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

Zoe Parks
Medical Staffing Manager
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

26 September 2022

Dear Madam,

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/or 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

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

Chair's Notice

[No 102 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:

Zoe Parks
Medical Staffing Manager
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 24th October 2022.**

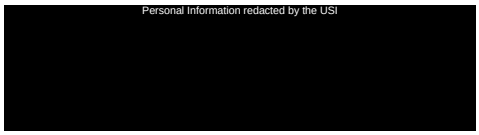
APPLICATION TO VARY OR REVOKE THE NOTICE

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 17th October 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 26th September 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE
[No 102 of 2022]

SECTION 1 – GENERAL NARRATIVE

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 or by you, meetings you attended, 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"). 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. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

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 and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

5. 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. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out 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.

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

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10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

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

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

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

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

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Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

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

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

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

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

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

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

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

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

40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

41. 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. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. 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?

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically 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?

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

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.

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UROLOGY SERVICES INQUIRY

USI Ref: Notice 102 of 2022
Date of Notice: 26 September 2022

Note: An addendum to this statement was received by the Inquiry on 11 May 2023 and can be found at WIT-94910 to WIT-94925

Witness Statement of: Zoe Parks

I, Zoe Parks, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

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 or by you, meetings you attended, 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 have taken account of the inquiry Terms of Reference and included a narrative account of my knowledge of all matters falling within the scope of those terms, since I joined the Trust in my Medical HR Role.

1.2 Back in April 2004, a new consultant contract was introduced in N Ireland. Those consultants interested in transferring had to complete a diary card for the first time to help determine number of working hours, to inform transfer over onto the new time based consultant contract. On re-reading Mr O'Brien's diary cards today, I can see that he referenced in these manual paper forms the following comments: *"service which has been in crisis for years; gross overburden of clinical work*" This paperwork would have been submitted to the Clinical Director at the time and then onward processing via Dr C Humphrey, the Medical Director office, for a job plan offer. I was a medical staffing officer at this time, helping to provide HR support to the Medical Directors office in the implementation of the new consultant contract.

1.3 In September 2005 all new consultant offers were being prepared by the then Medical Director, Dr C Humphrey. Mr O'Brien was offered 14

programmed activities. (PA's) – 4 additional programmed activities above the basic contract. A basic contract under the new terms and conditions is 10 PA's (40 hour week). Additional Programmed Activities above 10 can be offered but only where they are agreed by individual consultants. I recall this was one of the highest PA offers made at the time. The contract is a time based contract. A PA represents 4 hours of work in normal time (7am-7pm) time, however any time after 7pm or at weekends is considered premium time when a programmed activity is defined as every 3 hours. This offer was not accepted by Mr O'Brien – he states in the paperwork he was seeking an offer around 17 Programmed Activities (PA's) to reflect his workload.

1.4 In November 2005, Craigavon Area Hospital Group Trust asked an external consultant Dr Joe Gaston (a former consultant anaesthetist from Belfast Trust) to act as Job plan facilitator for those consultants who were unhappy with their original PA offer from the Medical Director. I was Medical Staffing Officer at that stage in my career and I was asked to work alongside Dr Gaston to provide HR support. In the context of Mr O'Brien's job plan offer, he reviewed all the information and held a facilitation meeting with Dr A O'Brien on 10 October 05. I attended this meeting. I do recall that Dr Gaston noted the following observations at the time:

"*During the review of diary cards, it became apparent that Mr A O'Brien spent a considerable amount of time on Patient Administration. This was significantly above the average for his colleagues and other General Surgeons. Although no adjustment was made, it was felt this should be addressed in the future*".

1.5 This information was shared with the Chief Executive Mr J Templeton and Medical Director whom I believe was Dr I Orr, at that time. Dr Gaston made a job plan offer of 14.5 PA's. This was not accepted by Mr O'Brien and he sought a Job Plan Appeal. Mr O'Brien stated in the paperwork he was seeking 17.5 PA's at this stage. To the best of my recollection, I believe the information observed around patient administration was also passed to the clinical manager by Dr J Gaston.

1.6 In July 2006, in preparation for a consultant Job Plan appeal stage, Dr Gaston on request from the Medical Director Dr I Orr and Chief Executive, Mr J Templeton took another look at all the information that had been captured by the Consultant Urologists retrospectively during their diary card analysis. This allowed a final offer, in advance of the

appeal hearing of 15.5PA's. Mr Templeton and Dr I Orr also dealt with a separate request from Mr O'Brien regarding work he said he had completed from August 1998-August 2004 as a registrar in addition to his own role. I recall that an ex-gratia payment of Personal Information redacted by the USI was made with this offer. I was not involved in how or why this payment was determined. I don't believe it was made to any other consultant at the time. A final offer letter was issued on behalf of the Medical Director, Dr I Orr at that time to confirm the final offer and the additional payment. This was accepted by Mr O'Brien. I would then have processed this for Mr O'Brien in his salary. *Please see:*

1. *2006 Mr AOBrien transfer onto new contract*
2. *30.10.2006 aobrien_externalduties*

1.7 Almost all of our consultants chose to move onto this new time based contract which offered higher salary scale at that time. Whilst the concept of job planning existed in the old consultant contract; this new contract made it more formalised. In November 2009 the Southern Trust established the Consultant Contract Steering Group and I was involved in drafting the Terms of Reference for this group that would be chaired by the Chief Executive and attended by the Directors/Clinical Directors/Associate Medical Directors. The key purpose of the Workforce Steering Group was to focus on supporting the Chief Executive and the Medical Director to improve the completion of consultant job planning in all specialties across the Southern Trust for 2009/10. I attended these meetings. I was also involved in working alongside our clinical managers at the time to develop our first Job planning Framework document that was then circulated around all consultants in 2009 and set out the expectations for Job planning.

