Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Mr. Robin Brown
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

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.

The Inquiry is aware that you have held posts relevant to the Inquiry's 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 details 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 are aware the Trust has already 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 the Trust's 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 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

Issued by the Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 20 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. Robin Brown
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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 10th June 2022.**

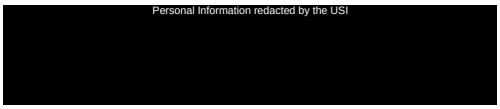
APPLICATION TO VARY OR REVOKE THE NOTICE

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 3rd June 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 29th April 2022

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 20 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"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation 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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

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 Director of Acute Services, Assistant Directors, the Medical Director, Associate Medical 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, if any, 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?

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. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were 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. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was 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 the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, 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. Identify the person/role to whom you were answerable.

26. What, if any role did you have in staff performance reviews?

27. Was your role 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, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

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/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. 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 other 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? As relevant to your role, 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 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 overseeing performance metrics?

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 who were involved when governance concerns having the potential to impact on patient care and safety arose. 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 refer to in order 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 Clinical Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

    (i) The Chief Executive(s);
    (ii) the Medical Director(s);
    (iii) the Director(s) of Acute Services;
    (iv) the Assistant Director(s);
    (v) the Associate Medical Director;
    (vi) the Clinical Lead;
    (vii) the Head of Service;
    (viii) the consultant urologists.

    When answering this question, the Inquiry is interested to understand how you liaised with these individuals 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 (ii) 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 support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 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 was your role and involvement, if any, 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? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

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? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding

concerns and proposed actions. Please provide dates and details of any discussions, including details of 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 comprehensive 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. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were

those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

64. 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 support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

65. 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.

Learning

66. 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.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

68. 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?

69. 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.

70. 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 utilised 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?

71. 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?

72. 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

UROLOGY SERVICES INQUIRY

Note: Two addenda to this statement were received by the Inquiry on 21 September 2023 at WIT-100409 to WIT-100418 and 31 October 2023 at WIT-103533 to WIT-103589. Annotated by the Urology Services Inquiry.

USI Ref: Notice 20 of 2022

Date of Notice: 29 April 2022

Witness Statement of: Mr Robert James Brown (Known as Robin Brown)

I, Robin Brown, will say as follows:-

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.

1.1 I was a Clinical Director (CD) for Surgery and Elective care (SEC) in the SHSCT from 02.01.2008 to 31.03.2016. Please see paragraphs 6.2-5 for full details of my changing role. In my role as CD, my responsibilities included operational management, performance, governance, recruitment, job-planning, appraisal, medical education and more – please see **Appendix 2**. In the beginning I was responsible for surgery and all surgical specialties across the Trust but, as I was located in Daisy Hill Hospital (DHH), this proved to be impractical, and my managerial influence on the Craigavon site was very limited. The Trust appointed a second CD, Ms Samantha Sloan, on the Craigavon site, with responsibilities including Urology, on 01.09.2010. I therefore had managerial responsibility for Urology from 01.01.2008 until 01.09.2010. Please see paragraphs 6.2-5 and **Appendices 2-4.**

1.2 My job was predominantly clinical management of my own patients. I was contracted for 12 PAs (professional activities). A PA is equivalent to 4 hours. I had an allocation of 1 PA, or 1/12 of my time, for management. Considering my location in Daisy Hill Hospital, my limited time for management, and all the elements of my role, I was only able to address urgent issues, especially staffing and recruitment and to address those issues of governance specifically brought to my attention. I didn't have oversight of governance but was only able to address concerns brought to my attention.

1.3 There were two occasions when I had significant managerial involvement in the Urology service. The first was during the Regional Review of Adult Urology Services 2008/2009. Please see paragraphs 8.2 & 13.1 and **Appendices 5-10**.The second was in 2013 when I assisted Michael Young to complete the job-plans for the Urology team. Please see paragraph 53.1 and **Appendices 19-21.**

1.4 There were two occasions when I addressed issues relating to Aidan O'Brien. The first was when I carried out an MHPS investigation in 2011. Please see paragraphs 24.2 & 55.2 and **Appendix 12.** The second was when I met with him in 2013 to address concerns about late triage and taking patients' charts home. Please see paragraphs 24.3 & 55.3 and **Appendix 13.**

1.5 There are no other occasions, that I can recall, when I had significant engagement in the Urology department.

1.6 I retired from clinical practice and my role as a CD on 31.03.2016. Please see paragraph 5.1.

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"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

Urology Services Inquiry

2.1 The following Appendices are appended and referenced in the relevant questions. The following Appendices are located in S21 No 20 of 2022, Attachments

- Appendix 1. JOB DESCRIPTION Consultant Surgeon DHH 1991
- Appendix 2. JOB DESCRIPTION Clinical Director General Surgery
- Appendix 3. Email 17.08. 2010 - S. Sloan appointed CD Urology
- Appendix 4. CD Post acceptance 12.04.2011
- Appendix 5. Team South Urology Steering Groups
- Appendix 6. PID Urology Review 27.04.10
- Appendix 7. Regional Review of Adult Urology Services 2009
- Appendix 8. Notes of Urology meeting to discuss MDT Meeting 10.10. 08
- Appendix 9. Team South Urology Steering Groups
- Appendix 10. Team South Agenda - 13 May 2010
- Appendix 11. CD Surgical Division JD June 2010
- Appendix 12. FINAL Disciplinary Report – A. O'BRIEN JUNE 2011
- Appendix 13. Email Trail, 21.11.2013 to 04.12.2013, re Missing Triage
- Appendix 14. Urology MDM Minutes 22.04.10
- Appendix 15. Urology MDM Minutes 03.06.10
- Appendix 16. FINAL JOB PLAN TEMPLATE 25.03.09
- Appendix 17. Introduction of Zircadian Job-Planning
- Appendix 18. Email Re. Incident Form Training
- Appendix 19. Emails Re. Urology Job-Plans, 17.12.2012 to 05.03.2013
- Appendix 20. Email from Malcolm Clegg (HR), 11.02.2013, re Urology draft job plans
- Appendix 21. Email Re Urology team Job Plans - meeting
- Appendix 22. Job description for Consultant Lead for Appraisal and Revalidation
- Appendix 23. Email relating to Triage Process
- Appendix 24. Triage Process
- Appendix 25. Consultants Associate Specialists Staff Grades Training Flyer
- Appendix 26. Mr Robin Brown Training Passport 2021
- Appendix 27. Mr Robin Brown M&M Cert 2021
- Appendix 28. Guidelines for Handling Concerns about Doctors
- Appendix 29. FW Urology Steering Group Meeting - 13th May 2010
- Appendix 30. SEC Agenda 19.08.09

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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

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

4.1 Qualifications:

M.B, B.Ch. The Queen's University of Belfast (QUB) - July 1979.
FRCS. Fellow of the Royal College of Surgeons of Edinburgh - May 1983.
MD. Doctor of Medicine, QUB - December 1989.

4.2 Occupational history:

01.08.79 - 31.07.80 - Junior House Officer. Royal Victoria Hospital, Belfast.
01.08.80 - 31.07.81 - Joint Appointment: QUB Department of Anatomy and Casualty Officer Ulster Hospital, Dundonald.
01.08.81 - 31.10.81 - Senior House Officer, Orthopaedics, Musgrave Park Hospital, Belfast.
01.11.81 - 31.01.82 - Senior House Officer, Fractures wards, Belfast City Hospital.
01.02.82 - 31.07.82 - Senior House Officer, General Surgery, Royal Victoria Hospital.
01.08.82 - 31.07.83 - Registrar, General Surgery, Downe Hospital, Downpatrick.
01.08.83 - 31.07.84 - Registrar, General Surgery, Belfast City Hospital.
01.08.84 - 31.07.86 - Tutor/Registrar, Department of Surgery, Q.U.B.

01.08.86 - 31.10.86 - Registrar, Plastic Surgery, Ulster Hospital, Dundonald.
01.11.86 - 31.01.87 - Registrar, Neurosurgery, Royal Victoria Hospital.
01.02.87 - 31.07.87 - Registrar, Fracture unit, Ulster Hospital, Dundonald.
01.08.87 - 31.07.88 - Registrar, Vascular Surgery, Royal Victoria Hospital.
01.08.88 - 31.07.89 - Senior Registrar, General Surgery, Ulster Hospital, Dundonald.
01.08.89 - 31.01.90 - Senior Registrar, Thoracic Surgery, Royal Victoria Hospital.
01.02.90 - 31.01.91 - Senior Registrar, General Surgery, Craigavon Area Hospital.
01.02.91 - 31.07.91 - Senior Registrar, Department of Urology, Victoria Infirmary, Glasgow.
01.08.91 - 31.12.07 - Consultant Surgeon, Daisy Hill 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.

5.1 **Clinical appointments:**

January 2008 – March 2016. Consultant General Surgeon - SHSCT. There was no new job description other than the one which I was given in 1991, when I was appointed to DHH, Newry and Mourne Trust (N&M). **Appendix 1.** The job description included inpatient and outpatient services to the surgical department and the Accident and Emergency department (A&E). It also included on-call emergency work, teaching and audit. The duties and responsibilities of the job constantly evolved over my career both in N&M, and subsequently in SHSCT. The A&E became a separate department and I developed an interest in Enteral Feeding (artificial tube feeding) and Medical Education. I had a special interest in Urology, but as I was not a fully trained Urologist, I was only able to provide diagnostic services and basic surgeries such as resection of small bladder tumours and circumcisions. The general principles of the job-description remained relevant, but some of the detail changed over time. It wasn't the practice to issue a new job-description to reflect every change in clinical profile.

April 2016 – September 2016 - Temporary General Surgeon DHH. This was really a continuation of my role as a consultant surgeon until a replacement was appointed. There was no new job description.

- October 2016 – March 2017. Temporary Urologist Craigavon Area Hospital (CAH). I just continued to provide the same basic urological services that I had delivered in DHH, but in CAH. There was no new job-description.

5.2 **Management appointments:**

- 2003 – December 2007. Clinical Director (CD) for Surgery, DHH, N&M. I no longer have the job description and the SHSCT email archive does not go back that far. I was responsible for the Surgical and Anaesthetic departments in DHH. My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and education.

- January 2008 – August 2010. Lead Clinician, but *de facto* CD for Surgery and Elective Care (including Urology) in SHSCT. I had a CD contract whilst I was CD in N&M, (2003-2007). I was unsuccessful in my application for the Associate Medical Director (AMD) post in the new SHSCT so, as the only other candidate, Patrick Loughran, Medical Director (MD), permitted me to continue as a CD, but without interview or job description. It was my view, and I believe the view of the Trust, that I was the CD for SEC. My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and education etc., over six clinical departments, General Surgery in DHH, and five departments in CAH. These five departments were General Surgery, Urology, ENT, Trauma & Orthopaedics and Ophthalmology. I would not be able to name all the individual clinicians in all of these departments, especially because there were numerous changes with new appointments, resignations and retirements. Precise records would be held by the Trust. Considering my location and limited availability, most of my CD activity was in DHH. Please see paragraph 1.2.

- September 2010 – February 2011. Lead Clinician, but *de facto* CD for Surgery and Elective Care, (not including Urology) SHSCT. Ms Samantha Sloan was appointed

CD for Urology on 01.09.2010 - **Appendix 3.** This was a continuation of my CD role but now only for general surgery in DHH and ENT & Ophthalmology in CAH.

- March 2011 – March 2016. CD for General surgery DHH and ENT in CAH (not including Urology). I had a job description for this post - **Appendices 2&4.** The job description suggests that I had responsibilities only for DHH but it was my understanding that it included ENT & Ophthalmology in CAH - **Appendix 3**. In my view the job-description was accurate and comprehensive. I don't think it was intended to be prescriptive as stated in the final sentence "*It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work"*

5.3 **Temporary non-clinical appointments since retirement:**

- April 2017 – June 2021. Undergraduate Lead for Surgery DHH. My role involved teaching medical students in DHH and occasionally in CAH and QUB. There was no job-description.

- July 2018 – Present. Lead Consultant for Appraisal and Revalidation SHSCT. I have a job-description - Document **22,** which reflects my roles and responsibilities fairly well. My duties predominantly involve quality assurance of appraisals and assisting doctors to prepare for revalidation.

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.

6.1. August 1991 - 2003. **Consultant General Surgeon DHH, N&M.** I reported to Mr Geoffrey Blake, (CD) and Dr Patrick Loughran, (MD). **Appendix 1.** My duties included delivery of emergency and elective surgical services to DHH and Kilkeel hospitals. These duties included outpatient clinics, inpatient elective surgery, inpatient emergency surgery, on-call emergency cover, patient administration, teaching and training. I had no management responsibility.

6.2. 2003 - December 2007. **Consultant General Surgeon and CD for Surgery and Anaesthetics, DHH, N&M.** I had managerial responsibility for the surgical and anaesthetic departments in DHH only. I reported to Dr Patrick Loughran (MD), **Appendix 2.** My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and education.

6.3. January 2008 – August 2010. **Lead Clinician**, but *de facto* CD, for SEC (including Urology), SHSCT. I reported to Eamon Mackle, AMD. I had managerial responsibility for the general surgical departments in DHH and CAH, as well as all surgical specialties in CAH, including Urology, Trauma & Orthopaedics, ENT and Ophthalmology. My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and education. By way of explanation I had a CD contract whilst I was CD in N&M (2003-2007). I was unsuccessful in my application for the AMD post so, as the only other candidate, I was permitted by Patrick Loughran, MD, to continue as a CD but without interview or job description. I was only served with a job-description in February 2011, after the CD role was divided up on 01.09.2010, and I was no longer responsible for Urology. I can't remember why it took some weeks for me to return the acceptance, **Appendices 2&4.** I would not be able to name all the individual clinicians in all of the departments mentioned above, especially because there were numerous changes with new appointments, resignations and retirements. Precise records would be held by the Trust.

6.4. September 2010 – February 2011. **Lead Clinician**, but *de facto* CD, for General Surgery DHH and ENT in CAH, (not including Urology) SHSCT. I worked with Samantha Sloan, and Sam Hall, (CD for Urology). Ms Samantha Sloan was appointed CD for Urology on 01.09.2010, **Appendix 3,** and was replaced by Mr Sam Hall on 12.12.2011. I also worked with Simon Gibson and, from April 2010, Heather Trouton, Assistant Director (AD).). I don't know exactly when Heather Trouton replaced Simon Gibson but it was around the middle to end of April 2010 because I remember that it was at the time of the Icelandic, volcanic ash cloud. I reported to Eamon Mackle, (AMD). My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and medical education.

6.5. March 2011 – March 2016. **Clinical Director** for General surgery DHH and ENT in CAH (not including Urology). I worked alongside Samantha Sloan and later Sam Hall,

(CD for Urology). Ms Samantha Sloan was appointed CD for Urology on 01.09.2010 and was replaced by Mr Sam Hall on 12.12.2011. I also worked with Simon Gibson (AD) and, from April 2020, Heather Trouton (AD). I reported to Eamon Mackle (AMD). **Appendix 2.** My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and education.

6.6. April 2016 – September 2016. **Temporary General Surgeon** DHH.I reported to the lead Consultant surgeon in DHH, Mr David Gilpin. I do not know who the CDs were at that time. I had no management responsibility.

6.7. October 2016 – March 2017. **Temporary Urological Surgeon** CAH. I was appointed to this short temporary post to help clear some of the Urology waiting list. My urological skills were limited. I was not a trained urologist so I did not have the skills to perform major urological surgeries such as endoscopic procedures on the ureters. I was however able to assess patients at outpatient clinics and decide if I could help them, or if they needed to be handed over to a urologist. I was able to deal with a number of patients with benign conditions, such as diseases of the genitals and I was able to perform cystoscopy (visualisation of the bladder with a telescope or camera). I could also manage some malignancies such as testicular cancer and small bladder cancers. I reported to Michael Young, Lead Urologist. I had no management responsibility.

6.8. April 2017 – June 2021. **Undergraduate Lead** for Surgery DHH. This is a role which I held as part of my General Surgery job, probably from about 2001, but then continued as my sole job in April 2017. My responsibility was the delivery of medical education to undergraduate surgical students form QUB. I reported to Dr Mae McConnell, Undergraduate Sub-dean.

6.9. July 2018 – Present. **Lead Consultant for Appraisal and Revalidation** SHSCT. My role is to support the appraisal process and help doctors to prepare for revalidation. Appraisal is an opportunity for an individual doctor to reflect and discuss, confidentially, with a peer, their achievements and challenges over the previous year, to assess progress against agreed personal objectives and to agree new personal objectives for the incoming year. In supporting the appraisal process, I quality assure yearly appraisals, engage in appraisal training, create new appraisal documents and keep abreast of new

developments in appraisal and revalidation. I report to Dr Damian Scullion Deputy Medical Director for Appraisal and Revalidation.

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

7.1. I had clinical managerial responsibility for Urology from 01.01.08 – 31.08.2010 as CD for SEC. I worked with Simon Gibson, AD, Heather Trouton, AD, and Michael Young, Lead Urologist. I reported to Eamon Mackle, AMD. My responsibilities included operational management, performance, recruitment, governance, job-planning, appraisal and Medical education. In terms of actual engagement, my management reach into CAH was very limited, as set out in paragraph 1.2. We were all engaged in governance but, in my role as a CD, this really only amounted to addressing issues brought to my attention – please see paragraphs 24.2 and 24.3.

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 Director of Acute Services, Assistant Directors, the Medical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

8.1. Given my location in DHH, most of my management activity related to DHH matters. I may have had responsibility for performance and governance in the Urology department in CAH, but given my remote location in DHH and having only less than one twelfth of my time allocated to management, I had very little engagement in the Urology unit in CAH except for particular circumstances listed below. Please see paragraphs 1.2, 8.2, 8.3, 24.2, 24.3 and 53.1.

8.2. I was included in the Regional Review of Adult Urology Services 2008/9, but only at a local level and most of the work was done by others, particularly Michael Young, Simon Gibson and Heather Trouton. **Appendices 5-7.** The main negotiations were done at a regional level and involved the urologists across the province. I was not involved in the

regional negotiations. My engagement in the local process was really about determining how the outcome would impact the basic urological service that I provided in DHH.

8.3. I was also informed of, if not very actively engaged in, the establishment of the Multidisciplinary teams for the management of Urological cancers in 2008. **Appendix 8**. This was very much a clinical exercise, facilitated by the Northern Ireland Cancer Network (NICaN), and involved Urologists from around the province. The clinical decisions were made by Urologists, rather than managers, and my main focus was on how it would change my DHH urological practice. I did make one recorded contribution at a local SHSCT meeting, which was that the regional cases could be discussed at the end of the Belfast meeting so that the other Trusts could link in. I believe that that was the plan anyway and I'd not imagine that it resulted from my suggestion at a local meeting.

8.4. I had fairly regular contact with the assistant directors, Simon Gibson and Heather Trouton and the Associate Medical Director, Eamon Mackle, less so with the Head of Urology Service, Martina Corrigan, the Directors of Acute Services, Jim McCall followed by Joy Youart followed by Dr Gillian Rankin, and the Medical Director, Dr Patrick Loughran. I do not know when these posts changed hands. That information would be available from the Trust.

8.5. The Director of Acute Services, Assistant Directors, the Medical Director, Associate Medical Director and Head of Urology Service all had responsibility for governance in the Urology department.

8.6. Governance is part of everyone's responsibility, from the individual doctor to the most senior managers. For my part, this amounted to dealing with issues brought to my attention. More senior managers would have had more oversight of governance.

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, if any, in the establishment of the urology unit in the Southern Trust area.

9.1. I was included in the Regional Review of Adult Urology Services 2008/9, but only at a local level, and most of the work was done by others, particularly Michael Young, Simon Gibson and Heather Trouton. **Appendices 5-7.** I was not involved in the regional negotiations. Even at a local level, I would not have had sufficient knowledge of the Urological department, over and above Michael Young's knowledge and experience, to significantly influence the decisions. It is worth noting that the Urology unit in CAH was established in 1993 by Aidan O'Brien and there were 3 urologists in the unit at the time of the Regional Review.

10. What, if any, performance indicators were used within the urology unit at its inception?

10.1. I don't know the answer to this question. Performance indicators are not familiar to me. Simon Gibson or Heather Trouton, (ADs), may be able to provide you with an answer.

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?

11.1. Whilst I am not aware that the actual protocol was sent to me or the Urology consultants, my understanding from my experience was that we were all familiar with the principles in the report, particularly in respect of triage and waiting list management. Our personal secretaries, the Heads of Service and Assistant Directors kept us informed. **Appendices 23 and 24.** The IEAP set out the principles for management of patients waiting for outpatient appointments, diagnostic procedures and elective access. The general principle is that patients are seen or treated in chronological order according to their clinical priority. It also determined that triage should be carried out daily and patient referrals be allocated to three priority groups, Red Flag (suspected cancer, maximum two-week appointment), Urgent and Routine.

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?

12.1 I have no recollection of being involved in monitoring time limits for the Urology service. The non-clinical managers (HOS & AD) handled this sort of information.

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.

13.1. I was on the Steering Group list, **Appendix 9**, for Implementation of "Team South", **Appendix 10**. Heather Trouton issued a Project Initiation Document in April 2010. **Appendix 6**. The first meeting took place on 13.05.10, **Appendix 29**. I was abroad on leave. I have not found any further correspondence relating to that project on my SHSCT email archive. I do not recall being involved in the implementation process. I have no recollection of involvement in a plan to deal with the backlog.

13.II. The Project Initiation Document, **Appendix 6**, lists the people who were on the sub-groups for the various work streams. I am listed on the steering group but not on any of the sub-groups. I do not recall having any significant involvement in this project. I don't know how it was implemented, reviewed or its effectiveness assessed. I think Heather Trouton or Michael Young would be able to answer this question.

13.III. I was on the steering group, but I don't recall being at any meetings or engaging in the project. The first meeting took place on 13.05.10, **Appendix 29**. I was abroad on leave. It was soon after that when Samantha Sloan was appointed to the post of CD in CAH with responsibility for Urology. I don't know if Samantha replaced me on that group but I have not found any further correspondence relating to that project on my SHSCT email archive.

13.IV. I do not know if the plan achieved its aims. I think Heather Trouton or Michael Young would be able to answer this question.

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.

14.1. I do not know the answer to this question. The Risk Register was managed by non-clinical managers. I think Heather Trouton (AD) would be able to answer this question. I think this question would be best addressed to Michael Young and Heather Trouton.

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?

15.1. I do not know the answer to this question. I do not recall being involved in the Implementation process. Please see answers to Question 13. I think this question would be best addressed to Michael Young and Heather Trouton.

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?

16.1. The Urology unit first opened in 1993 with a single-handed urologist, Aidan O'Brien. From memory I think the consultant team had increased to three when the Regional Review Implementation Plan was initiated. I understand that the number of consultants

has increased to six or seven (I'm not sure exactly) since then and there are many more middle grade and junior staff. The Trust would have information on the dates of appointment of new staff and dates when others left. I do know, from my own personal experience of referring patients to the unit, and later in 2016/7 of working in the unit, that all the consultants had long waiting lists for outpatient appointments and elective surgery. I do not know if these waiting lists were longer than waiting lists in other urology units across the province. I would not have sufficient knowledge of the staffing and throughput of the Urology department to say whether the long waiting lists were due to inadequate staffing or not.

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.

17.1. From about 1995 I became aware that the Urology service had long waiting times for outpatient and inpatient services. I knew about the long waiting times because I referred patients to the service. I do not know if this was due to staffing or demand. I do not know how, or if, this changed over time as more staff were recruited or if waiting times were significantly different to other urological units in the region. I was not involved in the recruitment process in the Urology department. I think Michael Young or Heather Trouton would be able to answer this question.

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?

18.1. The Trust would have records of the appointments, resignations and retirements of staff in the unit. I do not know if there were posts that were vacant for significant periods. Michael Young, Heather Trouton and Simon Gibson would have this knowledge.

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

19.1. In my view, practically every department in the HSC is under-resourced and understaffed. I do not know if the stresses felt in Urology were greater than other specialties. I do not know if there were staffing problems and, if there were, whether they impacted upon management and governance. I have had minimal, managerial involvement in the Urology unit for nearly 12 years, so I am not very familiar with these issues.

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

20.1. I had clinical engagement with the Urology service from 1993 to 2017. I provided a basic, and mainly diagnostic, urological service in DHH and I referred a lot of patients to the CAH Urology department. I observed the department develop from a single-handed consultant (Aidan O'Brien) to a team of six or seven consultants (I'm not sure exactly) and a complement of junior staff and trainees. During the period from 2008-2010 when I was CD, I think that the number of consultants increased to three. I know that there was Aidan O'Brien and Michael Young, but I am not completely sure if there was a third or of the name. There may have been other staff who were appointed resigned or replaced during my tenure, but I have no accurate recollection of precisely when staff came or left. The Trust could provide information on dates of appointments and resignations. Again I think Michael Young (Lead Urologist), Martina Corrigan (HOS) or Heather Trouton (AD) would be able to provide information on staffing.

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

21.1. Governance is part of the role of any clinical manager. Clinical managers include the Clinical Director, Associate Medical Director, Medical Director and Director of Acute Services. The CD's role was mainly dealing with high, and often immediate priority, issues such as staffing, recruitment, rotas, timetables etc. Governance was part of it, but I would not have had in-depth knowledge, or total overview, of all the governance arrangements and issues in all of the six departments for which I had responsibility. These six

departments were General Surgery in DHH, General Surgery CAH, Urology CAH, ENT CAH, Orthopaedics CAH and Ophthalmology CAH. Please see paragraph 1.2. I was CD for SEC (Including Urology) for 2 years and 9 months from 01.01.2008 to 31.08.2010 and CD for DHH (not including Urology) from 01.09.1010 to 31/03/2016. During that time my contribution to governance in Urology was mostly reactive, in that I addressed issues brought to my attention. Please see paragraphs 24.2 and 24.3.

22. Explain your understanding as to how the urology unit and urology services were 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. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1 The Urology Service was supported by the Head of Service, Martina Corrigan who reported to Simon Gibson (AD) followed by Heather Trouton (AD).There were many other non-clinical staff who worked with Martina, Simon and Heather but I am not able to accurately recall names and titles. I think that Martina Corrigan, Simon Gibson and Heather Trouton would be able to supply this information. There were, for example, operational support leads, cancer trackers and booking centre staff. I was based in DHH and virtually all the support services and non-clinical managers were located in CAH.

23. Do you know if there was 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?

23.1 To my knowledge each consultant had their own secretary. The Head of Service would have worked with the team and was not allocated to a particular consultant. I do not know how administrative workload was monitored. I would suggest that Martina Corrigan (HOS) or Heather Trouton (AD) could answer this question.

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

24.1. There were two occasions when concerns were raised with me. On both of these occasions I wasn't CD for Urology, though I think that we probably all worked together and didn't apply rigid boundaries. In the first instance, as set out in paragraph 24.2, the CD was Ms Samantha Sloan. In the second instance, as set out in paragraph 24.3, the CD was Mr Sam Hall.

24.2. The first was in respect of inappropriate disposal of chart material by Mr Aidan O'Brien. I was asked by Zoe Parks (HR) to carry out an investigation. I had training in MHPS investigations delivered by the National Clinical Assessment Service (NCAS) on 27.02.2008. I had carried out one previous investigation and assisted in a second. The role of the case investigator is to investigate the concern, produce a report, and forward it to the case manager. The role of the case investigator does not include deciding when to initiate an investigation or to decide what action should be taken as a result of the investigation. The report would have been forwarded to the case manager, Eamon Mackle, for information/action. **Appendix 12**. The case investigator takes no further part in the process. The case manager determines the outcome, and in this case I understand that it was an informal warning as I had suggested at the end of my report.

24.3 On a second occasion, in June or July 2013, Heather Trouton (AD) asked me to speak to Mr O'Brien regarding his practice of taking patient's charts home. I met him informally at the end of a clinic in the Outpatient department of CAH in June or July. I advised him that the practice was inappropriate as charts may be needed for other services. This was a verbal exchange, there is no written record. To my recollection he accepted that the practice was not appropriate. I spoke with him again in November 2013, by telephone, in relation to the same issue and also regarding missing triage. Again this was a verbal exchange, and whist there is no written record, it is mentioned in the email trail, **Appendix 13.** This email trail documents the efforts of Heather Trouton, Martina Corrigan, Michael Young, myself and others to address the issue of missing triage. I have removed the list of patients' names from the original email. The outcome of that exchange of emails was that Aidan O'Brien advised that he would catch up. *"I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion."* Michael Young also agreed that he and his colleagues in the Urology Unit would assist with the backlog.

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. Identify the person/role to whom you were answerable.

25.1. Day to day clinical management would have been carried out by the lead clinician, Michael Young, and any other team member to whom they delegated tasks such as MDM lead. During my tenure, Michael Young would have reported to me or Eamon Mackle (AMD). I use the term "reported" to describe lines of communication rather than the exchange of actual reports. I do not recall any concerns raised by Michael Young. I would have reported to Eamon Mackle. Non-clinical management would have been the responsibility of the Head of Service (Martina Corrigan) reporting to the Assistant Director (Simon Gibson and Heather Trouton).

26. What, if any role did you have in staff performance reviews?

26.1. In my role as a CD, I was not involved in any staff performance reviews. I don't know if anyone did performance reviews then or at any time since then.

27. Was your role 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, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

27.1. I did not have a performance review of my CD role. I had yearly appraisal by a peer doctor as is normal practice for appraisal and revalidation. Appraisal is a confidential exchange between the appraisee and a suitably trained appraiser. Appraisal is not performance or governance management but an opportunity for an individual doctor to reflect and discuss, confidentially with a peer, their achievements and challenges over the previous year, to assess progress against agreed personal objectives and to agree new personal objectives for the incoming year. I don't think that I would have included any information on my management role in my appraisal. I have no documents relating to performance review or appraisal of my CD 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.

28.1. In terms of management responsibility I was only able to address those issues brought to my attention, as set out in paragraph 1.2. In the case of Urology, the issues that I can recall are described in 8.2, 13.1, 24.2, 24.3 and 53.1. Given my location in DHH I wasn't in position to engage in regular management meetings with the urologists.

28.2. Most of my engagement with the Urology team was clinical, i.e. discussion in respect of patient management. I managed a basic and predominantly diagnostic urological service in DHH, from 1991 to 2016, and I referred many of my patients to the CAH team either by letter or in discussion at weekly virtual Multidisciplinary meetings (MDMs). Details of any patients to be discussed at MDM were sent to the MDM co-ordinator by email in advance. Local GP's referred a lot of urological patients to me. I initiated investigations, treated those that were within my capabilities and referred patients to CAH if they needed procedures or operations that I could not perform in DHH. I was strongly supported by the Urology team. The Urologists were always willing to give advice when I needed it and to readily accept referral of patients who needed specialist care in CAH. MDMs started in April 2009. The meetings were held in CAH, and initially I had some difficulty attending **Appendix14**. A video-link, **Appendix 15**, was set up, but it was sometimes not available either because someone else was using it or it wasn't working. I got a video-link installed on my computer. Also the MDMs often clashed with one of my clinical sessions so I had to arrange cover for part of the list. Even if I was unable to attend, my relatively small number of cases were discussed by the urologists, and I was advised by email as to whether they were taking over the case or advising continued management of the patient in DHH. The chair of MDM rotated, including Aidan O'Brien. It was always chaired very professionally.

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

29.1 In 2008-10 I was involved in the Regional Review of Adult Urology Services. As these meetings were held in CAH, I would only have attended either by travelling to CAH or engaging by way of a video-link and again only if it did not clash with a fixed clinical session. I don't know how many meetings I attended or if all the meetings were minuted. I don't remember how long the meetings lasted.

29.2. The MDM's started on 01.04.2010. I have attached minutes for the first meeting I was available to attend on 03.06.2010. **Appendix 15**.These meetings were held weekly and the content of the meeting was entirely related to the management of patient with proven cancers. My attendance was intermittent at the beginning for a number of reasons, (4 weeks of leave, Surgeon of the Week responsibilities, lack of access to a video-link or clashed with a fixed clinical session) but improved over the years between 2010 and 2016. My remote location in DHH meant that I could not attend in person. I was surgeon of the week for 10-11 weeks a year and for those weeks I was committed to emergency surgery. When I was not the emergency surgeon and on elective duties I still had the difficulty that the MDM sometimes clashed with my flexible cystoscopy (visualisation of the bladder with a telescope) list. I made an arrangement to allocate the less significant cases to the start of the list and scheduled my Associate Specialist colleague to start the list. The important thing to note is that all my cases were discussed by the Urologists at the MDM. Timely decisions were made and conveyed to me either at the meeting, if I was in attendance, or immediately afterward in the MDM report. The meetings would have lasted about 3 hours.

30. 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.

30.1. During my tenure the AMD was Eamon Mackle, the Head of Service was Martina Corrigan and the Assistant directors were Simon Gibson followed by Heather Trouton. I don't know exactly when Heather Trouton replaced Simon Gibson, as set out in paragraph 6.4. It was my experience that the urologists worked very well together and with me. I was not aware of any difficulties interacting with me or any of the clinical or non-clinical managers. Any management interaction I had with the Urologists, and for which I have

some recollection, was always very professional – please see paragraphs, 24.2, 24.3 and 53.1. I do clearly recall a lot of interaction with the urologists when I was employed as a locum in the urology department from 01.09.2016 to 31.03.2017 and it was always amicable. I saw the urologists interact with each other and with Martina Corrigan, Head of Service, and on all occasions the conversations were very professional.

Governance – generally

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

31.1 The great majority of my interaction with the urologists was clinical, i.e. referring and discussion of patient management, by letter, telephone conversation, or at MDM. Please see paragraphs 28.1 and 29.2. I can't remember having much conversation with junior staff.

31.2 I was CD for Urology from 01.01.2008 to 31.08.2010. My responsibilities included operational management, performance, recruitment, governance, job-planning appraisal and medical education. As outlined in paragraph 1.2, I was unable to have complete managerial oversight of all of these responsibilities in all services in CAH. Apart from the issues already outlined in my answers to question 24, I do not recall any other issues relating to governance in the Urology service.

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

32.1. The Medical Director oversees Clinical Governance. Clinical Governance encompasses a number of processes involving a number of departments, examples are listed in my answer to question 45. As a clinical director, my role was to address, or escalate to my AMD, any issues of clinical governance that were brought to my attention. The clinical and non-clinical managers would all have been involved in the governance arrangements. I was confident in the governance processes that were in place at that time.

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 assurances regarding the quality of services?

33.1. Governance was part of the role of all the clinical and non-clinical managers supported by the Medical Director, the Director of Acute Services and a number of departments in the Trust. Given my remote location, I had very little day to day oversight of governance in the Urology service, when I was CD from 01.01.2008 – 31.08.2010. I was aware that the consultants engaged in the Morbidity and Mortality (M&M) meetings and were subject to yearly appraisal. Other governance processes such as Incident reporting, MDMs and mandatory training were just being developed during my tenure. Governance arrangements have developed considerably since 2010 and continue to do so. Morbidity and mortality processes were in place at inception of the Trust. Incident reporting was introduced in January 2009 **Appendix 18**. I was never involved in reviewing IR1s (Incident Reports). Urology MDM's started on 01.04.2010. Mandatory training was introduced on 24/11/2009. **Appendix 25.** Mandatory training modules are added from time to time. I have appended my most recent training passport as an example, **Appendix 26.**

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

34.1 I did not take any active role in the management of performance metrics in the Urology Service. This data would most likely have been collated by the non-clinical managers, Martina Corrigan (HOS), Simon Gibson and Heather Trouton (AD's)

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?

35.1 I was happy with the systems and processes in place at the time and as described in my answer to Question 45. I did not have oversight of all the governance arrangements in the Urology department. I was only able to address governance issues brought to my attention.

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?

36.1. If an issue of concern was brought to my attention, this would have been done by direct contact from any member of staff or a non-clinical manager. Concerns would have been conveyed by word of mouth, telephone call or email – please see paragraph 24.3 and **Appendix 13,** for example.

36.2. Issues of concern could be raised as complaints, incident reports, significant adverse incidents (SAI) or MHPS investigations. Complaints from patients were dealt with by the complaints department. Complaints from staff could have been made directly to a clinical or non-clinical manager, referred to HR, or raised on an incident report (IR1). IR1s were completed on the Datix site on the Trust Intranet. I was not involved in review of complaints or IR1s (Datix reports) and I am not exactly sure who was, probably Eamon Mackle (AMD) and the AD, Simon Gibson, followed by Heather Trouton. SAIs were instigated at review of IR1s. Again I was not involved in this process. The decision to instigate an MHPS investigation was taken at a very high level of senior management, and I don't know who was on the oversight panel but I do know that it included the Medical Director and someone senior in HR. I would have been asked to do the case investigation either by Zoe Parks in HR or the Medical Director. I was happy that the systems in place at that time were effective. That was simply my view. This was a time of great change and new policies and protocols were being issued very frequently, (please see paragraph 33.1) not just governance, but lots of policies such as antibiotic policy for one. I was happy that the Trust was committed to excellence. It was just my opinion based on the number of new protocols cascading down to us.

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

37.1. Please see Question 45 for a list of the most important governance processes that I am familiar with. All, or most, of these processes have developed since inception of

the Trust in 2007 and continue to be modified and improved. I would not be sufficiently informed to list all the people involved in the development of Trust policies and procedures relating to governance. I would not be able to say who drew up the policies. I wasn't involved in the drawing up of policies. I just referred to them as and when I needed them. I think this question could be answered by someone very senior in the Trust who has an overview of all the governance structures such as the Medical Director.

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

38.1. I wasn't the overall manager of all the governance structures. My role was more reactive than pro-active. I addressed any specific concerns, raised by clinical and non-clinical staff that were brought to my attention. The non-clinical staff were Martina Corrigan (HOS), Simon Gibson followed by Heather Trouton, (ADs).The AMD was Eamon Mackle. As set out at paragraphs 24.2 and 24.3, to my knowledge, these were the only concerns brought to my attention. I was not involved in reviewing complaints, incident reports, SAI's or the findings of any internal investigations. These reports were reviewed by more senior clinical and non-clinical managers. Probably the AMD and AD.

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?

39.1. I was happy with the systems and processes in place at the time and as described in my answer to Question 45. I did not have oversight of all the governance arrangements in the Trust. I dealt with governance issues brought to my attention. I did not have any personal concerns that any issues were not being identified, escalated or addressed – please see paragraph 24.2.

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

40.1. I did not personally identify any issues of concern in the Urology department. I addressed any concerns brought to my attention formally or informally and dealt with them

appropriately as set out at paragraphs 24.2 and 24.3.To my knowledge, these were the only concerns brought to my attention.

40.2. SEC meetings were held in CAH monthly, I think, **Appendix 30**. Risk and governance were on the agenda. I do not recall any specific risk or governance issues relating to Urology being discussed. I think that there were high level risk and governance meetings in the Trust involving people more senior to me, but I would not have knowledge of who attended those meetings. Copies of the Risk Register and Records of Adverse incidents were sent by the Assistant Director. I don't remember any specific issues of concern relating to the Urology Service. The assistant Directors, Simon Gibson and Heather Trouton would be better able to answer this question.

40.3. Minutes of M&M meetings were distributed to all staff on a monthly basis. I do not recall any specific issues of concern relating to the Urology Service. Yearly attendance rates were sent out to every consultant**, Appendix 30**.

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

41.1. Data was collected by non-clinical staff. Martina Corrigan (HOS), Simon Gibson (HOS) or Heather Trouton would be able to answer this question.

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

42.1. The Trust collects a lot of data such as waiting lists and waiting times. Much of this is available to individual consultants. For example we get a yearly report on our attendance record at M&M meetings. These are also called Audit or Patient Safety Meetings. I have appended one of my most recent reports as an example, **Appendix 27**. It has proven to be very challenging to provide consultants with accurate CLIP (Clinician Level Indicator Report) report (Inpatient, day-case and outpatient data), but otherwise I have no concerns about the efficacy of the collected data. I am not sure why CLIP data is not totally accurate, but I think it relates to the complexity of compiling multiple data from multiple sources rather than any inefficiency in the system. Systems are always developing but I should

defer to non-clinical staff to provide detail. The non-clinical staff were Martina Corrigan (HOS), Simon Gibson followed by Heather Trouton, (ADs).

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.

43.1. Performance objectives were set out in the Regional Review of Adult Urological Services, **Appendix 7**, and included in the Trusts Implementation plan **Appendix 6**. I don't recall actively engaging in this process, so I am unable to comment on how well the objectives were set. I can only find evidence of one Urology steering group meeting, held on 13.05.2010, **Appendix 29**. I was on leave and could not attend that meeting. It was about that time that a second CD was appointed on the CAH site, with responsibilities that included urology. I don't recall any involvement in the implementation project. I think Michael Young, Simon Gibson or Heather Trouton could answer this question.

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

44.1 Job-planning had always been in existence since my first appointment in 1991, but it has progressed and developed over time to become more detailed. Initially job-plans remained unchanged for years but over time the job planning cycle became more frequent and job-plans are now reviewed yearly. Job-plans in 2008 were just basic timetables. A formal template for job-plans was issued in 2009, **Appendix 16**, and in November 2012 the Trust invested in a commercial package called Zircadian which facilitated detailed recording of job-plans, **Appendix 17**. Conversion of old job-plans to Zircadian was a slow process. We all took a while to get used to the Zircadian system and initial uptake by consultants was slow. I could not give you figures for yearly compliance, or when job plans started to be updated. Job-plans are now updated, or confirmed to be unchanged, on a yearly basis but I don't know when that started. HR would possible be able to furnish dates, if required. I think the job-planning process works quite well but, like all systems and processes, it is constantly reviewed and improved. **Appendices 16 and 17.**

44.2 Appraisal has also been constantly refined and improved over time and in the last few years in particular. Appraisal was already in place at the inception of the Trust. It was modified to a new format in 2011/12 and to an online system in 2018. Appraisal is a confidential exchange between the appraisee and a suitably trained appraiser. Appraisal is not performance or governance management but an opportunity for an individual doctor to reflect and discuss, confidentially with a peer, their achievements and challenges over the previous year, to assess progress against agreed personal objectives and to agree new personal objectives for the incoming year. Job-planning and appraisal are but elements of governance and performance management. Please see my answer to Question 45.

44.3. I think I started appraising in 2011 or 2012, and I have been an appraiser ever since. My view of appraisal is that it should be supportive rather than regulatory. The content of an appraisal is largely determined by the appraisee. The appraiser is trained to appraise (really a form of counselling in a sense) not to manage. Certain aspects of performance and governance are included in appraisal documentation such as CLIP report, M&M attendance, Complaints and Incident report and Training passport. The main purpose of including these is to encourage reflection, discussion, development and improvement. Please note, however, this is my personal view and I don't speak for the Trust.

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. 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 refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1. **Clinical governance** incorporated a number of systems and was managed by many different people. This is not a comprehensive list but only the most important governance processes that I was familiar with:

45.2. **Team Meetings.** Parallel with the Regional Review of Urology was the NICaN project to establish Multidisciplinary meetings (MDMs) for management of cancer patients. **Appendix 8.** This eventually led to the setting up of weekly MDM's which I attended until 2017 **Appendices 14 & 15**. These meetings are effective for benchmarking and ensuring best practice. Management plans for each patient were agreed by consensus and distributed to consultants by email. The chair of MDM rotated between the urology consultants. I do not recall any governance concerns being raised at these meetings.

