATE

	1.00 – 5.00	OFF	CAH					
<b>TOTAL HOURS:</b>				29.25	6			35.25
<b>TOTAL PROGRAMMED ACTIVITIES:</b>				7.31	1.5			8.81

### 4. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	11.4 hours per week		1.57
<b>TOTAL PA's for ON-CALL:</b>			<b>1.57</b>

\*Please refer to Medical Staffing / Trust Guidance for method for calculating on-call so that prospective cover is included – this means cover will need to be provided for absent colleagues on annual leave and study leave.

<b>On-call availability Supplement</b>	
On-call Category	A
Agreed on-call Rota Frequency	1:3 Prospective
On-Call Supplement	8%

### 5. SUPPORTING PROFESSIONAL ACTIVITIES (Section 9 in Regional Guidance)

- It is expected that PA's including SPA's will normally take place at a consultant's principal place of work if space, equipment and protected time are provided. Alternatives arrangements can be agreed with the Clinical Director.
- The Trust would expect that all consultants have a minimum allocation of 1.5 for supporting professional activities for maintaining a professional career. Where additional SPA's are undertaken to varying degrees by consultants these should be programmed into the Job Plan and agreed with the Clinical Manager.

Please provide full details on SPA responsibilities



## CONSULTANT JOB PLAN REVIEW TEMPLATE

- 6. EXTERNAL DUTIES** – Please refer to Trust Guidance on approval for External Duties. An External Duties approval form must be completed on an annual basis.

Please provide full details on External Duties, time frames, funding arrangements etc

--

- 7. Additional HPSS Responsibilities** – Please refer to Trust Guidance on approval of these duties. An HPSS Additional Responsibilities approval form must be completed on an annual basis.

Please provide full details on these duties, time frames, funding etc

--

### 8. PRIVATE PRACTICE & FEE PAYING SERVICES

Type	Please Tick:
You are not currently undertaking regular private practice however if this changes during the year you have agreed to inform the clinical director before any changes are made to your work-plan.	<input type="checkbox"/>
You are currently undertaking regular private practice as outlined in your job plan and will undertake an additional PA if offered, up to a maximum of 11 PA's per week, as detailed in the terms and conditions of service.	<input type="checkbox"/>
You are currently undertaking ad hoc private practice with the Trust and it is agreed that this practice will continue, provided it does not affect the efficiency of multidisciplinary team working. You have agreed to ensure that if any of your agreed NHS activity is displaced due to private practice you will carry out in NHS activity at an agreed later stage.	<input type="checkbox"/>

### 9. AGREEMENT:

<b>Signed: Doctor</b>		<b>Signed: Clinical Manager</b>	
Date:		Date:	
<b>Signed: Associate Medical Director &amp; Director of Service</b>			
Date:			

To be completed and forwarded to:

- The Medical Staffing Manager, Medical HR, Ground Floor, Trust HQ, CAH