1.8 In December 2009, the performance and reform directorate were asked to undertake a piece of work to help inform consultant job plans. On 22 December 2009 I wrote an email to Mrs Debbie Burns (Assistant Director Performance Improvement), Mrs Paula Tally (Head of Reform) and copied to the Director of Acute Services Dr G Rankin. This was in relation to a Urology team Analysis - demand and capacity work that had been undertaken by their team. The Chief Executive Mrs M McAlinden and Director of Acute Services Dr Rankin, had asked that demand and capacity data be reviewed to help feed into the job planning process for all specialties. My email from 22.12.09 is provided. *Please see:*

3. *14.08.09 Urology Team Analysis planning for JobPlans*
4. *18.2.2010 Email attachment D Burns presentation*
5. *18.2.2010 Email from DBurns re Urology*
6. *22.12.09 attachment with email 2*
7. *22.12.09 attachment with email 3*
8. *22.12.09 attachment with email D Burns*
9. *22.12.09 Attachment with email*
10. *22.12.09 Memo re Urology team analysis review*
11. *22.12.09 Urology Team Analysis for job plans Email HR to DBurns*
12. *22.12.2009 UROLOGY DRAFT TEAM ANALYISIS VERSION*
13. *22.12.09 Attachment with email 4*

1.9 In December 2009, I was involved in developing guidance to set out the principles for undertaking (extra contractual) waiting list initiative work within the Trust, which was approved by Senior Management Team and circulated to all consultants. This is work that consultants can choose to undertake in addition to their contractual requirement and use claim forms to claim enhanced payment for this work. I reference this as it is relevant to set the context to an email I received in 2012 from Dr Rankin regarding a complaint Mr O'Brien had about a claim submitted for WLI work undertaken. *Please see:*

14. *03.12.2009 Memo_AllCons_WaitingListInitiative*
15. *3.12.2009 Copy of New WLI Claim Form*
16. *9.12.2011 Memo to AMD and Directors re WLI Claims*
17. *18.11.10 reissue of WLI document agreed in Dec09 to all AMD to ensure compliance*

1.10 I was [redacted] from 22 March 2010 until 15 November 2010. A few days following my return from [redacted], I emailed all Associate Medical Directors and Clinical Directors on 18 November 2010 regarding waiting list initiative work. I stated in this email: **"***As you are aware a new process for waiting list initiatives was agreed within the Southern Trust late last year. The new documentation was forwarded to all consultants and the Senior Management Team in December 2009. I have been asked to re-issue this documentation to all Associate Medical Directors and Clinical Directors and ask that you please ensure that <u>all consultants</u> are reminded of the process and the requirement to comply with the agreed principles set out in the attached document. All of these*

documents are also available via the Trust Intranet site under Directorates, HR & Organisational Development, HR Medical & Dental."

1.11 On 2 June 2011, I was asked by the Chief Executive Mrs M McAlinden to issue a High level summary of progress with Consultant Job Planning by email to improve communication and transparency across the Trust to all Consultants and Staff Grade Doctors. *Please see:*

18. 00.06.2011 Update on Consultant Job Planning for all Consultants
19. 2.6.11 High level summary of Job planning to consultants
20. 2.6.2011 Email issuing high level summary

1.12 In July 2011, I assisted with a Disciplinary investigation concerning Mr A O'Brien relating to the disposal of clinical notes in a ward bin. I was asked to provide HR Support to Mr Robin Brown (a consultant surgeon from Daisy Hill Hospital site) who had been appointed at the Case Investigator. A full investigation report was completed and shared with the doctor and his managers. To our knowledge this was an isolated incident and resulted in an informal warning being issued to Mr A O'Brien. A full copy of the disciplinary report and outcome letter has been attached in my summary evidence table. *Please see:*

21. 01.06.2011 FINAL Disciplinary Report - A O'BRIEN
22. 9.8.2011 Informal warning outcome Mr A O'Brien

1.13 On 28 September 2011, Mr A O'Brien had a Job Plan Facilitation Meeting with Associate Medical Director, Dr P Murphy. This meeting was supported by my HR colleague Mr Malcolm Clegg. I was not in attendance. I am aware from paperwork that I have read in preparing for this public inquiry that the offer was 12.75 PA's WEF 1 October 11, to revert to 12PA with effect from 1 March 2012. The offer of the additional 0.75 for a period of time was for administration. Mr O'Brien responded at the time via email to my colleague Mr M Clegg at the time to say "…*By now, I feel compelled to accept the Amended Job Plan effective from 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the Job Plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate."*

1.14 I am aware that Mr M Clegg ensured this email response was forwarded to the clinical management team. He forwarded this to the Associate Medical Director, Mr Mackle and Head of Service, Martina Corrigan on 16 November 2011. In Malcolm's email he highlighted;

"…I have also advised him that I would be notifying you both of the comments he had made as you might need to discuss these issues further with him. We have decided to proceed with implementation of the 12.75PA job plan from 1 October 2011 as Mr O'Brien never formally requested an appeal despite now indicating his disagreement with the job plan. I do feel however that we cannot ignore Mr O'Brien's comments. Mr O'Brien was informed in his notification letter following Facilitation that the new job plan will require him to change his working practices and administration methods and that the Trust will provide any advice and support it can to assist him with this. It is important therefore in view of the comments made by Mr O'Brien that we follow through with this. Regards Malcolm."

1.15 Mr M Clegg was copied into an email response that was sent to Mr O'Brien on 5 December 2011 from Mr E Mackle as Associate Medical Director. It was also copied to the Director of Acute Services Dr G Rankin and the Assistant Director Mrs H Trouton at that time. This email stated*:*

"Dear Aidan, As you are aware in the letter post your job plan facilitation it was stated: 'This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.' I, as a result, organised a meeting to discuss same. I note however that you cancelled said meeting. I am therefore concerned that we haven't met to agree any support that you may need. I would appreciate it you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without need for Trust support then you obviously do not need to contact me to organise a meeting. Yours sincerely Eamon Mackle."

1.16 I do not have any further information on how this was handled locally within the specialty. *Please see:*

23. 5.12.11 Response to Mr AOB from Mr Mackle re Admin
24. 10.11.2011 E re Job Plan Facilitation - 10.11.2011
25. 16.11.2011 Email from Malcolm to AOB Clinical managers
26. 28.09.11 Notes of Facilitation meeting M Clegg

27. E re Job Plan Facilitation A2 - 31.10.2011

1.17 On 9 December 2011, I issued a memo via email to Associate Medical Directors and Clinical Directors regarding the process for Waiting List Initiatives and some issues that had been flagged to me across the Trust by payroll for this extra contractual work. This was a reminder email for all Clinical Managers about the process and how claims should be completed and approved.