45.3. **Morbidity and Mortality (M&M)** monthly meetings. The Urology team were engaged in the Morbidity (Complications) and Mortality (Deaths) process. Cases would have been forwarded to the Clinical Audit Facilitator and then presented at the M&M monthly meeting (also called Audit or Patient Safety Meeting). Attendance at M&M is recorded and accounted at appraisal. The M&M process was managed by Mr Raymond Haffey, Clinical Audit facilitator (non-clinical) and the monthly meetings were chaired by the Chair of M&M (Clinical). The chair rotates so I am not able to say who was chair at any time with any degree of accuracy. If a significant concern was raised about a patient management issue, the case could be escalated to an SAI.

45.4. **Adverse incident reporting** and investigation. Serious Adverse Incidents (SAI) are investigated by the Trust. These can come to attention in a number of ways, but mainly, by logging an IR1 report onto the DATIX incident reporting system. I am not sure who looked at the IR1s, or who decided when a case was appropriate for SAI (or MHPS) investigation, but I think it included the AMD and AD. Incident reporting was initiated in 2009, **Appendix 18**.

45.5 **Complaints**. Complaints from patients, relatives, and occasionally other staff, were investigated by the complaints department. I know that the replies were signed off by the Director of Acute Services but I don't know who else was aware of complaints. I was not routinely made aware of individual complaints.

45.6. **Litigation** was managed by the Litigation department. I would not have been made aware of litigation involving other clinicians. The Medical Director was responsible for the oversight of litigation.

45.7. **Coroner's cases**. Again I would not have been made aware of Coroner's cases. I am not sure who facilitated Coroner's cases but I think it was the litigation department.

45.8. **MHPS** investigations were carried out by case investigators reporting to case managers, and facilitated by senior Human Resources staff. Concerns can be raised in a number of ways **Appendix 28,** section 2. Most concerns are not investigated in this way. There are a small number of trained case investigators in the Trust. MPHS investigations are reserved for issues that reach a certain threshold of importance. I wasn't party to those discussions. I was just asked to do the investigation based upon the terms of reference and to hand my report over to the case manager for action. I carried out eight of these investigations, including one on Mr O'Brien. **Appendix 12**. Of all the investigations I carried out, it was the probably the least significant, in that there were no health, probity or capability concerns and no patient was harmed. Health generally refers to addiction or mental health issues. Probity generally refers to theft and dishonesty. Mr O'Brien acknowledged his error, agreed that there would be no repetition and was, I understand, issued with an informal warning. These investigations are facilitated by Human Resources, and in the case of Mr O'Brien's investigation, Mrs Zoe Parks.

45.9. **Mandatory Training** is carried out regularly by all staff including aspects of governance. Mandatory Training involves attendance at, or online training in, a number of Trust or HSC training modules, such as Fire Safety, Safeguarding, Infection Control, Equality and Diversity, Recruitment and Selection etc. The list varies according to the particular profile of the individual doctor. Mandatory training engagement is reviewed at appraisal and, if incomplete, then completion of mandatory training will be recorded as an action or Personal Development Plan (PDP) item. I have appended my own passport as an example, **Appendix 26**.

45.10. **Appraisal** is carried out yearly. Appraisal is a confidential exchange between the appraisee and a suitably trained appraiser. Appraisal is not performance or governance management but an opportunity for an individual doctor to reflect and discuss, confidentially with a peer, their achievements and challenges over the previous year, to assess progress against agreed personal objectives and to agree new personal objectives for the incoming year. Aspects of performance and governance are reviewed at appraisal for the purposes of reflection, discussion and development. Significant issues of

performance and governance revealed at these meetings should be brought to the attention of a clinical manager. I did not have any issues, arising from the appraisal of any urologist, raised with me as a CD.

45.11. There were, and are, a number of non-clinical departments with staff dealing with various aspects of performance, governance, reform, human resources etc. I would not be confident that I could accurately name all the individual departments and staff that were in place during my tenure or be sure when each of them came into being. I should imagine there are many more senior people who could furnish a more comprehensive list. Apart from HR, I didn't engage with these departments and I really don't know who worked in them.

45.12. I was CD for Urology during the early development and roll-out of many of these policies, processes and departments, and I was confident that the Trust was committed to governance. For example, Incident reporting was introduced on 24.09.2009, **Appendix 26**. Zircadian Job-Planning was introduced on 01.04.2010, **Appendix 17**. The first Urology MDT meeting was on 01.04.2010. The first one that I able to attend was on 03.06.10, **Appendix 15.** I wouldn't be able to furnish a list of all the policies protocols and processes instigated by all the departments in the Trust with any degree of accuracy. I expect there are people much more senior than me who would have that sort of information.

45.13. Whilst most concerns were addressed informally, more serious concerns were escalated to senior managers who assessed whether or not an MHPS investigation was appropriate. The results of any investigation were shared with the AMD and the case manager, if not the same person. Case investigations were retained on doctor's files.

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.

46.1. I was supported by my clinical line manager, Eamon Mackle (AMD) and Patrick Loughran (MD) and non-clinical managers, Martina Corrigan (HOS) and Simon Gibson & Heather Trouton (ADs). The vast majority of my interaction with my line managers related to general surgery and to Daisy Hill hospital. My interactions with the specialties on the CAH site, including Urology, were infrequent. Please see paragraph 1.2. I believe the Trust

recognised the difficulty I had engaging with surgical specialties on the CAH site and reacted appropriately in appointing a second CD, with responsibility for urology, on the CAH site in September 2010.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you, as Clinical Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

(i) The Chief Executive(s);

(ii) the Medical Director(s);

(iii) the Director(s) of Acute Services;

(iv) the Assistant Director(s);

(v) the Associate Medical Director;

(vi) the Clinical Lead;

(vii) the Head of Service;

(viii) the consultant urologists.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals 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 (ii) 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.

47.1. The chief executives were Colm Donaghy, followed by Mairead McAlinden. We received regular email notifications of new appointments, policies and procedures relating to governance in general. I only occasionally met with the chief executives. I do not recall any meetings specifically relating to urology governance issues. Examples of trust policies are listed in **appendices** 17, 18, 25 and 28. Some policies were sent by, or on behalf of, the chief executive and some by, or on behalf of, the Medical Director.

47.2. The Medical Director was Patrick Loughran. I attended meetings which included the medical director. I can't recall specific meetings and I do not recall any meetings about urology governance issues. Again, the main interaction was receipt of policies and procedures by email.

47.3. The Director of Acute Services was Jim McCall followed by Joy Youart followed by Dr Gillian Rankin. I attended meetings with all of the Directors but I do not recall any specific discussion about urology governance issues. I remember attending meetings with Joy Youart and Heather Trouton in 2008 relating to the reconfiguration of the wards in CAH. Eamon Mackle (AMD was off on compassionate leave at the time) Heather Trouton wasn't an AD at that time, but had been seconded to work solely on this project. I knew very little about the layout of the wards in CAH so inevitably Heather and Joy really did all the work and I only made a small contribution. The reconfiguration included all the surgical wards in CAH, including Urology.

47.4. The Assistant Directors during my tenure were Simon Gibson followed by Heather Trouton. Heather Trouton did ask me to address an issue with Aidan O'Brien, please see paragraphs 24.3 and 55.3. I had frequent formal and informal meetings with both of the ADs but I do not recall any specific discussion about urology governance issues. From memory, meetings would have been about matters of interest in all the surgical units. From memory, I think a lot of the content of those meetings would have been about staffing, recruitment, junior doctors' rotas, and matters of that nature.

47.5. The Associate Medical Director was Mr Eamon Mackle I have some recollection of a conversation relating to the long waiting times in Urology and another about the ratio of new to review clinic appointments, but I do not recall urology governance being discussed at any formal or minuted meeting. I am not sure, my recollection of conversations from 10-12 years ago is quite vague.

47.6. Heads of Service (HOS). I had a lot of interaction with the General Surgical HOS but really only interacted with Martina Corrigan, Urology HOS, in relation to my own limited urological practice. In particular I provided a haematuria (blood in the urine) service in DHH, which I would have discussed with Martina.

47.7. The Consultant Urologists were Aidan O'Brien, Michael Young and Mehmood Akhtar. I had frequent communication with all the urologists in relation to patient management. I engaged with the Michael Young in relation to the Regional Review of Urology Services, **Appendix 5**, and with NICaN in developing the Regional Urology Pathway for the management of Urological cancers **Appendix 8**. I addressed issues of concern with Aidan O'Brien, reference 24.2 and 24.3 and **Appendix 12 & 13.** Apart from the long waiting lists I do not recall any other specific issues about governance in Urology.

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.

48a. I addressed concerns that had been raised with me on two occasions. Please see paragraphs 24.1-3 and 55.2-3 for details. I do not recall any other concerns being raised with me.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

48b. I wasn't involved in risk assessment. Perhaps Simon Gibson or Heather Trouton (AD) could address this question.

(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.

48c.1. in relation to the MHPS investigation, as referred to at paragraphs 24.2 and 55.2, and **Appendix 12,** this incident was considered important enough to justify an investigation. In this regard therefore, any action worthy of investigation has a potential to impact on patient care and safety. However, I was happy that Mr O'Brien accepted his error and that repetition would not happen. To my knowledge this was the case.

48c.2. In relation to missing triage and taking charts home, please see paragraphs 24.3 and 55.3. At the request of Heather Trouton, I met with Aidan in June/July 2013 and advised him that it was inappropriate to take patients' charts home. These issues also had the potential to impact on patient care and safety. **Appendix 13** outlines the efforts that Heather Trouton, Michael Young and I invested in the issues of missing triage and charts at home. The outcome of that exchange of emails in November/ December 2013, was that Aidan O'Brien gave an assurance in an email (26.11.2013) that he would catch up. *"I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion."* Michael Young also agreed that he and his colleagues in the Urology Unit would assist with the backlog. There was a meeting planned between Heather Trouton, Aidan O'Brien and myself, but I don't know if this went ahead as there was already an agreed plan that the other Urologists would help out with the triage.

(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?

48d.1. In relation to the MHPS investigation, referred to at paragraph 24.2 and **Appendix 12, Mr** O'Brien accepted his error and that repetition would not happen. To my knowledge this was the case.

48d.2. Paragraphs 24.3 and 55.3 and **Appendix 13** outline the efforts that Heather Trouton, Michael Young and I invested in the issue of missing triage and charts at home. I met with Aidan in June/July 2013 and advised him that it was inappropriate to take patients' charts home. I am not sure if he took my advice or not as the email from Heather Trouton on 26.11.2013 indicates that 6 charts were missing and presumably in the care of Aidan O'Brien. . The outcome of that exchange of emails in November/ December 2013, was that Aidan O'Brien gave an assurance in an email (26.11.2013) that he would catch up. *"I can assure you that I will catch up, but am determined to do so in a chronologically*

ordered fashion." Michael Young also agreed that he and his colleagues in the Urology Unit would assist with the backlog. There was a meeting planned between Heather Trouton, Aidan O'Brien and myself, but I don't know if this went ahead as there was already an agreed plan that the other Urologists would help out with the triage.

(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?

48e.1. I have no recollection of any further engagement in the issues of missing triage and charts at home after November/ December 2013. I did not personally make any arrangements to assure that the agreements put in place at that time were working as anticipated. To my recollection I thought the issue was resolved and a satisfactory solution was in place. Perhaps or Heather Trouton (AD) would know.

(f) If you were given assurances by others, how did you test those assurances?

48f.1.In respect of the inappropriate disposal of chart Material, I was assured by Aidan O'Brien (AOB) that he would not remove and destroy material from charts. I would refer to paragraphs 24.2 and 55.3 and in particular, Mr O'Brien's statement ". *I didn't think it was wrong but I now realize that it is. It won't ever be a recurrent problem as I will never do it again" in* **Appendix 12,** "Final Disciplinary Report, Mr. O'Brien's statement, appendix 3**".** I was confident that AOB would accept my advice about taking charts home when we met in June/July 2013. I was assured that a solution was in place to address the issue of missing triage as referred to at paragraphs 24.3 and 55.3 and **Appendix 13**. To my knowledge, I did not hear anything more about these issues and so I had no reason to believe that they were not resolved. I did not apply any tests as such.

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

48g.1. I do not know if systems and agreements put in place were effective in the longer term. Perhaps Martina Corrigan (HOD) or Heather Trouton (AD) could address this question.

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

48h.1. I did not measure any performance indicators regarding of any issues of concern relating to Mr O'Brien. I wasn't involved in data collection and performance indicators. This sort of information would have been collected by non-clinical staff. Perhaps Martina Corrigan (HOD) or Heather Trouton (AD) could address this question.

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,

49.1. The two significant issues of concern raised with me were the inappropriate disposal of chart material as referred to at paragraph 24.2 and the issues relating to missing triage and taking charts home referred to at paragraph 24.3.

49a.2. The issue of inappropriate disposal of chart material outlined in paragraph 24.2 was properly identified by a member of the nursing staff, reported to HR and investigated appropriately. The complainant did not intend that it should result in an internal investigation, but the decision was made that it should be treated as an investigation. It was an appropriate decision but I don't recall who made that decision, perhaps Eamon Mackle, case manager.

49a.3. The issues of the missing triage and charts at home as outlined in paragraph 24.3 was properly identified by non-clinical staff, Leanne Browne, Acting Supervisor referral & Booking Centre, who referred to Mrs Katherine Robinson, Booking & Contact Centre Manager, who referred to Martina Corrigan (HOS), who addressed the issue directly with

Aidan O'Brien and referred it on to Heather Trouton. Heather Trouton then contacted Michael Young and myself.

(b) their extent and impact assessed,

49b.1. I think that the extent and impact of both issues was understood by all concerned.

(c) and the potential risk to patients properly considered?

49c.1. I think that the potential risk to patients were properly considered by all concerned.

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 support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

50.1. In respect of the concern relating to inappropriate disposal of chart material, as referred to at paragraph 24.2, I had an assurance from Mr O'Brien that it would not happen again, but apart from that I don't recall discussing the matter outside the confidential investigation or offering any support to other urology staff referred to in paragraph 24.2. The case investigator would not have any further involvement in an investigation once it is handed over to the case manager.

50.2 In respect of the concern about missing triage, as referred to at paragraph 24.3: this concern was raised by Leanne Browne, Acting Supervisor, Referral & Booking Centre through Martina Corrigan and Heather Trouton to me and Michael Young. Martina Corrigan, Heather Trouton, Michael Young and I all supported the Urology service, and the Referral and Booking Centre staff, in addressing the issue with Mr O'Brien and reaching, what I understood at the time, to be a satisfactory outcome. I do not recall discussing this matter with any other urology staff.

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

51.1 I have no recollection of quality improvement initiatives in the urology department during my tenure other than the Regional Review of Adult Urology and the introduction of cancer MDMs. Please see paragraphs 8.2 and 8.3, and **Appendices 5-10**. I do not know what support was offered to the urology department in relation to these initiatives.

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)?

52.1. I would have had contact, either in person or virtually, with Mr O'Brien two or three times a month for about twenty five years, but almost always clinically either in one-to-one conversation, at MDM, or by telephone. As CD for all of the surgical departments in DHH and CAH from 01.01.08 – 31.08.2010, I had management responsibility for Mr O'Brien. I do not recall any management interactions with Mr O'Brien during my tenure as CD for SEC. I met him twice after that in regard to management issues as referred to at paragraphs 24.1-3. I do not recall any other contacts other than social greetings and general conversation.

53. What was your role and involvement, if any, 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.

53.1. I was involved in the completion of the team job-plans for the five urology consultant jobs in 2013, **Appendix 19**. The email trail mentions that a lot of the preliminary negotiations had taken place at meetings, on Monday evenings, over a period of about 18 months to 2 years. I do not recall being involved in those meetings. I understand that they were attended by Gillian Rankin (Director of Acute Services), Eamon Mackle (AMD), Michael Young and Aidan O'Brien, but I don't know who else. It was my impression that the clinical activity in terms of operating sessions, outpatient clinics etc. had already been agreed.

53.2. So far as I can remember my task was to convert Michael Young's draft Job-plans into Zircadian. I had had some recent experience in Zircadian, having produced the job-plans for the DHH general surgeons. Malcolm Clegg and Zoe Parks did most of the work putting the urology job-plans onto Zircadian, **Appendix 20.** I assisted with the process, but in terms of the actual sessions and the layout of the job-plans, this was almost all done by Michael Young.

53.3. I don't recall any meetings with Aidan O'Brien to negotiate his job-plan. From my recollection, this had all been done in advance of my engagement by Michael Young. I know that I met with the urology team on 06.03.2013. **Appendix 21.** To the best of my recollection this meeting was just to formally agree the job-plans. I do not recall that any changes were made at that meeting. I had no further involvement in the Urology job-plans.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

54.1. I was made aware of the issue addressed in the MHPS investigation, **Appendix 12,** by Zoe Parks (HR) in June 2011, when she asked to be the case investigator **–** please see paragraph 24.2. The role of the case investigator is to investigate the concern, produce a report, and forward it to the case manager. The role of the case investigator does not include deciding when to initiate an investigation or to decide what action should be taken as a result of the investigation. Mr O'Brien admitted to inappropriate disposal of chart material. He agreed that it would not happen again and, to my knowledge, was issued with an informal warning. The case was forwarded to Eamon Mackle, case manager for action, and I had no further involvement.

54.2. I was made aware of the issues of missing triage, and taking patients' notes home, by Heather Trouton in June or July 2013 and again in November 2013, **Appendix 13** – please see paragraph 24.3. I don't know how long the problem had been in existence. Martina Corrigan would probably be able to answer that part of the question.

54.3. I first became aware of the more recent issues of concern about three and a half years after I retired on 31.03.2016. Mr Mark Haynes texted on 14.10.2020 requesting a Zoom meeting, which we had immediately. He advised me that issues had been raised about Mr O'Brien's management of some cancer patients and asked me if I could assist with a look-back exercise of patients' charts. I can't exactly remember what the issues were, but I think it was something about differences between his treatment of some cancer patients and guidelines. I advised him that I had a long and good professional relationship with Mr O'Brien and that I might not be considered sufficiently impartial. Mr Haynes advised me that my basic knowledge of urology placed me in an ideal position to do the exercise. I reluctantly agreed, but I did not hear from Mr Haynes again. I did not assist with the look-back exercise. I had no idea, until that telephone contact that there were any issues with Mr O'Brien's management of cancer patients.

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.

55.1. There were three occasions when I was involved in discussions about concerns in relation to Mr O'Brien – please see paragraphs 24.1-3 and **Appendices 12 & 13,** and paragraph 54.3.

55.2. The first issue of concern was in respect of inappropriate disposal of chart material by Mr Aidan O'Brien in June 2011.

- I was asked by Zoe Parks (HR) to carry out an investigation. I do not know if this was in person or by telephone call. I can't find an email relating to this.
- 22.6.2011. I wrote to Mr O'Brien inviting him to attend for interview on 23.06.2011 at 4pm. **Appendix 12**, "*Report of Disciplinary Investigation, appendix 1".*
- 23.06.2011. Zoe Parks and I Interviewed Aidan O'Brien in relation to the inappropriate disposal of chart material. "*Report of Disciplinary Investigation, appendix 3".*
- 24.06.2011, Zoe Parks and I Interviewed Shirley Tedford, (Urology Ward Sister) and, later in the same meeting, Sharon McDermott (Urology Ward Clerk), "*Report of Disciplinary Investigation, appendix 4".*

- The "*Report of Disciplinary Investigation"* records these conversations. I have no other memory of any other conversation on this matter other than what is documented in the report.

- The report was forwarded to the case manager, Eamon Mackle, for information/action. **Appendix 12**. I had no more involvement in this concern.

55.3. The second issue of concern was in respect of missing triage and taking charts home. So far as I can recollect, these were related issues, in that I think he was taking the charts home to do the triage of the letters relating to those patients.

- Sometime in June/July 2013 Heather Trouton asked me in person to speak to Mr O'Brien about his practice of taking charts home to his house. I arranged a meeting at the end of his clinic and I advised him that it was inappropriate as the charts might be required by other services in the hospital. So far as I can recall he accepted my advice. I can't clearly recall if Heather Trouton asked me to address missing triage on that occasion or, if she did, whether that formed part of the discussion. To my knowledge I reported back to Heather Trouton verbally, either in person or by telephone.

- 26.11.2013 Heather Trouton (AD) emailed Michael Young and me about Aidan O'Brien's missing triage.

- 30.11.2013 I responded to Heather Trouton's email advising her that I had a lengthy one-to-one meeting with Mr O'Brien in July on this subject, and that I had also spoken to him on the phone two weeks previously. I suggested that we should speak by phone, but I don't recall if that conversation took place. I wrote in the email that we were not making much headway and that perhaps Michael Young, Aidan O'Brien and I could meet and agree a way forward. I don't think that meeting took place as an action plan had been agreed between Heather Trouton, Michael Young and Aidan O'Brien. Aidan had agreed to address the backlog and Michael Young indicated that the other consultants would help out. I don't recall any further concerns being raised with me about missing triage.

55.4. Paragraph 54.3 documents the conversation I had with Mark Haynes relating to the request to participate in a look-back of Mr O'Brien's patients.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and

proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

56.1. In relation to the MHPS investigation, June 2011 as referred to at paragraphs 24.2 and 5.2 and **Appendix 12**, my report was forwarded to the case manager, Eamon Mackle for action. The case investigator does not take part in any discussions about the action that will be taken after submission of an Investigation Report.

56.2. In relation to the missing triage as referred to at paragraphs 24.3 and 55.3 and **Appendix 13,** paragraph 55.3 details all the meetings I had in respect of the missing triage. The specific actions that I took were:

- I met one-to one with Aidan O'Brien in June/July 2013 and advised him that he should not take charts home.
- I mentioned a telephone call with Aidan O'Brien in the email trail in November 2013 when I discussed the missing triage. I have no record or recollection of that conversation.
- The outcome was that Aidan O'Brien agreed to address the backlog and Michael Young indicated that the other consultants would help out. I don't recall any further concerns being raised with me about missing triage.

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

57(i).1. I did understand that delayed triage would impact upon patient care and safety, so I did take immediate action. I did not undertake a risk assessment. This was not something that CDs did. Risk assessment was part of the role of non-clinical managers, perhaps Heather Trouton, (AD) or Martina Corrigan (HOS) may be able to address this point.

(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.

57(ii).1. In relation to the MHPS inquiry, June 2011 as referred to at paragraphs 24.2 and 55.2 and **Appendix 12**, my report was forwarded to the case manager, Eamon Mackle, for action. The case investigator does not take part in any discussions about the action that will be taken after submission of an Investigation Report.

57(ii).2. In relation to the missing triage and notes at home, referred to at paragraphs 24.3 and 55.3 and **Appendix 13**, I did understand that delayed triage would impact upon patient care and safety, so I did take immediate action. My action to mitigate the risk was to meet Aidan O'Brien face to face in June/July 2013 and to speak to him again in November 2013 by telephone. I advised him that his actions were inappropriate. I also engaged in the email exchange with Heather Trouton and Michael Young. To my knowledge I was happy with the agreed solution and I don't recall hearing about it again.

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.

58.1. In relation to the MHPS inquiry, as referred to at paragraphs 24.2 and 55.2 and **Appendix 12**, I was happy with the assurances given by Mr O'Brien that he accepted his error and that repetition would not happen. To my knowledge this was the case. I considered that this was a satisfactory outcome. The case investigator does not take part in any further discussions about the action that will be taken after submission of an Investigation Report to the case manager.

58.2. In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.5 and **Appendix 13**, from the outset, Aidan O'Brien recognised the importance of the issue and agreed to remedy it. Quoting from Aidan O'Brien's email of 26th November 3013 and contained in **Appendix 13**, *"I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion*". Mr Young also agreed that the other urologists would assist with the triage. To my knowledge this was not raised as an issue of concern with me again.

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?

59.1. In relation to the MHPS inquiry, as referred to at paragraphs 24.2 and 55.2 and **Appendix 12**, I handed my Investigation Report over to the Case Manager. The Case Manager, would have taken over the case at that point. I do not know if further action was taken or how it was monitored.

59.2 In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.3 and **Appendix 13**, my impression was that the problem was resolved by the agreed actions as referred to in paragraph 58.2. I do not know what metrics were used in monitoring and assessing effectiveness. I expect the non-clinical managers, Heather Trouton (AD) or Martina Corrigan (HOS) will be able to answer this question.

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 comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

60.1. In relation to the MHPS inquiry, as referred to at paragraphs 24.2 and 55.2 and **Appendix 12**, I handed my Investigation Report over to the Case Manager. The Case Manager, would have taken over the case at that point. The Case Investigator plays no further part in the process.

60.2. In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.3 and **Appendix 13**, my impression was that the problem was resolved by the agreed actions as referred to in paragraph 58.2. To my knowledge this was not raised as an issue of concern with me again. I do not know if systems and agreements put in place at that time were sufficiently robust and comprehensive, and worked as anticipated. I do not know what standards were used to assess methods. I expect the non-clinical managers Heather Trouton (AD) or Martina Corrigan (HOS) will be able to answer this question.

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?

61.1. In relation to the MHPS inquiry, as referred to at paragraphs 24.2 and 55.2 and **Appendix 12**, Mr O'Brien agreed that he would not inappropriately dispose of chart material again. I am not aware of any repetition of this issue.

60.2. In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.3 and **Appendix 13**, to my knowledge a solution was agreed to address the missing triage and Mr O'Brien accepted that he should not take charts home. I had no further involvement in this matter after November 2013. At that time my CD role did not include Urology so, if there were on-going issues they may have been referred to one of the other clinical managers, Sam Hall (CD) or Eamon Mackle (AMD), but I don't know if that was the case.

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

62.1. I do not recall Mr O'Brien raising any concerns with me.

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?
(c) what action was taken by you and others, if any, after the issue was raised
(d) what was the outcome of raising the issue?
If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

63.1. I was not aware of any concerns about Mr O'Brien and I did not raise concerns about Mr O'Brien's conduct or performance during my tenure as CD for Urology, 01/08/2020 – 31/08/2010. I was not aware of any concerns thereafter, apart from those raised with me and addressed please see paragraphs 24.2, 24.3 and 55.2 and 55.3.

64. 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 support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1. In relation to the missing triage as referred to at paragraphs 24.3 and 55.3, to my knowledge a satisfactory plan had been agreed: The outcome of that exchange of emails was that Aidan O'Brien advised that he would catch up. *"I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion."* Michael Young also agreed that he and his colleagues in the Urology Unit would assist with the backlog. I engaged with Heather Trouton (AD) and Michael Young, Lead Urologist and Martina Corrigan (HOS) by email, but I do not recall engaging with other departments in relation to this concern. If there was engagement with other non-clinical support services, this would have been done by Martina Corrigan (HOS) or Heather Trouton (AD). I do not know of any other support provided to Mr O'Brien by the Trust.

65. 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.

65.1. I don't know if Mr O'Brien's raised concerns and if those concerns were reflected in the Risk Register or other Governance Appendices. I expect the non-clinical managers Heather Trouton (AD) or Martina Corrigan (HOS) will be able to answer this question.

65.2. In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.3, I don't know if those concerns were reflected in the Risk Register or other Governance Appendices. I expect the non-clinical managers Heather Trouton (AD) or Martina Corrigan (HOS) will be able to answer this question.

Learning

66. 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.

66.1. I retired from clinical practice on 31.03.2016. I continued to provide clinical services on a temporary contract until 31.03.2017 as set out at paragraph 5.1. Whist I still work part-time for the Trust, virtually all my work is done from home, (please see paragraph 5.3). I was told by Mr Haynes, on 14.10.2020, that there was a plan to review some of Mr O'Brien's patients, because his treatments of cancer patients was not consistent with guidelines as set out at paragraph 54.3. I understand from the media that a look-back exercise was undertaken. During the time when I was engaged in clinical practice, and particularly when I attended Urology MDMs, I was not aware of any variance in cancer management. I understand that this issue came to light after I ceased clinical practice.

66.2. In relation to the missing triage and charts at home as referred to at paragraphs 24.3 and 55.3, I understood that agreement had been reached then to address the issue. If there was an on-going issue with triage I would expect that it would have been drawn to the attention of one of the clinical or non-clinical managers on the CAH site. I was not aware on an on-going issue with triage.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

67.1. I never knew that Mr O'Brien's treatment of cancer patients was different to anyone else's. The principle of MDMs is that treatment plans are agreed by the team based upon guidelines and best practice. I don't know why he chose to treat his patients differently to guidelines or how this came to light. I don't know the reason why he did not apply the treatment plans agreed at MDM.

67.2. I also understand from the media that Mr O'Brien had fallen behind with triage again. I do not know if the problem persisted or recurred. If it was a persistent problem, then I think that information would have been known to the non-clinical managers, Martina

Corrigan (HOS) and Heather Trouton (AD). I don't know how Mr O'Brien's triage was managed after 2013.

68. 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?

68.1. The principle of MDMs is that treatment plans are agreed by the team based upon guidelines and best practice. This is meant to ensure consistent practice between consultants. I don't know why he then chose to treat his cancer patients differently to guidelines. I don't know how you would find out if this was happening, but once it is known then it is appropriate to look back at his practice and investigate any variance. I understand that the GMC have been informed and that Mr O'Brien is under investigation. It is my impression that appropriate action was taken. I don't know what could have been done differently.

68.2. I do not know if the problem with triage persisted or recurred. If it was persistent, I don't know who knew about it or who was dealing with the issue. In terms of learning then maybe a more robust approach to Mr O'Brien's triage may have been appropriate.

68.2. I am not aware of issues relating to the Urology unit as a whole but only to Mr O'Brien specifically.

69. 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.

69.1. I know about my own engagement, which was reactive rather than proactive, as referred to in paragraph 69.3 below. I was CD for Urology from 01.01.2008 to 31.08.2010, and I assisted with the job-planning process in 2013, as described in my answer to question 53. I also addressed issues relating to Aidan O'Brien in 2011 and 2013, as set out in paragraphs 24.2, 24.2, 55.2 and 55.3. Even in retrospect, I don't think I could have done much more**.**

69.2. I know that there was a lot of management engagement in Urology. I refer to my answer to question 13 re Regional Review of Adult Urology Services. I also refer to paragraph 53.1 in relation to the urology job-plans, and the comment in appendix 19 from Mr Eamon Mackle (AMD), in an email to me on 02.03.2013, *"Dr Rankin and I met with Michael and Aidan over a period of 18 months every Monday evening to regarding TYC and Urology. A lot was discussed and decided"* Reference paragraph 53.1 and **Appendix 19.** To my recollection, I was not involved in those meetings.

69.3. I was CD for the whole of SEC (including Urology), across two hospital sites, from 01.08.2008 to 31.08.2010, and based in DHH. I had 4 hours a week for all of my management roles – please see paragraph 1.2. In retrospect this was an impossible task. Being located in DHH I was remote from the units in CAH, and almost all the non-clinical managers and services were based in CAH. A second CD, Samantha Sloan was appointed on 01.09.2010 and more CD's were appointed after that. I don't know when. I do recall that after I retired the Trust employed 4 CD's, one in DHH and three in CAH. The learning from my experience is that a CD cannot have sufficient interaction with a unit on another hospital site to support all their management requirements and be fully aware of all the governance issues. Clearly the Trust has learned, and acted appropriately, by increasing the number of CDs across the Trust.

70. 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 utilised 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?

70.1. In respect of the MHPS investigation relating to the inappropriate disposal of chart material, as referred to at paragraphs 24.2 and 55.2, I think this was dealt with properly, and I am not aware that it happened again. I think this issue was handled properly.

70.2. In respect of the missing triage, as referred to at paragraphs 24.3 and 55.3, I now know that this issue either recurred or persisted. I don't know if it was brought to the attention of anyone else after me. In retrospect I could have checked to see if the arrangements, that were agreed, remained effective.

70.3. In respect of the management of cancer patients, I understood that the principle of MDMs was to standardise cancer management in line with best practice. I do not know how you would go about finding out if an individual consultant then changes the patient management. I think the key point is that once identified that it is properly investigated and I think this was the case. I don't know how you would stop an individual consultant changing a patient's treatment plan.

70.3. During my tenure as CD for Urology, 01.01.2008 – 31.08.2010, I don't recall any governance issues arising or being brought to my attention. Mr O'Brien would have had a yearly appraisal then but I was not his appraiser so I cannot comment on his compliance either in terms of completeness or timeliness. Detecting and addressing performance and governance issues is not the primary function of appraisal. (Please see paragraph 45.10 in relation to a description of appraisal). Matters of concern can arise and, if so, will be referred to a CD or AMD. No issues were raised with me about Mr O'Brien's appraisals during my tenure.

71. 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?

71.1. In retrospect there were not enough clinical directors between 2008 and 2010. I was not able to significantly engage in six departments, five of which were in another hospital. This was recognised and addressed by appointing a second CD on the CAH site. I don't know who made that decision.

71.2. In respect of the missing triage, as referred to in paragraphs 24.3 and 55.3, I now know that this issue either recurred or persisted. I don't know if it was brought to the attention of anyone else after me. In retrospect I could have checked to see if the

arrangements, that were agreed, remained effective. I don't know what systems were put in place to monitor Mr O'Brien's triage after my involvement in 2013.

71.3. Apart from paragraphs 71.1 and 71.2, I did not have any concerns about the governance arrangements in the Trust and I did not raise any concerns with anyone that I can recall.

72. 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?

72.1. Throughout my career, I had the greatest respect for Aidan O'Brien. He was the founder of the Urology service in CAH and the senior member of the urology team. In my clinical practice in DHH I reviewed patients previously seen by him and they frequently told me how very pleased they were with his care. I was completely taken aback by the content of Mark Haynes' telephone contact on 14.10.2020 as referred to in paragraph 54.3, as this was not in keeping with my view of Aidan O'Brien at that time. I was disappointed to hear that questions were being raised about his management of cancer patients, and subsequently, that his triage had fallen behind again.
I would like to convey my sympathy and condolences to the patients, and relatives of patients, who have suffered in any way as a result of the issues raised in respect of Mr O'Brien.

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 Appendices 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.

Statement of Truth

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

Signed: _____ [redacted] _____

Date: _____15/06/2022_____

Section 21 Notice Number 20 of 2022

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R. Brown

SOUTHERN HEALTH AND SOCIAL SERVICES BOARD

CONSULTANT SURGEON

JOB DESCRIPTION

Title: Consultant Surgeon

Specialty: General Surgery

Base: Daisy Hill Hospital, Newry

The Southern Health Board's area has a total population of 291,200 distributed between 5 Units of Management. The Newry/Mourne Unit of Management is a combined hospital and community unit and serves a population of 88,900. The successful applicant will be based at Daisy Hill Hospital and will share with two other Consultant Surgeons responsibility for in-patient and out-patient acute general surgical services and an Accident and Emergency department surgical services. At present one out-patient session on alternate weeks is provided to the Mourne Hospital, Kilkeel. A special interest within the surgical specialty would be desirable for any potential candidate.

Daisy Hill Hospital

Daisy Hill Hospital has 302 beds which include the specialties of General Surgery, General Medicine, ENT, Gynaecology, Obstetrics, Paediatrics, high-dependency Neonatal care and Geriatric Medicine. There are 68 beds in the specialty of General Surgery and a further 10 paediatric surgical beds.

In addition there are 6 post-operative surgical beds in a separate unit in close association with the continuing care unit.

Diagnostic facilities, general radiological ultrasound services and laboratory services are available at the hospital.

The hospital is modern, having been completed in two phases, opened in 1973 and 1981 respectively.

Staffing

The Surgical Staff establishment is as follows:-

Present Consultants	-	Mr G Blake
	-	Mr B Cranley
Registrars	-	1 and 1 locum Registrar in Accident and Emergency (Dr McCann)
Senior House Officers	-	4
Junior House Officers	-	3

Daisy Hill Hospital is recognised for Pre and Post Fellowship

training of Senior House Officers and Registrars and when required medical students are taken for elective periods.

Newry is within easy access of Banbridge, Belfast and Dublin and offers a wide range of recreational facilities.

Support Services

Full Physiotherapy and Occupational Therapy Services are provided at Daisy Hill Hospital. Physiotherapy is provided by a staff of 14 Physiotherapists of whom 5 work in the community. The Occupational Therapy Department has a staff of 7.

Chiropody and Speech Therapy are provided by the community staff in the Unit of Management.

The Radiological Department with a staff of 10 Radiographers offers a full range of radio-diagnostic procedures.

The Laboratory: A full range of facilities are provided on site.

Conditions of Appointment

The appointment will be either whole-time or maximum part-time. Candidates must be Fellows of a Royal College of Surgeons in the United Kingdom or Republic of Ireland, and should normally have had at least seven years experience calculated from the date of graduation to the date of taking up the appointment. Candidates shall be required to have undertaken a programme approved for Higher Surgical Training by the relevant specialist Advisory Committee or have had clinical training comparable in extent, duration and standard to that expected from a candidate who has followed the pattern of experience previously outlined.

The appointment will be whole-time or maximum part-time based in the Newry/Mourne Unit of Management with duties at Daisy Hill Hospital, Newry. The successful candidate will be responsible for the operation of the General Surgical department at Daisy Hill Hospital in conjunction with the other Surgeons. He/she will be expected to apply and develop his/her special interest as appropriate to the needs of the Service.

The successful candidate will share in in-patient and out-patient management of all General Surgical patients as well as Accident and Emergency patients seen at Daisy Hill Hospital. He/she may wish to use one or more sessions in his/her own special interest. He/she would take part in the on-call rota to cover the General Surgery side of the hospital. He/she would also be expected to take part in medical audit and in the teaching, administration and development of modern hospital practice.

The appointee will be required to reside within a reasonable distance of Daisy Hill Hospital and his/her private residence shall be maintained and in contact with the public telephone service.

There are opportunities to develop research activities involving clinical work.

The appointee will be required to undergo a medical examination in the Board's Occupational Health department to establish fitness to undertake the duties attached to the post.

Service in H.M. Forces will be taken into consideration.

The post is covered by the Terms and Conditions of Service for hospital medical and dental staff.

The post is subject to termination at any time by three months notice given on either side.

Should the successful candidate choose to contract on a whole-time basis he/she shall declare annually that his/her gross income from private practice did not exceed 10% of his/her gross Health Service income (including distinction and meritorious service awards if applicable).

The post will be superannuable unless the successful candidate decides to opt out of the scheme or is ineligible to join.

Annual leave is six weeks per annum plus twelve statutory and public holidays.

The age of retirement is such as may be fixed by the Board from time to time. Under the current rules officers are required to retire on reaching the age of 65 years.

Requirements of the Post

The Consultant will have the continuing responsibility for the patients under his/her care and for the proper functioning of his/her department.

The Consultant will undertake the administrative duties associated with the care of his/her patients and the running of his/her department.

While the appointee would have complete clinical independence it would be expected that he/she will work as a team with his/her colleagues.

The Unit General Manager has overall responsibility for acute services in the Newry/Mourne Unit of Management. The Consultant appointed will have accountability to the Unit General Manager for the appropriate and smooth delivery of service.

General Information

The Southern Board participates in the Car Leasing Scheme and the successful applicant may be considered under the regulations of the scheme.

A charge will be made for any accommodation and services provided in connection with the post.

Salary Scale: £32,520 - £41,980 per annum

From 1 January 1990 medical staff have not been required to subscribe to a Medical Defence Organisation. It should be noted, however, that the Board's Indemnity only covers the Board's responsibilities and, therefore, you are advised to maintain membership of a recognised professional defence organisation for any work which does not fall within the scope of the Indemnity Scheme.

Candidates selected for interview are encouraged to visit the hospital to which the appointment relates. The Southern Board will, on request, make the necessary arrangements.

Canvassing will disqualify. Any approach to a member of the Board or the Agency or a member of any Committee or Panel of the Board or the Agency by or at the request of a candidate, for the purpose of obtaining support for his/her application, will be treated as canvassing.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

Tile of Post:	Clinical Director – General Surgery Daisy Hill Hospital
Directorate/Division:	Acute Services Directorate
Responsible to:	Director of Acute Services
Operationally Responsible to:	Associate Medical Director
Accountable to:	Chief Executive
Hours:	Salaried Part Time position

KEY RESPONSIBILITIES

OPERATIONAL EFFECTIVENESS OF SERVICES

Operational Management

- Attends Directorate wide meetings with Service Director, AMD, and Assistant Directors etc.
- Holds a regular Divisional meeting for medical staff – often as Chair of meeting.
- First port of call for Assistant Directors for issues arising at Divisional level.

Service Development:

- Provides a medical perspective on protocols/pathways related to service improvements within the Division.
- Actively participates in discussions about service change and medical capacity.
- Leads the medical aspects of service change at Divisional level, and contributes to the implementation of required multi-disciplinary change.

Budgetary Awareness:

- Takes account of the financial implications when making decisions in conjunction with Assistant Directors and with the support of Finance staff. (for example, taking account

of medical staffing/locum costs within service delivery and development; cost of sickness absence, approval of doctors expenses etc).

GOVERNANCE AND PROFESSIONAL PRACTICE STANDARDS

Divisional Governance Forum

- Participates in Divisional governance activities/meetings, as agreed with Associate Medical Director.
- Working with the Trust/Directorate Governance manager to ensure effective clinical governance.
- Involved in complaints investigation and resolution, critical incident reporting and follow-up, risk management and audit.

Standards

- Providing advice to Assistant Director and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidance etc.,
- Assisting in the preparation for external inspections.
- Working with relevant managers and colleagues on implementation plans to address issues highlighted by external audits/reviews (e.g. RQIA, CMOs office, Child Protection etc.,) overseeing development and roll out of implementation plans in conjunction with the Director/ADs.

Public Health and urgent operational issues

- Contributes to the roll out of contingency plans, working with identified leads and the Associate Medical Director. (e.g. Swine flu, hyponatraemia)

Education and Research

- Contributes to decisions to resolve tensions at Specialty level between the demands of service delivery and training.

Note: Some Clinical Directors have an education and training remit

MEDICAL MANAGEMENT

Appraisal

- Undertakes appraisal for a number of Consultant staff (usually 5-6).
- Assures AMD that appraisals have been completed and reports on common issues arising.

Job Planning

Participates in Job Planning as agreed with Associate Medical Director (delegated function).

Application of Medical HR policies

- Undertakes a management role in the application of relevant medical HR policies and the provision of advice to medical colleagues, in areas such as.
  - Annual leave
  - Study leave
  - Performance
  - Sickness

- Liaises with Human Resources for appropriate advice and support.

- May be the nominated person for the Directorate in specific HR policies.

Communication

- Facilitates good communication with medical staff, formally through meetings and informally through other opportunities.

- Liaises with other clinical managers in support of good multidisciplinary team working.

- Acts as a primary communication point within the Division for management and medical colleagues.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

From: Stinson, Emma M <[redacted]
Sent: 17 August 2010 10:57
To
Brown, Robin <[redacted]>; Subject: Re: Clinical Director Surgery and Elective Care

Dear All

Mr Mackle and myself are pleased to inform you of the appointment of Ms Samantha Sloan to the role of Clinical Director in SEC. Ms Sloan will have responsibility for General Surgery in CAH, T&O, Urology and Oral Surgery. Mr Robin Brown has responsibility for General Surgery in DHH, ENT and Ophthalmology.

Please share this email with your clinical teams

Regards

Mr E Mackle – Associate Medical Director (Surgery and Elective Care) Dr Gillian Rankin – Interim Director of Acute

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

ACCEPTANCE OF TERMS & CONDITIONS OF EMPLOYMENT

I accept the post of Clinical Director, General Surgery - Daisy Hill Hospital, based on the terms and conditions contained in this letter.

Signed: Personal Information redacted by the USI Date: 12/4/11

Printed Name: ROBIN BROWN

Mr Robin Brown

Personal Information redacted by the USI

Southern Health & Social Care Trust

Trust review of Urology

Steering Group meeting
16th February 2009

Present

Joy Youart (chair)
Mairead McAlinden
Charlie McAllister
Michael Young
Simon Gibson
Robin Brown
Eamon Mackle

Apologies

Paddy Loughran

Membership

Additional membership – Jerome Marley

Terms of reference

Joy Youart gave a context to the discussions and outlined the terms of reference. Mairead McAlinden informed group of need for detailed business case to submit against £8.5million being held regionally for elective access for 09/10 – Urology will be the first call against this money. Joy Youart outlined the issues raised by Catherine McNicholl with regard to the current regional view:

Simon

I am currently writing up the report and its going to take another couple of weeks before the draft goes out.

The issue about beds is not based on any model-- (I was told not to allow for beds!) However I do believe trusts will be able to modernise and reform service provision to free up capacity. Have just looked at average LOS across all sites and Craigavon has the highest for elective at 4.14 in 07/08 with a regional average of 3.37.

There is also an opportunity for you to reduce LOS in non elective- emergency and with your volumes (the same as belfast at 780 per annum) 1/2 to 1 day reduction would free up considerable capacity. Western, Northern and SouthEastern only have about 200. I understand why Belfast is so high but I cannot understand Craigavon's activity. In your last review it said that it was because of long waiting times for elective and that it would reduce once the 3rd Consultant was employed and waiting times fell-- but it hasn't. Daycase rates are also the lowest at 60% with belfast sitting at 69%, Altnagelvin 74% and Southeastern at 85%. When M45'S (cystoscopies) are excluded your daycase rate drops to 52% but so does everyone else's.

Cystoscopies is not really day surgery and therefore should be excluded. In a specialty you should expect to see a daycase rate of at least 60-65%. A few of the procedures are in the "basket" for which performance should be 75%. More admission on the day of surgery, pre-op assessment and LOS of less than a day (23hr) are all clearly going to help.

As a separate issue the volume of elective work per Consultant appears lower than elsewhere (Particularly AOB) and compared with recommended levels of activity and therefore you may not actually require a 5th Consultant.

Hope you are well

Catherine.

-----Original Message-----
From: Gibson, Simon Personal Information redacted by the USI
Sent: 15 February 2009 22:14
To: McNicholl, Catherine
Cc: Youart, Joy; McAlinden, Mairead
Subject: RE: Trust review of Urology

Dear Catherine

Thanks for this - are there any data files breaking down the demand/capacity figures from the regional review you could share with us?

One point I would like to explore is the assumption you make that the removal of 20 radical cancers per year and increasing DC% and decreasing ALOS would balance out the bed requirements which would come with an additional 2 WTE surgeons. Is there any modeling you have undertaken which would evidence this expectation that you refer to?

Kind regards

Simon

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI

-----Original Message-----
From: McNicholl, Catherine Personal Information redacted by the USI
Sent: 10 February 2009 08:09
To: Gibson, Simon
Cc: Youart, Joy; McAlinden, Mairead
Subject: RE: Trust review of Urology

Simon, apologies for not responding sooner-I hope this is in time for your meeting.

Thank you for asking me these questions as it has made me think about some aspects of the service that I had yet to consider-- Mairead had a quick chat with me on the same issue last week and that also made me think.

I have begun to write up the Review Report but I still have some unanswered questions and outstanding issues to be clarified. (The 3 team model still isn't definitely signed off yet!) Currently the 3 team model assumes a Southern (south/west) team which includes your current resident pop along with fermanagh only at 61,291 bringing your resident pop up to just over 400,000. Based on a consultant ratio of 1:80,000 we are assuming you will have a team of 5 wte.

Team North and West will still serve omagh and surrounding areas-- western currently provides a small outreach service to the Tyrone County with any subsequent inpatient work going to Altnagelvin. It is likely that our proposals will include strengthening OP/DAYCASE provision in Omagh as an outreach from team north and west.

The West doesn't currently provide any out reach service in the Erne. I suspect a small section of this community are already coming to Craigavon for treatment-- you should be able to get this info internally. Equally small numbers from cookstown currently go your direction and we do not envisage this changing-- it would be impossible to draw strict demarcation lines on a map and expect GP's to follow them rigidly.

With a team of 5 consultants it would be wise to look to the future and plan to provide some services outreached to the Erne which will be an enhancement for that population making assessment and diagnostics more locally accessible.

I will try to obtain more info on flows of patients and activity numbers for OP/Ins/Days currently within the Western Trust and in particular the activity generated from Fermanagh. Please also remember that your current resident population is not the same as catchment as some patients flow to belfast/southeastern and to a lesser degree northern. Adlele Graham presented actual catchment for southern elective inpatients and days as 305,000 and 287,000 respectively.

Remember to factor in the transfer of about 20 radical pelvic ops per year to belfast--they take up considerable theatre time/ ICU requirements and probably have the longest length of stay and therefore will release bed days. The costings for the review will not include anything for extra beds/ward staff regardless of additional activity as Trusts will be expected to reduce LOS, do higher % of day surgery and look at 23hr models which are suitable for some/many urology cases.

As part of your review could I suggest you specifically look at emergency admissions to Urology-- I am not going to focus on it in my review but Craigavon's appear unusually high-- is it a recording issue? Can you put systems in place to avoid admission? How many of them go on to have surgical intervention during admission? Can you break them down into conditions e.g. renal colic, acute retention, acute obstruction? With this info you will see what you are dealing with and makes plans to avoid admission, if appropriate, and free up bed and other capacity.

Hope this is enough info to get you started.

Regards

Catherine.

-----Original Message-----
From: Gibson, Simon [redacted] **]**
Sent: 03 February 2009 11:31
To: McNicholl, Catherine
Subject: Trust review of Urology

Dear Catherine

We are commencing an internal Trust Review of Urology - I have attached a draft terms of reference, for information. There are also some initial actions we need to pursue, a number of which I am hoping you can help with:

- **What are givens in the new service model?**
- **Specifically, what expectations will there be in relation to Outpatients and Daycase demand generated in the Fermanagh area?**
- **Are there any other expectations in any new service model?**
- **Would you have available the broken down demand/capacity volumes undertaken as part of your regional review which could inform our new service model?**
- **What is the increase in the flows to the Southern Trust? Looking at the map, my assumption is that a 3 centre model will see patient choosing to attend CAH for Urological care from the districts of Cookstown, Fermanagh and the lower quarter of Omagh. Certainly our recent experience of ENT IP services withering in Tyrone County has been these localities flowing to ourselves.**
- **This would equate to roughly 111,711 patients - is this your expectation, or do you have a different view?**

Simon

Work streams

The following workstreams were agreed:

First strand - Need to have an agreed service design model, built on standards we will base our new service model on, and then describe how we deliver it across the 3 sites within a business case to be submitted at the time of the Ministers announcement**. Action : Michael Young and Simon Gibson to define standards we want to base our service model on**

Second strand - need to map out capacity demand model, based upon agreed service model and new catchment area**. Action** : **Simon Gibson to send out existing demand and capacity analysis.**

Third strand will be around workforce planning – team job plans of 3 consultants, done in conjunction with review of clinical support teams, to be incrementally built upon by 4th, 5th and ?6th post. Need central agreement of phasing of 4th post and then a 5th post to ensure equity across the province in line with consultant appointments within other units.

Fourth strand will be around equipment and accommodation – both outpatients and theatres for IP/DC sessions, across all sites

Southern Health and Social Care Trust

REVIEW OF ADULT UROLOGY SERVICES

PROJECT INITIATION DOCUMENT

Version	Draft 0.1
Date	27-Apr-10

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1.0 Introduction & Background

1.1 Introduction

This document outlines the key objectives and project management structure for taking forward the recommendations arising from the Review of Urology Services in Northern Ireland.

1.2 Background

A regional review of (Adult) Urology Services 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. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, is recommended. All core urology will be undertaken and the following special interest areas are suggested:

- Uro-oncology (2 consultants);
- Stones/endourology (2 consultants);
- Functional/female urology (1 consultant).

It is proposed that the main acute elective and non elective inpatient unit will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, Daisy Hill and the Erne Hospitals. Outpatient clinics will be held at Craigavon, South Tyrone, Daisy Hill, Banbridge, the Erne and Armagh.

The Minister has endorsed the recommendations and Trusts have been asked to develop business cases and implementation plans to take forward the recommended team model and to secure the necessary investment.

.

2.0 Objectives and Constraints

The key objectives of the project are to:

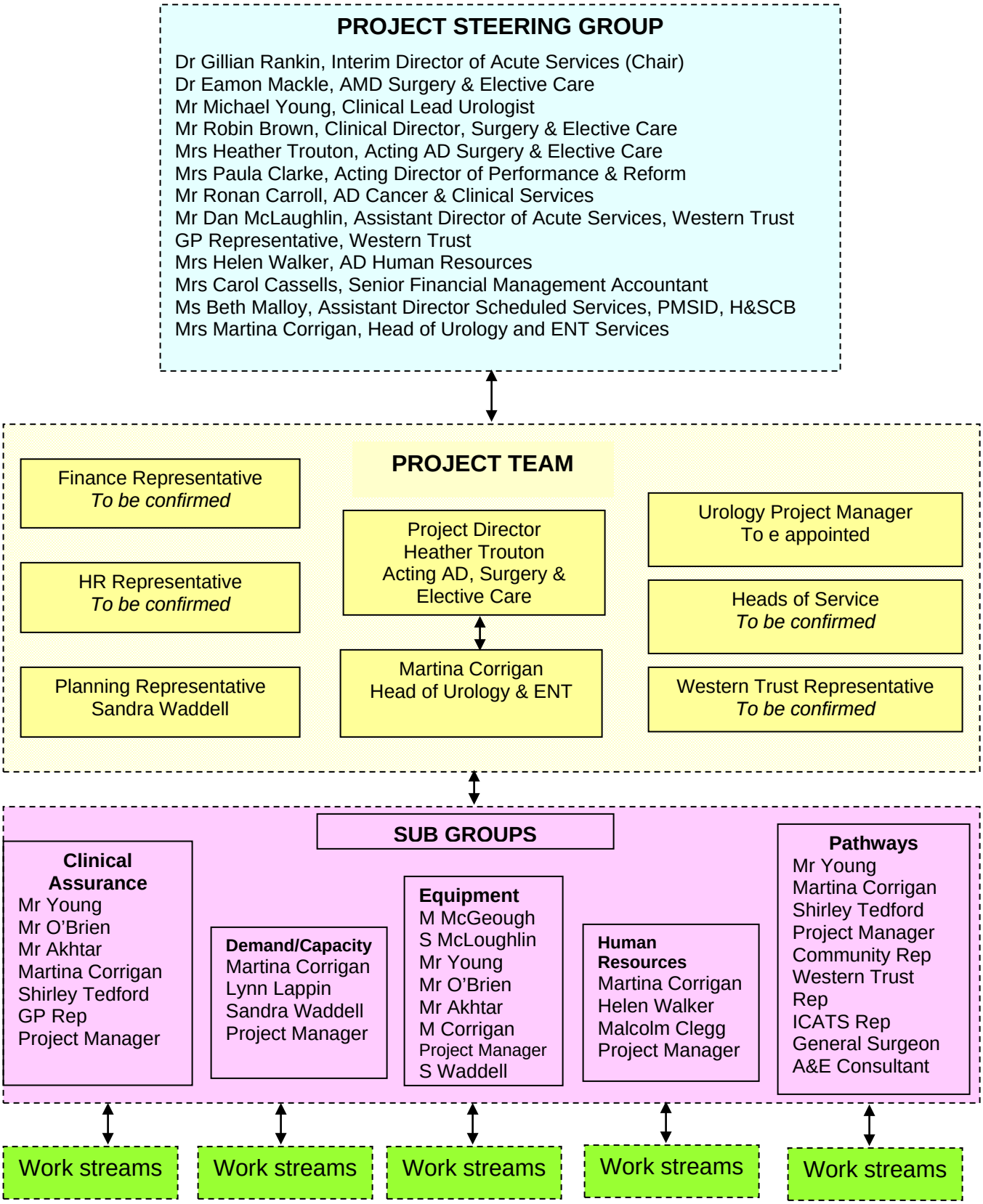
- *Carry out a baseline assessment of the Trust's urology service;*
- *Agree patient pathways;*
- *Develop an implementation plan for urology services based on the recommendations set out in the regional review (for submission to the Regional HSC Board by 11 June 2010);*
- *Establish bed requirements;*
- *Review the demand for the service;*
- *Identify staffing required for the new model of care;*
- *Identify training needs required for the new model of care;*
- *Identify additional equipment needs;*
- *Prepare a business case.*

The key constraint to the project is:

- Limited funding for the project - both revenue and capital (for equipment). It is unclear how equipment will be funded and whether this will need to come from Trust general capital.

3.0 Project Management Structure

A project management structure based on PRINCE 2 methodology for project management is given overleaf. It identifies the key stakeholders and interfaces throughout the lifespan of this project.



3.1 Sub Groups/ Work Packages

Many of the deliverables relate directly to recommendations arising out of the regional review. Where this is the case the recommendation number is noted in brackets.

3.1.1 Clinical Assurance

Key tasks for the Clinical Assurance Group include the following:

- Develop an implementation plan for the delivery of the key elements of the Elective Reform Programme including admission on the day of surgery, pre-operative assessment and increasing day surgery rates (Rec 11, 13 & 15);
- Develop an implementation plan for the delivery of a single visit for suspected urological cancer patients (Rec 12);
- Undertake benchmarking and agree target lengths of stay for specified urological conditions/procedures (Rec 14);
- Undertake a review of outpatient review practice with a view to reducing new: review ratios to the level of peer colleagues (Rec 16);
- Undertake a review of outpatient clinic templates and booking practices (Rec 17);
- Quality assure/approve clinical pathways developed by the Clinical Pathways Sub Group.

3.1.2 Demand/Capacity

The key tasks for the Demand/Capacity sub group include the following:

- Undertake an assessment of the current service;
- Review the demand/capacity analysis;
- Establish bed requirements for the service.

3.1.3 Human Resources

The key tasks for the Human Resources sub group include the following:

- Develop team job plans and job descriptions for medical staff (Rec 6, 21 & 22);

- Developing job plans and job descriptions for Clinical Nurse Specialists (Rec 23);
- Quantify the support staff required to deliver the projected activity levels;
- Identify training needs.

The Human Resources sub group will develop an implementation plan for the appointment of additional staff including timescales.

3.1.4 Pathways

The Pathways sub group will develop care pathways for the following patient groups/conditions:

- Urology patients requiring admission who present at Daisy Hill and the Erne (Rec 7 & 9);
- Urology patients requiring admission who present at Craigavon Area Hospital (Rec 8);
- Erectile dysfunction, benign prostatic disease, LUTS and continence services (Rec 3 & 10).

3.1.5 Equipment

The Equipment sub group will identify additional equipment requirements and prepare equipment specifications if required.

4.0 Project Timescales

(suggested)
A revised demand/capacity and bed requirement analysis will be completed by **28-May-10**

A draft implementation plan with timescales will be completed for presentation to the Trust's Senior Management Team by **31-May-10**

A business case will be completed by **30-Jun-10**

Health and Social Care Board

Review of Adult Urology Services in Northern Ireland

A modernisation and investment plan

March 2009

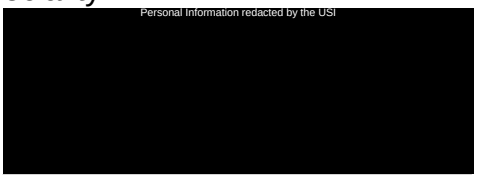
Ministerial Foreword

The health service in Northern Ireland has been able to make remarkable progress in improving access to services and sustaining the quality of those services. That work, as part of the current programme of modernisation and reform of health and social care services is ensuring that many more patients are gaining timely access to the services they need than was the case only a few short years ago. I am determined that this progress should continue.

However, whilst reducing waiting times generally there have been some concerns about the capability of our urology services as they are currently arranged, to continue to deliver care of the highest standard while striving to meet increasing demand. The capacity within the HSC to deal with an increasing demand for urology services was the principal reason why this review was commissioned.

The review considers workforce planning, training and development needs and future resourcing and proposes a model of service delivery which I am confident will produce a reformed service fit for purpose, with high quality services provided in the right place at the right time by appropriately trained and skilled staff.

Ensuring that the patients who need our health and social care services remain at the centre of everything we do is of course a fundamental step of developing and improving service provision. I hope that many of you, especially those with experience of the service, will respond with comments and suggestions which will inform the future development of this important
Speciality.



Michael McGimpsey
Minister for Health, Social Services and Public Safety

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1. SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

For the purposes of this review all Urology services and Urological related procedures should be taken in the context of Adult Urology only.

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.

2. INTRODUCTION AND CONTEXT

Introduction

2.1 A regional review of Adult Urology Services 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.

2.2 A multi-disciplinary and multi-organisational Steering Group was established under the Chairmanship of Mr H. Mullen, Director of Performance and Provider Development and this group met on five occasions between September 2008-March 2009. Membership of the group is included in Appendix 1.

2.3 An External Advisor, Mr Mark Fordham, a Consultant Urologist, Royal Liverpool and Broadgreen University Hospital Trust, was appointed and attended all Steering Group meetings and a number of other sub group sessions.

2.4 Terms of Reference were agreed (Appendix 2), with the overall purpose of the review being to;

Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.

2.5 A literature search of guidance and policy documents was undertaken. This included consideration of reports on previous reviews in Northern Ireland. A list of the key documents considered during this review is included as Appendix 3. Sections in italics within this report are direct quotes from these documents.

2.6 During the course of the review, a significant number of discussion papers, detailed information and datasets were collated, copies of which are not included in this report but are available on request.

Context

2.7 The speciality of Urology predominately covers the assessment, diagnosis and treatment of Urogenital Conditions involving diseases of the Kidney, Bladder, Prostate, Penis, Testis and Scrotum. Bladder dysfunction, Male and Female Continence Surgery and Paediatric Peno-Scrotal Conditions make up the rest.

2.8 Thirty years ago the field of Urology was one of the many that was the province of the General Surgeon. Since that time, Urology has developed and evolved as a separate surgical specialty. Higher specialist training in General Surgery no longer covers Urology, which now has its own training programme.

2.9 Prior to 1992, fully trained dedicated Urologists were based only at the Belfast City (BCH) and Royal Victoria (RVH) Hospitals providing a unified service to these two sites and a referral service for the rest of Northern Ireland. In 1992, Urologists were

appointed at Craigavon, Mater and Altnagelvin Hospitals. By 1999 there were ten full time Urologists in post, providing services on the above sites along with Lagan Valley and Coleraine Hospitals. In addition to these ten Urologists, there were two Consultant General Surgeons (one based in Mater, one based in Ulster) who were accredited as Urologists and whose workload was increasingly in the field of Urology. Since 2002, further appointments were made in the Belfast Hospitals, Altnagelvin and Craigavon Hospitals, along with the development of a Urology Service based in Causeway Hospital. At the time of this review 2008/2009, there is a funded establishment of 17 wte Consultant Urologists, which is in line with the recommendations of the 2000 Northern Ireland Review. However, the 2000 Review envisaged the Northern Board area Urology Services being based in Antrim Area Hospital rather than at Causeway Hospital.

2.10 Urology work can be divided into two categories;

- Medical and surgical treatment of the urinary tract, (kidneys, bladder, ureters, urethra, prostate), with these surgical procedures known as 'M'code (OPCS 4.4)
- Medical and surgical treatment of the genital and reproductive system (peno-scrotal), with these surgical procedures known as 'N'code (OPCS 4.4)

2.11 Both categories comprise elective and non-elective and cancer and non-cancer elements, albeit there are much fewer non elective and cancer cases in the 'N' code category.

2.12 In recent years, with the retirement of General Surgeons who historically undertook a substantial amount of Urology work, the number of General Surgeons who undertake urinary tract operative procedures (M Code) has significantly reduced. A small number continue to undertake diagnostic cystoscopies, which to varying degrees represents a substantial proportion of their workload. Should any subsequent treatment be required, the patient is referred into the Urology Team. A General Surgeon in the Northern Trust continues to undertake Inpatient and Day Case "M" code work in the Mid-Ulster Hospital.

Recommendation

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.

2.13 Peno-scrotal operative procedures ('N' Code) continue to be undertaken by many General Surgeons predominately based outside of Belfast. This position is not surprising given the current number of urologists in the Southern, Western and Northern Trust areas.

2.14 Table 1 below identifies the type, volume and surgical speciality for N Code work.

Table 1 - Analysis of 'N' Code (Male Genital) Surgical Operations and Procedures Undertaken by Urologists and General Surgeons (2007/08)

Trust	Total Activity	General Surgeons	Urologists	% of 'N' Code undertaken by Urologists	Number / % undertaken as day case		V	C	H
NHSCT	807	767	40	5%	701	87%	517	129	35
SHSCT	612	521	91	15%	493	81%	314	135	36
WHSCT	614	544	70	11%	528	86%	318	143	38
SEHSCT	1244	650	594	48%	1148	92%	860	147	45
BHSCT	674	103	571	85%	407	60%	209	164	49
Total	**3951**	**2585**	**1366**	**35%**	**3277**	**83%**	**2218**	**718**	**203**

V **Vasectomy**
C **Circumcision**
H **Hydrocele**

2.15 Consultant General Surgeons have gained substantial experience and expertise in these procedures over the years and it is not envisaged that Trust's should make any immediate plans to pass this work onto Urologists. However, it is likely that future appointees to Consultant General Surgeon Posts, will have had little experience in undertaking such procedures and therefore Trust's will need to plan and consider the implications of impending retirements in General Surgery.

Recommendation

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.

2.16 Gynaecology is another specialty which undertakes urinary tract diagnostic and operative 'M' code procedures and medical treatments for female bladder dysfunction (non cancer) and incontinence. The surgical specialty of Uro-Gynaecology has developed in the last decade, with most Trusts now having trained surgeons in post, for whom, such surgical procedures, represent a significant proportion of their surgical workload.

2.17 More complex surgical procedures are referred to Urologists and this aspect of Urology is termed as female/functional Urology. The demand for these specialist surgical services is increasing and there is a need, in some cases, to have joint working e.g. complex cancer Gynaecological Surgery and complex Urological Surgery.

2.18 Female continence (stress and urge incontinence) services (non surgical) are provided in Primary Care, Community Services and in Gynaecology Secondary Care. However, *there is evidence of large undeclared demand for continence services which is held in check by the embarrassment factor* (Action On Urology). Current services in NI are fragmented, disparate and are not managed in accordance with NICE Guidelines –Urinary Incontinence: The Management of Urinary Incontinence in Women (2006).

2.19 The referral review exercise undertaken as part of the review demonstrated that GP's are not generally referring these patients into urology and as 80-90% of such patients will not require surgical intervention, it was agreed that this service would not be considered as part of this review. However, it is clear from developments

elsewhere in the UK, that continence services can be significantly enhanced and redesigned within a multidisciplinary team model (GP's, Urologists, Gynaecologists, Physiotherapists and Nurse Practitioners) and is very suitable for development in a non secondary care environment.

Recommendation

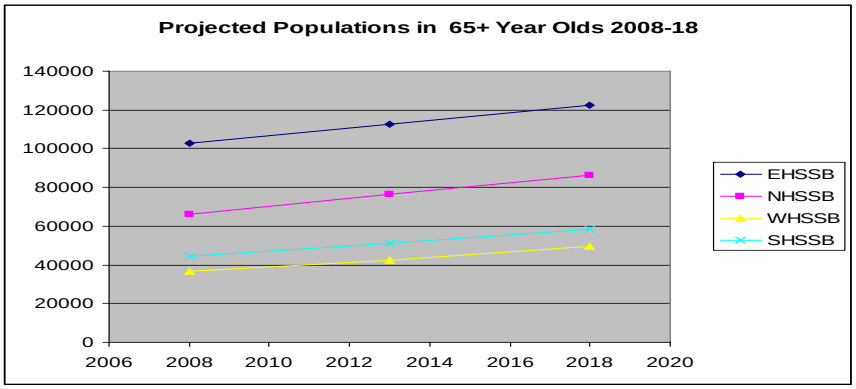
3.	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Demography

2.20 The current population in Northern Ireland is 1.76 million with a projected rise to 1.89 million by 2018. The greatest increase will be seen in the 65+ year age group from 249,663 in 2008 to 316,548 (+27%) in 2018. This is particularly relevant for Urology as it is the ageing population that makes the heaviest demands upon Urology care (cancer and non cancer).

Figure 1

Demography 65+ years (Health and Social Services Boards)



Source NISRA

Total	249,663	282,877	316,548

3. CURRENT SERVICE PROFILE

Location of Urology Services

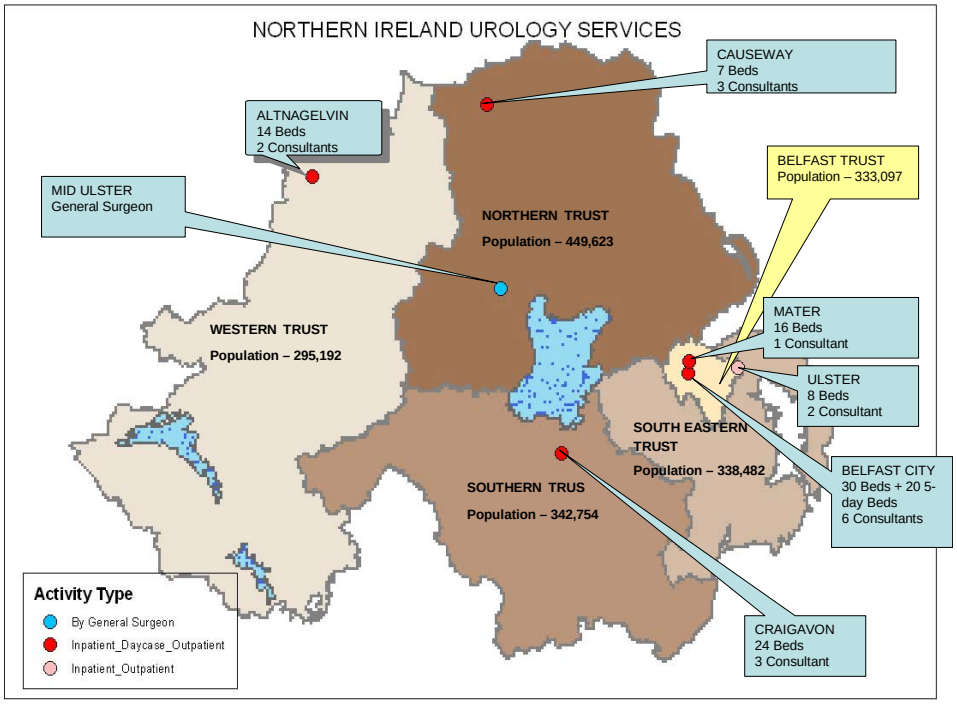
3.1 Consultant led Adult Urology Services are provided in each of the five Trusts. Table 2 below outlines the number of Consultants, Specialist Nurses and Main Hospital bases.

Table 2 – Consultant/Nurse Staffing and Inpatient Units

	Northern	Southern	South Eastern	Western	Belfast	Total
Consultants	3	3	2	2	7	17
Specialist Nurses	3	2	1	3 (2.6 WTE)	3	12 (11.6 WTE)
Hospital Base	Causeway	Craigavon	Ulster	Altnagelvin	BCH/ Mater	

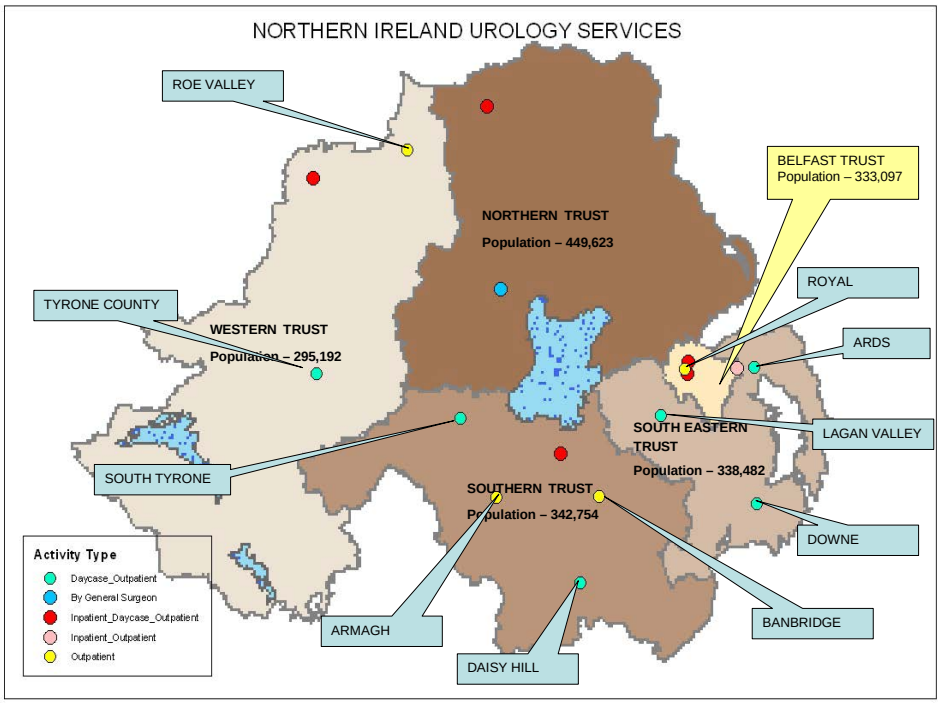
3.2 Figure 2 depicts the five Trusts, their respective resident population, and location and number of Inpatient beds.

Figure 2 – Urology Services – Inpatient Services



3.3 Figure 3 layers on the additional sites within each Trust which provide a range of Outpatient, and Day Surgical Services.

Figure 3 – Urology Services – Outpatients, Day Surgery



3.4 Figures 2 and 3 identified the resident populations for each of the 5 Trusts, however, the actual catchment populations significantly differ when adult only services and patient flows are considered. Table 3 indentifies the inpatient and day case population served by each Trust/Consultant.

Table 3 – Catchment populations served by each Trust

	Consultant urological surgeons number	Inpatient catchment population	Inpatient catchment population per consultant	Daycase catchment population	Daycase catchment population per consultant
BHSCT	7	873,000	124,700	646,000	92,300
NHSCT	3	218,000	72,700	245,000	82,000
SEHSCT	2	130,000	65,000	321,000	160,000
SHSCT	3	305,000	102,000	287,000	96,000
WHSCT	2	236,000	118,000	262,000	131,000
Total	**17**	**1,762,000**	**103,000**	**1,762,000**	**103,000**

3.5 This analysis demonstrates a significant flow of inpatient/day case work (and therefore outpatient/assessment and diagnostic workup) from the Northern Trust area to Belfast. It also demonstrates that although South Eastern Trust services a significant catchment population for day case work (and outpatient, assessment and diagnostics) it serves a smaller proportion of its population with inpatient care. This is due to the fact that a significant volume of outpatients, diagnostics and day surgery is undertaken in the Lagan Valley Hospital by a Consultant Urologist outreached from Belfast. Any subsequent inpatient treatment is then carried out in BCH.

Outpatient (new) Services

3.6 A referral review exercise was held in December 2008, at which a number of primary and secondary care clinicians (5 General Practitioners and 5 Consultant Urologists) and Trust Managers undertook a quantitative and qualitative analysis of all new outpatient referrals received (368) in Urology for a full week in November 2008.

Table 4 - Analysis of Urology Referral Letters

Gender	Belfast	Northern	Western	Southern	SE	Regional
Male	111	39	34	42	55	**281**
Female	33	13	10	11	18	**85**
Blank	0	1	1	0	0	**2**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Age Range	Belfast	Northern	Western	Southern	SE	Regional
0-14	2	0	0	1	0	**3**
15-30	17	4	5	3	7	**36**
31-40	19	4	5	8	4	**40**
41-50	29	9	4	7	5	**54**
51-60	18	13	9	6	4	**50**
60+	59	22	22	28	9	**140**
Blank	0	1	0	0	44*	**45**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Urgency	Belfast	Northern	Western	Southern	SE	Regional
Red Flag	6	2	3	3	4	**18**
Urgent	30	11	10	10	12	**73**
Routine	108	40	32	40	57	**277**
Blank	0	0	0	0	0	**0**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Named Cons	Belfast	Northern	Western	Southern	SE	Regional
Y	35	13	6	12	15	**81**
N	109	40	39	41	58	**287**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Ref Source	Belfast	Northern	Western	Southern	SE	Regional
Non-GP ref's	15	12	1	5	14	**47**
GP Ref's	129	41	43	48	59	**320**
Blank	0	0	1	0	0	**1**
Total	**144**	**53**	**45**	**53**	**73**	**368**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

** Data on percentages is **Appendix 4**

3.7 Regionally 76% of the referrals were male, which was to be expected. 87% of the referrals were from GPs with the remaining 13% spread across Consultant to Consultant (internal and external), A&E referrals and other sources. 78% of the referrals were referred into Urology as a specialty, with only 22% having a named Consultant. Regionally (excluding SET) 63% of the referrals related to the over 50's age range. Referrals marked by GPs as red flag or urgent represents 25%.

3.8 A breakdown of the referrals by presenting symptoms/conditions is in Table 5 below. Data on percentages is included in Appendix 5. Clinicians have indicated that this outcome is fairly representative of the nature and type of referrals they receive.

Table 5 - Analysis of presenting symptoms/conditions

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**19**		**10**		**10**		**5**		**12**		**56**	
	frank		*11*		*3*		*4*		*2*		*6*		*26*
	microscopic		*6*		*5*		*6*		*2*		*6*		*25*
	blank		*2*		*2*		*0*		*1*		*0*		*5*
Prostate/raised PSA		**14**		**7**		**8**		**9**		**12**		**50**	
Other		**21**		**4**		**5**		**8**		**8**		**46**	
Ncode procedure (All)		**21**		**2**		**1**		**3**		**14**		**41**	
	vasectomy		*11*		*0*		*1*		*1*		*4*		*17*
	foreskin		*1*		*0*		*0*		*2*		*7*		*10*
	epididymal cyst		*3*		*2*		*0*		*0*		*3*		*8*
	hydrocele		*4*		*0*		*0*		*0*		*0*		*4*
	varicocele		*1*		*0*		*0*		*0*		*0*		*1*
	blank		*1*		*0*		*0*		*0*		*0*		*1*
Recurrent UTI's		**17**		**9**		**4**		**6**		**4**		**40**	
LUTS		**11**		**7**		**2**		**5**		**7**		**32**	
Prostate/BPH/prostatitis		**11**		**5**		**4**		**6**		**2**		**28**	
Renal stones/colic/loin pain		**11**		**5**		**1**		**2**		**4**		**23**	
Testicular/ Scrotal lumps or swelling		**8**		**0**		**5**		**0**		**8**		**21**	
Andrology (ALL)		**7**		**2**		**3**		**6**		**2**		**20**	
	erectile dysfunction		*2*		*2*		*0*		*3*		*1*		*8*
	Peyronie's disease		*2*		*0*		*2*		*0*		*0*		*4*
	blood in ejaculate		*3*		*0*		*0*		*0*		*0*		*3*
	ulcer/lesion on gland		*0*		*0*		*1*		*1*		*0*		*2*
	balanitis/discharge		*0*		*0*		*0*		*2*		*0*		*2*
	Blank		*0*		*0*		*0*		*0*		*1*		*1*
Unknown		**3**		**1**		**1**		**2**		**0**		**7**	
Ca Bladder/Kidney		**1**		**1**		**0**		**1**		**0**		**3**	
Blank		**0**		**0**		**1**		**0**		**0**		**1**	
Total		**144**		**53**		**45**		**53**		**73**		**368**	

3.9 The categorisation of patients by presenting symptoms/condition is a useful process and the outcomes of this exercise should assist Urology teams in determining the nature and frequency of assessment and diagnostic clinics. There was an overlap in symptoms for some patients e.g. many patients with enlarged prostate, known benign prostatic hyperplasia (BPH) or prostatitis have a range of lower urinary tract symptoms (LUTS). However, for the purposes of this exercise, if prostatic disease was identified on the referral letter, these patients were recorded as such, whereas patients presenting with just LUTS were categorised as such. Where LUTS

services are in place, both of these groups of patients are seen and treated within the same pathway.

3.10 General comments;

- A small number of the referrals (<10) were not for a new outpatient appointment but were asking for a review appointment, which was overdue, to be expedited. In addition, a small number of referrals (<10) were for patients who had been discharged from outpatients due to not responding to a booking letter or had DNA'd and who had subsequently visited their GP and asked for another referral to be processed.

- In overall terms, the quality and appropriateness of the referrals was deemed to be good. Internal referrals (A&E, inpatient etc) were often handwritten and were not as structured as GP referral letters.

- The exercise included looking at the time between the date recorded on the referral letter and the hospital date stamp indicating receipt. A significant variance between these two dates was noted in internal referrals (Consultant to Consultant). There did not appear to be any significant delays with regard to GP referrals.

Recommendation

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.

- Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. This is particularly relevant when considering the service capacity requirements to assess and investigate potential cancers within cancer standard timescales. This has been confirmed in a recent Cancer Registry, full year analysis of the cancer waiting times database, with a total of 700 red flag GP referrals and 875 referrals which Consultants upgraded to red flag at triage recorded.

- It has been noted that the development of agreed referral guidelines/criteria for suspected Urological cancers is a priority piece of work for the recently formed NICaN Group and this should work should be advanced as soon as possible.

Recommendation

5.	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.

Areas of Urology

3.11 As a specialty, Urology can be sub-divided into a number of special interest areas, most of which also comprise elements of general or 'core' Urology work.

3.12 **Core Urology** includes the assessment, diagnosis, medical treatment and (non complex and/or endoscopic) surgical treatment of diseases/conditions of the kidney,

bladder, prostate, penis and scrotum. LUTS, BPH, haematuria, simple stones, erectile dysfunction (ED) and 'N' code work are considered to be core Urology. Urologists in NI, regardless of special interest area, all provide core Urology services. Over 80% of all 'M' and 'N' code inpatient and daycase procedures are peno-scrotal, cystoscopy, TURBT (trans urethral resection of bladder tumour), TURP (trans urethral resection of prostate) and urethral catheterisation.

3.13 **Uro-Oncology.** Around 40% of Urology work is cancer related and most of the assessment, diagnostics and medical/ simple surgical treatments are appropriately undertaken at local level. Less than 10% of Urological cancers require radical/complex surgery. (see section 7).Specialist cancer services are based in BCH, where there are three designated 'cancer' Urologists. One Urologist in Altnagelvin and one/two in Craigavon would also be considered to have a special interest in cancer.

3.14 **Stones/Endourology** includes the management and treatment of renal and ureteric calculi. This involves open surgery, endoscopic intervention or stone fragmentation using multimodal techniques such as laser, lithoclast with or without US (ultrasound) and ESWL (Extracorporeal shock wave lithotripsy). Craigavon has the only fixed-site lithotripter, with BCH and Causeway serviced by a mobile facility on a sessional basis. With regard to special interest Urologists, there are currently two in Belfast Trust and one in each of the other four Trusts.

3.15 **Andrology** includes the treatment of erectile dysfunction, particularly post prostate surgery, penile curvatures and deformities (Peyronie's disease) and other conditions of the male reproductive organs. Currently all Consultants provide andrology services within their commitment to core Urology. The service would benefit from having a specialist Urologist to manage and treat the more complex cases, including penile prostheses work.

3.16 **Reconstruction,** which is often combined with the functional side of Urology, includes reconstruction of urinary continence in men, bladder reconstruction after oncological surgery and in a neuropathic bladder, e.g. spina bifida, spinal cord injury, bladder reconstruction in congenital and developmental LUT pathology (adolescent), urethral reconstruction for strictures and reconstruction prior to transplantation. There are currently two Consultants (one on long term sick leave) in Belfast who specialise in this area, working closely with the Uro-oncology team and with supra regional support provided by University College Hospital London.

3.17 **Female/functional** relates to the management and treatment of incontinence and bladder dysfunction in women, which on some occasions overlaps with reconstruction surgery. Some of this work is undertaken by Urologists however, the majority is undertaken by Uro-Gynaecologists as outlined in section 2. There is a shared view among Urologists that each Urology team should have at least one Urologist with a special interest in female/ functional Urology, and who for this aspect of their work, should work within a multidisciplinary team of Gynaecologists, physiotherapists and nurse practitioners in providing care for urinary incontinence, prolapse and fistula repair.

Recommendation

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

Non-Elective Services

3.18 There are approximately 2,500 non-elective FCE's (coded as Urology on admission or discharge) per annum (approximately 7 a day) with little variation in these numbers from year to year.

3.19 In broad terms, non-elective admissions fall into the following categories;

- Testicular torsion/infections
- Renal colic/Acute kidney obstruction
- Infection—recurrent UTI's/ pyelonephritis
- Urinary retention /haematuria

3.20 The majority of admissions fall into urinary retention and renal colic which do not usually require an immediate surgical operation, neither does treatment of infections. Testicular torsion and acute kidney obstruction require emergency (often surgical) intervention.

3.21 There are currently 15 hospitals in NI with A&E Departments (varying opening times) and acute medical and surgical facilities. With the implementation of DBS (Developing Better Services) this position will change in future years. However, for the purposes of this review the profile of services and location of non-elective Urology patients is assumed to be as is at present.

3.22 The majority of non-elective admissions are admitted to the 'presenting' acute hospital and unless it is BCH or CAH are admitted (out of hours) under General Surgery, until transfer to the care/specialty of Urology, if appropriate, on the next working day.

3.23 Even in a redesigned Urology service it is not envisaged that these arrangements will change for the foreseeable future, as it would not be viable to provide 24/7 onsite Urology cover in all 15 hospitals. However, the requirement to have clearly defined protocols and pathways in place for the management of these admissions has been identified.

Recommendations

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.

ICATS (Integrated Clinical Assessment and Treatment Services)

3.24 ICATS was launched in NI in 2005/06, as one element of the Department's Outpatient Reform Programme and in response to very lengthy waiting times for first outpatient appointments.

3.25 ICATS were designed to provide services, in a variety of primary and secondary care settings by integrated multidisciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. One of the fundamental elements was that many patients didn't need to be seen or assessed by a hospital Consultant at an outpatient clinic and that quick triage of referral letters and assessment and diagnostics by the most appropriate health care professional within ICATS teams, with onward referral to secondary care, only if required, would divert large numbers of outpatient referrals from hospital consultants. Another fundamental design principle was that non urgent referrals would, in the first instance, go to ICATS to be triaged and that all subsequent flows to secondary care consultants would be from the ICATS team.