1.18 On 6 January 2012, I emailed Mr Colin Weir a copy of the NCAS Handling Concerns good practice guidance. To the best of my recollection, this was in the context of planning for a training workshop for consultants on handling concerns (particularly junior doctors), in his role as Director of Medical Education and Training. On Mr Weir's request, I later delivered a local training workshop on handling concerns about doctors on 2 October 2013. This was provided on a further occasion on 22 September 2015**.** I don't have an attendance list of who attended as this would have been held by the Medical Education Office. *Please see:*

28. 2.10.13 Case Studies for Managing Concern Workshop
29. 2.10.13 Handling Concerns Medical Staffing Presentation - Z PARKS
30. 2.10.2013 Copy of concerns presentation to Mr C Weir
31. 6.1.12 NCAS -Handling Concerns good practice
32. 6.1.2012 Email to C Weir with Concern Guidance
33. 22.9.15 Managing Concerns Presentation

1.19 On 30 January 2012, The Director of Acute Services, Dr G Rankin forwarded me a letter she had received by email from Mr O'Brien regarding a complaint he had around incorrect payment for waiting list initiative (extra contractual work) he had undertaken during July 2010-Feb 2011. I was asked to look into the complaint. I could see from the claim form that the amounts claimed by Mr O'Brien were completed on Fridays and some weekends. There were no times recorded. A WLI session is paid differently to contractual programmed activities, WLI are enhanced rates of £[redacted] per 4 hour session or [redacted] per 4 hour session at weekends. 21 sessions were being claimed (15 on Fridays and 6 on Saturdays; total amounting to £[redacted].) When the claim form had gone to Mr Mackle and Mrs H Trouton for approval it appeared that the amounts being claimed had been halved (in pen on the form) before approval. These forms do not get submitted via Medical HR (they go via Medical Directors office) so on receipt of Mr O'Brien's complaint, I had

to contact the managers to determine what this was all about. When I spoke to Mr Mackle and Heather Trouton at the time (as confirmed in my email records), they were querying how this was all undertaken outside already contracted and paid job plan time. (15 PA job plan) In response to the complaint from Mr O'Brien they advised me there was some misunderstanding about what had been agreed against his job plan. They had changed the forms when they came to them for approval, however they agreed they would concede as changes (i.e. the form figures halved) shouldn't have taken place without prior discussion with Mr O'Brien. I was asked to make the payment as originally claimed on the form. Dr Rankin was advised. I do not know if Mr O'Brien offered or was asked to undertake additional extra contractual work. I did feel this was highly unusual given the extent of programmed activities he was paid. I would have indicated this at the time. I don't know if this was a one off or if he worked regular extra contractual sessions. Consultants are contracted to Programmed Activities. One programmed Activity is 4 hours in normal time (i.e. 7am-7pm) or 3 hours in premium time (after 7pm or at weekends). A weekly contract of 15 PA's could represent a working week of up to 60 hours. It was the highest we had at the time in the Trust. Our average PA's were around 11.4 PA's. Any job plan over 12 PA's is typically not compliant with EWTD and we would try to ensure these were flagged to the Medical Director and Director of Service for information/review. *Please see:*

34. 6.3.2012 Email to payroll re outcome of wli claims
35. 6.3.2012 Response to Mr AOB re WLI claims
36. 24.2.12 Response to payroll for paying wli claims changed
37. 30.1.2012 Mr O'Brien Grievance re WLI Claims

1.20 On 20 December 2013, I attended a meeting with the HR Director Mr Kieran Donaghy, the Associate Medical Director, Mr Mackle and my HR colleague Mr Malcolm Clegg to discuss a concern we had with the urology (junior doctor) registrar working pattern. We raised the concern that the two registrars were working in excess of 60hours per week at times according to our monitoring data. At present they were the only staff working 60 hours per week, which was a concern for us. This also meant they were non complaint with working time legislation. We discussed the necessary action that was required and suggested that it should be placed on the directorate risk register. Medical HR prepared a draft risk assessment which was shared at the meeting for onward consideration within the Acute Services Directorate at that time. There was a discussion on recruitment for a clinical fellow and we highlighted

the need for the service to obtain a derogation from the two doctors. These concerns related specifically to the two junior doctors training doctors posted in urology. The above actions were completed, followed up and passed to the Acute Services Directorate for ongoing management. The Associate Medical Director, Mr Mackle responded to confirm: *"I will chase up with Martina re the issues which I have already raised with Michael Young. I met with Michael early last month and he was to get the derogation signed and reduce their hours but I can't say if it was done."* I informed my Director of HR Mr Kieran Donaghy on these updates. My view is that it was reviewed and taken forward at the time. It was subsequently arranged that General Surgery doctors would cover into Urology after 11pm weekdays and 6pm on weekends. They also provided doctors to assist in Theatre whilst the Urology trainees took their leave and attempts were made for additional Clinical Fellows at that time. *Please see:*

38. *1.8.2014 urology regRotaActions*
39. *2.12.2009 Draft Risk Assessment Template*
40. *3.3.2014 Chaser email re registrar working patterns*
41. *4.2.14 - Response email from Mr Mackle indicating M Young was to reduce hours*
42. *4.2.14 memo to Mr Mackle re Urology*
43. *4.2.14 Response to memo re registrar urology working pattern*
44. *20.12.2013 Attachent EWTD Opt out form*
45. *20.12.2013 Meeting to discuss Urology Registrars DirHR AMD*

1.21 On 27 January 2014, I received a 'notification' from Mr A O'Brien. This wasn't an email that came from him directly to me but via a portal on Personal Information redacted by the USI that consultants can add a message. This redirects the messages to Medical HR. This notification said the following: "*Yesterday, I accessed for the first time my current job plan on Zircadian, and was taken aback to find that the last job plan, to which I had agreed and signed up to, has been changed with effect from 01 April 2013 to a job plan which has not been implemented, is markedly different from previous job plan, bears little resemblance to it and which I did not sign up to, even though it is indicated on Zircadian system that I had not so. I would be grateful if this could be addressed and remedied."* This does seem to indicate this was the first time Mr O'Brien had accessed his online job plan – we had the system in place from 2012. I brought this notification to the attention of the Head of Service Martina Corrigan and Mr Mackle at the time. Please see:

46. *20.6.2011 M CORRGIAN REQUESTING CHANGES TO MR AOB JOB,PLAN*
47. *24.1.14 Notification from MrAOB re JobPlan via SouDocs*
48. *27.1.14 Response to changes to AOBJobPlan*
49. *27.1.2014 Email from Mr AOB t job plan online for first time*
50. *27.1.2014 Notification from Mr OB re Job Plan changes followup*

1.22 **October 2014 – January 2015:** Due to [redacted] I was working from home [redacted] during this period. **12 January 2015 – 10 Jan 2016:** [redacted]. **18 March 2016 – 1 March 2017:** [redacted].