3.26 It was agreed that, to begin with, ICATS would be implemented in a small number of core specialities (4) and these were identified based on those specialities with the highest volumes and longest waiting times in 2005/06. Urology was one of the 4 initial specialties identified. Across all ICATS specialties £2m was allocated in 2006/07, increasing to £9m recurrently from 2007/08.

3.27 The design of ICATS included 5 possible next steps/pathways for patients referred into the service-

- to diagnostics,
- for direct treatment on an inpatient/day case list,
- for return to primary care with advice on further management,
- to tier 2 outpatient services (non Consultant assessment and treatment) or
- to hospital (Consultant) outpatients.

3.28 For a variety of reasons, the development of Urology ICATS has been difficult, slower than planned and somewhat fragmented with regard to service model design, which differs significantly in each of the Board areas.

3.29 Table 6 below outlines the progress to date in Urology ICATS.

Table 6 - Urology ICATS - Current Position

Board Area	Current Position	Ring fenced funding/ Investment Made	Comments
NHSSB	Hospital based (Causeway) Nurse specialists undertaking mostly cystoscopies. Consultant led referral triage.	£642K	Original intention to expand nurse service to LUTS/haematuria/prostate clinics and review/follow-up clinics.
SHSSB	GPSI and specialist nurse Tier 2 clinics for haematuria, prostate, LUTS, stones, andrology. ICATS in separate building on Craigavon Area Hospital site. Consultant led referral triage.	£240K	Oncology review and urodynamics clinics being established.
WHSSB	Nurse led clinics (LUTS, prostate) and single visit haematuria clinics with nurse specialists/staff grade in place for some years. Predominately hospital based (Altnagelvin). Consultant led referral triage.	£211K	ICATS plan now approved – expanding diagnostic, LUTS services and involving GPSI'S in referral triage process in order to improve links with primary care and improve referral information and patterns.
EHSSB	SET – plan approved by EHSSB late 2008. Nurse specialist undertaking cystoscopies for some time outwith any ICATS model. BELFAST – no progress but nurse led services in place for some time and single visit haematuria clinic established late 2008. Consultant led referral triage in both SET +Belfast	£350K	GPSI'S appointed some time ago but posts not yet activated.

3.30 It is clear that Urology services have been developing non Consultant delivered outpatient, assessment and diagnostic services, such as haematuria, LUTS, ED, prostate, stones etc for some years prior to the launch of ICATS. These services were/are largely provided by nurse specialists, staff grades and radiology staff in a hospital environment.

3.31 Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process.

3.32 They indicate that they are fully committed to developing further non Consultant assessment, diagnostic and some treatment services and supportive of *providing appropriate, safe and sustainable, cost effective care closer to home, so that urology services are delivered in the right setting, with the right equipment, performed by the appropriate skilled person* (NHS, Providing Care for Patients with Urology Conditions- Guidance).

3.33 This approach was evident during the referral review exercise in December 2008, with Consultants readily indicating that patients should be booked straight into diagnostics or nurse led clinics such as LUTS, prostate, haematuria.

3.34 Consultant Urologists are very clear that the need to ensure that whoever the specialist practitioner is and wherever they work, they should be part of, or affiliated to, the local Urology team, led by a Consultant Urologist.

3.35 In light of the already changing shape of Urology services and the further developments that will arise out of this review, it is appropriate and timely to take stock of ICATS, its design principles and future development and investment. A review of all ICATS Services is planned for the first quarter of 2009/10 year and the outcomes of this review should guide the future direction of travel for ICATS services within Urology .

Recommendation

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.

Links with Renal Transplantation

3.36 Renal transplantation is the definitive preferred treatment for end-stage renal failure. Kidneys for transplantation become available from either deceased or live donors. In 2006 the DOH commissioned a Taskforce to investigate and make recommendations to increase the level of organ donation. In 2008/09 the DHSSPS set a target for access to live renal transplantation and investment has been made to increase the live donor programme at Belfast City Hospital.

3.37 There are currently two wte transplant surgeons in post, a long-term locum transplant surgeon and in addition there is 0.2 wte input from an Urologist. The Urologist only undertakes live donor kidney retrieval using laparoscopic techniques, which is an essential quality component for the live donor programme.

3.38 Taskforce recommendations would suggest that cadaveric retrievals and transplantations should be increased to 50 per year (currently approximately 30) and within Priorities for Action there is a target for an additional 20 live donor retrievals and transplantations per year by March 2011. With the increase in laparoscopic live donor retrieval, additional input from Urologists may be needed and the current review of the renal transplantation service will need to take account of this requirement, along with the Urology input required if any reconstruction of the urinary drainage system is needed before transplantation.

4. CAPACITY, DEMAND AND ACTIVITY

4.1 Urology is a specialty that is categorised by high numbers of referrals for relatively simple initial diagnostics (often to exclude pathology) or surgical procedures. In addition, around 40% of Urology is cancer related and as more elderly patients are referred and treated, there is a need for follow-up services and patient surveillance.

4.2 The increasing demand for Urology services in Northern Ireland is similar to that being experienced in the rest of the UK.

4.3 The Action On Urology Team (March 2005) reported that:

Demand for Urology services is rising rapidly and the pattern of disease is changing.

- *There is an overall rise in demand from an ageing population especially the over 50's who make the heaviest demands upon Urology care.*
- *Prostate disease incidence is rising rapidly and PSA requests are generating further demand.*
- *Haematuria/bladder disease demand is also rising, stimulated by the combined availability of dipsticks and flexible cystoscopes.*
- *Work is shifting away from surgery towards diagnostics and medical treatment.*

4.4 In addition, there has been an increased "medicalisation" of Urology as the pharmacology of the urinary tract has become better understood and the increasing availability and ever improving range of drugs.

Activity/Demand/Capacity Analysis

4.5 During the review detailed analysis was undertaken by SDU and the Boards, and the following represents the most accurate information available at this time.

Outpatients

4.6 New outpatient referrals and attendances (activity) have been increasing year on year. Not all referrals result in attendance as many are removed for "reasons other than treatment" (ROTT) and are appropriately discharged from the system without having been seen.

4.7 The most recent analysis undertaken is estimating an 18% increase in predicted (GP) demand from 2007 to 2008 (2008 ROTT rates applied). This does not however represent a 'true' picture as during this period two Trusts changed their recording/management of activity from General Surgery to Urology. It has been difficult to quantify, with a degree of accuracy, the impact of these changes on the information, as increases, (albeit smaller), in General Surgery are also being estimated. Notwithstanding the above difficulty, it has been accepted that there is a significant increase in demand, which is likely to be between 10 and 15%. It has also been concluded that this increase is likely to be as a result of those factors outlined at the beginning of this section i.e. ageing population, patient expectation and demand with the increased emphasis on men's health, changing pattern of disease, availability of assessment and diagnostic modalities to exclude pathology, along with decreasing waiting times and previously unmet need.

4.8 A regional referrals management review, led by SDU Primary Care advisors is due to commence in April 2009.

Table 7 - Urology – Service and Budget Agreement Levels and Activity

	SBA (1)	07/08 Outturn(2+4)	Projected 08/09 Outturn (3+4)
Elective Inpatients	4,155	4,937 + 295(IS)	5,823+606(IS)
Non-elective Inpatients	2,109	2,369	2,496
Daycases	8,715	12,416 + 462 (IS)	13,252+1028(IS)
New Outpatients	5,824	7,593 + 571 (IS)	9,984 +519(IS)
Review Outpatients	12,566	15,967	19,224

(1) Information from 4 Boards SBAs
(2) 2007/08 outturn from PAS (includes in-house additional activity)
(3) Projected 2008/09 outturn (including in-house additional activity) based on November 2008 position
(4) IS information provided by EHSSB

4.9 In 2008, the Boards completed a detailed capacity and demand model across a number of specialities, inclusive of Urology. A number of assumptions/estimates were applied and both the recurrent gap against SBA and non-recurrent (backlog) was identified. The recurrent gap does not take account of growth in demand. The backlog (non-recurrent) gap relates to the in-year activity required due to the need to reduce waiting times for inpatient/day cases and outpatients to 13 and 9 weeks respectively by March 2009.

4.10 It has been agreed that the maximum elective access waiting times for 2009/10 will remain at 13 and 9 weeks and with a year of steady state, Trusts and Commissioners will therefore be better placed to assess both the 'real' demand and capacity to treat.

4.11 As part of this review EHSSB undertook further analysis of demand and capacity within urology and identified a significant recurrent gap, against SBA volumes.

Conclusion

4.12 Both the demand and activity in Urology is significantly greater than the current SBA volumes. Some of this is non-recurrent backlog created by the reducing waiting times since 2005/06 and the remainder is recurrent based on 2007/08 demand. Significant non-recurrent funding has been allocated in recent years to ensure Trusts were able to undertake this activity and to meet the elective access waiting times and cancer access standards. Within Trusts large numbers of additional clinics and theatre sessions have been funded non-recurrently and there has also been significant use of the independent sector.

4.13 Both increased and additional capacity to assess and treat patients is urgently required in Urology. However, additional recurrent investment in capacity (resources-human and physical) which is required in this speciality and is detailed later in this report is not the only solution. Trusts will also be required to ensure optimum use and efficiency of their existing capacity and will need to be creative in developing new ways of working and re-designing and modernising services to increase the capacity already in the system and to manage the increasing demand into secondary care.

4.14 The IEAP (Integrated Elective Access Protocol) provides detailed guidance on tried and tested systems and processes which ensure effective and efficient delivery of elective services, along with improvements to the patient experience. The Scheduled Care Reform Programme (2008-10) includes significant developments such as, pre-op assessment, admission on day of surgery, increasing day surgery rates, reducing cancelled operations, optimising the use and productivity of theatres, booking systems and a management of referral demand exercise. All of these will build/create additional capacity within the system.

Recommendation

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

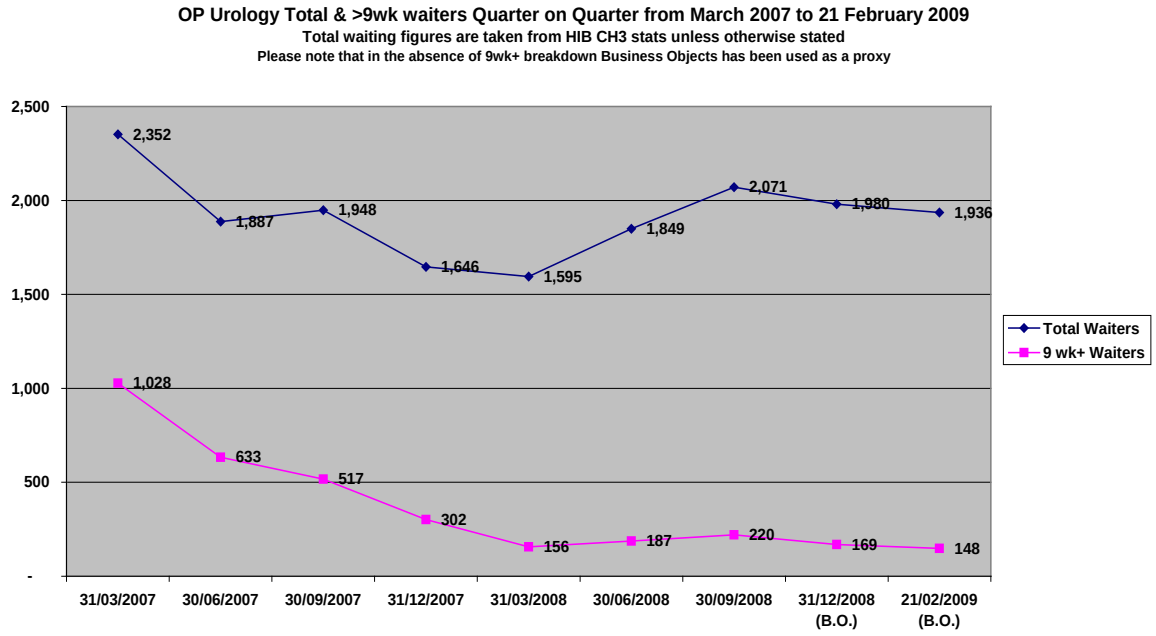
5. PERFORMANCE MEASURES

Elective access waiting times

5.1 There have been significant reductions in waiting times since 2005, in line with PFA (Priorities for action) targets and as a result of the elective reform and modernisation programme.

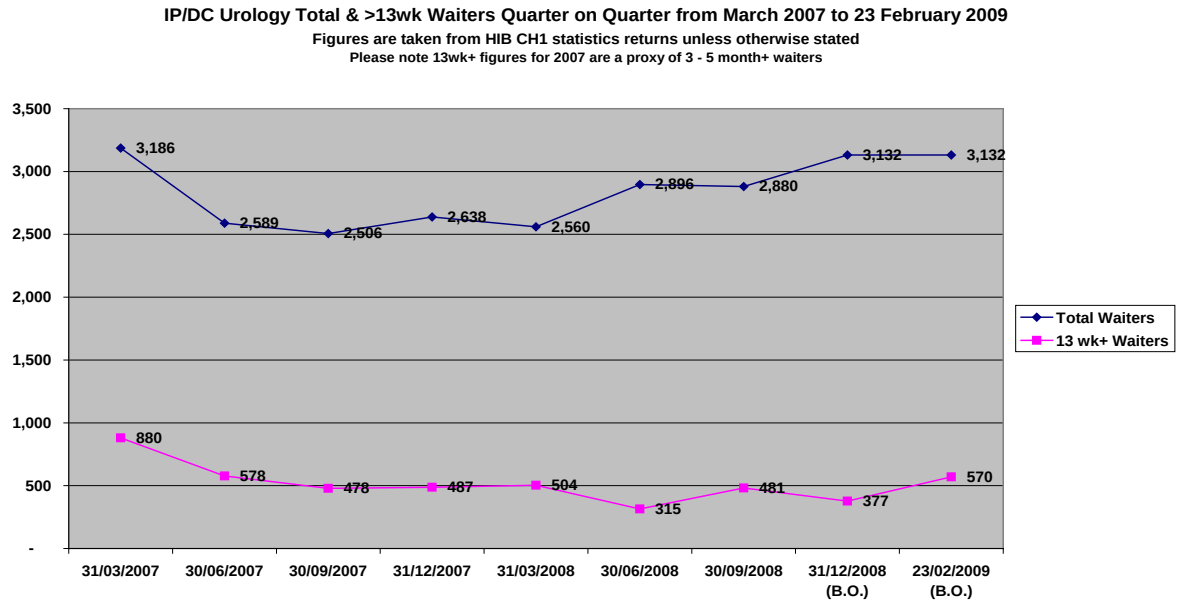
PFA 2008/2009: By March 2009, no patient should wait longer than 9 weeks for first outpatient appointment and/or diagnostics
By March 2009, no patient should wait longer than 13 weeks for Inpatient or daycase treatment.

Figure 4



(B.O. – refers to Business Objects)

Figure 5



5.2 As at February 2009, all Trusts, with the exception of Belfast, are indicating that they will meet the target waiting times for outpatients, diagnostics, Inpatients and daycases. Belfast Trust is reporting in excess of 100 anticipated breaches in Inpatient/daycase work.

Urology Cancer Performance

5.3 The Cancer Access Standards were introduced from April 2007. These introduced waiting times standards for suspected cancer patients both urgently referred by the General Practitioner or those referrals triaged by the Consultant as suspected cancer. It also set standards for those patients diagnosed with cancer and how long they should wait for treatment.

5.4 The 2008/09 Cancer Access Standards were defined as below:

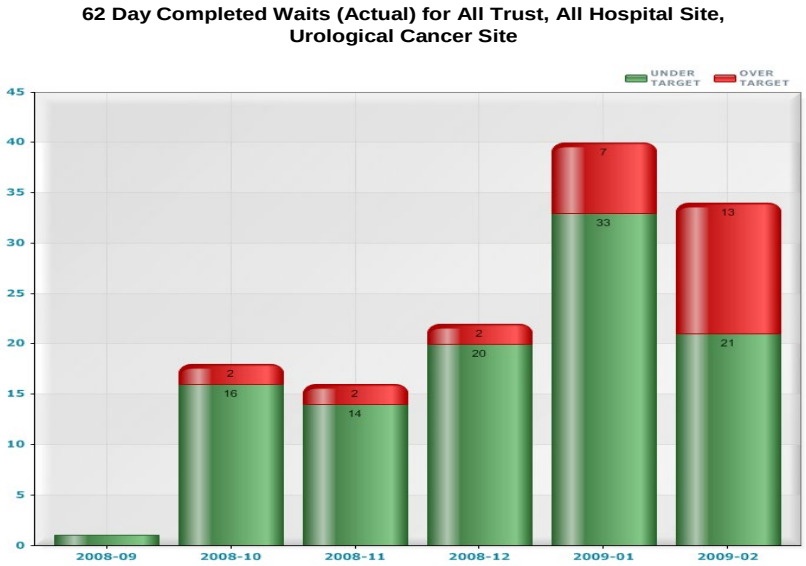
- 98% of patients diagnosed with cancer from decision to treat, should begin their treatment within a maximum of 31 days
- 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days.

* decision to treat is the date on which the patient and clinician agree the treatment plan.

5.5 It is recognised that a considerable amount of the actions required to achieve the cancer access standards are associated with service improvement. These include the identification and agreement of the suspected cancer patient pathway, the introduction of robust administrative systems or processes and the proactive management of patients.

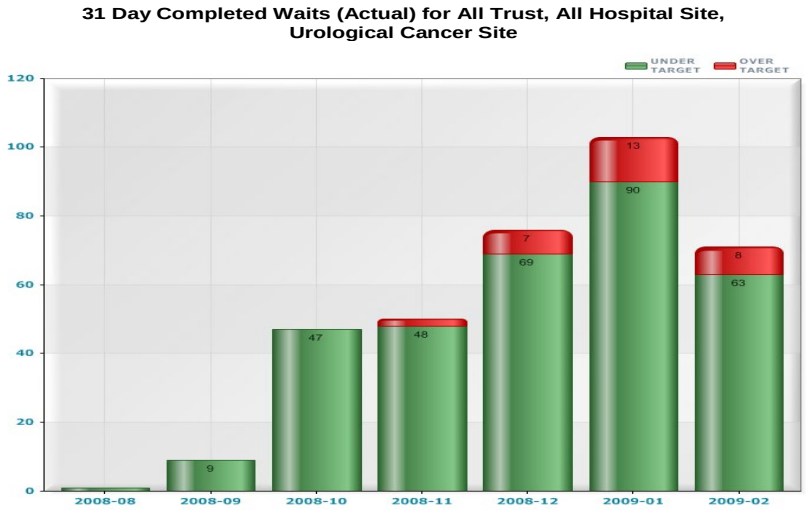
5.6 The recent cancer access standard performance in relation to the 62 day standard shows that up to 24 February 2009, across all Trusts, the number of Urological cancer patients achieving the 62 day standard is at 62%. This shows that of the 34 confirmed cancers treated up to this date, 13 of these had not been treated within 62 days.

Figure 6



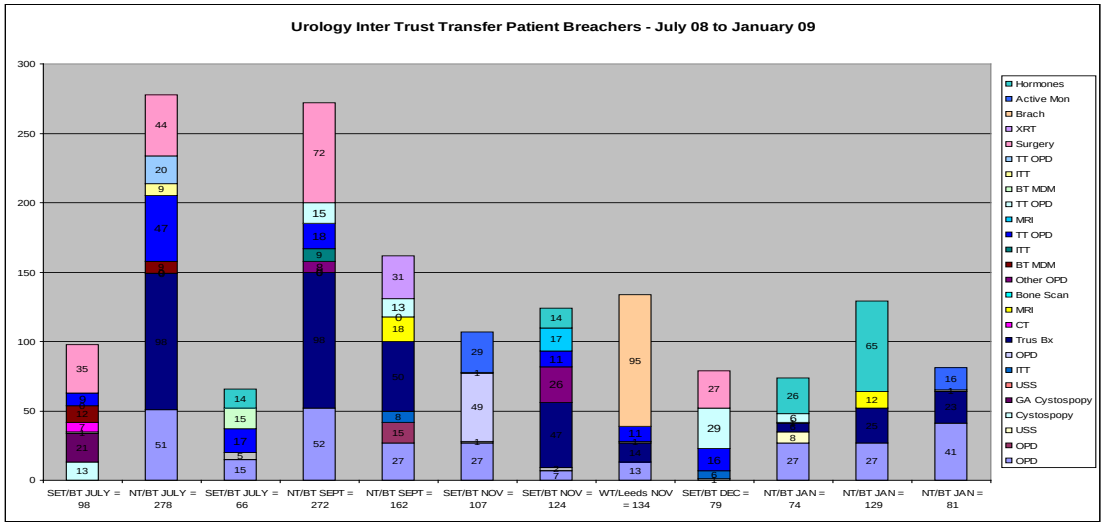
5.7 For the same period in February, the performance in relation to the 31 day standard shows that, only 87% of those Urological cancer patients (63 of 71 patients) were treated within 31 days of the decision to treat. From a sample of 9 patients that breached the 31 day standard in January 2009, they waited on average 50 days from their decision to treat to their first treatment.

Figure 7



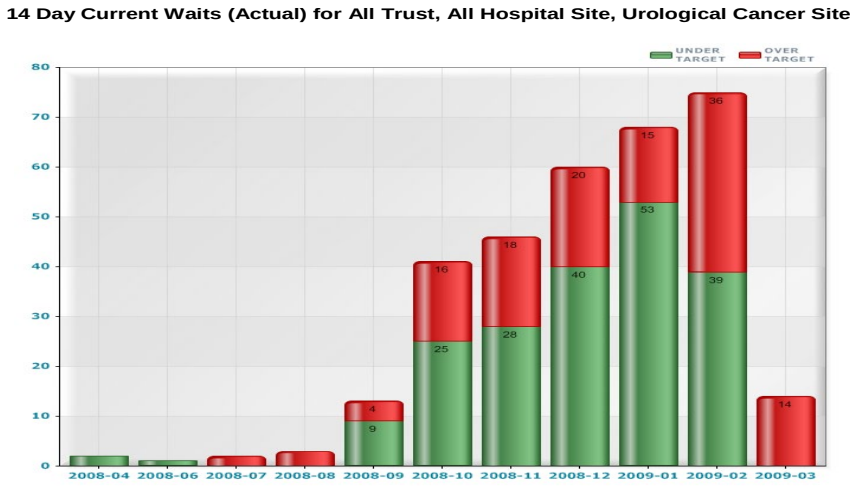
5.8 It is accepted that those patients who transfer from one Trust to another for treatment are more likely to breach the target, than those who remain within the one Trust for their complete pathway. These patients are referred to as Inter Trust Transfer (ITT) patients. These ITT patients that breach the target are analysed in more detail. The detail for the period July 2008 to January 2009 is shown on Figure 8 below. This shows that of the suspected 'red flag' cancer patients referred who breached the 62 day target, 12 of these were ITT patients and they waited from 66 to 278 days from referral to their first treatment. It is accepted as a regional standard, for all tumour sites that if the patient is to be transferred for treatment, all diagnostic investigations should be completed and the patient should be ready for transfer by day 28 of the 62 day pathway. From this evidence it shows that this is not happening in the majority of cases.

Figure 8



5.9 Whilst this analysis only refers to ITT patients, it is probably representative of the pathway for those patients that breach the target and remain only within the one Trust. For example, for the 'front end' of the patient pathway, the number of days the patient can wait for their initial outpatient appointment and subsequent investigation can be over 150 days. This has improved in recent months, but to achieve the 28 day standard this should be completed within approximately 21 days. This is further evidenced by the analysis of the 14 day waiting times for suspected Urological cancers referrals; this showed that of the referrals seen in February only 52% were seen within 14 days. As highlighted any delay at the front end of the pathway will have an impact on the Trusts ability to achieve the treatment times and the 62 day standard.

Figure 9



5.10 Whilst it is clear that some element of redesign of the pathway is required, the evidence appears to indicate that for the number of suspected 'red flag' cancer referrals received or triaged by the Consultants, additional capacity at the front end to complete timely investigations is required. For example, the introduction of one-stop clinics for investigations such as haematuria can have an impact and reduce the number of days the patient waits for investigations as well as reducing the number of times that the patient has to attend the hospital. This needs to be matched with sufficient Consultant capacity for treatments, including theatre capacity, Oncologists for oncology and radiotherapy.

5.11 All Trusts have reported that Urology is the key tumour site which they are at most risk with and their achievement of the cancer access standards by March 2009. In addition, at a recent ITT Executive Directors Services Steering Group the Belfast Trust reported they estimate 15 to 20 urological patients will breach the cancer access standards. Some of this is due to the late transfer of patients, but also due to a lack of available Consultants and theatre capacity. If the number of patients forecasted breach the target, this will mean that as a region NI will not achieve the cancer access standard.

Recommendation

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.

NHS Better Care, Better Value Indicators

5.12 A number of better care, better value Indicators are useful performance measures to apply to Urology in assessing levels of efficiency, productivity and patient experience.

5.13 Length of stay (LOS) is one of the greatest variables between Trusts, hospitals and individual Consultants. By reviewing and improving admission and discharge processes, Trusts can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money.

5.14 Some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater co-morbidity and patients with higher levels of social deprivation.

Table 8
Urology Episodic Average Length of Stay (06/07, 07/08, 08/09 - Apr 08 to Nov 08)

	Elective			Non Elective		
	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Regional average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

	Elective			Non Elective		
Trust	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	3.9	3.4	3.3	5.5	4.9	5.0
Northern Health and Social Care Trust	2.3	2.9	2.5	4.3	5.4	5.6
South Eastern Health and Social Care Trust	3.8	3.9	3.3	3.9	4.4	3.4
Southern Health and Social Care Trust	3.7	4.0	3.5	4.5	4.8	4.9
Western Health and Social Care Trust	3.6	2.8	3.1	3.9	3.8	3.7
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

	Elective			Non Elective		
Site	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	3.6	2.8	3.1	3.9	3.8	3.7
Belfast City Hospital	4.1	3.5	3.4	5.5	4.7	5.0
Causeway	2.3	2.9	2.5	4.3	5.4	5.6
Craigavon Area Hospital	3.7	4.0	3.5	4.5	4.8	4.9
Down and Lisburn	1.0	0.0	1.2	0.0	0.0	0.0
Mater Infirmorum Hospital	3.2	2.7	2.5	5.9	6.4	5.0
The Royal Group of Hospitals	0.0	0.0	0.0	0.0	0.0	0.0
Ulster Community and Hospitals	3.8	4.0	3.5	3.9	4.4	3.4
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.15 All Trusts have longer average LOS for non elective patients than elective. The Southern Trust has the longest average LOS for elective patients and for elective and non-elective combined. Northern Trust has the shortest elective LOS which reflects their lower levels of major surgery.

5.16 Hospital Episode Statistics (HES) data, which combines elective and non-elective LOS, indicates a reduction in England over a three year period from an average of 3.8 days in 2005/2006 to 3.3 days in 2007/2008. Only South Eastern and Western Trusts have an average (combined) LOS of less than 4 days.

Recommendations

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.

Day Surgery

5.17 For any surgical operation there is a large variation in performance throughout the UK with regard to time spent in hospital. Some units favour certain procedures to be performed on a day case basis while others, for the same procedure may regard an overnight stay as the norm. (BADS Directory of Procedures 2007)

5.18 Hospitals are increasingly focussing on the short stay elective pathway. Carrying out elective procedures as day cases, where clinical circumstances and specialist equipment and training allows, saves money on bed occupancy and nursing care, as well as improving patient experience and outcomes.

5.19 The Audit Commission has identified 25 operations across a number of surgical specialties which could be carried out as day cases and has set a target of an average day case rate of 75% across the 25 procedures. This target has now been adopted within Priorities for Action, to be achieved by March 2011. Three of the procedures specifically relate to Urology (orchidopexy, circumcision, transurethral resection of bladder tumour). BADS (British Association of Day Surgery) identifies another 28 Urology operations (M and N code) which could be done as day surgery. The BADS Directory also suggests a % rate that can be achieved, which is 90% for the majority of the operations.

5.20 Table 9 below identifies the day case rates (% of all elective work undertaken as day case) in Urology by Trust and by hospital. It excludes Independent Sector activity and cystoscopies (M45) and prostrate TRUS, +/- biopsy (M70), both of which are not considered to be 'true' surgical operations and could equally be treated and coded as an outpatient with procedure case.

Table 9 Urology Day Case Rates excluding M45 and M70.3 & Y53.2 (06/07, 07/08, 08/09- Apr 08 to Nov 08)
Independent Sector Activity has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional Total	50.0	48.4	48.7

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	47.1	42.9	46.4
Northern Health and Social Care Trust	31.1	32.6	27.9
South Eastern Health and Social Care Trust	78.0	74.0	69.9
Southern Health and Social Care Trust	43.7	45.4	49.1
Western Health and Social Care Trust	47.1	51.3	42.2

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	47.1	51.3	42.2
Belfast City Hospital	49.9	45.5	48.9
Causeway	31.1	32.6	27.9
Craigavon Area Hospital	43.7	45.4	49.1
Down and Lisburn	98.8	100.0	89.3
Mater Infirmorum Hospital	4.9	4.2	6.9
The Royal Group of Hospitals	100.0	100.0	100.0
Ulster Community and Hospitals	76.6	71.2	66.3

5.21 There is a significant variation in day case rates across the Trusts/hospitals, ranging from 30% in Northern to 70% in South Eastern. Some of this can be explained due to the variation in 'N' code work undertaken by Urologists as opposed to General Surgeons (see Chapter 2). Trusts have also reported that on some sites access to dedicated day surgery facilities is limited and that this hampers the development of short stay elective pathways.

5.22 The CSR (Comprehensive Spending Review) is driving Trusts to reduce inpatient costs and to redesign/remodel their bed stock. This along with day surgery targets in Priorities for Action and the HSC Board's Elective Reform Programme will require Urology services to be creative in the development of day and short stay surgery, ensuring the provision of a safe model of care that provides a quality service to patients.

5.23 Trusts will need to consider procedures currently undertaken using theatre/day surgery facilities and the appropriateness of transferring this work to procedure/treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery. Some operations will require specialised equipment and training for clinicians and some require longer recovery or observation times and so are only possible as a true day case if performed on morning sessions. Therefore, the development and expansion of day surgery may require reconfiguration of day surgery/main theatre lists, redesign of clinical pathways and investment in appropriate equipment/technology.

Recommendation

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.

Outpatients

Table 10

Urology Outpatient Attendances - Consultant Led (06/07, 07/08, 08/09 - Apr 08 to Nov 08) - New : Review ratios

Independent Sector has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional new to review ratio	1.93	2.04	1.93

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	1.68	2.14	1.97
Northern Health and Social Care Trust	1.97	1.74	1.46
South Eastern Health and Social Care Trust	1.15	1.10	1.09
Southern Health and Social Care Trust	4.04	3.27	3.85
Western Health and Social Care Trust	2.34	2.21	2.78
Average new to review ratio	**1.93**	**2.04**	**1.93**

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	2.34	2.21	2.78
Belfast City Hospital	1.84	2.90	2.44
Causeway	1.97	1.74	1.46
Craigavon Area Hospital	4.04	3.27	3.84
Down and Lisburn	1.06	1.18	1.24
Mater Infirmorum Hospital	1.63	1.11	1.47
The Royal Group of Hospitals	0.83	0.91	0.88
Ulster Community and Hospitals	1.19	1.07	1.01
Average new to review ratio	**1.93**	**2.04**	**1.93**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.24 Regionally, there is an average new: review ratio of 1:2, with little variation from year to year. English HES data for 2006/07 reports a 1:2.4 new: review ratio. Variations are to be expected between hospitals and individual Consultants when case mix and complexity are taken into account e.g. BCH, due to a more complex case mix and Lagan Valley/RGH due to the fact that only day surgery is undertaken on these sites.

5.25 Craigavon Hospital is an outlier with regard to review ratios, with Altnagelvin Hospital having the second highest ratio.

5.26 It is disappointing to note that at the time of this review Trusts have reported a total of 9,386 patients for whom the (intended) date of their review has past (some by many months). This is referred to as a review backlog and if most of these patients had been seen within the same 2008/09 timeframe for the data above, then the new: review ratios would have been higher, particularly in Belfast and Southern Trusts. (Backlog; Belfast 5,599, Southern 2,309, Northern 668, South Eastern 431, Western 379). All Trusts have submitted action plans to address the review backlog that has arisen across a number of specialties.

Recommendations

16. Trusts should review their outpatient review practice, redesign other methods/staff 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.

6. CHALLENGES AND OPPORTUNITIES

6.1 At an early stage in the Review, an extensive round of meetings/discussion sessions were held with the various stakeholder organisations and staff to scope the challenges and opportunities of service delivery.

Challenges

6.2 A number of key themes were articulated and are summarised below:

- Increasing demand and workload pressures which were understood to be as a result of an ageing population along with people living longer, increased cancer detection and shorter waiting times arising from the elective access targets and cancer access standards, which is generating a previously unmet need in assessment and diagnostics.

- Capacity pressures (staffing), with a workforce struggling to cope with the increasing workload and meet the current targets and quality/clinical standards. This has resulted in significant reliance on independent sector and large numbers of additional clinics and theatre sessions being held internally. Both of these have been funded non-recurrently, year on year and are not sustainable in the future.

- Capacity pressures (infrastructure), on some sites, with regard to access to theatres and day surgery sessions which again results in transfer of work to independent sector. Access to elective Urology beds, in times of emergency admissions pressures, was also an issue for some sites.

- The challenges presented by the operation of 2 to 3 person Consultant teams outside of Belfast and the impact this has on on-call/cross cover arrangements, attraction and retention of clinical staff and the opportunity to develop sub specially interests and expertise. The size of the team is directly linked to its catchment population and the viability and sustainability of Urology services is dependent on a critical mass of work, of sufficient variety of conditions and treatments, to attract both training and substantive posts. The arrangements for the management and admission of acute Urological patients, particularly out of hours, in some Trusts, and the impact that the lack of such a service has on other sites was also raised as an issue.

- Impact of junior doctors hours, EWTD (European Working Time Directive) and in particular, changes to the training programme have resulted in a reduction in "the medical workforce", a shift from Consultant led services to Consultant delivered services and additional requirements on Consultants to directly provide and supervise training opportunities.

- Challenges around the cancer agenda and in particular, compliance with IOG (Improving Outcomes Guidance) and preparing for the Peer Review Exercise in 2010.

- Concerns were expressed about how service development tends to take place within and is restricted by Trust/Organisational boundaries. Also about inconsistent access/pathways for patients.

Opportunities

6.3 Within the various service and staff groups there was a strong desire and commitment to making significant improvements to Urology services in Northern Ireland.

6.4 There was general acceptance that additional investment was not the only solution: Making better use of the existing resources was also necessary and that the review of Urology services created significant opportunities to develop and re-design services, provide high quality, timely and cost effective services to patients and the community and to support and develop the individual and teams within this important specialty.

6.5 There was also a strong sense of wanting to do things differently and of the need to change and adapt to a changing landscape in terms of public expectations, targets and standards, changing pattern of disease and treatment, new technologies and techniques and employment and training legislation and entitlement.

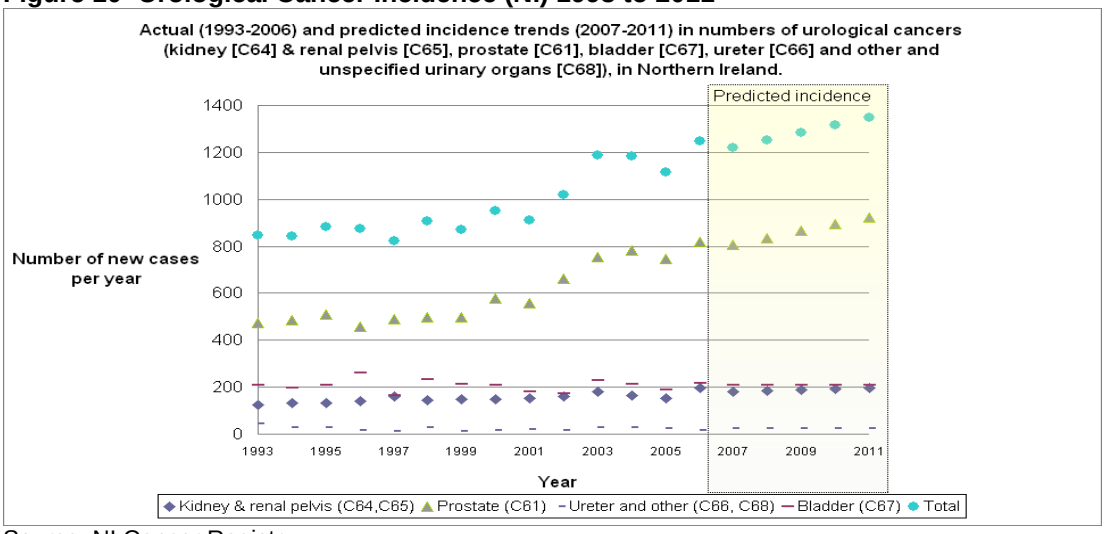
7. UROLOGICAL CANCERS

7.1 Around 40% of Urology work is cancer related and in addition to intensive assessment, diagnostics and treatment requirements, there is also a requirement for considerable patient follow-up, support and surveillance services. Cancer becomes more common with increasing age with almost 2 out of every 3 cancers diagnosed in people aged 65 and over.

7.2 Cancer of the prostate, testis, penis, kidney and bladder as a group has the highest volume of cancer incidence than any other specialty, with 1,246 incidence recorded on the cancer registry for 2007. The next highest is breast, followed by colorectal and lung.

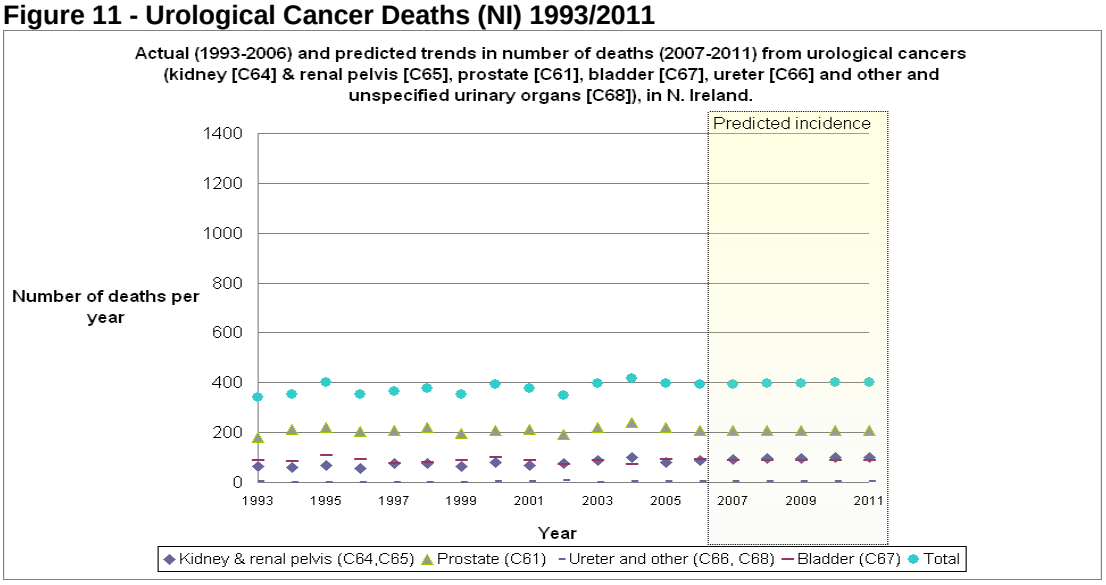
Cancer Incidence and Mortality

Figure 10- Urological Cancer Incidence (NI) 1993 to 2011



Source: NI Cancer Registry

Figure 11 - Urological Cancer Deaths (NI) 1993/2011



Source: NI Cancer Registry

7.3 Bladder and ureter incidence has been and is likely to remain stable (approximately 230).

7.4 Kidney cancer incidence has increased by almost 50% between 1993 and 2006 (196 in 2006), with a corresponding rise in deaths. By 2011, there could be further slight increases.

7.5 Prostate cancer incidence increased by 70% between 1993 and 2006 (817 in 2006). By 2011, it is predicted to increase by a further 20% compared with current incidence, but the number of deaths remains stable.

7.6 Prostate cancer is the second most frequently diagnosed cancer among men of all ages; testicular cancer, although relatively infrequent, is nevertheless the most common cancer in men under 45 years of age. Cancer of the penis, by contrast, is rare. Cancers of the kidney and bladder are roughly twice as common among men.

7.7 The main presenting symptoms of primary urological tumours fall into 3 groups:

- Lower urinary tract symptoms
- Haematuria and
- Suspicious lumps.

7.8 Haematuria is the most common symptom of both bladder and kidney cancer, although kidney cancer is often asymptomatic until it reaches a later stage.

7.9 Early, asymptomatic prostate cancer is being diagnosed more in recent years due to increase use of PSA testing and men's health awareness programmes.

Guidance and Standards

7.10 The NI Report "Cancer Services: Investing in the Future" (The Campbell Report) published in 1996 recommended that delivery of cancer services should be at three levels: Primary Care, Cancer Units and the Cancer Centre. The 2000 Review of Urological Services in Northern Ireland endorsed the principles of the Campbell Report and took account of them in their recommendations.

7.11 In 2002, NICE published guidance on cancer services-"Improving Outcomes in Urological Cancers-The Manual" (IOG).

7.12 The key recommendations from IOG are in Appendix 6. The recommendations relate to the requirement to have dedicated, specialist, multidisciplinary Urological cancer teams, making major improvements in information and support for patients and carers, with nurse specialist having a key role in these services, and having specific arrangements in place to undertake radical surgery for prostate and bladder cancer.

7.13 In 2008, under the auspices of NICaN (Northern Ireland Cancer Network) a new Urological tumour group was set up and has to date met on three occasions. Mr H Mullen chairs this group with Mr P Keane, Consultant Urologist, Belfast Trust, serving as the lead clinician. Mr Keane is also a member of the Review Steering Group (as a NICAN lead) along with Dr D Hughes, NICaN Medical Director and Mrs B Tourish, NICaN, Clinical Network Co-ordinator.

7.14 The NICaN Group has agreed priority areas of work, based on IOG, including the development and implementation of formal dedicated MDTs / MDMs, implementing

referral guidelines and agreed pathways for diagnostics and treatment of each of the cancers, developing patient information and guidance and ensuring suitable arrangements are in place prior to the Peer Review planned for 2010.

Recommendation

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.

7.15 A key element of IOG is the requirement to undertake radical pelvic surgery on a single site, serving a population of 1 million or more, in which a specialist team carries out a cumulative total of at least 50 such operations (prostatectomy (M61)and cystectomy (M34) per annum.

7.16 Tables 11 and 12 outline the number of radical pelvic operations carried out in 2006/07 and 2007/08 by Trust and Consultant.

Table 11 – Radical Pelvic Surgery 2006/07

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	3	11	*14*
	Cons B	8	14	*22*
	Cons C	9	11	*20*
	Cons D	5	0	*5*
Total		**25**	**36**	***61***
SHSCT	Cons A	3	1	*4*
	Cons B	8	5	*13*
	Cons C	2	5	*7*
Total		**13**	**11**	***24***
WHSCT	Cons A	3	17	*20*
Total		**3**	**17**	***17***
Grand Total		**41**	**64**	***105***

Table 12 – Radical Pelvic Surgery 2007/08

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	6	12	*18*
	Cons B	7	18	*25*
	Cons C	20	12	*32*
	Cons D	3	0	*3*
	Cons E	1	0	*1*
Total		**37**	**42**	***79***
SHSCT	Cons A	0	1	*1*
	Cons B	3	1	*4*
	Cons C	5	3	*8*
	Cons D	0	3	*3*
Total		**8**	**8**	***16***
WHSCT	Cons A	0	7	*7*
Total		**0**	**7**	***7***
Grand Total		**45**	**57**	***102***

7.17 The Northern and South Eastern Trust do not undertake such operations and patients requiring/choosing radical surgery are referred to BCH.

7.18 In 2007/08 77% of radical pelvic operations were undertaken in Belfast Trust (BCH). Neither the Southern or Western Trust (separately or together) undertake the required number (50) of such operations. Four of the existing Consultants undertake small (<5) numbers of each of the procedures. With a total of just over 100 procedures a year, a population less than 2 million and, with the potential for this activity to reduce with the implementation of a brachytherapy service in the next year, a single site for radical pelvic surgery is considered to be the appropriate way forward if IOG compliance is to be achieved.

Recommendations

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).

8. CLINICAL WORKFORCE REQUIREMENTS

Consultant staffing

8.1 In 1996, BAUS (British Association of Urological Surgeons) recommended a Consultant: Population ratio of 1:80,000 by 2007. In 1999 the ratio in Northern Ireland was 1:167,000 population reducing to 1:103,000 population at the time of the review in 2009, with a funded establishment of 17 wte Consultants.

8.2 In the 2000 "Report of a working group on Urological Services in Northern Ireland" a ratio of 1:100,000 population was recommended due to Northern Ireland's younger age profile. BAUS had indicated that the demand for Urological Services is related to the age structure of the population and specifically with the proportion of 65 years.

8.3 In 1996, the percentage of those aged 65 years and over in Northern Ireland was 12.85% and at this time was considerably lower than in England (15.8%) and Wales (15.2%). By 2007 Northern Ireland's percentage of over 65 had risen to 14.1% and is predicted to rise further to 16.7% by 2018.

8.4 A total population of 1.76 million in 2008 and a Consultant to population ratio of 1:80,000, would equate to a funded establishment of 22 wte Consultant Urologists.

8.5 The NI Urology SAC (Specialist Advisory Committee), in estimating the number of higher specialist trainees required by 2018, have used a Consultant Urologist workforce of 38 wte by 2018. In projecting future staffing, SAC took account of "Developing a Modern Surgical Workforce" published by the Royal College of Surgeons in England (2005) and subsequent interim review of October 2006. The Royal College suggests that for a population of 1 million the requirement will be 8-9 specialist surgeons and 8-10 generalists.

8.6 Based on an average age of retirement of 60 years of age, the anticipated retirements in Urology between 2009 - 2018 is four. Taking this into account along with the Royal Colleges projected future staffing requirements, SAC have recommended an increase in the number of higher specialist trainees from the current 8 at ST3+ (year 3 and above) to up to 15 by 2018.

8.7 SAC have confirmed that they are content, at this time, with the Consultant to population ratio proposals within this review i.e. 1:80,000.

Consultant Programme

8.8 Guidelines for a Consultant job plan (agreed by the Royal College of Surgeons and adopted by the Association of Surgeons of Great Britain and Ireland) are based on a commitment of 10 notional half days.

8.9 The traditional Consultant contract has 6 + 1 (special interest) fixed sessions with 3 flexible sessions. BAUS Council recommend a 5 + 1 fixed session contract with 4 flexible sessions for Consultant Urologists.

"A Quality Urologist Service for Patients in the New Millennium - Guidelines on Workload, Manpower and Standards of Care" (BAUS 2000) recommends a typical job plan as outlined below:

Operating Theatre	3 NHD
Outpatient Clinics	2 NHD
Specialist Interest	1 NHD
Ward Round plus on-call	1 NHD
Post Graduate Education:	1NHD

To Include:

- Audit, teaching
- Pathology and X-ray meetings
- Clinical Governance
- Quality Assurance
- Mortality and Morbidity meetings

Flexible commitment	2 NHD

On-call rota 1:5

- *Special interest sessions may be used to provide additional operating, specific outpatient clinics, uro dynamics, lithotripsy or to supervise the research activities of the Department.*
- *Involvement in clinical management, audit and clinical governance will occupy significant clinical time and provision must be made for these activities within the job plan, as should participation in MDM's for all Urologists.*
- *Flexible sessions cover duties, which may be performed at different times, over different weeks and even sometimes outside standard working hours. These will include clinic administration, travel, inter-departmental referral and continuing clinical responsibility. They will also include time spent after operating sessions and clinics "tidying the desk", talking to patients relatives, visiting patients on the ward prior to operation, reviewing patient notes, results and ensuring that these are made known to patients and to the relevant medical practitioners.*

Workloads

8.10 Both BAUS and The Royal College of Surgeons outline similar workloads/activity that can be expected from a Consultant's working week, based on a 42 week working year.

8.11 **Outpatients (new and review) -** A Consultant working alone should see between 1176 and 1680 patients per annum. *Consultants with a major sub specialty interest e.g. oncology, will see significantly fewer patients due to case complexity and a need to allocate more time to each patient. Teaching, particularly under graduates and house officers, will also reduce the number of cases per clinic.*

8.12 To allow sufficient time for proper assessment and counselling, it is accepted practice to allow approximately 20 minutes for a new patient consultation and 10 minutes for a follow-up consultation. Therefore in a standard clinic an Urologist, working on his own should see 7 new patients and 7 follow-up patients. This can be

adjusted locally depending on case complexity up to a maximum of 20 patients (new and review) per clinic.

8.13 **In patient/day case activity -** *The average Consultant Urological Surgeon, and his team, should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum. The exact number will depend on sub specialty interest, case mix, the number of operating sessions in the job plan and whether the Urologist has an obligation to train a specialist registrar. For example, some specialists in oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts.*

8.14 The activity analysis outlined in section 4 of the report outlines projected activity of 21,571 episodes in 2008/09. This figures includes in-house additional activity provided by Trusts but excludes activity sent out to the Independent Sector. With no further reduction in elective waiting times in 2009/10, it will be possible to make a more robust assessment of recurrent demand during the year.

8.15 The activity delivered by Trusts in 2008/09 equates to 21.5 wte consultant staff, taking account of the average workload figures above. However, due to complexity/casemix issues not all Consultants will perform the average number of FCEs. For example, with the creation of single site for radical pelvic surgery there will be a requirement for an additional Uro-oncology Consultant at the BCH.

Recommendation

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.

8.16 This level of investment in staffing infrastructure will allow Urology services to be recurrently provided at 2008/09 outturn levels. In terms of future proofing, Trusts will be required to look at further efficiencies within existing capacity with a view to increasing the average workload per Consultant to the higher level in the context of changing demographics with an older population which will place additional demands on Urology services over the coming years. This is particularly relevant to the Northern and Southern Trusts where Consultant workloads are significantly below their peer colleagues and BAUS guidelines.

Recommendation

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.

Nurse Staffing

8.17 The additional nursing and support staff requirements to support the additional clinics and theatre sessions that will be implemented with the appointment of new Consultants are included in the estimated costing in Appendix 7.

8.18 To ensure high quality nursing services and effective and efficient use of highly specialised equipment and instruments it is essential that nurses working in Urology wards, theatres and other departments are fully trained and competent in the field of Urology.

8.19 Specialist nurses and practitioners have a key and expanding role to play in a modern Urology Service. There are many examples of nurses, within and outwith ICATS teams, undertaking assessment, diagnostic, treatment and follow-up of areas of Urology such as erectile dysfunction, LUTS (Lower Urinary Tract Symptoms), haematuria clinics, stones etc.

8.20 Specialist (Uro-Oncology) nurses must be dedicated, fully participating members of any cancer MDT, actively represent the patient's interests at MDM's and have a key role to play in carrying out detailed assessment of patients needs in order to provide, or coordinate good care. They have a particular role to play at "results" clinics and in assisting patients and carers in making informed decisions and choices regarding treatment options, the management of and living with the symptoms and consequences of their cancer and the treatments/interventions.

8.21 Under the auspices of NICaN, in collaboration with the senior nurses for cancer services across the Northern Ireland and English networks, a number of cancer site specific, clinical nurse specialist benchmarking censuses have been completed. There are a total of 12 specialist nurses in Urology in Northern Ireland at this time. However, few of these staff are solely dedicated to cancer care and therefore an estimate of the wte (whole time equivalent) has been made. In November 2008 there were estimated to be 4 wte oncology nurse specialists -1.5 in BCH, 2 in Altnagelvin and .5 in the Ulster.

8.22 Table 13 below outlines the results of a benchmarking exercise completed in November 2008, in which each of the cancer networks identified the incidence of cancer and calculated an average caseload per Clinical Nurse Specialist (CNS).

Table 13 - CNS caseload benchmarking data

	Lung	Breast	Urology	Colo-rectal	Gynae	Upper GI	Haem	Skin	Head & Neck	Brain
Cancer incidence	845	1,031	1,246	995	450	562	411	208	127	109
Total no CNS in post 2008	7.5	14	4	3	2	1	3	3	2	1
NI mean caseload	112	73	311	331	225	562	137		63	109
England mean caseload	122	81	131	89	77	98	70		66	81
Additional nos needed	3	2	5	4	4	3.5	5	1	2.5	1
Future NI mean caseload	80	64	138	142	75	125	52		51	54.5

8.23 There are higher numbers of Urological cancer incidences than in any other speciality and these CNSs have the third highest (upper GI is the highest at 562) mean caseload at 311, which is more than double the English mean caseload.

8.24 This shortfall will need to be addressed if significant improvements are to be made in the cancer pathways, waiting times, support and follow-up for Urology patients in Northern Ireland.

Recommendation

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 CNSs should be undertaken in mid 2010.

Radiology Staffing

8.25 The assessment and diagnostics of Urological diseases/conditions involves intensive and high volumes of radiology services across a broad range of modalities-ultrasound (KUB, TRUS), IVP, CT and MRI scans, along with the provision of an interventional radiology service. As Urology services are redesigned and streamlined, radiology services will be required to respond and adapt to the new service models and pathways and in particular accommodate more single visit haematuria, LUTS, prostate and stones clinic.

8.26 In addition to any further investment, radiology services will be required to ensure optimum and enhanced use of current available capacity by modernising and reforming the systems and processes currently in place.

8.27 In recognition of the significant capacity gap in Urology to meet the growing demand, a number of additional Consultants will be appointed and a significant number of additional patients will need to be assessed and treated internally. Additional radiology staffing to support these appointments (included in the estimated costs in Appendix 7) has been calculated using the Adenbrookes formula of .3 wte Consultant Radiologist per wte Consultant Urologist and a ratio of 6 wte band 5 Radiographers per wte Radiologist.

Pathology and Radiotherapy Services

8.28 It is recognised with the volumes of Urological cancers, the Urology service is a high user of both pathology and radiotherapy services. However, given the work being undertaken by NICaN, within the Cancer Services Framework and the supporting cancer investment plan, and the Pathology Services Review, published in December 2007, it was agreed that the current Urology review would not include a detailed assessment of these services. Investment in an additional band 7, BMS is however included in the estimated costs in appendix 7, in recognition of the increased diagnostic workload associated with growing PSA work and the centralisation of radical pelvic surgery on the BCH site.

9. SERVICE CONFIGURATION MODEL

9.1 In section 6 the key challenges currently being faced by the service were outlined. In summary, these related to the capacity to deliver a modern, quality service and the ability to achieve and sustain long term stability and viability, with a stable workforce that can continue to attract the necessary expertise across all of the professions.

9.2 It has been recognised that investment in additional capacity and staff will not on its own resolve the challenges relating to long term service stability. This will require a reconfiguration of teams/services into more sustainable units thus enabling the service to make the best use of any investment made.

9.3 A number of models (6) for future service delivery were developed. These ranged from 5 teams in NI, with each Trust having its own discrete urology service and its staffing and workload based on its current catchment population, to 2 teams in NI.

9.4 A sub group of clinicians, Trust and Board Managers developed criteria and a weighted scoring system against which each of the models could be assessed. The 5 criteria (Appendix 8) were:

- Service stability/sustainability (population, team size, dedicated skilled radiology and nursing staff, rotas and EWTD.
- Feasibility (ease and speed of implementation).
- Compliance with DHSSPS policy/strategy, commissioner intent/support, compatibility with Trusts strategic development plans and impact on other services.
- Inpatient accessibility.
- Organisational complexity.

9.5 At the Steering Group meeting on 20 January 2009, each of the 6 models was evaluated against the agreed criteria. Model 3 (Appendix 9) was agreed as the preferred model and was deemed to be the most appropriate way forward for urology services.

Recommendation

24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

9.6 Model 3 comprises 3 teams, which for ease of description are called Team North, Team South and Team East. Table 14 below outlines the main elements of each of these teams.

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call). One local MDT/MDM plus regional/specialist MDM.*** Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

Table 14 Elements and Arrangements in Three Team Model

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

*** MDM reconfiguration has been approved by NICaN Group

9.7 In response to concerns expressed at the Steering Group Meeting in January 2009, Speciality Advisor (local and 'Island of Ireland') advice was sought around the issue of a single handed Consultant doing on-call from home covering elective and non elective patients on different sites. The advice has confirmed that such arrangements are possible and that a similar situation exists in other specialties e.g. Trauma and Orthopaedics.

9.8 Urologists have advised that there are very few occasions when a Consultant's presence is required, out of hours, to deal with an elective post operative complication/event. Equally, as described in the previous section of this report, the vast majority of non elective admissions, out of hours, do not require a Consultant's intervention. However, surgeons undertaking elective inpatient surgery on a site other than the main acute unit should use morning lists so as to further ameliorate the impact of out of hour's events. They can minimise the impact further through careful choice of the nature and type of surgery undertaken.

Recommendations

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.

10. IMPLEMENTATION ISSUES

10.1 To implement the review recommendations a recurrent (full year) investment of £2.875m has been estimated (Appendix 7). Commissioners will need to consider the method of allocating funding to support the full implementation of the recommendations, particularly with regard to aligning the allocation to the additional Consultant distribution profile.

10.2 Trusts and Commissioners will need to take forward discussions with General Practitioners around referral pathways and patient flows in the context of the proposed three team model.

10.3 Trusts will be required to submit detailed business cases prior to funding being released.

10.4 Trusts and Commissioners will need to agree timescales and the measurable outcomes in terms of additional activity, improved performance, a phased reduction in Independent Sector usage and service reform and modernisation plans.

10.5 The implementation of the recommendations of the review may/ will require capital investment to put in place additional physical infrastructure such and to fund equipment associated with technologically driven sub-specialty areas. e.g. endo-urology, reconstruction, laser surgery. Where capital requirements are identified, Trusts should process these bids through their normal capital and business planning cycle.

10.6 The new Teams (Trust partnerships) will be required to submit project plans for implementation of the new arrangements which is envisaged to be on a phased and managed basis. The new Health and Social Care Board will establish an Implementation Board to oversee the process.

GLOSSARY OF TERMS/ABBREVIATIONS

BADS- British Association of Day Surgery

BPH – Benign Prostatic Hyperplasia
A non –cancerous condition in which an overgrowth of *prostate* tissue pushes against the *urethra* and the bladder, restricting or blocking the normal flow of urine. Also known as benign prostatic hypertrophy. This condition is increasingly common in older men.

Biopsy
Removal of a sample of tissue or cells from the body to assist in diagnosis of a disease.

Bladder reconstruction
A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.

Brachytherapy
Radiotherapy delivered within an organ such as the prostate.

CNS
Clinical Nurse Specialist

Cystectomy
Surgery to remove all or part of the bladder.

Cystoscope
A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.

Cystoscopy
Examination of the bladder and *urethra* using a *cystoscope*.

ED
Erectile dysfunction

EWTD
European Working Time Directive

Genital
Referring to the external sex or reproductive organs.

Haematuria
The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.

HES/Hospital Episode Statistics
HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.

Incontinence
Inability to control the flow of urine from the bladder (urinary) or the escape of stool from the rectum (faecal)

IVP – Intravenous Pyelogram
An x-ray examination of the kidneys, ureters and urinary bladder that uses iodinated contrast material injected into veins.

KUB
Kidney, Ureter, Bladder (Ultrasound)

Laparascopic surgery
Surgery performed using a laparascope; a special type of endoscope inserted through a small incision in the abdominal wall.

LUTS
Lower Urinary Tract Symptoms

MRI - Magnetic resonance imaging
A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).

MDMs
Mutli-disciplinary meetings

MDTs
Mutli-disciplinary teams

NICaN
Northern Ireland Cancer Network

Oncology
The study of the biology and physical and chemical features of cancers. Also the study of the causes and treatment of cancers.

Prostatectomy
Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.

Prostate gland
A small gland found only in men which surrounds part of the urethra. The prostate produces semen and a protein called *prostate specific antigen (PSA)* which turns the semen into liquid. The gland is surrounded by a sheet of muscle and a fibrous capsule. The growth of prostate cells and the way the prostate gland works is dependent on the male hormone *testosterone*.

PSA – Prostate Specific Antigen
A protein produced by the *prostate gland* which turns semen into liquid. Men with prostate cancer tend to have higher levels of PSA in their blood (although up to 30% of men with prostate cancer have normal PSA levels). However, PSA levels may also be increased by conditions other than cancer and levels tend to increase naturally with age.

Radical treatment
Treatment given with curative, rather than *palliative* intent.

Radiologist
A doctor who specialises in creating and interpreting pictures of areas inside the body. The pictures are produced with x-rays, sound waves, or other types of energy.

Radiotherapy
The use of radiation, usually x-rays or gamma rays, to kill tumour cells. Conventional external beam radiotherapy also affects some normal tissue outside the target area. Conformal radiotherapy aims to reduce the amount of normal tissue that is irradiated by shaping the x-ray beam more precisely. The beam can be altered by placing metal blocks in its path or by using a device called a multi-leaf collimator. This consists of a number of layers of metal sheets which are attached to the radiotherapy machine; each layer can be adjusted to alter the shape and intensity of the beam.

Renal
Of or pertaining to the Kidneys.

Resection
The surgical removal of all or part of an organ.

Scrotum
The external sac that contains the testicles.

Testicle or testis (plural testes)
Egg shaped glands found inside the scrotum which produce sperm and male hormones.

TRUS Tran-rectal ultrasound (TRUS)
An *ultrasound* examination of the prostate using a probe inserted into the rectum.

Trans-uretharal resection (TUR)
Surgery performed with a special instrument inserted through the urethra.

Trans-urethral resection of the prostate (TURP)
Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.

Ultrasound
High-frequency sound waves used to create images of structures and organs within the body.

Ureters
Tubes which carry urine from the kidneys to the bladder.

Urethra
The tube leading from the bladder through which urine leaves the body.

Urogenital system
The organs concerned in the production and excretion of urine, together with the organs of reproduction.

Urologist
A doctor who specialises in diseases of the urinary organs in females and urinary and sex organs in males.

Urology
A branch of medicine concerned with the diagnosis and treatment of diseases of the urinary organs in females and the urogenital system in males.

Uro-oncologist
A doctor who specialises in the treatment of cancers of the urinary organs in females and urinary and sex organs in males.

Vasectomy
Surgery to cut or tie off the two tubes that carry sperm out of the *testicles*.

WTE
Whole Time Equivalent

APPENDICES

Appendix 1

Regional Urology Steering Group

Membership

Mr Hugh Mullen (Chair)	SDU, Director of Performance and Provider Development
Mr Mark Fordham	External Advisor, Consultant Urologist
Ms Catherine McNicholl	SDU, Programme Director (Project Manager)
Mr Paul Cunningham	SDU, Performance Manager
Dr Hubert Curran	SDU, Primary Care Advisor
Dr Windsor Murdock	SDU, Primary Care Advisor
Dr Miriam McCarthy	DHSS&PS, Director Secondary Care
Dr Dermot Hughes	NICaN, Medical Director
Mr Patrick Keane	Belfast Trust, Lead Clinician NICaN Urology Group
Dr Diane Corrigan	SHSSB, Consultant Public Health
Dr Janet Little	EHSSB, Acting Director Public Health
Dr Christine McMaster	EHSSB, Specialist Registrar, Public Health
Dr Adrian Mairs	NHSSB, Consultant Public Health
Mr Alan Marsden	NHSSB, Elective Care Commissioning Manager.
Dr Bill McConnell	WHSSB, Director Public Health
Mrs Rosa McCandless	WHSSB, Information Manager
Mrs Karen Hargan	Western Trust, Assistant Director Surgery/Acute Services
Mr Colin Mulholland	Western Trust, Consultant Urologist
Ms Carmel Leonard	Western Trust, Lead Nurse Surgery
Mr Paul Downey	Northern Trust, Consultant Urologist
Mr Martin Sloan	Northern Trust, Director Elective and

	Acute Services
Dr Brian Armstrong	Belfast Trust, Co-Director Specialist Services
Mr Chris Hagan	Belfast Trust, Consultant Urologist
Mr Brian Duggan	Belfast Trust, Consultant Urologist
Mr Brian Best	South Eastern Trust, Consultant Urologist
Mr John McKnight	South Eastern Trust, Consultant Urologist
Mrs Diane Keown	South Eastern Trust, Assistant Director Surgery.
Ms Joy Youart	Southern Trust, Acting Director Acute Services
Mr Michael Young	Southern Trust, Consultant Urologist
Mrs Jenny McMahon	Southern Trust, Nurse Specialist.

Appendix 2

Regional Review of Adult Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Appendix 3

UROLOGY REPORTS/ REVIEWS

Northern Ireland Review Reports

Report of the EHSSB Sub Group on Urological Cancer	Sept 1997
Report of the Working Group on Urology Services in Northern Ireland	May 2000
Update on Urology Cancer Services in the EHSSB	Oct 2001
External Review of Urology Services for Craigavon Area Hospital Group	Aug 2004
Draft Service Framework for Cancer Prevention, Treatment and Care – (Urology section)	Version 7 June 2008

National Reports

BAUS – A Quality Urological Service for Patients in the New Millennium	Oct 2000
BAUS – The Provision of Urology Services in the UK	Feb 2002
NICE – (Guidance on Cancer Services) Improving outcomes in Urological Cancers	Sept 2002
Modernisation Agency – Action on Urology – Good Practice Guide	Mar 2005
Providing Care for Patients with Urological Conditions: guidance and resources for commissioners (NHS)	2008
NICE – Urinary Incontinence: the management of urinary incontinence in women	2006
NICE – Prostate Cancer: diagnosis and treatment	2008
NICE – (Urological) Referral guidelines for suspected cancer	2005

Appendix 4

GP REFERRAL EXERCISE - PERCENTAGES

Gender	Belfast	Northern	Western	Southern	SE	Regional Average
Male	77	74	76	79	75	**76**
Female	23	25	22	21	25	**23**
Blank	0	2	2	0	0	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Age Range	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
0-14	1	0	0	2	0	**1**
15-30	12	8	11	6	10	**10**
31-40	13	8	11	15	5	**11**
41-50	20	17	9	13	7	**15**
51-60	13	25	20	11	5	**14**
60+	41	42	49	53	12	**38**
Blank	0	2	0	0	60*	**12**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Urgency	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Red Flag	4	4	7	6	5	**5**
Urgent	21	21	22	19	16	**20**
Routine	75	75	71	75	78	**75**
Blank	0	0	0	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Named Cons	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Y	24	25	13	23	21	22
N	76	75	87	77	79	78
Total	**100**	**100**	**100**	**100**	**100**	**100**
Ref Source	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Non-GP ref's	10	23	2	9	19	**13**
GP Ref's	90	77	96	91	81	**87**
Blank	0	0	2	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

Appendix 5

GP REFERRAL EXERCISE – PRESENTING SYMPTOMS (PERCENTAGES)

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**13**		**19**		**22**		**9**		**16**		**15**	
	frank		*58*		*30*		*40*		*40*		*50*		*46*
	microscopic		*32*		*50*		*60*		*40*		*50*		*45*
	blank		*11*		*20*		*0*		*20*		*0*		*9*
Prostate/raised PSA		**10**		**13**		**18**		**17**		**16**		**14**	
Other		**15**		**8**		**11**		**15**		**11**		**13**	
Ncode procedure (All)		**15**		**4**		**2**		**6**		**19**		**11**	
	vasectomy		*52*		*0*		*100*		*33*		***29***		***41***
	foreskin		*5*		*0*		*0*		*67*		***50***		***24***
	epididymal cyst		*14*		*100*		*0*		*0*		***21***		***20***
	hydrocele		*19*		*0*		*0*		*0*		***0***		***10***
	varicocele		*5*		*0*		*0*		*0*		***0***		***2***
	blank		*5*		*0*		*0*		*0*		***0***		***2***
Recurrent UTI's		**12**		**17**		**9**		**11**		**5**		**11**	
LUTS		**8**		**13**		**4**		**9**		**10**		**9**	
Prostate/BPH/prostatitis		**8**		**9**		**9**		**11**		**3**		**8**	
Renal stones/colic/loin pain		**8**		**9**		**2**		**4**		**5**		**6**	
Testicular/ Scrotal lumps or swelling		**6**		**0**		**11**		**0**		**11**		**6**	
Andrology (ALL)		**5**		**4**		**7**		**11**		**3**		**5**	
	erectile dysfunction		*29*		*100*		*0*		*50*		*50*		*40*
	peyronie's disease		*29*		*0*		*67*		*0*		*0*		*20*
	blood in ejaculate		*43*		*0*		*0*		*0*		*0*		*15*
	ulcer/lesion on gland		*0*		*0*		*33*		*17*		*0*		*10*
	balanitis/discharge		*0*		*0*		*0*		*33*		*0*		*10*
	blank		*0*		*0*		*0*		*0*		*50*		*5*
Unknown		**2**		**2**		**2**		**4**		**0**		**2**	
Ca Bladder/Kidney		**1**		**2**		**0**		**2**		**0**		**1**	
Blank		**0**		**0**		**2**		**0**		**0**		**0**	
Total		**100**		**100**		**100**		**100**		**100**		**100**	

Appendix 6

NICE – Improving outcomes in Urological Cancers (IOG) – The Manual (2002)

Key Recommendations

The key recommendations highlight the main organisational issues specific to urological cancers that are central to implementing the guidance. As such, they may involve major changes to current practice.

- All patients with Urological cancers should be managed by multidisciplinary Urological cancer teams. These teams should function in the context of dedicated specialist services, with working arrangements and protocols agreed throughout each cancer network. Patients should be specifically assured of:
    - Streamlined services, designed to minimise delays;
    - Balanced information about management options for their condition;
    - Improved management for progressive and recurrent disease.
- Members of Urological cancer teams should have specialised skills appropriate for their roles at each level of the service. Within each network, multidisciplinary teams should be formed in local hospitals (cancer units); at cancer centres, with the possibility in larger networks of additional specialist teams serving populations of at least one million; and at supra-network level to provide specialist management for some male genital cancers.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Whilst these teams are being established, surgeons carrying out small numbers (five or fewer per annum) of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- Major improvements are required on information and support services for patients and carers. Nurse specialist members of urological cancer teams will have key roles in these services.
- There are many areas of uncertainty about the optimum form of treatment for patients with urological cancers. High-quality research studies should be supported, with encouragement of greater rates of participation in clinical trials.

Appendix 7

Estimated Cost of Implementation of Recommendations.

Staffing	Number	Band/Grade	Unit Cost	Total
Consultant Urologist	6	Consultant	£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	3.6	Consultant	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	1.8	Consultant	£104,000	£187,200
Radiographer @ 6 per wte Con Radiologist	10.8	Band 5	£27,995	£302,346
Nursing @ 1.8 wte per Con. Urologist	10.8	Band 5	£27,995	£302,346
Nursing @ 0.46 wte per Con. Urologist	2.7	Band 3	£19,856	£53,611
Specialist Nursing	5	Band 7	£41,442	£207,210
Nursing @ 0.64 wte (day surgery)	0.64	Band 5	£27,995	£17,917
Pers. Secretary @ 0.5 wte per consultant urologists	3	Band 4	£23,265	£69,795
Admin support to radiologists at 0.5 wte per Radiologist	1	Band 3	£19,856	£19,856
Admin Support to Specialist Nurses @ 0.5 wte per Nurse	3	Band 3	£19,856	£59,568
Medical Records support 0.5 per unit	2.5	Band 4	£23,265	£58,162
MLSO – Bio-medical Science	1	Band 7	£41,442	£41,442
Support Costs				
Surgical G&S @ £94,500 per Con. Urologist	X 6		£95,400	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	X 6		£50,000	£300,000
Radiology G&S per Con. Urologist	X 6		£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	X 6		£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	X 12		£10,000	£120,000
Sub Total				**£3,511,853**
Less Consultant funded in 2008				**(£437,076)**
Sub Total				**£3,074,777**
Less 2008/09 Cancer Funds				**(£200,000)**
FINAL TOTAL				**£2,874,777**

Appendix 8

Evaluation Criteria

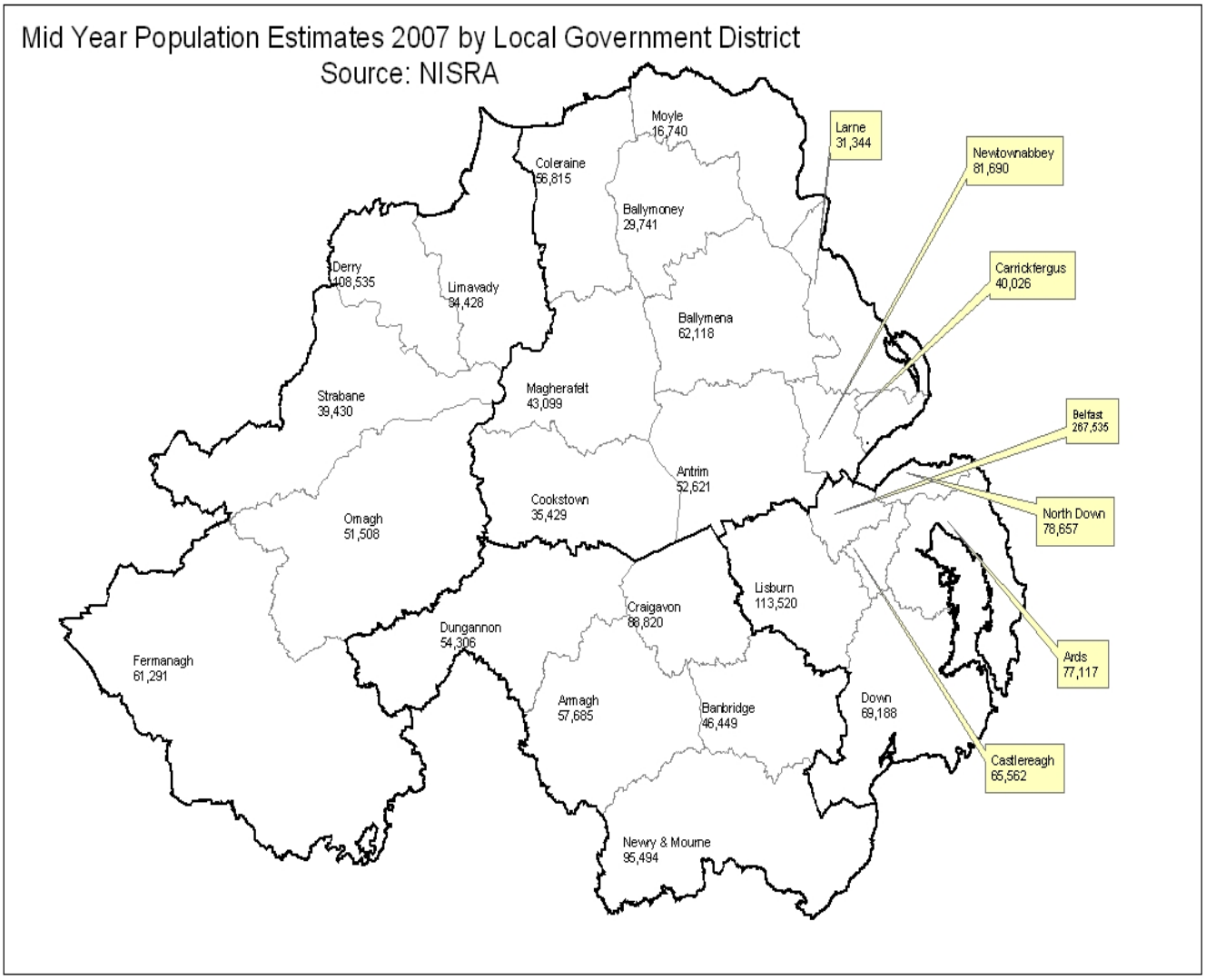
Criteria	Definitions
1. Service Stability / Sustainability	This is the criterion of the highest priority/value. The long term stability and hence viability and success of the service depends on a stable workforce – a workforce that can develop the service further and continue to attract the necessary expertise across all its professions. The criterion is sub-divided into four closely related sub-categories. a. Population – smaller catchment populations restrict the generation of a critical mass of work (cancer and non cancer). Using BAUS recommendations of 1 consultant per 80,000, each team should serve a catchment population of no less than 400,000. b. Team Size – A team of at least five to six consultants is preferred. This will improve long term attractiveness of each team in terms of recruitment and retention. It will also enable at least 2-3 to sub specialise, with dedicated sessions in the sub specialty e.g. uro-oncology, endourology/stones, female urology c. On site interventional radiology and trained urological nursing – These are key quality aspects. On site radiology to ensure timely access to interventions for emergency and urgent cases and sufficient total activity to justify 24 hour urology nursing experience in wards and theatres. This is to enhance multi-disciplinary working and support the development of nurse-led services. d. Commitment to Rotas and Working Time Directive – The service must be capable of sustaining adequate and acceptable on-call arrangements (elective and emergency), compliance with EWTD and equitable provision of emergency care.
2. Feasibility (ease and speed of implementation)	This criterion concerns the need to maximise the use of existing capital infrastructure (beds, theatres, equipment, clinic accommodation). The additional activity required and the appointment of additional Consultants and Nurse Specialists will require additional access to clinical facilities (as described above). It is assumed that the more new capital development is required, the longer the lead in time for starting new teams, and the longer the reliance on the independent sector. Preference will be given to those models that require the least capital resources and restructuring of premises. Consideration of the availability of trained staff will also be given. A particular model will lose points if it is unlikely that trained staff will be available in the numbers required to fill necessary posts.
3. Compliance with DHSSPS Strategy / Commissioner Support / Compatibility with Trust Strategic Plans/impact on other services	A model will lose points if it does not reflect specific regional health and wellbeing strategies/policies – DBS (the location of major hospitals with inpatient care), Cancer Framework (location of cancer units and Cancer Centre). Models should also attract commissioner support. Alignment with Trust Strategic Plans and impact on other services should also be considered.
4. Accessibility for Inpatient Elective Care	It is assumed that each model will be able to facilitate the flexible locating of outpatient and diagnostic service and will therefore be difficult to discriminate scores on this basis. Agreed pathways for emergency care is also assumed. Variation in local provision of elective inpatient care is more discriminatory. A model will lose points if it requires significantly greater travel time (from the do nothing case) for a substantial number of patients.
5. Organisational Complexity	A service should have unambiguous clinical and managerial leadership and accountability arrangements. Some potential models will need to transcend Trust organisational boundaries. This criterion concerns how complicated such arrangements are likely to be and weights each model accordingly – the more complicated the fewer the points awarded.

Appendix 9

Model 3: Three Teams/Networks

Team North and West:	• Upper 2/3rds of Northern and Western integrate to form one Team/Network • Main base Hospital - Altnagelvin • Potential for small number of inpatient beds in Causeway Hospital to be used for selected elective work subject to satisfactory arrangements for the post-operative management of these patients
Team South and West:	• Lower 1/3rd of Western (Fermanagh) and all of Southern integrate to form one Team/Network • Main base Hospital – Craigavon
Team East:	• SET and Belfast integrate to form one Team/Network • Continue to provide services to the southern sector of Northern population by outreach – Outpatient/Diagnostics/Day Surgery in Antrim and Whiteabbey hospitals with inpatients going to Belfast

Appendix 10



Notes of Urology meeting to discuss MDT meeting 10th October 2008

Present: J McAleese, R Brown, P Hughes, D Stewart, M Aktar, R Convery, G McCusker, K O'Neill, J McMahon, M Young, A O'Brien

Issue/Update	Action
-Local MDM Discussed requirement for local MDM to fit in with regional priorities. Current X-Ray approx 8.30-9.30 meeting & grand ward round Thursday Mark McClure happy to be the nominated Radiologist <u>Current services</u> Thursday am clinic for oncology Regional MDM in Belfast Thursday afternoon 2 – 4.15pm currently Urology consultants Thursday afternoon outreach clinics – Mr Young & Mr O'Brien Thursday (pm)- Mr O'Brien 1,2, 5th Outreach Mr Young 3, 4 Mr Aktar Direct clinical care pre op ward round. Admin session. 2/4 alternate Thursday afternoon prostate biopsy clinics Dr McClure usually afternoon off. 2-3pm Monday Pathology 8.30-10.00am Thursday Radiology meeting	**Discuss potential to move pathology to before MDM Thursday. Propose Grand ward round first then radiology then pathology & then MDM**
<u>Proposed MDT</u> Suggest average number of cases 8-10 per week – perhaps increase with red flagged patients Discussion undertaken regarding the local discussion and then regional discussion – Agreed feasible to discuss the complex regionally rather than all cases. Job plans discussed re: availability to move urologists to be free for MDM. Basically agreed that majority of patients need to be discussed with oncology. Mr Brown propose model to run parallel for	**All Clinicians** **To discuss feasibility of switching job plans with Mr Mackle** **A session each week.** **David Stewart to look into feasibility of teleconference facilities at Belfast to support this** **Mr Young - ?start local first & gain skills & then build on to Belfast.** **Mr A O'Brien start lead MDM 3pm – 4pm with/without oncology. Initially to discuss superficial & then from 4pm discuss after.**

MDMs for all centres & then at end complex cases discussed.	**Prostate patients discussed prior to MRI – would be at local level**
Agreed to push for Thursday afternoon. Want good quality MDT. Consultants concerned re MDT not good quality. Agree that need the time and support required with an applicable tool to measure outcomes & audit	**Grainne McCusker would have staff for Thursday pm. Discuss superficial bladder. Cancers locally**
STH CT Scans films coming up on time to CAH	**Dr Convery to raise issue with all slicies Dr Hall**
Teleconference Room	**Teleconference room to be block booked from 1st November onwards**

Team South Urology Steering Group / Project Board

Dr Gillian Rankin	Interim Director of Acute Services (Chair)
Dr Eamon Mackle	Associate Medical Director – Surgery & Elective Care
Mr Michael Young	Clinical Lead Urologist
Mr Robin Brown	Clinical Director – Surgery & Elective Care
Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care
Mrs Paula Clarke	Acting Assistant Director of Performance & Reform
Mr Ronan Carroll	Assistant Director of Acute Services – Cancer & Clinical Services
Mr Joe Lusby	Deputy Chief Executive, Director of Acute Services, Western Trust
GP Representative	Western Trust
Mrs Helen Walker	Assistant Director – Human Resources
Mrs Carol Cassells	Senior Financial Management Accountant - Acute Services
Ms Beth Malloy	Assistant Director Scheduled Services, PMSID, H&SCB

Project Team

Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care (Chair)
Mrs Martina Corrigan	Head of Urology & ENT
Sandra Waddell	Head of Planning – Acute
Project Manager	To be appointed
Heads of Service	As needed
Finance Representative	
HR Representative	

Clinical Assurance Group

Mr Young
Mr O'Brien
Mr Akhtar
Mrs Martina Corrigan
Mrs Shirley Tedford
GP Representative

AGENDA

TEAM SOUTH UROLOGY STEERING GROUP MEETING ON 13 MAY 2010 AT 10.00 PM IN CRAIGAVON HOSPITAL,

1. **WELCOME AND INTRODUCTIONS**

2. **MINISTERS ENDORSEMENT OF ALL UROLOGY REVIEW RECOMMENDATIONS**

3. **UPDATE ON PROJECT MANAGEMENT ARRANGEMENTS FOR TEAM SOUTH – MEMBERSHIP AND CHAIR**

4. **UPDATE ON PROGRESS WITH RECOMMENDATIONS – IDENTIFICATION OF ANY KEY RISKS AND ACTIONS TO RESOLVE**

5. **IDENTIFY KEY PATIENT PATHWAYS AND PROTOCOLS**

6. **BUSINESS CASE FOR SERVICE EXPANSION**

7. **AGREE NEXT STEPS AND TIMETABLE**

8. **ANY OTHER BUSINESS**

Southern Health and Social Care Trust
Clinical Director Surgery/Elective Care Division

Tile of Post:	Clinical Director Surgery/Elective Care Division
Directorate/Division:	Acute Services Directorate – Surgery/Elective Care Division
Operationally Responsible to:	Associate Medical Director – Surgery/Elective Care Division
Professionally Accountable to:	Medical Director
Hours:	Salaried Part Time position
Base:	Craigavon Area Hospital

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of the Surgery/Elective Care Division across the Trust. This is one of two Clinical Director posts in the Surgical Division and the appointee will have responsibility for the following areas;

- General Surgery at Craigavon area Hospital
- Urology Team South and
- Trauma & Orthopaedics in the Southern Trust

He/She will:

- participate as a member of the Surgery/Elective Care Divisional Team.
- lead the General Surgery speciality on the Craigavon site
- be responsible for surgical/elective care sub-speciality outreach
- provide professional advice to the Associate Medical Director and Divisional team on professional medical issues within the division
- support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY RESPONSIBILITIES

OPERATIONAL EFFECTIVENESS OF SERVICES

Operational Management

- support the Trust in the development of a high quality, responsive elective care service, ensuring that regional and local targets are achieved
- provide leadership and direction to consultants and other medical staff within the division
- Attend Directorate wide meetings with Service Director, AMD and Assistant Directors etc
- Take such action as may be necessary in disciplinary matters in accordance with Trust procedures.
- Chair a regular Divisional meeting for medical staff
- Be first contact point for Assistant Directors for issues arising at Divisional level.

Service Development

- Provide a medical perspective on protocols/ pathways relating to service improvements/ modernisation within the Division

- Actively participate in discussions about service change and medical capacity

- Work with the Divisional team to support and develop the modernisation of services.

- Lead the medical aspects of service change at Divisional level and contribute to the implementation of multi disciplinary change

Budgetary awareness

- Work to deliver efficient and effective services within agreed financial budgets and to provide advice and guidance on the costs and benefits of planned developments.