1.23 On 6 June 2017, the Trust received a draft Urology Medical Workforce Report 2017-24 carried out by Public Health Agency on behalf of the Department. They were seeking comments from Trusts at that time. I have an email record that the Medical Director Dr R Wright at the time did not have any comments to add. *Please see:*

51. *6.6.2017 Draft Medical urology Review report*
52. *6.6.2017 UrologyWorkforceReport MDView*
53. *15.6.16 Medical Workforce Planning for urology Appendix 1*
54. *15.6.2016 Medical Workforce Planning for Urology-Southern*
55. *26.05.17_Peter Barbour_Urology Workforce Planning Report*
56. *26.5.2017 Urology Workforce planning report*
57. *2017 urology Workforce PLanning Report*

1.24 In July 2020, I was approached by my Director of HR, Mrs Vivienne Toal and my manager, Mrs Siobhan Hynds in the summer of 2020 to ask if I would assist in being the link person in HR for an external panel. They had asked the panel to hear a Grievance that had been received from Mr O'Brien in connection with his MHPS process. I was not aware when this grievance was received into the Trust. The initial Grievance Panel consisted of Mrs Shirley Young (an external panel member) and a newly appointed Deputy Medical Director in the Southern Trust Dr A Diamond. I acted as an HR co-ordinator, setting up meetings with witnesses, circulating papers, confirming appointments. I also communicated regularly with Mr O'Brien and his representative, his son Mr [redacted] O'Brien during this time. I did not attend any of the meetings but I would have had sight of some of the documentation that I was asked to issue to Mr O'Brien.

1.25 Following the outcome of the Grievance, Mr O'Brien indicated he wished to appeal but didn't want to participate in any further meetings. A decision was taken by the Director of HR, following legal advice, to set up an independent external panel to review the Grievance decision. I was again asked to be the HR link person to the panel Mrs Therese McKernan and Dr Ronan O'Hare. They were provided with all the papers and worked independently without contacting me very often. I did not attend any of their meetings. I made myself fully available for them should they wish to contact me at any time, including out of hours. When their draft report was issued, it stated the following: Section 2.1 Mr O' Brien's appraisal documents for the years 2014 onwards. Mr O' Brien's appraisal documents for 2017 and 2018 were provided. The Trust failed to provide the 2014 and 2015 documents. In Para 6.4 & 6.5 they stated "*To furnish this panel only partially with Mr O'Brien's appraisals, leaving out the most important years 2014/15 is concerning, despite several requests. The decision of omission has been made by the current management team*" It is important for me to state that this statement is **categorically untrue**.

1.26 I was shocked when I read the draft report as I knew that I did provide **all** these documents (including the years 2014/15) to Mrs Therese McKernan via email. I was on holiday when I read it and made every effort to immediately pull all my email evidence to indicate that the files had been sent as I had not received any bounce back. It was only when they sent us their 'draft' report (before it had been finalised), that I was first aware there had been any issue and Theresa indicated she hadn't received these copies. At no time did she contact me by telephone to advise this. I also immediately made arrangements to post the documents by recorded next day delivery.

1.27 There was absolutely no decision of omission made by the current management team. This statement is categorically untrue. Mrs T McKernan confirmed she had received the documents that I had posted by recorded delivery and indicated she would speak to Dr R O'Hare. She later confirmed in writing they were not willing to change the report. I understood this was because they had no further time available to review it. All of the relevant evidence documenting when and how I had sent these documents to Therese – both by email on several occasions and then immediately by recorded delivery on receipt of their draft report, is included as evidence. *Please see:*

58. 2021 050607 EMAIL TRAIL BETWEEN ZOE AND THERESE

Urology Services Inquiry

1.28 I thought it was important to highlight the periods of time when I was absent from work: **25 March 2010 – 15 November 2010:** Personal Information redacted by the USI [redacted] during October 2014 – January 2015. From **12 January 2015 – 10 Jan 2016:** Personal Information redacted by the USI [redacted] from **18 March 2016 – 1 March 2017.** I returned to work part time in March 2017 and resumed full time work in 2019.

1.29 It may also be helpful to summarise the number of occasions the medical resourcing department where asked by the operational management team to advertise posts for Urology. *Please see:*

59. Summary of Recruitment and Urology Numbers

Urology Services Inquiry

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"). 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. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 Any documents referenced in this statement can be located in folder S21 102 of 2022 – Attachments

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 and, as far as possible, to address your answers in a chronological format.**

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

4.1 I have been employed in the Human Resources Department in the Southern Trust (formerly Craigavon Area Hospital Group Trust) since January 2003 not long after qualifying from university with a First Class honours degree in Business Management in 2001. I went on to complete my postgraduate diploma in Queens University in HR Management with Employment Law which I studied part time whilst working. I commenced as a temporary HR Project Officer on 15 January 2003. This was made permanent on 1 June 2003.

4.2 In 2004, I commenced an internal management trainee role, where I was successfully appointed by the then Human Resources (HR) Director Mrs Myrtle Richardson to train alongside the existing Medical Staffing Officer, Mrs Betty Williamson as part of succession planning. I commenced this role on 2 February 2004 and took over as Medical Staffing Manager from April 2007 when the previous post-holder retired. I continue in this role today, which is now known as the Head of Medical HR.

4.3 The main duties and responsibilities for the Medical HR manager role include providing advice, support and guidance to all medical staff and managers in relation to HR matters such as recruitment and selection, employee relations, contracts etc. This is an administrative role. It is not a clinical role. *Please see:*

60.00.04.2007 Medical Staffing Manager JD

4.4 Following the final implementation of Agenda for Change, my role was re-banded to band 8a.

5. 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.

5.1 I have had line management responsibility for the HR staff working within the Medical HR section, since April 2007.

5.2 I reported directly to the Assistant Director of Human Resources (Business Partner aligned to Acute Services), Mrs Helen Walker from April 2007. When the new Deputy Director positions were created and recruited in January 2019, my line manager changed to Mrs Siobhan Hynds.

5.3 In April 2007, Medical HR was a very small team consisting only of my role with the following supporting staff: 2 x band 4 HR Officers and 1 x band 3 HR Administrator. This team was responsible for all HR matters including payment processing, contracts and terms and conditions advice for medical and dental staff across the Trust.

5.4 In 2009, there was a need for me to develop a business case for an additional band 6 resource in response to junior doctor working hours and European Working Time Directive requirements (EWTD). Mr Malcolm Clegg was appointed on 9 February 2009. Following the final

implementation of Agenda for Change notifications, Malcolm's role was re-banded to band 7.

5.5 In November 2018 I was asked to take over responsibility for all medical recruitment activities, when they were centralised within my team. This inherited the following staff to the Medical HR Team. 1 x Band 5 Medical Recruitment Lead and 2 x band 4 Medical Recruitment Officers. This team is responsible for the administration of medical and dental recruitment of all permanent and temporary doctors across the Trust.

5.6 In November 2018, I was also asked to take over responsibility for the medical Locum office (flexible recruitment) when this area was centralised within my team. This inherited the following staff to the Medical HR Team. 1 x Band 5 Medical Locum lead, 1 x Band 4 HSC E Locums system administrator and 3 x Band 3 Medical Locum Administrators. This team is responsible for all administration for medical bank and locum agency short and long term locum shift bookings across the Trust. (Approximately 10,000 locum shifts requests per year).