- Take account of financial implications when making decisions in conjunction with Assistant Directors and with the support of Finance staff. This could include for example medical staffing/ locum costs within service delivery and development, cost of sickness absence, approval of doctors expenses etc

GOVERNANCE AND PROFESSIONAL PRACTICE STANDARDS

Divisional Governance Forum

- Participate in Divisional Governance activities/ meetings as agreed with the Associate Medical Director
- Work with the Trust/ Directorate Governance manager to ensure effective clinical governance
- Involvement in complaints investigation and resolution, critical incident reporting and follow up, risk management and audit

Standards

- Providing advice to the Assistant Director and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc
- Assisting in preparation for external inspections
- Working with relevant managers and colleagues on implementation plans to address issues highlighted by external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) overseeing development and roll out of implementation plans in conjunction with the Director/ Assistant Director

Public Health and urgent operational issues

- support the Trust in planning a response to major incidents and outbreaks
- Contributes to the roll out of contingency plans, working with identified leads and the Associate Medical Director (e.g. swine flu, hyponatraemia).

Education and Research

- Work with the Associate Medical Director to support the development and delivery of Education and Research within the Division, ensuring the appropriate Governance arrangements are in place
- Contribute to decisions to resolve tensions at specialty level between the demands of training and service delivery.

MEDICAL MANAGEMENT

Appraisal

- Undertake appraisals for all grades of staff in line with regional guidance
- Liaise with Associate Medical Director re completion of appraisals and reports on common issues

Job Planning

- Undertakes job planning role as agreed with Associate Medical Director

Application of Medical HR policies

- Undertakes a management role in the application of relevant medical HR policies and the provision of advice to medical colleagues in areas such as;

  Annual Leave
  Study Leave
  Performance
  Sickness absence

- Support the Associate Medical Director in the effective implementation and monitoring of EWTD for junior doctors

- Liaise with Human Resources for appropriate advice and support

- May be the nominated person for the Directorate in specific HR policies

Communication

- Facilitate good communication with medical staff, formally through meetings and informally through other opportunities
- Liaise with other clinical managers in support of good multidisciplinary team working
- Actively promote the development of clinical and professional networks between the Daisy Hill and Craigavon Area Hospital sites.
- Act as a primary communication point within the Division for management and medical colleagues

Southern Health and Social Care Trust
Clinical Director Surgery/Elective Care

Personnel Specification

Applicants must be a permanent Consultant within the Southern Health and Social Care Trust, Surgery/Elective Care Division of the Acute Services Directorate.

Knowledge, Skills & Experience

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

Please write expressing your interest in this position by **12:00 noon** on **Monday 9th August 2010** to **Malcolm Clegg, Medical Staffing Department, Southern Health and Social Care Trust, Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown BT63 5QQ** or email: [redacted]
Personal Information redacted by the USI

The selection process will be based on skills and experience for the post. Candidates will be invited to an interview which will be conducted by the Medical Director, Associate Medical Director and Director of Acute Services.

The successful candidate will be appointed on a four year rolling contract.

Strictly Private and Confidential

Southern Health and Social Care Trust

Report of Disciplinary Investigation

Mr Aidan O'Brien, Consultant Urologist, Craigavon Area Hospital

Investigation Team:
Mr Robin Brown, Clinical Director, General Surgery
Mrs Zoe Parks, Human Resources Manager

Date:
June 2011

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Appendices

1. Formal Correspondence to Mr A O'Brien
2. Email correspondence raising concern
3. Statement from Mr O'Brien
4. Statement from Shirley Tedford / Sharon McDermott
5. Southern Health and Social Care Trust Disciplinary Procedure

1.0 INTRODUCTION AND BACKGROUND

Mr Aidan O'Brien has been employed as a Consultant Urologist by the Southern Health and Social Care Trust from 6 July 1992. He was initially employed as a locum consultant from 31 August 1991.

On 16 June 2011, an incident was reported relating to the inappropriate disposal of confidential patient information normally filed in the patient chart. This was initially reported by a nursing assistant to Sharon McDermott, Ward Clerk who advised the ward sister and her line manager. The nursing assistant said that she had found the material in a confidential waste bin and she returned it to the ward clerk for filing in the patient's chart. The materials included fluid balance, Gentamicin charts, drugs kardexes, etc. The incident was reported to Shirley Telford (Ward Sister) and subsequently to Mr Eamon Mackle, Heather Trouton and Helen Walker.

Because of the seriousness of this allegation, a disciplinary investigation was undertaken. I, Mr Robin Brown, Surgical Director and Mrs Zoe Parks, Medical Staffing Manager were appointed to undertake this investigation.

2.0 APPROACH & METHODOLOGY

2.1 Written correspondence to Mr O'Brien dated 22 June 2011

On 22 June 2011, Mr O'Brien was advised in writing of the allegation that had been made against him. The correspondence advised that as the allegation was serious, it would have to be investigated under the remit of the Trust's disciplinary process and he was asked to attend a meeting on 23 June. **Appendix 1**

2.2 Meeting with Mr A O'Brien on 23 June 2011

The Investigation Team met with Mr O'Brien on 23 June 2011, at which stage he was advised that the matter was to be fully investigated under the Trust's Disciplinary Procedures. He was advised that he could be accompanied at this meeting but declined this offer.

The investigation team took a statement from Mr O'Brien in relation to the alleged incident at this meeting. This statement is contained in **Appendix 2.**

2.3 Meeting with Witnesses on 24 June 2011

The investigation team met with the Ward Sister, Shirley Telford on the morning of 24 June 2011 and also with the Ward Clerk, Sharon McDermott. They were asked to provide their comments in relation to the allegation. **Appendix 3**

3.0 ISSUE OF CONCERN/ALLEGATIONS

As a result of the investigation the allegation to be considered is:

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

4.0 FACTS & FINDINGS ESTABLISHED

The findings in relation to the allegations are listed below:

4.1 Zoe Parks and I met with Aidan O'Brien on the afternoon of 24th June 2011. I advised him that there had been a complaint made about the inappropriate disposal of patient confidential information and that the matter was being investigated under the Trust Disciplinary Procedure. I advised him that the material which he had disposed of was not unimportant and the matter was being considered as a case of misconduct. Mr O'Brien agreed that he had acted inappropriately and apologised for his behaviour. He agreed that the material which he had removed from the chart had been of value should a case arise and require subsequent investigation. Further he agreed that he would not act in a similar way in the future. Mr O'Brien went on to describe how he has the utmost respect for patient notes and how he takes a great deal of time filing, reorganising charts and writing lengthy notes in readable handwriting to make sure that there are good and clear patient records. He explained that the reason why he had removed the large amount of material was that the patient's chart had become so bulky that he found it difficult to retrieve important information from the chart and found it difficult to write in the chart. In the end however, he agreed that disposal of the material concerned was inappropriate and that it would not happen again.

Meeting with Shirley Telford 24 June 2011

Zoe Parks and I met with Shirley Telford on the morning of 24t June 2011. Shirley confirmed that materials had been found by a nursing auxiliary in the confidential waste and returned to Sharon (ward clerk) for filing in the patients chart. The materials included fluid balance charts, Gentamicin charts, drugs kardexes etc. Shirley felt that this sort of information would be of use, should there ever be a case of complaint or litigation or the requirement for root cause analysis. Shirley had challenged Mr O'Brien after talking to some of the other nurses and he admitted that he had disposed of the materials in the confidential waste. I invited Shirley to make any other further complaint that she wished to make, but she said that she had nothing further to add. I also

asked if she would require facilitation at the end of the process but she felt that there would be no need for facilitation.

We were subsequently contacted after the meeting by Shirley Telford via email on 27 June 2011 to indicate that her initial intention was that the e-mail should be treated as information and not as a direct complaint.

5.0 CONCLUSION

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

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

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

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

Mr Robin Brown
Clinical Director
General Surgery

Mrs Zoe Parks
Medical Staffing Manager

Southern Health and Social Care Trust

Appendix Section

APPENDIX ONE

22 June 2011

STRICTLY PRIVATE AND CONFIDENTIAL

Mr Aidan O'Brien
Consultant Urologist
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by
Personal Information redacted by the USI

Dear Mr O'Brien

RE: INVESTIGATION UNDER THE TRUST'S DISCIPLINARY PROCEDURES

I refer to your Contract of Employment with the Southern Health and Social Care Trust as a Consultant Urologist and I wish to confirm that an allegation has been made against you. This allegation relates to a large section of patient filing which you were said to have disposed of in a bin, which was later found and retrieved by an auxiliary on the ward. The filing was reported to have consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription forms and prescription Kardex, belonging to two current inpatients in Urology.

This allegation is serious and therefore will have to be investigated under the remit of the Trust's Disciplinary Procedure. I will have the responsibility to gather facts in relation to the concerns for possible presentation at a Disciplinary Hearing. I will be supported by Mrs Zoe Parks, Medical Staffing Manager from the Trust's Human Resources Department.

I would like to meet you to discuss this matter as soon as possible and I would be grateful if you could confirm your availability to meet immediately after the MDM on **Thursday 23 June at 4pm in Seminar Room 2, Medical Education Centre**. Please contact me on Personal Information redacted by the USI to confirm if you will be available to attend.

I will keep you advised about the progress of my investigation as per the Disciplinary Procedure which I have enclosed for your information, and would draw to your attention the right to be accompanied at any future meetings by either a trade union representative or work colleague.

Yours sincerely
Mr Robin Brown
Clinical Director General Surgery

APPENDIX TWO

From: Tedford, Shirley
Sent: 27 June 2011 07:32
To: Parks, Zoe
Subject: meeting last friday

Zoe,

I have been thinking over the weekend about our meeting on Friday, if its not too late can I add something to the notes. I would like it recorded that when I emailed this information to Martina it was information and not as a direct complaint although this is how it has been dealt with.

Can you give me a ring if you haven't already met with Aoidan.

Shirley

From: Corrigan, Martina
Sent: 16 June 2011 15:56
To: Mackle, Eamon; Trouton, Heather; Walker, Helen
Subject: FW: Refiling of binned documents

As discussed

Martina

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

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Tedford, Shirley
Sent: 16 June 2011 15:07
To: Corrigan, Martina; Scott, Jane M; McDermott, Sharon
Cc: Trouton, Heather
Subject: filing issue

Hi all,

I have spoken with staff at ward level and have ascertained that the person concerned was Mr O'Brien and he has admitted to disposing of the documentation in the bin. I have addressed the issue with him and pointed out that this information is a legal requirement and if there was cause eg RCA this is our evidence for proving the treatment the patient received by whom and when. He stated that as Fluid balance charts are not a legal document and they take up a lot of room in charts he would remove them as he had other bits he wanted to file.

I hope the fact that this has been highlighted to him will deter any future issues of this kind but it could potentially happen again, as Sharon has pointed out this is not the first time this has happened.
Shirley

From: Tedford, Shirley
Sent: 15 June 2011 12:33
To: McDermott, Sharon; Scott, Jane M
Cc: Corrigan, Martina; Sharpe, Dorothy; Henry, Gillian
Subject: RE: Refiling of binned documents

Sharon,

I will look in to this matter, I think I know who may be responsible. I will speak to you regarding the patient concerned as I am nearly sure It is not nursing staff but medical.

Shirley
From: McDermott, Sharon
Sent: 15 June 2011 11:20
To: Tedford, Shirley; Scott, Jane M
Subject: Refiling of binned documents

Hi Shirley and Jane,

Could you follow up on the following incident?

On arrival to the ward this morning I found a pile of filing (about 3 or 4 cm thick) on my desk for two current inpatients on the urology side of the ward. The pile of filing consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription form and a prescription cardex. It appeared in the order it would have been in a chart and was already hole-punched.

When I had started to file this into the charts, an auxiliary approached me and indicated that this pile of filing had been retrieved from one of the bins on the ward. This has happened once before when a nurse indicated that a similarly composed pile of filing was retrieved from the bin.

I'm concerned that this may happen again without someone being able to retrieve them and also about the time spent filing these documents only to have to re-file them which in turn delays other duties.

Regards,

Sharon

APPENDIX THREE

Southern Health and Social Care Trust

STRICTLY PRIVATE AND CONFIDENTIAL

On 23 June 2011, I, Mr Aidan O'Brien, Consultant Urologist, met with Mr Robin Brown, Surgical Director and Mrs Zoe Parks, Medical Staffing Manager as part of the disciplinary investigation in respect of myself. I was unaccompanied to this meeting

The following is an accurate account of the information I provided.

Mr Brown advised me the nature of the allegation that had been made against me regarding the inappropriate disposal of patient information in the confidential waste.
I advised that at the time, I didn't appreciate that I was doing anything wrong. I needed to make room for continuation sheets. I now appreciate that the Trust regards it to be wrong. However I would like to add that I spend more time than anyone I know, in writing legibly and putting things in chronological order within patient files. I feel there is misuse of Trust property as many files are in disorder and have a large quantity of loose sheets or dismembered charts. I confirmed that the information that I did put into the confidential waste included fluid balance sheets from months ago. I discussed the patient in question with Mr Brown who has been an inpatient since August of last year, hence why her file had become quite large.

Mr Brown confirmed that the information that was disposed is not without value and would be needed in the event of any look back exercise or root cause analysis. I confirmed that I have no desire to discard of any information as I have more things to do with my time. At the time I was faced with a file of up to 6 inches and I needed to add a new chart.

I have done it before when you have duplication for example three signed copies of the same document. Mr Brown confirmed that this would not be unusual and it would be acceptable to cleanse the files where there are clear duplicates. I advised that I had spent 40 minutes last night sorting a file into order so that I could make sense of it as it had been neglected.

Mr Brown confirmed that there may be an issue of the charts themselves, but the remit of this investigation was to investigate the complaint.

I confirmed that although I have done it before, I have a lot of respect for patient notes and spend a lot of time tidying them so that they can be understood. I didn't think it was wrong but I now realize that it is. It won't ever be a recurrent problem as I will never do it again.

Signed:

_____

Date:

_____

APPENDIX FOUR

Southern Health and Social Care Trust

STRICTLY PRIVATE AND CONFIDENTIAL

On 24 June 2011, I, Shirley Tedford, Ward Sister, met with Mr Robin Brown, Surgical Director and Mrs Zoe Parks, Medical Staffing Manager as part of the disciplinary investigation in respect of Mr A O'Brien.

The following is an accurate account of the information I provided.

I confirmed that Sharon come to me and said that one of the nursing auxiliary's had come to her with filing that she had found in a bin. It was fluid balance charts and drug kardexes. It was in the same order as was filed in the chart. Sharon asked if I could do anything about it and I asked her to put it in writing to me.

The kardexes had been in use. These were filed in a patient's file who has been with us for 10 months. I asked Mr Brown if he was aware of the patient (he confirmed Mr O'Brien had given him an outline of her case) I advised that in my opinion, the information that was binned would be of value if we ever needed to do a root cause analysis. That is the evidence of care that we provided and I feel it would be needed in the event of any complaint.

I work on the basis that if the information is blank then it could be binned if necessary, but if it has a name or anything else, then it needs to be

maintained on the file. This information did not have a duplicate on the file and does therefore have a value. Mr Brown asked me why I think the information was thrown out. He told me it was taking room in the chart and he need to file his information.

When I became aware of the incident, I didn't go directly to Mr O'Brien, I spoke to other members of staff on the ward and then I mentioned to him and he openly said that he had taken the information out and put it into the bin. I said it was a legal document (he said that it wasn't) and then I said that I accepted it was not a "legal" document but that we needed it in case of a root cause analysis.

Mr Brown advised me that Mr O'Brien confirmed to him during his meeting that he hadn't thought of the importance of the information at the time but he does now and that he has a huge regard for patient notes. I confirmed that he is meticulous which is good for patients. He does take time to file loose sheets and time to ensure information is filed properly and in order. I confirmed that I felt Mr O'Brien knew that he was wrong and he admitted he disregarded them. Mr Brown and I had a brief discussion on the nature of patient notes and systems to improve – including reference to the system in Daisy Hill Hospital. I confirmed that I was not aware if Mr O'Brien had ever done anything similar in the past.

Sharon McDermott (Ward Clerk) attended the meeting at this point. She confirmed that she had come onto the ward that morning to a pile of notes on her desk. She lifted them to file them when an auxiliary came to her to say they had been retrieved from the bin.

I emailed Zoe Parks on 27 June to ask that it be recorded that when I emailed this information to Martina it was information and not as a direct complaint although this is how it has been dealt with.

Signed: _____Date: _____

APPENDIX FIVE

Southern Health and Social Care Trust

DISCIPLINARY PROCEDURE

1. INTRODUCTION

This procedure is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behaviour. The aim of the procedure is to ensure:

- The Trust can operate effectively as an organisation.
- Disciplinary action taken is fair, appropriate and consistent and all who are involved in the process are treated with dignity and respect
- Managers, employees and their representatives are aware of their rights and obligations in matters relating to disciplinary and appeals procedure.

This Procedure applies to all Trust staff. It should be noted that in relation to Medical and Dental staff issues of general/professional misconduct are dealt with under this procedure. Further relevant procedures are contained in circular HSS (TC8) 6/2005 “Maintaining High Professional Standards in the Modern HPSS – a framework for the handling of concerns about doctors and dentists employed in the HPSS”.

This disciplinary procedure should be read in conjunction with the Trust's Disciplinary Rules, which are set out in Appendix 1 of this Procedure.

Issues of competence and job performance or absence will be dealt with under the Trust’s Capability Procedures.

2. GUIDANCE AND DEFINITIONS

"Trust Employee" is anyone employed by the Trust.

"Investigating Officer" is any person authorised to carry out an investigation into alleged breaches of discipline to establish the facts of the case.

“Presenting Officer” is usually the investigating officer and presents the evidence to the Disciplinary Panel

"Employee Representative" is any employee of the Trust who is an accredited representative of a trade union, professional organisation or staff organisation or a full time official of any of the above organisations or a fellow Trust employee. Legal Representation will not be permitted at any stage of this Disciplinary Procedure.

"Disciplinary Panel" is the person or persons authorised to take disciplinary action.

"Misconduct" is a breach of discipline which is considered potentially serious enough to warrant recourse to formal disciplinary action (please refer to Disciplinary Rules).

"Gross Misconduct" is a serious breach of discipline which effectively destroys the employment relationship, and/or confidence which the Trust must have in an employee or brings the Trust into disrepute (please refer to Disciplinary Rules).

3. PRINCIPLES

The following general principles are applicable to all disciplinary cases:-

a. Employees are directed by their contract of employment to ensure they familiarise themselves with these procedures and the consequences of breaching the Trust's Disciplinary Rules.

b. In cases where an investigation is necessary, disciplinary action will not be taken against an employee until such an investigation is completed. However, the Trust reserves the right to proceed with disciplinary action where an employee fails to co-operate with an investigation.

c. Where a case is being investigated under this Disciplinary Procedure, the employee will be provided with a copy of this procedure as soon as possible. At every stage in the procedure the employee will be advised of the nature of the complaint, and will be given the opportunity to state their case before any decision is made.

d. At all stages during the disciplinary procedure, the employee will have the right to be accompanied and/or represented by an employee representative.

e. No employee will be dismissed for a first breach of discipline except in the case of gross misconduct where the disciplinary action may be summary dismissal.

f. An employee will have the right to appeal against any disciplinary action imposed.

g. In deciding upon appropriate disciplinary action, consideration will be given to the nature of the offence, any mitigating circumstances and previous good conduct.

h. The Trust will collect information from relevant witnesses. Trust employees who are witnesses to alleged misconduct will be required to give evidence and may be required to attend disciplinary meetings and/or hearings.

i. At all stages disciplinary proceedings will be completed as quickly as practicable.

j. Any disciplinary action will be appropriate to the nature of the proven misconduct.

4. FAILURE TO ATTEND MEETINGS/HEARINGS

Employees are expected to participate fully with the disciplinary process. If a Trust employee cannot attend a meeting/hearing through circumstances outside her/his control and unforeseeable at the time the meeting/hearing was arranged they must notify the HR Department and provide reasons. The Trust will arrange one further meeting/hearing. Failure to attend this rearranged meeting/hearing may result in the disciplinary process continuing in their absence based on the information available.

5. ACTION IN PARTICULAR CASES

a. Disciplinary action in the case of an employee representative, who is an accredited representative of a Trade Union, Professional Organisation or Staff Organisation

Although normal disciplinary standards apply to the conduct of an employee representative, no disciplinary action beyond the informal stage should be taken until the matter has been discussed with a full-time official of the employee's trade union, professional organisation or staff association.

b. Police enquiries, legal proceedings, cautions and criminal convictions not related to employment

Police enquiries, legal proceedings, caution or a conviction relating to a criminal charge shall not be regarded as necessarily constituting either a reason for disciplinary action or a reason for not pursuing disciplinary action. Consideration must be given as to the extent to which the offence alleged or committed is connected with or is likely to adversely affect the employee's performance of duties, calls into question the ability or fitness of the employee to perform his or her duties or where it is considered that it could bring the Trust into disrepute. In situations where a criminal case is pending or completed the Trust reserves its right to take internal disciplinary action.

c. Trust's duty to make referrals

The Trust is required, under the Protection of Children and Vulnerable Adults (NI) Order 2003, to make a referral to the DHSS&PS if a person working in a child care or vulnerable adults position has been dismissed, would have been dismissed, or considered for dismissal had he/she not resigned, or has been suspended, or transferred from a Child Care or vulnerable adults position.

Further, the Trust has a duty to make referrals to relevant professional bodies e.g. NMC, GMC, NI Social Care Council, HPC and also to the Police Service of Northern Ireland (PSNI) in appropriate cases.

In cases of alleged theft, fraud or misappropriation of funds, action should include consultation with the Director of Finance, DHSSPS and the PSNI as appropriate.

d. Suspension from Work

Management reserves the right to immediately suspend an employee with pay. Precautionary suspension must be authorised by the appropriate senior manager or suitable deputy.

The reason for suspension should be made clear to the employee and confirmed in writing. When the reason for suspension is being conveyed to the employee, where possible, he or she should be accompanied by an employee/trade union representative. Suspension is not disciplinary action, and as a consequence carries no right of appeal. The appropriate senior manager should consider other alternatives, for example transfer of employee, restricted or alternative duties if considered feasible and appropriate.

Any decision to precautionary suspend from work, restrict practice, or transfer temporarily to other duties must be for the minimum necessary period of time. The decision must be reviewed, by the appropriate senior manager, every 4 weeks.

6. DISCIPLINARY PROCEDURE

This section sets out the steps which may be taken following a breach of the Trust's Disciplinary Rules

6.1 COUNSELLING AND INFORMAL WARNINGS

a. The manager has the discretion to address minor issues through either counselling or the issue of an informal warning. At this informal stage matters are best resolved directly by the employee and line manager concerned.

b. Counselling does not constitute formal disciplinary action. Counselling should be conducted in a fair and reasonable manner and the line manager should ensure that confidentiality is maintained. This should take the form of pointing out any shortcomings of conduct or performance and encouraging improvement and may include an agreed training or development plan. It is the line manager's responsibility to ensure that notes of the counselling meeting are shared with the employee, are stored securely and that the situation is monitored. This counselling does not in any way prevent the line manager from instigating formal disciplinary action if appropriate. If the faults are repeated, or the conduct does not improve, the formal disciplinary procedure may be instigated

c. The line manager has the discretion to issue an informal warning. If this is applicable, the manager will follow these steps:

- Manager investigates matter
- Manager meets with employee
- Manager issues informal warning

- Informal warning is confirmed to employee in writing and is deleted from their record after 6 months
- Employee has right to appeal to the next line manager
- Appeal request should be submitted within 7 working days

d. The right to be accompanied by an employee representative will apply throughout the informal process.

e. In the event that issues cannot be resolved with counselling or informal warnings the Formal Disciplinary Procedure should be invoked.

FORMAL DISCIPLINARY PROCEDURE

6.2 INVESTIGATION

a. The Investigating Officer is responsible for establishing the facts of the case. The investigation will be conducted as quickly as is reasonable taking account of the extent and seriousness of the allegations. The Investigating Officer should meet with the employee who may be accompanied and/or represented by an employee representative. The Investigating Officer should explain the alleged misconduct to the employee. The Investigating Officer should ensure that any witnesses are interviewed and that all relevant documentation is examined before a decision is made on the appropriate course of action.

b. It should be noted that, if an issue has already been investigated under another agreed procedure (e.g. harassment and bullying) and disciplinary action has been recommended, then there is no requirement to reinvestigate under this Disciplinary Procedure.

6.3 HEARING

a. If it is considered that there is a case to be answered, the employee should be called to attend a disciplinary hearing before the appropriate Disciplinary Panel. A copy of this Disciplinary Procedure should accompany the letter advising of the hearing. The employee should be informed in writing of the allegation and the right to be represented. Any documentation intended for use by either party at the Disciplinary Hearing should be exchanged no later than 5 working days prior to the hearing.

b. The Disciplinary Panel is made up of 2 managers at an appropriate level.

c. Where an employee's professional competence/conduct is in question the Disciplinary Panel may, if needed, invite a suitably qualified experienced person from the same profession to attend the Hearing as an expert adviser. The adviser does not have a decision-making role.

d. In cases of professional misconduct involving medical or dental staff, the Disciplinary Panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) who is not

currently employed by the Trust (see Maintaining High Professional Standards in the Modern HPSS (Nov 2005) Section III Para 1). The advice of the appropriate local representative body should be sought.

e. The employee shall normally be present during the hearing of all the evidence put before the Panel; however the employee may choose not to attend the hearing. It should be made clear that the hearing will proceed in his or her absence. Any submission by the employee in writing or by his or her representative will be considered. The Trust reserves the right to proceed to hear a disciplinary case in the absence of the employee where no adequate explanation is provided for the employee's absence.

f. Any witnesses required to attend the hearing should be granted the appropriate time off from their work. The employee representative cannot be a witness or potential witness to the disciplinary process.

g. At the Hearing, the case against the employee and the evidence should be detailed by the presenting officer and the employee should set out his/her case and answer the allegations.

h. Witnesses may be called by either party and can be questioned by the other party and/or by the Disciplinary Panel. The presenting officer and the employee / representative will have the opportunity to make a final submission to the Disciplinary Panel at the end of the Hearing with the presenting officer going first. The Disciplinary Panel has the right to recall any witnesses but both sides and their representatives have the right to be present.

6.4 DISCIPLINARY DECISION

a. The Disciplinary Panel will review all the evidence presented before taking its decision. The Disciplinary Panel will determine on a balance of probability whether the allegations were or were not proven. Before deciding on the appropriate disciplinary action, the Disciplinary Panel should consider any mitigating circumstances put forward at the hearing and take account of the employee's record.

b. The decision should be communicated in writing to the employee normally within 7 working days of the date of the hearing. In the case of formal or final written warnings, the timescale of any sanction should be specified. The employee should be advised of the consequences of further breaches of discipline and informed of the right and method of appealing the decision.

c. In the case of dismissal, the employee should be advised that the decision of the Disciplinary Panel will be fully implemented pending appeal. Pay pending appeal will only be paid in the following circumstances (with the exception of summary dismissal):

- In all circumstances an appeal hearing shall be organised within 12 weeks of the original hearing.
- The appeal hearing should be organised in a timescale which allows proper representation to occur, consistent with principles of natural justice.
- Payment will be recommenced at week 6 in circumstances where management alone have failed to convene an appeal hearing within the aforementioned timescale.

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6.5 DISCIPLINARY ACTION

The Disciplinary Panel may impose one or more of the following disciplinary sanctions / actions

a. Formal Warning

A formal warning may be given following misconduct or where misconduct is repeated after informal action has been taken. A formal warning will remain on the employee's record for a period of one year. The warning should be accompanied by advice to the employee on the consequence of any repetition or continuance of the misconduct that has given rise to the disciplinary sanction / action.

b. Final Warning

A final warning may be given when the misconduct is considered more serious or where there is a continuation of misconduct which has lead to previous warnings and/or informal action. A final warning will remain on the employee's record for a period of 2 years. The warning should be accompanied by advice to the employee on the consequence of any repetition or continuance of the misconduct that has given rise to the disciplinary sanction/action.

c. Transfer and/or Downgrading

The Disciplinary Panel may decide that the most appropriate course of action should be either transfer, downgrading or both. These disciplinary actions may be imposed in addition to either a formal warning or a final warning as appropriate.

d. Dismissal

Dismissal will apply in situations where previous warnings issued have not produced the required improvement in standards or in some cases of Gross Misconduct.

e. Summary Dismissal

In some cases where Gross Misconduct has been established, an employee may be summarily dismissed, i.e. without payment of contractual or statutory notice.

NOTE: If the misconduct is proven the Disciplinary Panel may recommend that any associated financial loss should be recouped from the employee. This should be referred to the Director of Finance for further consideration.

7. DISCIPLINARY APPEALS

a. An employee wishing to appeal disciplinary action should write to the Director of Human Resources stating the grounds of their appeal within 7 working days of receipt of the letter containing the disciplinary decision. The appeal hearing will be arranged as early as practicable and the employee will have the right to be represented. The employee will normally receive 7 working days notice of the date of the appeal hearing.

b. The Appeal Panel, will comprise 2 managers from the Trust who have had no previous involvement in the case and who are normally at a more senior level than the Disciplinary Panel. In professional misconduct appeals involving medical staff and/or dentists, the Appeal Panel will comprise one additional medically/dentally qualified panel member who is not employed by the Trust or has not been previously involved in the disciplinary case. Where the employee's professional competence / conduct is in question, the Appeal Panel may invite a suitably qualified and experienced senior officer in the same profession from the trust or outside the Trust to attend the hearing as an assessor. The assessor has no decision making role. The Appeal Panel will permit additional evidence not available or provided at the Disciplinary Hearing to be considered only if it is considered relevant to the original allegation.

c. The Appeal hearing will be a full rehearing of the case.

d. The Appeal Panel will have the authority to confirm, set aside, or reduce the decision of the Disciplinary Panel. It will not have the right to increase the decision of the Disciplinary Panel. Where the decision of the Appeal Panel involves a variation of the original disciplinary decision, it should state the reasons and any operative date. The decision of the Appeal Panel is final and will be conveyed in writing to the appellant within 7 working after the hearing. In the event of delay a written explanation will be provided.

e. In the event of reinstatement following an appeal the appropriate back payment will be made.

8. REVIEW OF THE PROCEDURES

These procedures should be reviewed periodically in consultation with recognised staff side representatives via the HSC (NI) Joint Negotiation Forum.

Signed on behalf of Staff Side:

Personal Information redacted by the USI

Lily Kerr, Staff Side Secretary

Personal Information redacted by the USI

Kevin McAdam, Staff Side Secretary

Date: 14th September 2007.

Signed on behalf of Trust:

Personal Information redacted by the USI

Kieran Donaghy

Date: 14th September 2007

These procedures are effective from 1 September 2007.

APPENDIX 1 TRUST DISCIPLINARY RULES

In accordance with paragraph 1 of the Trust's Disciplinary Procedure, Disciplinary Rules are set out below. Conduct is categorised under the headings of **"Misconduct**" and **"Gross Misconduct".** This list should not be regarded as exhaustive or exclusive but used simply as a guide.

In determining the appropriate heading, managers are required to carefully consider the circumstances and seriousness of the case.

MISCONDUCT

Listed below are examples of offences of misconduct, other than gross misconduct, which may result in disciplinary action and/or counselling/informal warning in the light of the circumstances of each case. Where misconduct **is** repeated this may lead to dismissal.

- **Inappropriate or unacceptable conduct or behaviour towards employees, patients, residents, clients, relatives or members of the public.**
- **Abuse of employment position and/or authority.**
- **Absenteeism.**
- **Unauthorised Absence.**
- **Insubordination.**
- **Poor Time-keeping.**
- **Dishonesty.**
- **Unsatisfactory Performance and Conduct.**
- **Failure to adhere to contract of employment.**
- **Failure to comply with the responsibilities and duties of employment position.**
- **Failure to comply with Trust Rules and Procedures, Policies and Practices.**
- **Failure to declare outside Employment/Activities**
  - Failure to declare any outside activity which would impact on the full performance of contract of employment.
- **Failure to conform with safety, hygiene, security rules and regulations.**
- **Misuse of Trust Resources**
  - internet, e-mail, telephone, etc (see Trust policies).
- **Misuse of Trust Property**
  - neglect, damage, or loss of property, equipment or records belonging to the Trust, clients, patients, residents or employees.
- **Use of foul language.**
- **Gambling on Trust Premises.**
- **Dangerous horseplay.**
- **Discrimination, victimisation, harassment or bullying on any grounds.**
- **Breach of confidentiality.**
- **Alcohol/Drugs misuse.**
- **Being an accessory to a disciplinary offence.**

GROSS MISCONDUCT

The following are examples of Gross Misconduct offences which are serious breaches of contractual terms which effectively destroy the employment relationship, and/or the confidence which the Trust must have in an employee. Gross misconduct may warrant summary dismissal without previous warnings.

- **Theft -** Theft from the Trust, its employees, patients, clients, residents or the public including other offences of dishonesty.
- **Fraud -** Falsification of documentation or records pertaining to patients, clients, staff, or other persons. Misrepresentation which results, or could result in financial gain (e.g. applications for posts, pre-employment medical forms, time-sheets, clock-cards, subsistence and expenses claims etc.)
- **Being under the influence or misuse of Alcohol or Drugs -** Being under the influence of alcohol, unauthorised consumption while on duty or during working hours. Reporting for duty smelling of alcohol. Misuse of drugs, e.g. through misappropriation or being under the influence of drugs.
- **Breaches of safety, hygiene, security rules and regulations endangering one's own or another's physical well-being or safety.**
- **Issues of probity.**
- **Physical violence / assault or other exceptionally offensive behaviour.**
- **Criminal Conduct** - including failure to notify the Trust of a criminal offence either at work or outside of work. Consideration will be taken of criminal conduct / convictions and relevance to the employee's position.
- **Breaches of Confidentiality.**
- **Discrimination, victimisation, harassment or bullying on any grounds.**
- **Serious Breaches of Trust Rules, Policies, Procedures and Practices.**
- **Malicious or vexatious allegations or intimidation against another employee.**
- **Serious Insubordination.**
- **Ill-treatment or wilful neglect of patients, clients, residents.**
- **Negligence.**
- **Breaches of contract of employment and/or Professional Codes of Conduct.**
- **Some outside Employment/Activities -** Engaging in outside employment / activities that would prevent the efficient performance of duties, adversely affect health, bring into question loyalty and reliability or in any way weaken confidence in the Trust's business. Engaging in outside employment when contracted to work for the Trust unless otherwise agreed or where outside work is undertaken in competition with the Trust.
- **Abuse of sick pay provisions.**
- **Bringing the Trust into Disrepute.**
- **Misuse or unauthorised use of Property -** Unauthorised use or removal of Trust property. Damage caused maliciously or recklessly to property, equipment or records belonging to the Trust, clients, patients, residents or employees.
- **Misuse of Trust resources, including IT resources (see IT policies), or misuse of Trust name.**

- **Serious professional misconduct or negligence.**
- **Unauthorised sleeping on duty.**

APPENDIX 2 – PANELS FOR HEARINGS AND APPEALS

MISCONDUCT		
	Hearing	**Appeal**
Staff at below 4th Level	Level 4 or appropriate delegated level	Level 3
Staff at 4th Level	Level 3	Level 2
Staff at 3rd Level	Level 2	Level 2
Staff at 2nd Level	Level 1 / Level 2	Chair / Level 1 / Level 2
GROSS MISCONDUCT		
	Hearing	**Appeal**
Staff at below 4th Level	Level 4	Level 3
Staff at 4th Level	Level 3	Level 2
Staff at 3rd Level	Level 2	Level 2
Staff at 2nd Level	Level 1 / Level 2	Chair / Level 1 / Level 2

Level 1 – Chief Executive
Level 2 – Director
Level 3 – Assistant / Co-Director
Level 4 – Senior Manager

-----Original Message-----
From: Trouton, Heather <[redacted]>
Sent: 04 December 2013 18:40
To: Young, Michael <[redacted]>; Brown, Robin <[redacted]>
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

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 Personal information redacted by USI Personal information redacted by USI 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

email to monica 11.11.13

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

MDT UROLOGY CANCER MEETING
THURSDAY 22nd APRIL 2010
VENUE: TUTORIAL ROOM 1, MEC

PRESENT Mr M Akhtar (Chair), Dr G McClean, Dr M Williams, Dr Funso Abogunrin, Vicki Graham, Jenny McMahon, Marie Dabbous, Dr Siddiqui

MINUTES

1. APOLOGIES

Mr M Young, Mr R Brown, Mr A O'Brien, Dr M McClure, Alison Porter

2. MINUTES OF LAST MEETING

E-mailed to Urology MDM circulation list 08.04.10.

3. PRESENTATION OF CASES

All patients were discussed as per patient list. There were no additional patients discussed.

4. AOB

Dr G McClean & Mr Akhtar discussed the advantages of having suitable viewing equipment to view & project histology slides at the MDM. This has been costed round £1200. This information has been passed onto Alison Porter.

After the MDM it was discussed with Dr M Williams that he would personally like only 1 list to be distributed with the patients to be discussed @ MDM on the Wednesday morning and that this list is to clearly identify why the patients are to be discussed i.e. Radiology, Pathology, etc,. This was agreed by tracker and will be effective from Wednesday 28th April. 1 list will also only be circulated the distribution list.

Vicki Graham & Mr Akhtar discussed the possibility of changing the layout of the patients that have to be discussed and to see if they can be discussed in certain clusters i.e. Radiology, Pathology, Post Surgery, discussion following staging investigations. This is to be re discussed during the week with Mr Akhtar & Vicki.

5. DATE OF TIME OF NEXT MEETING

The next meeting is to take place at 2.15 pm on **Thursday 29 April 2010** in Tutorial Room 1, MEC, CAH, and Tutorial Room, DHH.

MDT UROLOGY CANCER MEETING
THURSDAY 3rd June 2010
VENUE: TUTORIAL ROOM 1, MEC

PRESENT Mr M Akhtar (Chair), Dr G McClean, Dr M Williams, Vicki Graham, Kate O'Neill, Mr Young, Mr O'Brien, Mr R Brown, Dr M McClure

MINUTES

1. APOLOGIES

Dr Funso Abogunrin, Dr M Sut, Dr Siddiqui, Sr S Tedford

2. MINUTES OF LAST MEETING

E-mailed to Urology MDM circulation list 21.05.10.

3. PRESENTATION OF CASES

All patients were discussed as per patient list. There were no additional patients discussed.

4. AOB

[redacted] Irrelevant information redacted by the USI

Mr Akhtar has requested that a fan be available for next weeks MDM as the room gets very warm.

5. DATE OF TIME OF NEXT MEETING

The next meeting is to take place at 2.15 pm on **Thursday 10th June 2010** in Tutorial Room 1, MEC, CAH, and Tutorial Room, DHH.

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Job Plan Dates
This job plan is effective from:
Next Job Plan Review Due on/before:

Personal details:	
Name:	Contract:
Directorate/Division & Location:	☐ Whole Time ☐ Part Time

On-call availability supplement:		
Rota Frequency – i.e. Number of Consultants on rota:	1 **in:** ☐	
Rota Category:	Category A ☐	Category B ☐

Summary of Programmed Activities:		
Direct Patient Care:	☐ PA's	
Supporting Professional Activities:	☐ PA's	
On-Call Allocation:	***Predictable*** ☐ PA's	***Unpredictable*** ☐ PA's
Any Annualised Activity & Reason	☐ PA's	
TOTAL PA's: **(Rounded to nearest 0.25)**	☐ **PA's**	

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

This job plan is subject to review at least once per year by you and your Clinical Director/Associate Medical Director before being approved by the appropriate Director. In the case of a new employee a review of the job plan will take place 3 months after commencement and annually thereafter. If it is not feasible to agree a job plan, either initially or at annual review there are agreed procedures for facilitation and appeal with the final decision normally being accepted by Trust Board.

1. OBJECTIVES: [Please set out objectives under the following sub headings]

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 SPA]
- Objectives for external duties

Team Objectives

- As appropriate to the team job plan

2. EDUCATION AND TEACHING RESPONSIBILITIES

- Service based teaching forms part of direct clinical care
- Additional teaching can be agreed as part of SPAs
- Externally Funded ☐

Please provide detail of agreed teaching activities:

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

3. RESEARCH

- Separate Research activity to be defined
- Research activity should, where possible be aligned to Trust objectives
- Acknowledged via basic or objective based SPA allowance
- Externally Funded ☐

Please provide detail of agreed research activities:

4. EXTERNAL DUTIES

- May be annualised due to the nature/irregular timing of the work
- Consultants must have CD/AMD approval before accepting external duties
- Timeframes must be defined
- Consideration to be given to SPA contribution of external duties [50%]
- Externally Funded ☐

- Options for dealing with external duties:
  - Substitute DCC/SPA for external duties
  - Agree annualised job plan with aggregation of work across the year
  - Use of special leave
  - No need for PA allocation
  - Assumes no work is done at that time and no work is displaced
  - Assumes colleagues are not required to do additional work to cover absence

Please insert duties/responsibilities as agreed with your clinical Director/Associate Medical Director

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

5. SUPPORTING PROFESSIONAL ACTIVITIES

- To be delivered on-site – alternative short term arrangements can be negotiated with Clinical Directors

- **Basic SPA Allowance [1.5 PAs]**
- Job planning
- Appraisal
- Audit
- CPD
- Other duties – can include: [C & SCG, teaching; data collection, , university/college activity; patient safety roles]

- **Objective Based SPAs – Agreed with Directorate; normally aligned with Global Objectives of the Trust**
- Research
- Defined role in Education & Teaching responsibilities
- Defined Clinical management
- Acknowledgement of roles in Audit /Clinical governance/patient safety roles
- Specialty lead
- External Duties

6. DIRECT CLINICAL CARE

- Emergency attendance
- Outpatient/other clinics
- Operating Sessions
- Ward Round
- Other patient treatment/relative consultation
- Telephone advice to hospital
- MDT meetings about DDC
- Investigative, diagnostic or laboratory work
- Public Health Duties
- Travelling Time between sites
- Patient Administration
- Service linked training [such as during ward round]
- Clinical Supervision

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

7. REGULAR WEEKLY COMMITMENTS

(If appropriate cut and paste your job plan into this space set out in the following format.)

Week 1:

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS		Total	Prem
				DCC	SPA		
Mon							
Tues							
Wed							
Thurs							
Fri							
TOTAL HOURS							
AVERAGE HOURS							

8. PROGRAMMED ACTIVITIES

Programmed Activity	Number of PA's per week	
Direct Clinical Care		
Supporting Professional Activities		
Core SPAs		
Objective Based SPAs		
PA's for on-call*		
Total SPAs		
External Duties		Reason:
Annualised PA's		Reason:
Total Number PAs		

- ***Method for calculating on-call:*** *The total number of hours PER WEEK undertaken as a result of being on-call for the whole team (not individual consultants); divided by 3 (premium time PA's); multiplied by 52 weeks of the year and divided by 42 weeks of the year and finally divided by the number of consultants on the on-call rota = total weekly PA allocation for each consultant on the on-call rota. (Same calculation for predictable and unpredictable on-call)*

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

9. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work			
Unpredictable Emergency on-call Work	On-Call Period	On-site; at home; travelling to and from site	
TOTAL ON-CALL			

Type	
Agreed on-call Rota Frequency	
Agreed Category	
On-Call Supplement	

- If your agreed availability is Category A when on-call you need to be available within 30 minutes travel time of the site to which you are on call to.
- If your agreed availability is Category B when on-call it is expected that your will typically respond by giving telephone advise or returning to work later, with occasional immediate return to work being the exception

10. PRIVATE PRACTICE & FEE PAYING SERVICES

Type	Please Tick:
You are not currently undertaking regular private practice however if this changes during the year your have agreed to inform the clinical director before any changes are made to your work-plan.	☐
You are currently undertaking regular private practice as outlined in your job plan and have agreed to undertake an additional PA if offered, up to a maximum of 11 Pas per week, as detailed in the terms and conditions of service	☐
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.	☐

Southern Health and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

11. AGREEMENT:

To be completed and forwarded to:

- ***The Medical Director, Trust Headquarters, Craigavon Area Hospital***

AND

- ***The Medical Staffing Manager, Medical HR, Ground Floor, Trust Headquarters, Craigavon Area Hospital.***

Signed	_____	Signed	_____
Consultant		**Clinical Director/Associate Medical Director**	
	_____		_____
Date	_____	Date	_____
Signed	_____		
Director			
	_____		
Date	_____		

Southern Health and Social Care Trust

Memorandum

To: All Consultants and SAS doctors

From: Dr John Simpson Medical Director

Date: 1 November 2012

RE: **Job Planning**

All job plans for consultants and Specialty/Associate Specialists have now been transferred into the electronic job planning system (Zircadian). A total of 187 Consultant Job Plans and 83 Specialty/Associate Specialist job plans can now been accessed electronically via this web-based system. Those doctors who didn't have a job plan at the time of set up will have a blank job plan and details of your job plan will still need to be entered.