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

6.1 I currently have 3 direct reports within the Medical HR Team - I line manage the band 7 and 2 x Band 5 positions across the team. The remaining band 4 and band 3 positions are line managed by their team leads. I have monthly 1:1 meetings with my direct reports and all team members have 1:1 meetings with their immediate line managers.

6.2 During our 1:1 meetings, we review our annual performance development plans (PDP's) which we agree annually for all staff. All PDP's are documented and saved in our staff management files.

6.3 I hold daily catch up calls with the team to ensure I am aware of any emerging issues, monitor and allocate work and ensure the team know how to escalate any concerns if necessary. We have a continuous improvement culture and encourage all staff to raise any suggestions for better work practices where necessary. We also have a department work plan.

6.4 I have a monthly 1:1 with my line manager which informs the work for my team.

Urology Services Inquiry

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

7.1 HR are involved with documenting, consulting and agreeing HR policies and procedures (based on contractual terms and conditions of service) that set out expectations, establish roles and responsibilities and communicate processes. This will include regionally agreed and locally negotiated policies and procedures. Some policies and procedures are applicable to all Trust staff and others will be specifically for medical and dental employees. Within our limited resourcing, we try to provide as much training/communication as possible to ensure the documents are read and understood. I have also tried to develop online resources to ensure medical staff can easily access relevant HR guidance/policies/procedures that are applicable to them, as and when they need them.

7.2 The Chartered Institute of Personnel and Development (CIPD) is the professional body responsible for defining what professionalism in HR and Learning and Development looks like, and provide the tools and resources to help members meet those standards. I obtained chartered membership of CIPD in July 2010.

7.3 I have monthly 1:1 meetings with my line manager to allow them to discuss my performance and direct/focus plans for the future.

7.4 Internal Audit periodically review the effectiveness of various HR processes and policies, such as payments to staff, absence management, waiting list initiative (WLI) payments and Medical locums. This system of internal audit monitors compliance with required processes to not only identify issues and vulnerabilities but provide an opportunity to provide independent recommendations for improvement. We work closely with internal audit to ensure recommendations are actioned.

7.5 Medical HR work closely with the Local Negotiating Committee (LNC) of the British Medical Association (BMA); as the main union for Medical and dental staff. There are formal quarterly meetings which are attended by the Chair of LNC, BMA members, the Medical Director, Director of HR, Director of Service and Head of Medical HR. My role as Head of Medical HR requires me to liaise frequently (often monthly basis) with the BMA on an informal basis to proactively address/avoid any concerns around applications of processes and/or management of staff. The LNC working in partnership with

employers help us to address issues relating to all aspects of working life of medical and dental staff, including terms and conditions of service, working conditions, facilities, policies and procedures relevant exclusively to medical and dental staff in the organisation, including arrangements for the application of national terms and conditions of service. This provides a further mechanism to ensure any issues with standards or application of terms and conditions are scrutinised and addressed.

7.6 Throughout my career, I have attended formal NCAS/NHS Resolution training for both Case Manager and Case Investigator on approximately 9 separate occasions since 2007. To date, I have provided HR support to Clinical Managers, Case Investigators and Case Managers across the Trust on upwards of 30 cases (both formal and informal). I have also arranged NCAS (NHS Resolution) training sessions throughout the years which would have been offered to Clinical Directors, Associate Medical Directors and HR and to the best of my capacity contributed to local training sessions with consultants and other staff.

7.7 I have been involved in developing and updating specific HR guidance, policies and procedures for medical staffing over the years, for example:

7.7.1 Guidance on Handling concerns about agency locum doctors 2021;
7.7.2 Guidance on Assessing concerns and judging risk 2021;
7.7.3 Guidelines for acting up to Consultant 2020;
7.7.4 Guidance on Consultants covering absent colleagues 2019;
7.7.5 Job planning Framework 2019 (previously agreed in 2009) ;
7.7.6 Guidelines on Medical Staff Annual Leave 2019;
7.7.7 Waiting List Initiative Extra Contractual work 2019;
7.7.8 6 Fundamentals for supporting, developing and retaining SAS doctors 2018;
7.7.9 Updated Guidelines for handling concerns about doctors 2017.

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out 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.

8.1 Yes my role is subject to annual review/Personal Development Plan appraisal.

8.2 All “Agenda for Change” (i.e. non-medical terms and conditions for service) roles are managed under the Knowledge and Skills Framework (KSF), which is a developmental tool designed to provide the basis for career and pay progression within Agenda for Change Pay Bands.

8.3 The Performance Development Review (PDR) process is expected to be based on a cycle of learning and is repeated each year. It consists of:-

(a) A joint review between the individual and their reviewer of the individual’s work against the demands of their post

(b) The production of a Personal Development Plan (PDP), which identifies the individual’s learning and development needs and interests – the plan is jointly agreed between the individual and their reviewer

(c) Learning and development undertaken by the individual, supported by their reviewer

(d) An evaluation of the learning and development that has taken place and how it has been applied by the individual in their work.

8.4 I would have prepared a work-plan/draft PDP for discussion with my line manager at my 1:1 meetings. Initially these would have been with Mrs Helen Walker as Assistant Director of Human Resources (Acute Services) and then later by Mrs Siobhan Hynds (Deputy Director of Human Resources).

8.5 There was a period (I do not recall the exact dates), but I believe it was during 2014-2016, when I also reported directly to the Director of Human Resources: Mr Kieran Donaghy – so I would also have had several 1:1 meetings with him. This was arranged at his request as it was an opportunity to ensure the Director was fully aware of all Medical HR matters.

8.6 The relevant guidance/framework documents for carrying out the PDP are as per Knowledge and Skills Framework (KSF) are outlined in question 9a below. I have attached a few samples of my work plans which would have translated into my PDP’s that would have been discussed over the years. *Please see:*

61. 001.01.2017 2018 Medical Workforce Plan
62. 2019. 2010 Medical HR ActionPlan

Urology Services Inquiry

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

9.1 Please see attached the SHSCT Knowledge and Skills Framework guidance. *Please see:*

63. KSF Guidance Document

10. What performance indicators, if any, are used to measure performance for your role?

10.1 The Knowledge and Skills Framework and PDPs are developed with reference to the National Job Profiles. Profiles are developed on the basis that there are posts in the NHS which are standard and have many common features. The job evaluation scheme uses a common language and a common set of terms to describe all jobs. It uses these to highlight similarities between jobs.

10.2 All job roles will have been matched against National Job Profiles to determine their pay banding and job expectations.