The system doesn't replace job plan meetings but you can use it to view your job plan and request approval for any changes. It will also store all versions of your job plans for future reference. You can access this website from any computer (home or at work) where you have internet access.

Login at: [redacted]

I have arranged for login and password details to be reissued to all those doctors who have not yet signed into the system. These details will be emailed to you from [redacted] If you didn't receive this email, please contact Mrs Zoe Parks immediately so she can arrange to have these details resent.

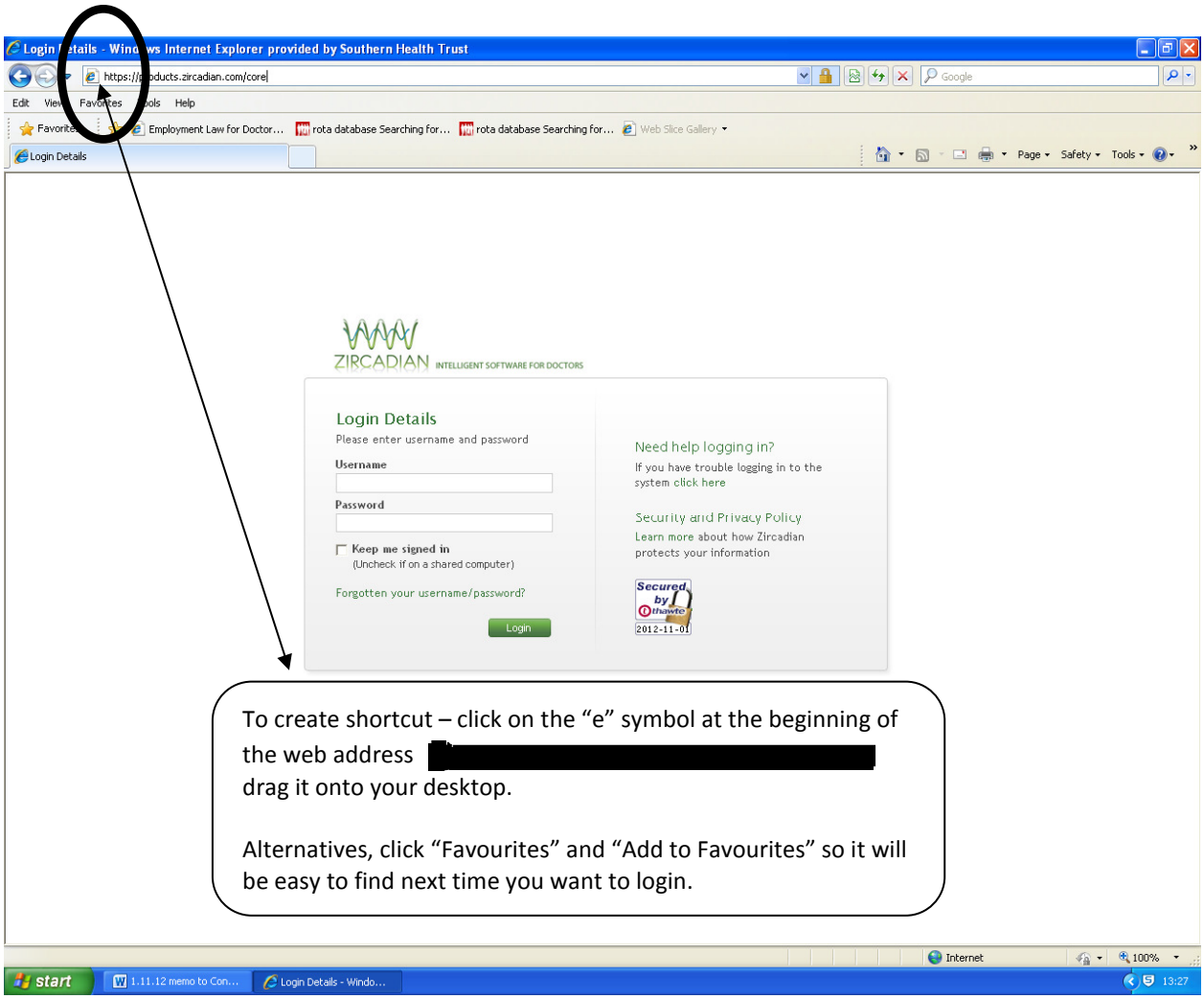
To date, very few doctors have actually logged into the system to view their job plan. Can I please **encourage you all to log into the electronic system now** to view your job plan and ensure that it accurately reflects your indicative working pattern. It may not be necessary to make any changes at this stage however it is important that you are familiar with the system so that it can be used to update your working pattern in the next job planning round.

If you require any help with the online system, you can contact the Zircadian helpdesk Monday to Friday (9-5) on 020 8946 8199 or [redacted] or alternatively contact Mrs Zoe Parks on [redacted] or email [redacted] for assistance.

Yours sincerely

Dr John Simpson
Medical Director

Save the website on your desktop or in your favourites bar for easy access:



-----Original Message-----
From: Elliott, Noleen <Personal Information redacted by the USI>
Sent: 22 January 2009 11:54
To: Rutherford, Alison <Personal Information redacted by the USI>; Dillon, Martin <Personal Information redacted by the USI>; McNally, Stephen <Personal Information redacted by the USI>; Campbell, Helen <Personal Information redacted by the USI>; Donaghy, Kieran <Personal Information redacted by the USI>; Walker, Helen <Personal Information redacted by the USI>; Personal information redacted by USI Personal Information redacted by the USI; Burns, Sinead <Personal Information redacted by the USI>; Donnelly, Raymond <Personal Information redacted by the USI>; Mallon, Maura <Personal Information redacted by the USI>; Toal, Vivienne <Personal Information redacted by the USI>; Hynds, Siobhan2 <Personal Information redacted by the USI>; Personal information redacted by USI Personal Information redacted by the USI; Trainor, Rita <Personal Information redacted by the USI>; Patterson, Karyn <Personal Information redacted by the USI>; King, Ray <Personal Information redacted by the USI>; Taylor, Janet <Personal Information redacted by the USI>; Gordon, Lynda <Personal Information redacted by the USI>; Boyce, Susan <Personal Information redacted by the USI>; Personal information redacted by USI Personal Information redacted by the USI; Loughran, Patrick <Personal Information redacted by the USI>; McAlinden, Mairead <Personal Information redacted by the USI>; Kelly, Martin2 <Personal Information redacted by the USI>; Burns, Deborah <Personal Information redacted by the USI>; Hanna, Siobhan <Personal Information redacted by the USI>; Metcalfe, Alan <Personal Information redacted by the USI>; Youart, Joy <Personal Information redacted by the USI>; Stead, Lindsay <Personal Information redacted by the USI>; McVey, Anne <Personal Information redacted by the USI>; Carroll, Anita <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Gibson, Simon <Personal Information redacted by the USI>; Donaldson, Ruth <Personal Information redacted by the USI>; Hall, Stephen <Personal Information redacted by the USI>; Murphy, Philip <Personal Information redacted by the USI>; Mackle, Eamon <Personal Information redacted by the USI>; Hogan, Martina <Personal Information redacted by the USI>; Weir, Colin <Personal Information redacted by the USI>; Sharpe, Peter <Personal Information redacted by the USI>; Brown, Robin <Personal Information redacted by the USI>; Personal information redacted by USI Personal Information redacted by the USI; Convery, Rory <Personal Information redacted by the USI>; Personal information redacted by USI Personal Information redacted by the USI; Fawzy, Mohamed <Personal Information redacted by the USI>; McCusker, Grainne <Personal Information redacted by the USI>; Damani, Nizam <Personal Information redacted by the USI>; Ritchie, Kate <Personal Information redacted by the USI>; OReilly, Seamus <Personal Information redacted by the USI>; McCaffrey, Patricia <Personal Information redacted by the USI>; Heasley, Noel <Personal Information redacted by the USI>
Cc: Wilson, Roberta2 <Personal Information redacted by the USI>; Moonan, Beatrice <Personal Information redacted by the USI>
Subject: Incident Form Training

Dear Colleagues,

The new SHSCT IR1 Form (Incident Reporting) is now available for use Trustwide. Rolling Training Sessions for Acute Services staff on the completion of the IR1 Form will take place as below. Please ensure that all staff who have responsibility for completion of Incident Forms within your area attend one of the training sessions as the IR1 Form will be distributed following attendance at same.

Timetable for training in CAH:

Date: 28th January 2009 Venue: Lecture Theatre, MEC, CAH
Morning Sessions
1st 0900 - 0945
2nd 1030 - 1115
3rd 1115 - 1200

Date: 28th January 2009 Venue: Boardroom CAH
Afternoon Sessions:
1st 1330 - 1415
2nd 1415 - 1500
3rd 1515 - 1600

Date: 3rd February 2009 Venue: Tutorial Room 2, MEC, CAH
Afternoon Sessions:
1st 1415 - 1500
2nd 1515 - 1600

Date: 17th February 2009 Venue: Lecture Theatre, MEC, CAH
Morning Sessions
1st 0900 - 0945
2nd 1030 - 1115
3rd 1115 - 1200

Date: 17th February 2009 Venue: Tutorial Room 3, MEC, CAH
Afternoon Sessions:
1st 1330 - 1415
2nd 1415 - 1500
3rd 1515 - 1600

Timetable for training in DHH:

Date 5th February 2009 Venue: Committee Room 1, DHH
Morning Sessions
1st 0900 - 0945
2nd 1030 - 1115
3rd 1115 - 1200

Date: 5th February 2009 Venue: Classroom, Nurses Home, DHH
Afternoon Sessions:
1st 1415 - 1500
2nd 1515 - 1600

Date 10th February 2009 Venue: Discussion Room, Nurses Home, DHH
Morning Sessions

1st 0900 - 0945
2nd 1030 - 1115
3rd 1115 - 1200

Date: 10th February 2009 Venue: Classroom, Nurses Home, DHH
Afternoon Sessions:
1st 1415 - 1500
2nd 1515 - 1600

Timetable for training in STH:

Date: 19th February 2009 Venue: Lecture Theatre, STH

Afternoon Sessions:
1st 1330 - 1415
2nd 1415 - 1500
3rd 1515 - 1600

Beatrice Moonan
Risk Manager Acute Services

This email is confidential and intended solely for the use of the individual(s) to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent those of Southern Health and Social Care Trust. If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited. If you have received this email in error please notify the sender.

-----Original Message-----
From: Corrigan, Martina <[redacted]>
Sent: 05 March 2013 14:51
To: ([redacted]>; AJay Pahuja [redacted]>; Glackin, Anthony [redacted]>; Young, Michael <[redacted]>; O'Brien, Aidan [redacted]>; Tony Glackin [redacted]>
Cc: Brown, Robin [redacted]>; Trouton, Heather <[redacted]>; Mackle, Eamon <[redacted]>
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

From: Young, Michael Personal Information redacted by the USI >
Sent: 04 March 2013 12:31
To: Mackle, Eamon < Personal Information redacted by the USI >
Cc: Corrigan, Martina Personal Information redacted by the USI >; Trouton, Heather < Personal Information redacted by the USI >; Brown, Robin < Personal Information redacted by the USI >
Subject: urology

Eamon

Thank you for your remarks. Although not actually stated, I would assume that most might interpret, from the length and content, that you neither support the new post nor the whole urology team plan. This is disappointing as considerable in-depth thought has been put into the whole process.

The Trust, several years ago, defined activity levels with the DoH. This indeed relates to the monday evening meetings held by the Trust, to which you refer. The outcome was clearly acknowledged in terms of outpatient clinics required to meet DoH requests as well as theatre and day surgery sessions. In summary, this was 11 clinics and 9 theatre sessions per week with each consultant doing 0.5 dsu per week.

The job plans recently presented for the team delivers on average 2.5 clinics per week per consultant, as near as the Trust can provide 2 theatre sessions and alternate week dsu. In addition to this, the necessary speciality sessions, which were not addressed adequately in the previous proposed plans, are now introduced. Our thoughts on the shortfall in oncology and stone specific clinics are now included to a certain degree as well. The dsu, theatre and clinics per week comply in full with the DoH agreement. I have discussed with Martina the exact clinics, in terms of type and number per week/month, to be performed (as certain clinics have different templates). The mathematics for the new system has been calculated and this indeed complies with the agreements as calculated by the Trust's administrative team. Our current clinic setup now have defined templates set by the Trust which comply in terms of template design (but may in some circumstances need extended in duration ie 3 to 4 hours to help with capacity).

The design in the individual job plans has in fact been so finely tuned that amalgamating them has created a team program, which allows for a team approach to look after the departments needs when for instance someone is on leave.

It should also be noted it has been clearly defined in meetings with DoH that demand beyond contract is not the Trust's responsibility .ie excessive referrals. I agree that we need to ensure and focus on the clinic slots being correctly and fully filled. If this is achieved then any excess is outside of contract yet with full slot allocation we meet our objective. All this is not helped by changes imposed by DoH targets since the original agreement. It should be noted that current job plans are different to the proposed ones. It should also be noted that there will be other possibilities to enhance the outpatient numbers during the emergency week's clinical duties.

The whole urology team plan is presented to the Trust. It provides the complete requirements the DoH has asked for in terms of what the Trust has signed up to do on a sessional basis. Further to the anticipated plans and the aspirations for urology in the Southern Trust, in good faith, the team members have already started the extra services in the Western Board and the evening theatre lists which is outside of existing job plans (again may I note this has been done in good faith).

May I note that there were no similar demands for the same team plan when advertising last year and my offer to apply the same job plan to the post in question being re advertised was rejected. This, I must say, does raise certain doubts about the process and line taken currently.

I would like to point out that the whole urology team, having been fully involved in the process, are in agreement and committed to the plans currently provided. It would be a shame for the Trust to reject such an approach of a department.

Further points are raised in your email in reference to urodynamics, ward round and mdt. There still is a misunderstanding about what is involved in urodynamics and what we do in that specific clinical session. Further information on this should be discussed. The agreement with regards to the ward round was in fact that the time allocated would be split 50/50 DCC/SPA. With hand over of clinical care for on-call, makes such a round necessary. Core MDT membership is different to attending mdt. There will be cases and circumstances when the urologists providing the bulk of the stone surgery will want to discuss their oncology work load. Exclusion from this risks loosing their services for that activity (not sure this is a good avenue to go down). With regards to WLI, I would record that we have been asked to do these sessions. Since we already currently have job plans this should not be an issue.

In case you think I am looking at this whole issue purely from a one sided perspective, I would like to reassure the Trust that I am fully aware of both sides of this process having been one of the few involved in the urology review and implementation groups from its inception. I do appreciate both sides views. It is however important to put together a service for our patient population that can be delivered.

I do feel that the opportunity to further explain how these job plans were created would in fact be advantageous as possibly not enough time to fully appreciate its layout was afforded to you before you wrote back.
I would welcome a further review of your decision. A meeting this week on the matter would probably be the best way forward.

MY
Lead Clinician Urology

-----Original Message-----
From: Mackle, Eamon [redacted]>
Sent: 02 March 2013 17:38
To: Brown, Robin [redacted]>
Cc: Corrigan, Martina <[redacted]>
Subject: Urology Job Plans

Hi Robin

Further to my email at lunchtime on Friday I met with Dr Rankin to discuss the Urology Job plans and advertising the 5th post. The situation is as I stated i.e. it is essential that the 5 job plans that are produced generate a level of activity which matches the SBA. As Kieran Donaghy stated the amount the Trust is paying for WLIs as well as activity going to the private sector is checked by the Auditors, therefore we don't have a choice but to make sure that each job plan produces an agreed level of activity. The Review of Urology Services in Northern Ireland laid down that level of activity. Other trusts work to that level therefore we have no choice but to ensure that the Southern Trust is productive. Therefore it is essential Robin when you have the job planning meetings with the urologists that this is taken into account. Kieran Donaghy suggested that HR get actively involved in job planning i.e. not just supporting but actually deciding what level of activity and type of sessions each consultant provides. I am not keen on going down this route and Dr Rankin likewise has resisted same. The quid pro quo is that if we are producing job plans we have to deliver value for money and not just what our colleagues desire.
Dr Rankin and I met with Michael and Aidan over a period of 18 months every Monday evening to regarding TYC and Urology. A lot was discussed and decided:
1. Stone Treatment clinics minimum of 6 New and 11 Review – 1.5 clinics per week 2. Outreach (SWAH/STH/DHH/BAN/ARM) minimum of 5 New and 7 Review - 2 outreach clinics per week 3. General Urology Clinics at CAH minimum of 6 New and 8 Review which means PM clinic starting at 1:30pm - 3 general clinics per week.
4. Oncology clinics minimum of 3 red Flag and 4 Protective Review and 4 uro-oncology review – total of 3.75 per week 5. D4 Clinics minimum of 4 patients (review) – 1 clinic per week 6. Prostate D1 minimum of 8 red flags and 2 News 1 clinic per week 7. Urodynamics is nurse-led and cannot be counted in Consultant activity The above activity does not include the additional activity required if a non-consultant is also at the clinic. Also note 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 don't know the exact amount of activity that needs to be carried out at Day Surgery lists and In-Patient lists but Martina will be able to fill you in on same.
The expected activity for Clinics and for Theatre/Endoscopy needs to be included in each job plan. Also at the Monday meetings it was decided that the Grand Rounds are to be considered as SPA. Furthermore the 2 stone consultants are not expected to be Core Members of the MDT and thus are not expected to attend the MDTs.
I know Michael has stated that Patrick Keane won't pass a job that doesn't have 2 SPAs but it has not been Trust policy nor for that matter the DHSSPS's to routinely have 2 SPAs in job plans. I am however keen not to delay the approval of the job plan by Patrick so I suggest that the 5th post is organized so that he/she teaches the third years (I think this is Tuesday morning) this equates to 0.25S PA and when you add in the monthly M&M (another 0.25) this equates to a total of 2.0 SPAs.
You will obviously have to meet with each of the Urologists to ensure that they understand what the job plan entails and what they are being asked to sign up to. I think it is essential that you lead

the job planning and not Michael because as CD you better understand the demands facing the Trust and the changes that have taken place in Commissioning.
The other issue, that I mentioned in my email of 19th February, is that all this needs completed by mid-March so it is imperative that progress is made this week.
Thanks
Eamon.

From: Mackle, Eamon
Sent: 01 March 2013 12:16
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina
Subject: FW: Urology job plans

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

-----Original Message-----
From: Brown, Robin <Personal Information redacted by the USI>
Sent: 27 February 2013 22:30
To: Young, Michael <Personal Information redacted by the USI>
Subject: FW: Urology job plans

See below
Eamon wants to exchange steps 4 and 5 of my plan I have no objections Would you be happy to forward the job-plans to Eamon before the team have agreed them?
I don't think that is an unreasonable request Call me tomorrow am

Robin

-----Original Message-----
From: Mackle, Eamon <Personal Information redacted by the USI>
Sent: 27 February 2013 17:30

To: Corrigan, Martina <Personal Information redacted by the USI>; Brown, Robin <Personal Information redacted by the USI>
Cc: Trouton, Heather <Personal Information redacted by the USI>
Subject: RE: Urology job plans

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

-----Original Message-----
From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 05 March 2013 14:51
To: <Personal Information redacted by the USI>; AJay Pahuja (<Personal Information redacted by the USI>); Glackin, Anthony <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Tony Glackin (<Personal Information redacted by the USI>) <Personal Information redacted by the USI>
Cc: Brown, Robin <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI>; Mackle, Eamon <Personal Information redacted by the USI>
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

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

-----Original Message-----
From: Young, Michael <Personal Information redacted by the USI>
Sent: 25 February 2013 15:59
To: Brown, Robin Personal Information redacted by the USI>
Subject: urology job plans

Dear Robin

There has been a lot of work done by all on the urology team's individual job plans.
Each is similar in content but with a specialty bent.
I was working these out with a few base line principles, namely number of outpatient sessions and theatre time which the Trust agreed with the department of Health.
This has been accomplished.
The Trust has wished to recheck this data against the expected SBA. Martina tells me this still matches.
I fortuitously happened to meet the regional advisor and mentioned our fifth post. He would need to see a job plan nearer the 10 PA and more SPA than is currently in the job plan. Martina informs me that dropping a clinic per week will still allow activity to be met.
I have got two version for the new job – one as per the rest of us and the second to meet the advisors criterion (I hope) which is 10.5 pa job including 1.93 spa. With luck the new incumbent will wish the same job as the rest of us.

I have had a chance to speak with Aidan, Tony and AJ with reference to their job plans. There is broad agreement with doing these clinical sessions, ie number of clinics and theatre sessions.
Although the theatre times are not ideal, we appreciate the lack of space available and feel this is the best we can do. Hopefully when more space on the CAH site becomes available we will get first option. There undoubtedly will be a few points raised about time allocation for certain activities that we have not thought about but I believe they will be small and easily resolved.

We therefore have a gentleman's agreement on the layout of the proposed job plans which apply to a five person team. It can only be implemented when the fifth person is on board.

I hope this can now satisfy the Management team so that the job plan can go to the regional advisor (who goes on leave at the end of the week) and we can advertise this post without delay.

MY

-----Original Message-----
From: Brown, Robin <Personal Information redacted by the USI>
Sent: 12 February 2013 12:44
To: Young, Michael <Personal Information redacted by the USI>
Cc: Clegg, Malcolm <Personal Information redacted by the USI>
Subject: RE: Urology job plans

Virtual clinics are in response to Aidan's suggestion that urologists spend a lot of time managing patients from their offices. Spoke to Heather about this and I think, in time, we will need to record these interactions.
Personally I do as much virtual clinic work as actual face to face.

Robin

From: Young, Michael
Sent: 12 February 2013 12:20
To: Brown, Robin
Subject: RE: Urology job plans

Have gone over all job plans this morning. I plan to meet with Malcolm at 11.30 tomorrow am. I think there is some tweaking to do. Not sure where virtual clinics come in as it puts the principle of five clinic per fortnight over = but it is an area to explore. SBA is a trust issue = if we can show the 11 clinics per week then we have documented the deal with the dept. (extra pt will be picked up via virtual clinics and emergency session to compliment the overall numbers)

I must say the way it is laid out is good Thanks MY

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

-----Original Message-----
From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 03 January 2013 17:02
To: Brown, Robin <Personal Information redacted by the USI>
Subject: RE: Urologist Job Plans

Great many thanks

Happy new year.

Zoe

From: Brown, Robin
Sent: 03 January 2013 16:59
To: Parks, Zoe; Mackle, Eamon
Cc: Corrigan, Martina
Subject: RE: Urologist Job Plans

This is a work in progress

The urologists have agreed to a very complex timetable of sessions which I am struggling to understand.
We will meet again soon – hopefully next week and then I expect we will need to try to translate it all into "zircadian".
The other complication, of course is that the day Mr Young presented the agreed timetables Mr Connolly announced his departure.
I was off over Christmas so I'll pick things up with Mr Young next week.

Robin

From: Parks, Zoe
Sent: 03 January 2013 15:43
To: Mackle, Eamon; Brown, Robin
Cc: Corrigan, Martina
Subject: Urologist Job Plans
Importance: High

Mr Mackle / Mr Brown,

I was just wondering if there had been any developments with the working patterns/hours following the new Urologist appointments? Will new job plans be drawn up. Do I need to flag this as a potential issue for other areas such as Anaesthetics so job plans can be amended in appropriate time to avoid extra duty payments etc.

Look forward to hearing from you.
Zoe

From: Parks, Zoe
Sent: 17 December 2012 11:20
To: Brown, Robin ([redacted]); Mackle, Eamon
Subject: Urologist Job Plans
Importance: High

Mr Brown,

RE: Urologist Job Plans

I am aware that from early January, the Consultant Urologists may be required to work longer days to facilitate more operating which I believe may involve working to 8/9pm. I was wondering if this will be factored into job plans to avoid any precedent of additional payments?

If there are any draft job plans – can these be shared with me as we will need to liaise with Dr McAllister to review the Anaesthetist job plans to ensure their job plans can be amended to reflect these new changes.

Look forward to hearing from you.

Thanks

Zoe

Mrs Zoe Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

-----Original Message-----
From: Clegg, Malcolm <Personal Information redacted by the USI>
Sent: 11 February 2013 10:42
To: Young, Michael <Personal Information redacted by the USI>
Cc: Brown, Robin <Personal Information redacted by the USI>; Parks, Zoe <Personal Information redacted by the USI>
Subject: Urology draft job plans

Mr Young,

Following a further meeting with Mr Brown on Friday afternoon, I have attached individual draft job plans for the five consultants in Urology for your consideration.

Private practice is included in your job plan for a Wed afternoon, but may need to be included for the others.

Malcolm & Zoe

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

Tel: Personal Information redacted by the USI

Southern Health and Social Care Trust.

This job plan started 01 April 2012.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	11 Feb 2013
Expected number of weeks in attendance	42
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

In 'Discussion' stage	5 Feb 2013	Mrs Zoe Parks

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.88	9.88	36:00
Supporting Professional Activities (SPA)	1.60	1.60	6:24
Total	11.48	11.48	42:24

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	Yes
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00
Do you work your on-call on a specific day?	No fixed day
Weekend on-call work:	
What are your average hours of predictable emergency work per weekend on-call?	0:00
Does this work replace or run concurrently with other activities?	No
What are your average hours of unpredictable emergency work per weekend on-call?	0:00
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)
PA Count:	
The number of PAs arising from your predictable on-call work is:	0.00
The number of PAs arising from your unpredictable on-call work is:	1.00
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Director	Role: Clinical Manager	Role: Clinical Director
Name: Dr Simpson, John	Name: Mr Mackle, Edward	Name: Dr Rankin, G
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30	Patient related admin (reports, results etc)	Day surgery	Patient related admin (reports, results etc)		Planned in-patient operating sessions		
08:45							
09:00				Grand Round			
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Continuous professional development.	Clinic	Virtual Clinic	Surgery MDT			
13:15							
13:30							
13:45							
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19:00							

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30	Day surgery						
08:45							
09:00		Urodynamics	Other CPD (please specify)	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
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10:30							
10:45							
11:00				Continuous professional development.			
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12:30							
12:45							
13:00	Continuous professional development.	Clinic		Surgery MDT	Virtual Clinic		
13:15							
13:30							
13:45							
14:00			Planned in-patient operating sessions				
14:15							
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21:00							

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30	Patient related admin (reports, results etc)		Patient related admin (reports, results etc)				
08:45							
09:00		Virtual Clinic		Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
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10:45							
11:00				Continuous professional development.			
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12:45							
13:00	Continuous professional development.	Clinic		Surgery MDT			
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13:45							
14:00			Planned in-patient operating sessions				
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Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
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08:15							
08:30							
08:45							
09:00	Clinic	Urodynamics	Other CPD (please specify)	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
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10:45							
11:00				Continuous professional development.			
11:15							
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12:45							
13:00	Continuous professional development.	Clinic		Surgery MDT	Virtual Clinic		
13:15							
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14:00			Planned in-patient operating sessions				
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21:00							

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions		
09:15							
09:30							
09:45							
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13:00	Clinic	Clinic	Day surgery	Surgery MDT	Planned in-patient operating sessions		
13:15							
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18:45							
19:00							

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	10.48	41:36
Mon	08:30 - 13:00	1, 3	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.45	1:48
Mon	08:30 - 13:00	2	Day surgery	Southern He..	Erne Hospit..	DCC	8.4	0.23	0:54
Mon	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	09:00 - 13:00	4	Clinic	Southern He..	Armagh Comm..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:00	5	Clinic Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.80	3:12
Tue	08:30 - 13:00	1	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54
Tue	09:00 - 13:00	2, 4	Urodynamics	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Tue	09:00 - 13:00	5	Emergency operating sessions Comments: consultant of the week	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	09:00 - 13:00	3	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	1-4	Clinic	Southern He..	Craigavon A..	DCC	33.6	0.80	3:12
Tue	13:00 - 17:00	5	Clinic Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	08:30 - 13:00	1, 3	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.45	1:48
Wed	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	09:00 - 13:00	2, 4	Other CPD (please specify) Comments: MDT Preparation	Southern He..	Craigavon A..	SPA	16.8	0.40	1:36
Wed	13:00 - 17:00	5	Day surgery Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:00	1	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Wed	14:00 - 20:30	2-4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	25.2	1.05	3:54
Thu	09:00 - 11:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36
Thu	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	11:00 - 13:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36
Thu	13:00 - 17:00	1-4	Surgery MDT	Southern He..	Craigavon A..	DCC	33.6	0.80	3:12
Thu	13:00 - 17:00	5	Surgery MDT Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	08:30 - 17:30	1	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.45	1:48
Fri	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	09:00 - 13:00	2-4	Clinic	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Fri	13:00 - 17:00	2, 4	Virtual Clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Fri	13:00 - 17:30	5	Planned in-patient operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
			Total:	1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

Resources

Staff

Equipment

Clinical Space

Other

Additional comments

None

Southern Health and Social Care Trust.

This job plan started 01 April 2012.

Job plan for Mr Young, Michael in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time

Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	11 Feb 2013
Expected number of weeks in attendance	42
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

In 'Discussion' stage	5 Feb 2013	Mrs Zoe Parks

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.51	9.51	34:33
Supporting Professional Activities (SPA)	1.55	1.55	6:12
Private Professional Services (PPS)	Does not attract a value		2:24
Total	11.06	11.06	43:09

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	No
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00
Do you work your on-call on a specific day?	No fixed day
Weekend on-call work:	
What are your average hours of predictable emergency work per weekend on-call?	0:00
Does this work replace or run concurrently with other activities?	No
What are your average hours of unpredictable emergency work per weekend on-call?	0:00
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)
PA Count:	
The number of PAs arising from your predictable on-call work is:	0.00
The number of PAs arising from your unpredictable on-call work is:	1.00
Your on-call availability supplement is:	5%

Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Director	Role: Clinical Manager	Role: Clinical Director
Name: Dr Simpson, John	Name: Mr Mackle, Edward	Name: Dr Rankin, G
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00		Planned in-patient operating sessions	Planned in-patient operating sessions				
08:15							
08:30					Day surgery		
08:45							
09:00	Patient related admin (reports, results etc)			Grand Round			
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00				Stone treatment clinic	Clinic		
13:15							
13:30	Stone treatment clinic						
13:45							
14:00		Continuous professional development.	Private Professional Services				
14:15							
14:30							
14:45							
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18:45							
19:00							

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Patient related admin (reports, results etc)	Continuous professional development.	ESWL Stone Treatment	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Continuous professional development.			Surgery MDT			
13:15							
13:30							
13:45							
14:00		Planned in-patient operating sessions	Private Professional Services				
14:15							
14:30							
14:45							
15:00							
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15:30							
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20:30							
20:45							
21:00							

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Clinic	Day surgery	ESWL Stone Treatment	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00				Stone treatment clinic			
13:15							
13:30	Stone treatment clinic						
13:45							
14:00							

14:15							
14:30							
14:45							
15:00							
15:15							
15:30			Private Professional Services				
15:45							
16:00							
16:15							
16:30							
16:45							
17:00							
17:15		Planned in-patient operating sessions					
17:30							
17:45							
18:00							
18:15							
18:30							
18:45							
19:00							
19:15							
19:30							
19:45							
20:00							
20:15							
20:30							
20:45							
21:00							

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Patient related admin (reports, results etc)	Continuous professional development.	Patient related admin (reports, results etc)	Grand Round	Patient related admin (reports, results etc)		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							

12:15							
12:30							
12:45							
13:00	Continuous professional development.			Surgery MDT	Clinic		
13:15							
13:30							
13:45							
14:00		Planned in-patient operating sessions	Private Professional Services				
14:15							
14:30							
14:45							
15:00				Stone treatment clinic			
15:15							
15:30							
15:45							
16:00							
16:15							
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18:30							
18:45							
19:00							
19:15							
19:30							
19:45							
20:00							
20:15							
20:30							
20:45							
21:00							

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Continuous professional development.		
09:15							
09:30							
09:45							
10:00							

10:15					Emergency operating sessions			
10:30								
10:45								
11:00								
11:15								
11:30								
11:45								
12:00								
12:15								
12:30								
12:45								
13:00	Clinic	Clinic	Clinic	Clinic	Clinic			
13:15								
13:30								
13:45								
14:00								
14:15								
14:30								
14:45								
15:00								
15:15								
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16:30								
16:45								
17:00								
17:15								
17:30								
17:45								
18:00								
18:15								
18:30								
18:45								
19:00								

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	10.06	42:21
Mon	09:00 - 13:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	09:00 - 13:00	1-2, 4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Mon	09:00 - 13:30	3	Clinic Comments: Banbridge 30 minutes travel to Craigavon Area Hospital.	Southern He..	Banbridge P..	DCC	8.4	0.23	0:54
Mon	13:00 - 17:00	5	Clinic Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 18:00	2, 4	Continuous professional development.	Southern He..	Craigavon A..	SPA	16.8	0.50	2:00
Mon	13:30 - 17:30	1, 3	Stone treatment clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Tue	08:00 - 14:00	1	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.30	1:12
Tue	08:30 - 13:00	3	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54
Tue	09:00 - 13:00	5	Emergency operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	09:00 - 13:00	2, 4	Continuous professional development.	Southern He..	Craigavon A..	SPA	16.8	0.40	1:36
Tue	13:00 - 17:00	5	Clinic Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	14:00 - 18:00	1	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Tue	14:00 - 20:30	2-4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	25.2	1.05	3:54
Wed	08:00 - 14:00	1	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.30	1:12
Wed	09:00 - 13:00	2-3	ESWL Stone Treatment	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Wed	09:00 - 13:00	5	Emergency operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	09:00 - 13:00	4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:00	5	Clinic Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	14:00 - 17:00	1-4	Private Professional Services	Southern He..	Craigavon A..	PPS	33.6		2:24
Thu	09:00 - 11:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36
Thu	09:00 - 13:00	5	Emergency operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	11:00 - 13:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36
Thu	13:00 - 15:00	4	Surgery MDT	Southern He..	Craigavon A..	DCC	8.4	0.10	0:24
Thu	13:00 - 17:00	5	Clinic Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	13:00 - 17:00	1, 3	Stone treatment clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Thu	13:00 - 17:00	2	Surgery MDT	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	15:00 - 17:00	4	Stone treatment clinic	Southern He..	Craigavon A..	DCC	8.4	0.10	0:24
Fri	08:30 - 13:00	1	Day surgery	Southern He..	Daisy Hill ..	DCC	8.4	0.23	0:54
Fri	09:00 - 10:00	5	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.05	0:12
Fri	09:00 - 13:00	4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	09:00 - 17:00	2-3	Clinic Comments: Prostate D4 clinic - am - weeks 2 and 3	Southern He..	Craigavon A..	DCC	16.8	0.80	3:12
Fri	10:00 - 13:00	5	Emergency operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.15	0:36
Fri	13:00 - 17:00	4	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:00	5	Clinic Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:45	1	Clinic 45 minutes travel to Craigavon Area Hospital.	Southern He..	Daisy Hill ..	DCC	8.4	0.24	0:57

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
			Total:	1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

Resources

Staff

Equipment

Clinical Space

Other

Additional comments

None

Southern Health and Social Care Trust.

This job plan started 05 February 2013.

Job plan for Dr Glackin, Anthony Jude in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	11 Feb 2013
Expected number of weeks in attendance	42
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

In 'Discussion' stage	5 Feb 2013	Mrs Zoe Parks

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	10.00	10.00	36:36
Supporting Professional Activities (SPA)	1.60	1.60	6:24
Total	11.60	11.60	43:00

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	No
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00
Do you work your on-call on a specific day?	No fixed day
Weekend on-call work:	
What are your average hours of predictable emergency work per weekend on-call?	0:00
Does this work replace or run concurrently with other activities?	No
What are your average hours of unpredictable emergency work per weekend on-call?	0:00
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)
PA Count:	
The number of PAs arising from your predictable on-call work is:	0.00
The number of PAs arising from your unpredictable on-call work is:	1.00
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Director	Role: Clinical Manager	Role: Clinical Director
Name: Dr Simpson, John	Name: Mr Mackle, Edward	Name: Dr Rankin, G
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							

08:00							
08:15							
08:30							
08:45							
09:00	Clinic	Continuous professional development.	Patient related admin (reports, results etc)	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Patient related admin (reports, results etc)	Virtual Clinic		Surgery MDT	Clinic		
13:15							
13:30							
13:45							
14:00			Planned in-patient operating sessions				
14:15							
14:30							
14:45							
15:00							
15:15							
15:30							
15:45							
16:00							
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18:45							
19:00							
19:15							
19:30							
19:45							
20:00							
20:15							
20:30							
20:45							

21:00							

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00		Planned in-patient operating sessions	Planned in-patient operating sessions				
08:15							
08:30	Day surgery						
08:45							
09:00				Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Clinic			Surgery MDT	Patient related admin (reports, results etc)		
13:15							
13:30							
13:45							
14:00		Virtual Clinic	Virtual Clinic				
14:15							
14:30							
14:45							
15:00							
15:15							
15:30							
15:45							
16:00							
16:15							
16:30							
16:45							
17:00							
17:15							
17:30							
17:45							
18:00							
18:15							
18:30							
18:45							

19:00							

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Clinic	Patient related admin (reports, results etc)	Continuous professional development.	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	TRUS & biopsy	Patient related admin (reports, results etc)		Surgery MDT	Continuous professional development.		
13:15							
13:30							
13:45							
14:00			Planned in-patient operating sessions				
14:15							
14:30							
14:45							
15:00							
15:15							
15:30							
15:45							
16:00							
16:15							
16:30							
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18:30							
18:45							

19:00							
19:15							
19:30							
19:45							
20:00							
20:15							
20:30							
20:45							
21:00							

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30		Day surgery					
08:45							
09:00	Clinic		Continuous professional development.	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00		Virtual Clinic	Continuous professional development.	Surgery MDT	Continuous professional development.		
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							
14:45							
15:00							
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16:45							

17:00							
17:15							
17:30							
17:45							
18:00							
18:15							
18:30							
18:45							
19:00							

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00							
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Clinic	Clinic	Day surgery	Surgery MDT	Planned in-patient operating sessions		
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							
14:45							
15:00							
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17:00							
17:15							
17:30							
17:45							
18:00							
18:15							
18:30							
18:45							
19:00							

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	10.60	42:12
Mon	08:30 - 13:00	2	Day surgery 30 minutes travel from Craigavon Area Hospital.	Southern He..	South Tyron..	DCC	8.4	0.23	0:54
Mon	09:00 - 13:00	5	Emergency operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	09:00 - 13:00	1, 3	Clinic Comments: prostate clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Mon	09:00 - 17:00	4	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.40	1:36
Mon	13:00 - 17:00	5	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:00	3	TRUS & biopsy	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:00	1	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:30	2	Clinic 30 minutes travel to Craigavon Area Hospital.	Southern He..	South Tyron..	DCC	8.4	0.23	0:54
Tue	08:00 - 14:00	2	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.30	1:12
Tue	08:30 - 13:00	4	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54
Tue	09:00 - 13:00	5	Emergency operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	09:00 - 13:00	3	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	09:00 - 13:00	1	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Tue	13:00 - 17:00	5	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	3	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	1	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	4	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	14:00 - 18:00	2	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	08:00 - 14:00	2	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.30	1:12
Wed	09:00 - 13:00	3-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	16.8	0.40	1:36
Wed	09:00 - 13:00	5	Emergency operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	09:00 - 13:00	1	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Wed	13:00 - 17:00	5	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:00	4	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Wed	14:00 - 18:00	2	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	14:00 - 20:30	1, 3	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	16.8	0.70	2:36
Thu	09:00 - 11:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36
Thu	09:00 - 13:00	5	Emergency operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	11:00 - 13:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36
Thu	13:00 - 17:00	1-5	Surgery MDT	Southern He..	Craigavon A..	DCC	42	1.00	4:00
Fri	09:00 - 13:00	5	Emergency operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	09:00 - 13:00	1-4	Clinic Comments: Oncology clinic	Southern He..	Craigavon A..	DCC	33.6	0.80	3:12
Fri	13:00 - 17:00	3-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	16.8	0.40	1:36
Fri	13:00 - 17:00	2	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:00	1	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:30	5	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
			Total:	1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

Resources

Staff

Equipment

Clinical Space

Other

Additional comments

None

Southern Health and Social Care Trust.

This job plan started 06 February 2013.