10.3 I have attached into evidence the HR related National Employee Profiles, which sets out the National Profile for a Head of Service in Human Resources. *Please see:*

64. human-resources-profiles

10.4 National Profile for HR Head of Service. This sets out the performance indicators that would be used to measure performance and discussed as part of PDP 1:1 meetings in my role. *Please see:*

65. Head of Service (Generic) Band 8a

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

11.1 I endeavour to ensure I am fulfilling my role by working closely with my manager, regularly reviewing our department work plan, reviewing performance against standards and working in collaboration with regional colleagues in similar roles. I strive for continuous improvement through close working relationships with the Medical Director and clinical/operational managers. I will also regularly review department of health strategies, Trust corporate plans and specific Medical & Dental contractual developments.

11.2 I will have monthly 1:1 meetings with my immediate line manager who will discuss my ongoing work plan to ensure I am accountable and that I adhere to the appropriate standards expected in my role.

11.3 I will discuss department work-plans with my line manager and with our LNC (Local Negotiating Committee) representatives of the BMA. I work to ensure I build trust with the Union as this provides a valuable mechanism for dialogue between workers and employers, which helps build trust and commitment among the workforce and ensures that problems can be identified and resolved quickly and fairly.

11.4 I will have regular contact (via emails/phone-calls) with medical staff, particularly Clinical Directors, Divisional Medical Directors and operational managers to ensure I understand their needs in relation to Medical HR services. I will respond to issues or concerns that are raised to me by clinicians or operational managers at all times, including out of hours and at weekends.

11.5 To encourage open, targeted and effective communication, I share agreed medical HR guidance, policies and procedures on our Medical HR HUB which was developed a number of years ago to provide an interactive portal which medics can access easily, as and when they need. This was launched back in 2020. Prior to these documents would have been available on our Medical HR Share point page. I have always been very focused on continuous improvement within my field of work and I am always working to ensure information is easily accessible by medical staff.

11.6 A copy of the email sharing the HUB with all Consultants and all SAS (specialty and Associate Specialist Doctors) doctors is attached in

evidence. It is also linked on our Medical HR Sharepoint pages and under all our email signatures in the Medical HR team. *Please see:*

66. 21.4.2020 New Medical HR HUB 2020

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

12.1 I am not aware of systems being by-passed that are there to ensure appropriate standards are being met in Medical HR.

12.2 With specific reference to Urology, I wouldn't have a close knowledge of the specific local systems that operate in their specialty to ensure appropriate patient safety standards are being met.

12.3 I am aware there wouldn't have been a signed off job plan for every consultant Urologist on our electronic job planning system on an annual basis. Job Planning is an annual contractual requirement between individual consultants and their clinical manager. The fact that there wasn't a signed job plan agreed on our job planning system for every consultant is not unique to Urology. This is an ongoing challenge across all specialties to ensure we have prospective job plan agreed and recorded onto the system every year. Whilst we have good engagement with our online job planning system (90% of 2021 job plans were fully approved before we had to move into 2022 job planning year) we do struggle to get 'prospective' job plans approved in advance of the job planning year (April – March). We also continue to encourage clinical managers and their operational teams to properly consider their capacity and demand planning in advance of job planning, to ensure we are making best use of resources. This emphasis was revisited in a recent presentation I gave at the Medical Forum on 16 September 2022. I recorded these presentations so they are available on our Job Planning HUB. Medical HR provide summary reports for the Associate Medical Directors and Medical Director to highlight those areas with low engagement as referenced under Q13 below.

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

13.1 As Head of Service for Medical HR, my small team are responsible for HR related activities for medical and dental staff across the Trust

(approx. 600 doctors) The Medical HR Team are responsible for ensuring we meet all legal and regulatory requirements in the recruitment and employment of medical and dental staff. The systems of governance we use include adherence to terms and conditions of service, policies, procedures and employment law. We also undertake internal self-audits against our standard operating procedures and use issue logs to help us track and manage risk within our own processes. We fully engage with internal audit to review areas as per their planned auditing schedules.

13.2 We provide monitoring information which summarises working hours and compliance with working time regulations for junior doctor hours to the Clinical Directors, Associate Medical Directors and Operational managers on a 6 monthly basis. This is also reported to the Department of Health.

13.3 We provide monthly recruitment reports for the Director of HR and Medical Directors summarising Medical HR recruitment activity including posts currently advertised, numbers of appointments and unfilled posts.

13.4 We provide detailed monthly reports for the Chief Executive, Director of HR and Medical Director (including deputies), summarising the use of locum doctors at Trust level and by specialty including number of shifts requested, no of shifts filled, any variance to payment rates and long term bookings.

13.5 We provide an annual report for the Medical Director, Divisional Medical Directors and Operational Directors summarising all the rota patterns for junior doctors across the Trust summarising their pay banding, total working hours and highlighting areas of risk.

13.6 We provide updates on Consultant and SAS Doctor job planning for the Medical Director and others (as necessary) to summarise completion of job plans by individual consultants, highlighting areas of low engagement for review. These reports are also available from our electronic job planning system that all Clinical Directors and Associate Medical Directors can view for their specialty area.

13.7 As capacity allows, we provide training and education for Medical and Dental staff to ensure they understand and apply employment guidance and policies. This has included face to face training sessions in the past. More recently recorded presentations are accessible via our Medical HR HUB, such as updates on Job Planning.

13.8 The Southern Trust was the first Trust in N Ireland to purchase E Job Planning electronic software back in 2012. This allowed all Clinical

Directors, Associate Medical Directors and Assistant Directors to have direct access to manage the job planning process online for their service areas. The Medical HR Department administer this system to ensure all new appointees are added onto the system and that it remains accurate and up to date with users. Medical HR in addition to the system provider, provide direct training as required in relation to using the Job Planning system (which is also recorded and available on our Medical HR HUB). There would have been Job Planning Steering groups in the past, as well as task and finish groups. An example of some of the minutes of these meetings/updates is included below for information. *Please see:*

67. 01.2018 Rotas at Risk shared with MD

68. 08.2021 Rotas at Risk shared with MD

69. 11 6 14 Notes of Consultant Job Planning Steering Group Meeting FINAL

70. 13.10.17 Copy of JP update for amd forum and MD

71. 13.10.2017 Update email to MD office on Job planning

72. 18.7.2014 Copy of ProgressReport to MD office Surgery

73. 18.7.2014 Progress report of surgery job plans to MD

74. 23.8.2017 Medical Staff Management Task and Finish Group action notes

75. 24.5.2019 UPDATE CONSULTANT JOB PLANNING HEADLINES to MD

76. 30.4.2018 Task and Finish Job planning

77. 2009.10 HSCT TERMS OF REFERENCE - CONSULTANT CONTRACT STEERING GROUP

78. 21.9.22 Job Planning Dashboard shared with MD

79. 24.5.19 - PROGRESS REPORTS shared with MD
80. 30.4.2018 Job plans completed - CONSULTANTS

13.9 We are involved with administering the following meetings which support some of the governance systems in the Trust:

(a) Local Negotiating Committee of the British Medical Association – Quarterly Meetings.