Job plan for Dr Pahuja, Ajay in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	11 Feb 2013
Expected number of weeks in attendance	42
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

In 'Discussion' stage	6 Feb 2013	Mrs Zoe Parks

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	10.08	10.08	37:06
Supporting Professional Activities (SPA)	1.45	1.45	5:48
Total	11.53	11.53	42:54

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	No
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00
Do you work your on-call on a specific day?	No fixed day
Weekend on-call work:	
What are your average hours of predictable emergency work per weekend on-call?	0:00
Does this work replace or run concurrently with other activities?	No
What are your average hours of unpredictable emergency work per weekend on-call?	0:00
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)

PA Count:	
The number of PAs arising from your predictable on-call work is:	0.00
The number of PAs arising from your unpredictable on-call work is:	1.00
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Director	Role: Clinical Manager	Role: Clinical Director
Name: Dr Simpson, John	Name: Mr Mackle, Edward	Name: Dr Rankin, G
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Continuous professional development.	Urodynamics	Patient related admin (reports, results etc)	Grand Round	Planned in-patient operating sessions		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Clinic	Clinic	Clinic	Virtual Clinic			
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							

14:45							
15:00	Urodynamics						
15:15							
15:30							
15:45							
16:00							
16:15							
16:30							
16:45							
17:00							
17:15							
17:30							
17:45							
18:00							
18:15							
18:30							
18:45							
19:00							

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Continuous professional development.	Day surgery	Patient related admin (reports, results etc)	Grand Round	Planned in-patient operating sessions		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Stone treatment clinic		Clinic	Virtual Clinic			
13:15							
13:30		Clinic					
13:45							
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18:15							
18:30							
18:45							
19:00							

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00							
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45	Continuous professional development.	Urodynamics	Patient related admin (reports, results etc)	Grand Round			
11:00							
11:15							
11:30							
11:45				Continuous professional development.			
12:00							
12:15							
12:30							
12:45							
13:00							
13:15							
13:30							
13:45	Clinic	Clinic	Clinic	Virtual Clinic			
14:00							
14:15							
14:30							

14:45							
15:00	Urodynamics						
15:15							
15:30							
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18:30							
18:45							
19:00							

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45		Day surgery					
08:00					Planned in-patient operating sessions		
08:15							
08:30							
08:45							
09:00	Continuous professional development.		Patient related admin (reports, results etc)	Grand Round			
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Stone treatment clinic	Clinic	Continuous professional development.	Surgery MDT			
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							

14:45							
15:00				Stone treatment clinic			
15:15							
15:30							
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18:15							
18:30							
18:45							
19:00							

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Clinic	Clinic	Clinic	Emergency operating sessions	Planned in-patient operating sessions		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
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11:00							
11:15							
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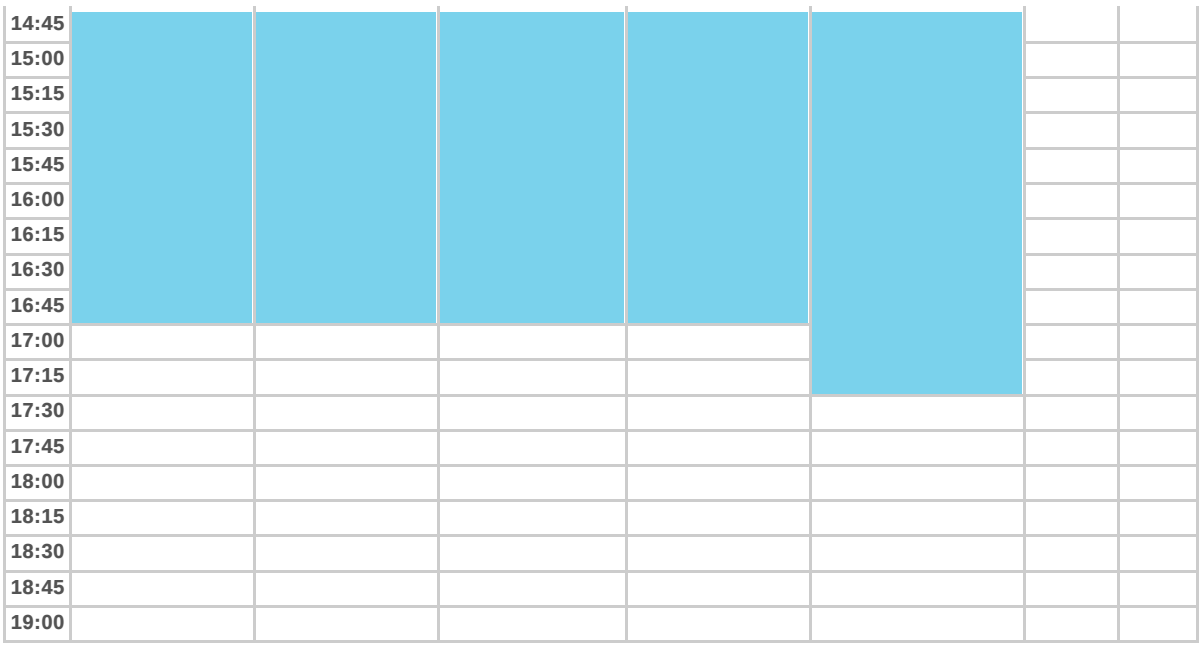
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions		
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							



Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	10.53	42:06
Mon	09:00 - 13:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.80	3:12
Mon	09:00 - 13:00	5	Clinic Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 15:00	1, 3	Clinic Comments: Prostrate Review Clinic D4	Southern He..	Craigavon A..	DCC	16.8	0.20	0:48
Mon	13:00 - 17:00	2, 4	Stone treatment clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Mon	13:00 - 17:00	5	Emergency operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	15:00 - 17:00	1, 3	Urodynamics	Southern He..	Craigavon A..	DCC	16.8	0.20	0:48
Tue	07:45 - 13:00	4	Day surgery 75 minutes travel from Craigavon Area Hospital.	Southern He..	Erne Hospit..	DCC	8.4	0.26	1:03
Tue	08:30 - 13:30	2	Day surgery 30 minutes travel from Craigavon Area Hospital.	Southern He..	South Tyron..	DCC	8.4	0.25	1:00
Tue	09:00 - 13:00	1, 3	Urodynamics	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Tue	09:00 - 13:00	5	Clinic Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	1, 3	Clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Tue	13:00 - 18:15	4	Clinic 75 minutes travel to Craigavon Area Hospital.	Southern He..	Erne Hospit..	DCC	8.4	0.26	1:03
Tue	13:30 - 17:00	2	Clinic	Southern He..	South Tyron..	DCC	8.4	0.18	0:42
Wed	09:00 - 13:00	5	Clinic Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	09:00 - 13:00	1-4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	33.6	0.80	3:12

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Wed	13:00 - 17:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:00	1-3	Clinic	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Wed	13:00 - 18:00	4	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.25	1:00
Thu	09:00 - 11:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36
Thu	09:00 - 13:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	11:00 - 13:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36
Thu	13:00 - 15:00	4	Surgery MDT	Southern He..	Craigavon A..	DCC	8.4	0.10	0:24
Thu	13:00 - 17:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	13:00 - 17:00	1-3	Virtual Clinic	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Thu	15:00 - 17:00	4	Stone treatment clinic	Southern He..	Craigavon A..	DCC	8.4	0.10	0:24
Fri	08:00 - 17:30	1-4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	33.6	1.90	7:36
Fri	09:00 - 13:00	5	Planned in-patient operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:30	5	Emergency operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
			Total:	1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

Resources

Staff

Equipment

Clinical Space

Other

Additional comments

None

Southern Health and Social Care Trust.

This job plan started 05 February 2013.

Job plan for Dr Consultant, New in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	11 Feb 2013
Expected number of weeks in attendance	42
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

In 'Discussion' stage	5 Feb 2013	Mrs Zoe Parks

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.91	9.91	36:21
Supporting Professional Activities (SPA)	1.48	1.48	5:54
Total	11.39	11.39	42:15

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	No
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00
Do you work your on-call on a specific day?	No fixed day
Weekend on-call work:	
What are your average hours of predictable emergency work per weekend on-call?	0:00
Does this work replace or run concurrently with other activities?	No
What are your average hours of unpredictable emergency work per weekend on-call?	0:00
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)

PA Count:	
The number of PAs arising from your predictable on-call work is:	0.00
The number of PAs arising from your unpredictable on-call work is:	1.00
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Director	Role: Clinical Manager	Role: Clinical Director
Name: Dr Simpson, John	Name: Mr Mackle, Edward	Name: Dr Rankin, G
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Clinic	Patient related admin (reports, results etc)	Virtual Clinic	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
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11:00							
11:15							
11:30							
11:45				Continuous professional development.			
12:00							
12:15							
12:30							
12:45							
13:00			Day surgery	Surgery MDT			
13:15							
13:30							
13:45							
14:00		Planned in-patient operating sessions					
14:15							
14:30							

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21:00							

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Clinic	Planned in-patient operating sessions	Virtual Clinic	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							

12:45							
13:00	TRUS & biopsy	Patient related admin (reports, results etc)	Continuous professional development.	Surgery MDT	Continuous professional development.		
13:15							
13:30							
13:45							
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17:45							
18:00							
18:15							
18:30							
18:45							
19:00							

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00		Planned in-patient operating sessions			Day surgery		
08:15							
08:30							
08:45							
09:00	Clinic		Virtual Clinic	Grand Round			
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							

12:45							
13:00			Continuous professional development.	Surgery MDT	Clinic		
13:15							
13:30							
13:45							
14:00		Patient related admin (reports, results etc)					
14:15							
14:30							
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18:30							
18:45							
19:00							

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00		Planned in-patient operating sessions					
08:15							
08:30							
08:45							
09:00	Clinic		Continuous professional development.	Grand Round	Clinic		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45							
11:00				Continuous professional development.			
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							

12:45							
13:00	TRUS & biopsy		Continuous professional development.	Surgery MDT	Virtual Clinic		
13:15							
13:30							
13:45							
14:00		Patient related admin (reports, results etc)					
14:15							
14:30							
14:45							
15:00							
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18:30							
18:45							
19:00							

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions		
09:15							
09:30							
09:45							
10:00							
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12:45							
13:00	Clinic	Clinic	Day surgery	Surgery MDT	Planned in-patient operating sessions		
13:15							
13:30							
13:45							
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18:30							
18:45							
19:00							

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	10.39	41:27
Mon	09:00 - 13:00	2, 4	Clinic Comments: Prostate clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Mon	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	09:00 - 17:00	1, 3	Clinic Comments: Oncoloyy Clinic	Southern He..	Craigavon A..	DCC	16.8	0.80	3:12
Mon	13:00 - 17:00	5	Clinic Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:00	2, 4	TRUS & biopsy	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Tue	08:00 - 14:00	2-4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	25.2	0.90	3:36
Tue	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	09:00 - 13:00	1	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	13:00 - 17:00	5	Clinic Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	14:00 - 18:00	2-4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Tue	14:00 - 20:30	1	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.35	1:18
Wed	09:00 - 13:00	5	Emergency operating sessions Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Wed	09:00 - 13:00	4	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Wed	09:00 - 13:00	1-3	Virtual Clinic	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Wed	13:00 - 17:00	1	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:00	5	Day surgery Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:30	2-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	25.2	0.68	2:42
Thu	09:00 - 11:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36
Thu	09:00 - 13:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Thu	11:00 - 13:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36
Thu	13:00 - 17:00	1-4	Surgery MDT	Southern He..	Craigavon A..	DCC	33.6	0.80	3:12
Thu	13:00 - 17:00	5	Surgery MDT Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	08:15 - 13:00	3	Day surgery 45 minutes travel from Craigavon Area Hospital.	Southern He..	Daisy Hill ..	DCC	8.4	0.24	0:57
Fri	09:00 - 13:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	09:00 - 13:00	1-2, 4	Clinic	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24
Fri	13:00 - 17:00	2	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Fri	13:00 - 17:00	4	Virtual Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:00	3	Clinic	Southern He..	Daisy Hill ..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:30	5	Planned in-patient operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
			Total:	1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

Resources

Staff

Equipment

Clinical Space

Other

Additional comments

None

-----Original Message-----
From: Corrigan, Martina [redacted]
Sent: 05 March 2013 14:51
To: [redacted]
Cc: Brown, Robin [redacted]; Trouton, Heather [redacted]; Mackle, Eamon [redacted]
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

Southern Health and Social Care Trust

Quality Care - for you, with you

APPLICATIONS ARE INVITED FROM ALL CONSULTANT MEDICAL STAFF CURRENTLY EMPLOYED IN THE SOUTHERN HEALTH AND SOCIAL CARE TRUST

Consultant Lead for Medical Appraisal and Revalidation (12 months initially)

The above role is for a 12 month period initially to support the Medical Director and the Trust's Revalidation Team in all aspects of medical appraisal and revalidation.

- Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings
- Evaluation and Quality Assurance of appraiser role
- Provide guidance and support to Consultants on compilation of supporting information for appraisal
- Support for Patient and Colleague Feedback for Consultants
- Quality Assurance of all medical appraisal documentation received
- Pre-screen of supporting information prior to revalidation
- Ensure College standards are communicated, understood and embedded into the appraisal process
- Ensure GMC standards are communicated and understood

For informal enquiries please contact Mrs Norma Thompson, Head of Revalidation.

PERSONNEL SPECIFICATION

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. You must be currently employed as a Consultant within the Southern Health & Social Care Trust.

2. Be a registered Medical practitioner with the General Medical Council.

The following are essential criteria which will be measured during the interview stage.

3. Excellent communication skills, both orally and in writing.

4. Ability to provide leadership to Consultant appraisers and mentors.

Please note that applicants must be able to dedicate 1PA per week to the role

-----Original Message-----
From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 13 September 2013 17:10
To: Hall, Stephen <Personal Information redacted by the USI>; Hogan, Martina <Personal Information redacted by the USI>; Mackle, Eamon <Personal Information redacted by the USI>; McAllister, Charlie <Personal Information redacted by the USI>; Murphy, Philip <Personal Information redacted by the USI>; O'Reilly, Seamus <Personal Information redacted by the USI>; Brown, Robin <Personal Information redacted by the USI>; Convery, Rory <Personal Information redacted by the USI>; Hall, Sam <Personal Information redacted by the USI>; Fawzy, Mohamed <Personal Information redacted by the USI>; McCaffrey, Patricia <Personal Information redacted by the USI>; McCusker, Grainne <Personal Information redacted by the USI>; OBrien, Charles <Personal Information redacted by the USI>; Sidhu, Harmini <Personal Information redacted by the USI>; Sim, David <Personal Information redacted by the USI>; Tariq, S <Personal Information redacted by the USI>; Boyce, Tracey <Personal Information redacted by the USI>; Conway, Barry <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI>; McVey, Anne <Personal Information redacted by the USI>
Cc: Lappin, Aideen <Personal Information redacted by the USI>; Burns, Deborah <Personal Information redacted by the USI>; Stinson, Emma M <Personal Information redacted by the USI>; Beattie, Pauline <Personal Information redacted by the USI>; Lindsay, Gail <Personal Information redacted by the USI>; McVeigh, Elizabeth <Personal Information redacted by the USI>; Renney, Cathy <Personal Information redacted by the USI>; Slaine, Delma <Personal Information redacted by the USI>; Smyth, Elizabeth <Personal Information redacted by the USI>; Anderson, Arlene <Personal Information redacted by the USI>; Brashaw, Isla <Personal Information redacted by the USI>; Callan, Susan <Personal Information redacted by the USI>; Hamilton, Pamela L <Personal Information redacted by the USI>; Magee, Christine <Personal Information redacted by the USI>; Travers, Marie <Personal Information redacted by the USI>; McEneaney, Lorraine <Personal Information redacted by the USI>; OBrien, Joanne <Personal Information redacted by the USI>; Robinson, Katherine <Personal Information redacted by the USI>; Forde, Helen <Personal Information redacted by the USI>
Subject: Triage Process

Dear all

It is necessary to remind everyone about the IEAP rules for triaging patients which states that all patient referrals should be triaged within 72 hours of receipt.

IEAP 3.4.5
All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the Health Records Manager or Departmental Manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

(However, even 1 week turnaround would be an improvement).

At this point I would ask that this is discussed within all Clinical teams and Clinicians are reminded of this protocol.

I also want to bring to your attention the attached process which has been shared with Secretaries, Service Administrators and OSLs to ensure we aim to work to these timescales and escalate issues. In this regard each secretary has been asked to set up a file/area in each office where Untriaged referrals can be stored. It will be the responsibility of the secretary to remind the Consultant if Untriaged referrals have not been actioned.

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI

TRIAGE PROCESS

(IEAP – 72 hrs)

- Every Thursday the RBC will run a report indicating those patients who have not been triaged at less than 2 weeks.

- This report will then be saved and split into specialties in Excel under the OPD/Health Records shared drive/Missing Triage.

- Each team, weekly, should update this report (Non Clinical Comments Column) with what action they have taken to 'chase' the triaged referral letter. Eg Email A Mulholland, CH 19/7/13. The initials of the member of staff chasing this is crucial and the date the email was sent.

- After this 'chase' a further update of any outcome eg the referral letter has now been triaged, added to the waiting list comments should be entered into the next column (WL Code Column).

- If there is no response/action after this 'chase' by Wed of the following week each Supervisor in the RBC will email the Service Administrator the list of patients to do a further 'chase' with the secretary/consultant.

- If the Service Administrator still has no outcome then the appropriate OSL should be informed. Christine Rankin and Katherine Robinson from the RBC should be copied into this.

Southern Health and Social Care Trust

Mandatory training for Consultants, Associate Specialists and Staff Grade Doctors

Who is it aimed at?

Consultants, Associate Specialists & Staff Grade Doctors

Topics Included:-

- Medical Negligence
- MEWS
- Infection Control
- Fire Safety

Venue: Lecture Theatre, South Tyrone Hospital, Dungannon

Date: 24th November 2009

Chair: Dr P Loughran

Please plan to attend and register by calling Education Learning & Development on [redacted]**.**

If you require special arrangements to be made for you to attend this course, eg an interpreter, please advise at time of booking.

Mandatory Training Passport

Robin (Robert James) Brown, General Surgery, Date Record Created 25/02/2022

Print as PDF

CORE MODULES

Module	Date	Date Renewal
FIRE	02/02/2022	02/02/2023
INFECTION CONTROL	04/02/2022	04/02/2024
SAFEGUARDING	25/01/2021	25/01/2024
INFORMATION GOVERNANCE	25/01/2021	25/01/2024
H&S COSHH	25/01/2021	25/01/2024
BACKCARE	25/02/2022	24/02/2025
RPRB DESIST?	RPRB Desist	26/02/2018

RPRB NOTICE The file cannot be found.

ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW

CPR	23/07/2015	23/07/2018

ADDITIONAL MODULES

Module	Date	Date Renewal
FRAUD AWARENESS	25/02/2022	24/02/2025
MAPA		
EQUALITY	16/02/2020	15/02/2023
RECRUITMENT SELECTION	12/02/2020	11/02/2023
SICKNESS ABSENTEEISM		
DoLs Lvl 2	11/02/2020	
DoLs Lvl 3	11/02/2020	
DoLs Lvl 5		
DoLs Lvl 4 DESIST?	DoLs Desist	11/02/2020

DoLs NOTICE DoLS Desist Notice 11.02

HYPO DESIST?

Module	Date	Module	Date
NEWS		PRESCRIBING	
OEWS		CLINICAL TRIALS	
PEWS		VTE	
CONSENT	13/07/2014	SAFE SEDATION	
BLOOD CULTURE		GASTRO ENDOSCOPY	
PERIPHERAL LINE		CHEST DRAIN	
USE OF ANTICOAGs		BLOOD GAS	
NG TUBE		APPRAISER	04/09/2020
ACTIONS FOLLOWING DEATH		APPRAISSEE	12/05/2015
PM CONSENT		NEGLIGENCE	
Complaints / Incidents		CORONERS	

Received from Robin Brown on 16/06/22. Annotated by the Urology Services Inquiry.

	HYPONATRAEMIA		17/11/2022
V			
	Cyber Security	21/02/2022	20/02/2025

COURSES FOR RECOGNISED TRAINERS

GMC Recognised Trainer	11/02/2022	03/10/2022
Supervisory Skills Workshop	22/10/2020	
Effective Feedback	19/11/2019	
Teach the Teacher	03/10/2019	
Trainee Support Workshop	23/01/2019	
Doctors in Difficulty	23/01/2019	

Southern Health and Social Care Trust

Quality Care - for you, with you

Record of Attendance
Morbidity and Mortality Meetings

NAME	Mr Robert (Robin) Brown
DIVISION	Elective Care
SPECIALTY	General Surgery
LOCATION	Daisy Hill Hospital

Year	Possible Attendance	Actual Attendance	% Attendance
2021 (Nov 20 to Oct 21)	10	5	50
2020 (Jan 20 to Oct 20)	4	2	50
2019	11	5	45
2018	9	5	56
2017	11	6	55

The following rates are based on the signed attendance sheet at M&M. These do not take account of a Consultant's attendance at Regional Specialty Audit meetings or Consultants who work on a part time basis. The attendance rates have been adjusted on a pro rata basis for those Consultants who commenced / left mid-year.

M&M Certificate 2021

2018

Southern Health and Social Care Trust

Quality Care - for you, with you

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

October 2017

INTRODUCTION

1.1 **Maintaining High Professional Standards in the Modern HPSS:** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as (MHPS)) was issued by the then Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides the legally binding framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction of practice or suspension (known in MHPS as exclusion).

1.2 This guidance document seeks to underpin the principle within MHPS that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patients harmed.

1.3 MHPS is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.4 MHPS states that each Trust must have in place procedures for handling concerns about an individual's performance which reflect the framework. This guidance, in accordance with MHPS, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response must be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem. *MHPS Intro Para10*

1.5 This guidance also seeks to take account of the role of Responsible Officer and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems. Refer: Responsible Officer NI legislation

1.6 This guidance applies to **all** medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.7 This guidance should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005
Annex B
"How to conduct a local performance investigation" NCAS, 2010
Annex C
SHSCT Disciplinary Procedure
Annex D
SHSCT Bullying and harassment Procedure

2.0 WHAT IS A CONCERN?

2.1 The management of performance is a continuous process which is intended to identify problems early to ensure corrective action can be taken. Everyone has a responsibility to raise concerns to ensure patient safety and wellbeing. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which do not necessarily require formal investigation or resort to disciplinary procedures.

2.2 Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:

MHPS Section1 para 2

- *Concerns expressed by other HPSS (HSC) 1staff*
- *Review of performance against job plans and annual appraisal*
- *Monitoring of data on clinical performance and quality of care*
- *Clinical governance, clinical audit and other quality improvement activities,*
- *Complaints about care by patients or relatives of patients*
- *Information from the regulatory bodies*
- *Litigation following allegations of negligence*
- *Information from the police or coroner*
- *Court judgements or*
- *Following the report of one or more critical clinical incidents or near misses*

- Failure to report concerns

2.3 Concerns can also come to light where a member of staff raises a complaint in relation to poor behaviour they find threatening, humiliating, unwanted, unwelcome or unpleasant. In line with the Trust's Conflict, Bullying and Harassment in the workplace policy, harassment can represent a single, serious incident or persistent abuse.

2.4 If it becomes evident that an individual or individuals were aware of a concern(s) but did not escalate or report it appropriately – this in itself can also represent a concern, which may necessitate intervention, particularly where there are patient safety implications.

2.5 WHO TO TELL?

2.5.1 A concern of any kind should be raised with the practitioner's immediate Clinical Manager. This will normally be the doctor's supervising consultant e.g:

Concerns relates to	**Clinical Manager**
Junior Doctor/SAS Doctor:	Supervising Consultant
Consultant	Clinical Director
Clinical Director	Associate Medical Director
Associate Medical Director	Medical Director

2.6 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) (the NCAS guide) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation in needed. The NCAS Guide also indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

3.0 SCREENING PROCESS / *Preliminary Enquiries* *MHPS Section1 para 15*

3.1 AS CLINICAL MANAGER - WHAT ACTION DO I TAKE?

3.1.1 If you receive a complaint or concerns are raised with you, the first step is to seek advice from the Medical HR Manager and have a "Screening of the Concern" to establish the immediate facts surrounding the complaint. This can include any documentary records such as timesheets/ written statements from the member of staff who raised concern and any other witnesses. At this stage, you are only seeking information that is **readily available**.

3.1.2 **Important:** There is **no** need at this stage to be inviting people to formalised investigative meetings as this would be part of any subsequent investigation process if needed. There may be certain circumstances however where an initial meeting will be necessary to establish facts and

provide an opportunity for the practitioner to hear the concerns and respond which can help determine what, if any action needs to be taken. In any event you will need to inform the practitioner who is the subject of the concerns, advising that you are making them aware of the complaint as part of this process. Do this sensitively and reconfirm that you are establishing the facts and no formal process has been entered into at this time. Assure the individual you will keep them informed and the matter will be progressed at pace.

3.1.3 The purpose of this stage is to gather enough information to enable the Clinical Manager, supported by a senior HR Manager to assess the seriousness of the concern/complaint raised and help inform and rationalise whether this needs to be resolved through a more formal route or informally.

3.1.4 It is important that the process is transparent. Early communication and discussion with the practitioner concerned, aimed at improving their performance or conduct may be sufficient to resolve the issue and identify early interventions to facilitate a resolution. The practitioner's early response can be helpful in deciding whether to carry out an investigation.

3.1.5 Contact with the practitioner who could potentially be subject to a formal investigation may not be appropriate if a counter fraud agency or the police advise early meetings or early disclosure could compromise subsequent investigations. The Director of HR will ensure there is close liaison with the CFPS and/or PSNI in such cases

3.1.6 In situations where a practitioner's ill health may be a significant contributory factor to their conduct or performance then appropriate advice should be sought from the Occupational Health Department.

3.2 DIFFERENCE BETWEEN SCREENING OF CONCERNS AND FORMAL INVESTIGATION

Screening / Establishing Facts (Informal)	Investigation (formal)
Clinical Manager gathering facts /information that has given rise to concern – readily available	Case Investigator – trained in MHPS and equality has been appointed by the Case Manager - this would not ordinarily be the supervising consultant.
Information readily available is gathered quickly, surrounding the concern/complaint	Investigation is directed by Terms of Reference established and agreed by Medical Director/Case Manager
The practitioner has been made aware	Individual would have been notified formally

informally that there is a concern	by Med Director /case manager that a formal investigation under MHPS is being commenced
Issue is managed locally with general advice from NCAS or Occupational Health if appropriate	Case has been formally logged with NCAS
No notice is required i.e. no invite to formal meeting	Right to notice to prepare following formal invite to a meeting in writing
Normally the initial meeting is between the manager and the individual concerned.	Right of representation applies
Progress is being managed locally with HR support	Progress is being monitored by a nominated NED – Case manager/ Medical Director and HR/CEO
No formal process to follow	Any action must be in line with MHPS /Trust disciplinary procedure for medical staff

3.3 SUPPORT FOR DOCTORS DURING SCREENING

Clinical Managers must consider the emotional wellbeing of individuals throughout this process and must not underestimate the impact this may have on a practitioner, so should be encouraged to seek assistance through the Occupational Health department and/or Care Call counselling services. The practitioner should be reminded that support is also available to them through their trade union representative and/or medical defence organisation.

3.4 WHAT HAPPENS AT THE END OF SCREENING PROCESS

The Clinical Manager and the nominated senior Human Resources Manager will be responsible for screening the concerns raised and assessing what action should be taken in response. In line with MHPS Section 1 para 15, this decision will be taken in consultation with the Medical Director, Director of HR and operational Director. Possible action could include:

3.4.1 Action in the event that reported concerns have no substantial basis or are completely refuted by other evidence.

No further action is required. The reasons for this decision should be documented and held by the responsible clinical manager.

3.4.2 **Action in the event that there are minor shortcomings** Minor shortcomings can initially be dealt with informally. The practitioner's Clinical Manager will be responsible for discussing the shortcomings with a view to identifying the causes and offering help to the practitioner to rectify them. Such counselling will not in itself represent part of the disciplinary procedures, although the fact and date that counselling was given, should be

recorded on a file note and retained on the practitioner's individual file.

3.4.3 A local action plan can be developed to address the issues with advice from NCAS if appropriate. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

3.4.4 In some cases, the Clinical Manager may feel it is appropriate to give an informal warning without a disciplinary investigation or hearing for the purposes of improving behaviour and in order to assist the practitioner to meet the standards required. The informal warning should be confirmed in writing to the practitioner. Advice must be sought from the Medical HR Manager. This is not a formal disciplinary sanction.

3.4.4 Action in the event that potentially serious shortcomings are identified or previous informal action has not resulted in the required change.

When potentially significant issues relating to performance are identified which may affect patient safety, the matter must be immediately escalated to the Associate Medical Director/Medical Director and Operational Director to consider whether it is necessary to consider 'Immediate Exclusion' from work (Refer to MHPS Section 1 para 18-27).

Depending on the facts of a particular case, it may be necessary to place temporary restrictions on a practitioner's practice. Any voluntary agreement to restrictions should be recorded in writing including any undertaking to apply the same restrictions in any practice elsewhere (outside the Trust employment).

The Medical HR Manager must also be informed of any action taken to ensure the Chief Executive is notified and the correct procedures are followed including the necessity for NCAS to be informed prior to any immediate exclusion. (Reference Section 1 Para19 MHPS)

A Formal Investigation will usually be appropriate where the screening process identified information to suggest that the practitioner may pose a threat to patient safety, expose services to financial or other substantial risk, undermine the reputation or efficiency of services in some significant way or work outside acceptable practice guidelines and standards. (NCAS Good Practice Guide Section 1: pg. 7) In these situations, a thorough and robust investigation and report will help to clarify any action needed. Before the investigation proceeds, consideration will also be given to the appropriate protection and support that needs to be afforded to patients, those raising concerns, and the practitioner. (Refer to NCAS Good Practice Guide Section 2)

The Medical Director will then appoint a Case Manager, Case Investigator and Designated Board Member (on behalf of the Chief Executive). The Medical Director (which may be delegated to the Case Manager) should then draft the Terms of Reference for the formal investigation and the formal approach as set out in MHPS Section 1 para 28-41 will be followed.

During all stages of the process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Para 30.

4.0 SUMMARY

4.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
Screening Process This can lead to resolution or move to:

Appendix 2
A formal investigation process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Formal exclusion can be used in the context of a formal investigation

Appendix 6
Role definitions

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs

Early in process
- Practitioner

For information only at this stage
- Chief Executive
- Medical Director
- Director of Human Resources

↓

Clinical Manager and Senior HR Manager undertake preliminary enquiries to identify the nature of the concerns and assess the seriousness of the issue on the available information.

↓

Clinical Manager and senior HR Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and senior HR Manager assess what action should be taken following initial screening process – in consultation with MD/Dir HR

→ No Action Necessary, Reason documented and held on file

→ Informal remedial action with assistance from NCAS, if appropriate: Local action plan and/or informal warning issued.

→ Matter escalated to Medical Director / AMD for consideration of immediate exclusion / restriction on duties.

→ Matter escalated to Medical Director / AMD to initiate a Formal Investigation and ensure a Terms of Reference are agreed.

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Appendix 1

Informal Remedial Action

A determination by the Clinical Manager and senior HR Manager is made to deal with the issues of concern through informal remedial action

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors compliance with agreed plan.

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

Appendix 2

Formal Investigation Process

A determination by the Clinical Manager and senior HR Manager is made to deal with the issues of concern through the formal process.

Medical Director (following discussions with Chief Executive, and HROD), appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator should, other than in exceptional circumstances complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Outcome of Formal Investigation:
Conduct Hearings / Disciplinary Procedures

Following the formal investigation, the Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

→ Case Manager informs:
- Chief Executive
- Designated Board member
- Practitioner

↓

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

↓

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

↓

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal act(s), the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Probity Service of BSO must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Medical Officer at the DOH or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 3a

Outcome of Formal Investigation:
Clinical Performance Hearings

Following the formal investigation, the Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

→ Case Manager informs:
- Chief Executive
- Designated Board member
- Practitioner

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Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

→ Following assessment by NCAS, if the Case Manager considers a Practitioner's practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel.

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Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

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Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

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Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

→ Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

During the hearing:
- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:
- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:
- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:
1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerns and/or their colleagues. (MHPS Section II para 6)
- Exclusions may be up to but no more than 4 weeks at a time.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions.

Immediate Exclusion

A proposal to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director or Associate Medical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis. MHPS Section 1: para 18-27.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Medical Director and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work (Section II MHPS)

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

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Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

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The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

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Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.
- **NCAS must be consulted where formal exclusion is being considered.**

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

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The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II paras 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive. (Refer to MHPS Section II para 28 for review process.

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager
This is the person to whom concerns are reported. This will normally be the supervising Consultant, Clinical Director or Associate Medical Director (although usually the Supervising consultant/Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial screening assessment along with a HR Case Manager.

Formal Process

Chief Executive
The Chief Executive in conjunction with the Medical Director appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of the formal investigation and request that a Non-Executive Director is appointed as "designated Board Member".

Case Manager
This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator
This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work nor should he/she make recommendations.

Note: Should the concerns involve a Clinical Director, the Case Manager should normally be the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager should normally be the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust.
Any conflict of interest should be declared by all parties before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must oversee the case to ensure momentum is maintained and consider any representation from the practitioner about his or her exclusion or any representations about the investigations.

From: Brown, Robin <Personal Information redacted by the USI>
Sent: 09 June 2022 09:37
To: Brown, Robin
Subject: FW: Urology Steering Group Meeting - 13th May 2010
Attachments: Team South Agenda - 13 May 2010.doc; REGIONAL REVIEW RECOMMENDATIONS.doc; Team South Urology Steering Groups.doc; Review of Urology Services update april 10.doc

-----Original Message-----
From: Stinson, Emma M <Personal Information redacted by the USI>
Sent: 12 May 2010 14:06
To: Armstrong, Andrea <Personal Information redacted by the USI>; Beth Malloy <Personal Information redacted by the USI>; Brown, Robin <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Cassells, Carol <Personal Information redacted by the USI>; Clarke, Paula <Personal Information redacted by the USI>; Dan McLaughlin <Personal Information redacted by the USI>; Lappin, Aideen <Personal Information redacted by the USI>; Mackle, Eamon <Personal Information redacted by the USI>; Murphy, Jane S <Personal Information redacted by the USI>; Radcliffe, Sharon <Personal Information redacted by the USI>; Renney, Cathy <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI>; Walker, Helen <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>
Subject: Urology Steering Group Meeting - 13th May 2010

Dear All

Please see attached papers previously sent for tomorrow's Urology Review.

Many thanks

Emma

Emma Stinson
PA to Dr Gillian Rankin, Interim 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

From: Stinson, Emma M
Sent: 23 April 2010 10:25
To: Mackle, Mr E; Young, Michael Mr; Brown, Robin; Trouton, Heather; Clarke, Paula; Carroll, Ronan; Walker, Helen; Cassells, Carol; 'beth.malloy Personal Information redacted by the USI 'joe.lusby Personal Information redacted by the USI
Cc: Renney, Cathy; McCorry, Monica; Akhtar, Mehmood; Murphy, Jane S; Radcliffe, Sharon; 'Lappin, Aideen'; Armstrong, Andrea; 'orla.morrow Personal Information redacted by the USI
Subject: Steering Group Meeting - 13th May 2010
Importance: High

Dear Everyone

The first meeting of the Steering Group to manage the planning and implementation of the Regional Urology Review will take place on Thursday 13th May 2010 starting at 10.00 am in the Board Room, Trust HQ.

I have attached the following documents in preparation:

• Agenda
• Steering Group, Project Team and Clinical Assurance Group Membership • Regional Review recommendations • Southern Trust outline position regarding recommendations

Given that Mr Mark Fordham, the Urology Surgeon engaged to provide clinical leadership to this NI Review, will be with the Trust for the day, I have invited Mr O'Brien and Mr Akhtar to join the Steering Group meeting and subsequent meetings on the day

The Steering Group will commence at 10am and is likely to take most of the morning. The remainder of the day will be used for clinical discussions with Mr Fordham on specific issues in relation to the review and visiting urology facilities in CAH.

I would be grateful for an indication of your availability if my office is not already aware of this.

Regards

Gillian

Dr Gillian Rankin
Interim Director of Acute Services

Emma Stinson
PA to Dr Gillian Rankin, Interim 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

AGENDA

TEAM SOUTH UROLOGY STEERING GROUP MEETING ON 13 MAY 2010 AT 10.00 PM IN CRAIGAVON HOSPITAL,

1. **WELCOME AND INTRODUCTIONS**

2. **MINISTERS ENDORSEMENT OF ALL UROLOGY REVIEW RECOMMENDATIONS**

3. **UPDATE ON PROJECT MANAGEMENT ARRANGEMENTS FOR TEAM SOUTH – MEMBERSHIP AND CHAIR**

4. **UPDATE ON PROGRESS WITH RECOMMENDATIONS – IDENTIFICATION OF ANY KEY RISKS AND ACTIONS TO RESOLVE**

5. **IDENTIFY KEY PATIENT PATHWAYS AND PROTOCOLS**

6. **BUSINESS CASE FOR SERVICE EXPANSION**

7. **AGREE NEXT STEPS AND TIMETABLE**

8. **ANY OTHER BUSINESS**

RELEVANT REVIEW 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.

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call). One local MDT/MDM plus regional/specialist MDM.*** Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

Table 14 Elements and Arrangements in Three Team Model

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

*** MDM reconfiguration has been approved by NICaN Group

Team South Urology Steering Group / Project Board

Dr Gillian Rankin	Interim Director of Acute Services (Chair)
Dr Eamon Mackle	Associate Medical Director – Surgery & Elective Care
Mr Michael Young	Clinical Lead Urologist
Mr Robin Brown	Clinical Director – Surgery & Elective Care
Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care
Mrs Paula Clarke	Acting Director of Performance & Reform
Mr Ronan Carroll	Assistant Director of Acute Services – Cancer & Clinical Services
Mr Dan McLaughlin	Assistant Director – Surgery and Anaesthetics, Western Trust
GP Representative	Western Trust
Mrs Helen Walker	Assistant Director – Human Resources
Mrs Carol Cassells	Senior Financial Management Accountant - Acute Services
Ms Beth Malloy	Assistant Director Scheduled Services, PMSID, H&SCB

Project Team

Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care (Chair)
Mrs Martina Corrigan	Head of Urology & ENT
Sandra Waddell	Head of Planning – Acute
Project Manager	To be appointed
Heads of Service	As needed
Finance Representative	
HR Representative	

Clinical Assurance Group

Mr Young
Mr O'Brien
Mr Akhtar
Mrs Martina Corrigan
Mrs Shirley Tedford
GP Representative

Health and Social Care Board

REGIONAL REVIEW OF ADULT UROLOGY SERVICES

April 2010

This document makes a total of 26 Recommendations, which are set out in Table 1 below.

Recommendation	Update 15 April 2010
1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial portion 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.	Only the Urologist's in the Southern Trust undertake these urological procedures.
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	The Trust will keep this under review as Consultant Surgeons retire and make appropriate plans to transfer the "N" code work to urologists.
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 2 – Introduction and Context, pg 5)	The Trust need to undertake this review and to take into account the service pathways from Primary Care to both Urology and Gynae services. **Action: Group to be set up to take this forward**
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.	This process was reviewed by the Trust last Summer and is in place.

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.	The Trust has a number of representatives that sit and attend meetings for this Group and have been involved in the discussion in respect to the referral guidelines and pathways. The Trust commenced its formal Multi-disciplinary Team meetings on 1 April on Thursday afternoons were suspected and confirmed urological cancer pathways and referrals are discussed.
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.	The Trust will take this into account when preparing job descriptions and job plans.
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. (Section 3 –Current Service Profile, pg 5).	The Trust have commenced work on this, for example patients presenting with Urinary Tract Retention. These have been shared with A&E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways.
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct	The Trust have commenced work on this, for example

transfer and admission to an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).	patients presenting with Urinary Tract Retention. These have been shared with A&E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways
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. (Section 3 –Current Service Profile, pg 5).	This recommendation will be actioned as part of the implementation of the review and will include representatives from Urology, A&E and General Surgeons from the those hospitals that do not have a Urology Unit. **Action:- Meeting to be set up to include all as mentioned above to take this forward**
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 3 –Current Service Profile, pg 5).	This recommendation has commenced as from week beginning 5 April the protected Urology Thursday slot will look at each of the ICATS services. 8th April looked at Andrology and it was agreed that this service would be split in two and one part will deal with erectile dysfunction. Today the discussions were concentrating on benign prostatic disease. Notes from these meetings will be available and then discussions and recommendations from these will be implemented.

	Action: these weekly meetings to continue
11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	The Trust currently adhere to key elements of the Elective Reform Programme, for example, IEAP, pre-op assessment, monitor admission on day of surgery, etc and through weekly dashboard reports etc will be able to evidence. For example the Trust are also looking at methods of operation e.g. TURP to increase day surgery and recognise that some investment is required for equipment to meet these targets and other of the key elements are being taken into consideration for Urology.
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. (Section 5 – Performance Measures, pg 6).	This redesign is all part of the protected 'Thursday' meetings and are currently aiming through Thorndale unit to facilitate a single visit for suspected urological cancer patients. we are currently drawing up a timetable at what will be discussed at each of these meetings so as to assist in taking forward these recommendations
13. Trusts should implement the key elements of the elective reform programmed with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	This is currently on-going as per recommendation 11

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. (Section 5 – Performance Measures, pg 6).	This point will part of the implementation plan and still needs to be actioned with Consultants. Mr Mark Fordham is visiting the Trust on 13 May and can be included in discussions with the Urologists.
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. (Section 5 – Performance Measures, pg 6).	This point will part of the implementation plan and still needs to be actioned with Consultants along with their colleagues in other Trusts
16. Trusts should review their outpatient review practice, design other methods/staff where appropriate and subject to casemix/complexity issues reduce new: review ratios to the level of peer colleagues.	This has partially commenced in the Dr Rodgers, General Practitioner with Specialist Interest (GPWSI) attends Mr Young's weekly CAH outpatient clinic to see reviews. Also Shirley Tedford the Urology Nurse Co-ordinator has started to do chart, letter and results reviews on review patients and then discusses their outcome with the consultants and agrees the best pathway for them.
17. Trust must modernise and redesign outpatient clinic templates and admin/booking processes to ensure their capacity for new and review patients and to prevent backlogs occurring in the future.	The admin/booking processes are in place. As part of the whole review each Urologist will be met to

	discuss their clinic templates and ensure that there is enough capacity for the new and review. This will also depend on the availability of Registrars/Junior Staff to assist at the clinics as there had been a deficit for a while. **Action: On-going**
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. (Section 7 – Urological Cancers, pg 6).	This is on-going with representatives of the Trust attending and actioning recommendations from the NICaN group
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. (Section 7 – Urological Cancers, pg 6).	There is ongoing discussions taking place regarding this recommendation
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 7 – Urological Cancers, pg 6).	There is ongoing discussions taking place regarding this recommendation

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. (Section 8 – Clinical Workforce Requirements, pg 6).	A business case needs to be prepared for two additional Consultant Urologists for the Southern Trust to include their support and any equipment required in order that they will take into account specialist interests as per Recommendation 6. Work has commenced on team job plans and job descriptions will now have to be drawn up.
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. (Section 8 – Clinical Workforce Requirements, pg 6).	Work has commenced on team job plans and job descriptions will now have to be drawn up. Discussions need to take place with Theatres to identify the additional operating sessions and take into account the other sites within the catchment area.
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 8 – Clinical Workforce Requirements, pg 6).	Job plans, job descriptions will have to be developed as part of the implementation plan.

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7).	Agreement that this is part of the implementation plan
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. (Section 9 – Service Configuration Model, pg 7).	Not applicable to this Trust
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. (Section 9 – Service Configuration Model, pg 7).	Meeting being set up for beginning of May with the Western Trust to begin to work in partnership to discuss the implementation plan.

Southern Health and Social Care Trust

Surgery and Elective Care, Acute Services Directorate

Wednesday 19th August 2009 at 1pm, Tutorial Room 2, MEC, CAH

AGENDA

1. Welcome/apologies

2. Minutes of last meeting – 17th June 2009 (previously circulated)
   a. Matters arising

3. Governance issues
   - Incidents – June – learning from events (attached)
   - Complaints
   - Control of Infection (previously circulated)
     - Hand Hygiene and Commode Audit
     - Root Cause Analysis Data
     - Central Line Infection

4. Finance issues
   - Division Position
   - Best Care, Best Value - 2008/09 outcome
     - 2009/2010 proposals

5. HR issues
   - Use of Agency/Overtime
   - Staff Structure – accountability framework

6. Divisional issues
   - STEEEP Presentation
   - Pandemic Flu
   - PPI Response – Surgical Division
   - Northern Trust
   - Business Case Progression
   - Staff Newsletter

7. A.O.B.

8. **Date of next meeting: Wednesday 16th September 2009 at 1pm, Tutorial Room 3, MEC, CAH**