(b) Medical & Dental (MHPS – Maintaining High Professional Standards) Oversight Meetings. These meetings, which are chaired by the Medical Director, have been arranged monthly since May 2020.

I attended a meeting in the Northern Trust which managed cases monthly and suggested this as a way forward in the Southern Trust.
(c) Prior to that they were arranged as and when required in line with open cases.

(d) I attend regional Medical & Dental Strategic meetings which are attended by Medical HR colleagues from all NI Trusts and the Department of Health. Medical HR also update the Medical Director on issued where necessary. *Please see:*

81. 01.5.2019 Regional Influence to Allocation to Trainees Report

82. 1.11.2018 Q_008 Trust Level Locum Usage

83. 10.5.2019 - REPORT FOR MEDICAL DIRECTOR

84. 10.5.2019 Deep Dive inTO MedicalHR issues report

This information may need redacted as other individuals named.

13.10 Since September 2022, in light of learning and our strive for continuous improvement in this area, I have completed:

(a) Monthly formal reports for the Medical Director to share with the Chief Executive registering all concerns that have been reported and discussed by Divisional Medical Directors at the monthly oversight group.
(b) Quarterly report summarising the formal MHPS cases to the Trust Governance Committee.
(c) Documented a training plan for MHPS (Maintaining High Professional Standards) to set out how we plan to improve our training for clinical managers, operational managers, Trust Board and other relevant individuals around the MHPS process. This will also include developing more structured training and awareness amongst all clinical and operational managers on how to handle low level concerns amongst medical staff. *Please see:*

85. 8.9.2022 Governance Report Formal MHPS Case - Sensitive info

86. 15.8.22 Training Plan MHPS 2022

87. 20.9.2022 All Cases to CX - Sensitive info

88. 20.10.2022 All cases to CX - Sensitive info

This information may need redacted as strictly confidential and other individuals named.

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

14.1 Medical HR Team recently applied for a quality improvement initiative in 2021 through the Q exchange programme which was supported by the Trust Quality Improvement Team. The project was to seek additional funding to allow us to modernise and digitise our locum booking system for managing all the locum bookings across the Trust. As this was a national opportunity, unfortunately we were not shortlisted on this occasion for support. We continue to raise this with our internal IT to identify any future possibilities for development funding.

14.2 I am aware of the Quality Improvement team and have had input and support from them on a couple of occasions throughout my career. I have attended the Southern Trust annual quality improvement event on several occasions, e.g. 2016 and 2017. Any projects I would have been involved with would have been linked to my own service area (i.e. Medical HR). I am aware that the QI team would have undertaken service led projects out in various specialties, but I do not know if any of these were within Urology. I am aware back in 2009, the performance/reform directorate undertook a piece of work to look at the demand/capacity of urology (in addition to other specialities at the time). This is referenced in section 1g. I do not know if this was revisited in recent years.

14.3 In 2003/04 I studied part time (which was supported and part funded by the Trust) to obtain my professional CIPD qualifications at Queens University Belfast via a 2 year part time course. I strive to remain up to date with quality improvement initiatives by attending relevant conferences, courses, meetings associated with my field of work. I was supported by the Trust in 2021 to complete an accredited training course to become a qualified coach from the institute of leadership and management in 2021/2022. I am also supported by the Trust to sit as a committee member on HPMA (Healthcare People Management Association).

14.4 I am very passionate about continuous improvement and strive every day to develop our resources within Medical HR Team, using technology where possible, to ensure we have the capacity, skills and expertise to support our Medical and Dental Workforce as best as possible. We have grown from a very small team back in 2007, taking on increased areas of responsibility over time, including administering all medical resourcing and all medical bank and locum engagements across the Trust. Whilst we still remain very small in numbers (particularly in terms of senior adviser roles), we work incredibly hard to run the Medical HR service. In recent years, our work has become more closely aligned with the Medical Directors office and we assist as much as possible with all maintaining high professional standards (MHPS) cases and administering the medical job planning system. Medical HR is a specialist HR area and we continue to push for additional resources/support where possible to support our team.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

15.1 It is my understanding that the quality of services in urology would have been the responsibility of the Clinical Director, Associate Medical Director, Medical Director and operational managers/directors.

15.2 My understanding of who occupied those roles was as follows:

(a) Clinical Director ENT/Urology: Mr Sam Hall (Jan 15 – Mar 16)
(b) Clinical Director Surgery including Urology: Mr C Weir (June 16 – Jan 22)
(c) Clinical Director ENT/Urology: (Vacant from 1 December 2021 as Mr McNaboe appointed temporarily to Divisional MD post)
(d) Associate Medical Director: Mr E Mackle (April 07 until 30 April 2016)
(e) Associate Medical Director (in addition to his ATICS AMD role) Dr C McAllister
May 2016 – April 2017.
(f) AMD/Divisional Medical Director: Mr M Haynes (AMD 1 October 2017 to 1 August 2021 & reappointed Divisional MD from 2 August 2021 ongoing)
(g) Divisional Medical Director: Mr T McNaboe (1 December 2021 ongoing as Mr Haynes seconded to another role. Prior to this he was Clinical Director 17 December 2018 to 30 November 2021).
(h) Assistant Director Surgery/Elective Care: Mr S Gibson (July 07-Sept -09)
(i) Assistant Director Surgery/Elective Care: Mrs H Trouton (Sept 09-Mar 16)
(j) Assistant Director Surgery/Elective Care: Mr R Carroll (April 16 ongoing)
(k) Director of Acute Services: Mr J McCall (April 07 – May 08)

(l) Director of Acute Services: Mr G Rankin (Mar 11 – Mar 13)
(m) Director of Acute Services: Mrs D Burns (April 13 – August 15)
(n) Director of Acute Services: Mrs E Gishkori (August 15 – Apr 20)
(o) Director of Acute Services: Mr M McClements (7 June 2019 –31 August 2022)

Medical Directors in post:

(p) Dr P Loughran, Medical Director (April 07 – Jul 11)
(q) Dr J Simpson, Medical Director (Aug 11 – July 15)
(r) Dr R Wright, Medical Director (July 15 – Aug 18
(s) Dr Ahmed Khan, Interim Medical Director **(**Aug 18 – Dec 18)
(t) Dr M O'Kane, Medical Director (Dec 18 – Apr 22)

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

16.1 I would not have any experience of how the oversight of the clinical governance arrangements within Urology was done. However my understanding is that it would have been the responsibility of the Clinical Lead, Clinical Director, Associate Medical Director, Medical Director alongside their operational Directors and heads of service. Names outlined above in Q15.

16.2 I believe there are clinical and social care governance officers/managers who assist with this role. I would be aware that consultants attend regular meetings such as morbidity and mortality and multi-disciplinary team meetings, as part of their own supporting professional activities and clinical governance.

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

17.1 As Head of Medical HR, my role is non-clinical. I lead the Medical HR Team in all HR operational matters pertaining to the medical staffing workforce. The role is a key source of expert knowledge and understanding of national medical staffing agendas, including terms and conditions, employee relations, job planning, rota design and employment contracts. I feel I was able to provide the requisite HR service and support to Urology as required.

17.2 My Medical HR role is a Trust wide advisory role relating to medical and dental staff, rather than being solely aligned to one specialty or programme of care. It is my role to respond to requests for information and provide advice and support if and when concerns are reported to me. In hindsight, it is surprising to me that concerns were not escalated and matters referred to HR for advice and guidance, given the reported concerns in Urology that have now come to light.

17.3 I was not made aware of any concerns or worries from this team in my role. If I draw a comparison to today, it would not be uncommon for Associate Medical Directors, Clinical Directors or consultants to contact me to seek advice if they were worried about something including staffing levels, performance concerns or perhaps other low level issues. Urology would not have been one of the areas brought to my attention in the past. I have noticed in my long career in Medical HR that it would have been much less common for concerns to have been brought to the attention of HR back in 2007, but over the passage of time, requests for guidance have grown to a position where it is far more common today. Medical HR also have a much closer working relationship with the Medical Directors office than would have been the case many years ago.

17.4 I feel I was able to respond to all requests for information, advice and HR support, as and when necessary, to all specialities across the Trust including Urology. Requests specifically related to Urology services were limited however it is a small sub specialty. The employee relations involvement relating to Urology that I can recall included:

(a) New Consultant Contract Job Plan facilitation from Consultant Urologist Mr O'Brien in 2006/2007. The full details of this are outlined in **paragraph 1.4- 1.6.** *Please see:*

1. 2006 Mr AOBrien transfer onto new contract
24. 10.11.2011 E re Job Plan Facilitation - 10.11.2011
27. E re Job Plan Facilitation A2 - 31.10.2011

(b) Providing HR support to Clinical Director, Mr R Brown in a disciplinary investigation concerning Mr A O'Brien in 2011 relating to the disposal of clinical notes in a bin on the ward. The outcome was copied via email to the Associate Medical Director Mr E Mackle and Mrs H Trouton on 15/8/11 and also the Assistant Director of HR aligned to Acute Services Mrs Helen Walker on 5/10/11. *Please see:*

21. 01.06.2011 FINAL Disciplinary Report - A O'BRIEN

89. 19.8.2011 Informal warning outcome Mr A O'Brien

(c) Providing HR Support to Clinical Director Mr R Brown in completing an investigation concerning clinical concerns relating to a short term temporary LAT (Locum Appointment for Training) doctor 'Dr [redacted]' in Urology in 2012. *Please see:*

90. 2012 Summary of Evidence Gathered [redacted] *- Sensitive info*

This includes details of another doctor that may need redacted

(d) Advising on communications with a Locums Agency and Responsible Officer regarding a concern involving a locum consultant urologist, Dr [redacted] in 2020 who was in a short term placement. *Please see:*

91. 2.9.2020 Screening of Concern [redacted]

This includes details of another doctor that may need redacted

(e) Asked to provide support in the summer of 2020 for co-ordinating a Grievance hearing with Mr A O'Brien and his representative in relation to the MHPS process heard by Mrs S Young and Dr A Diamond in 2020 and later by Mrs T Mckernan and Dr R O'Hare. My role here was to set up meetings, communicate dates/times and issue correspondence on request, to Mr O'Brien and his representative. I did not attend the actual meetings. Further relevant information in relation to this is also included in Q1u.

17.5 Just to Note; [redacted] from March 2010 to March 2011; January 2015 to January 2016, March 16 to March 17; so would not have been working during these periods.

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

18.1 Yes, I did not encounter any difficulty in my involvement with the staff within urology. I believe I had a good professional working relationship with all the staff, including all the consultants.

18.2 Medical HR would have liaised with Mrs Martina Corrigan as Head of Urology/ENT and on occasion, Mr M Young who acted as Clinical Lead in relation to HR issues. Mrs Corrigan and/or Mr Young would have contacted Medical HR to discuss issues such as finalising Job Descriptions for advertising Urology posts, terms and conditions advice, junior doctor rota templates to confirm pay bandings for junior doctor trainees, job plan queries and advice around performance; such as on one occasion, a concern with a locum consultant (as outlined in 17e iv) or a junior doctor trainees (as outlined in 17e iii). In comparison to others areas across the Trust, contact was infrequent but I would say similar to a specialty of similar size. (given urology is a small sub-specialty).

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 My role has no direct involvement in the operation, governance or clinical aspects of Urology.

19.2 However I do have an HR role to develop policies and procedures to ensure robust accountability arrangements in the management of the Trust Medical Workforce e.g. Waiting List Initiatives, Job Planning. I worked alongside our local Negotiating Committee to ensure the Southern Trust had such agreed policies in place that apply across the Trust.

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 In the main my key contacts would be/have been:

(a) Mrs Martina Corrigan – Head of Service (from 28.9.09 to 6.6.21)
(b) Mrs W Clayton – Interim HOS (ongoing)
(c) Mr Michael Young – Clinical Lead Urology
(d) Mr E Mackle – Associate Medical Director (April 07 until 30 April 2016)
(e) Mr M Haynes – Divisional Medical Director (ongoing) currently interim replaced by Mr T McNaboe
(f) Assistant Director Surgery/Elective Care: Mrs H Trouton (Sept 09- Mar 16)

(g) Assistant Director Surgery/ Elective Care: Mr R Carroll (April 16 ongoing)

20.2 Medical HR would not have had any formal meetings with Urology. Advice would primarily have been via email and telephone contact.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

21.1 My Medical HR role is not directly relevant to the operational, clinical and governance aspects of Urology services on a day to day basis.

22. **What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?**

22.1 My ability to provide a view of the efficiency and effectiveness of governance processes and procedures within Urology is limited, given my role is not directly linked to these areas.

22.2 I can comment on my knowledge of the completion of consultant Job plans within urology. I would have been aware that engagement from consultants in completing their online prospective Job Plans annually was not always in line with required standards. Some consultant urologists were much better with this requirement than others. I note Mr O'Brien did not engage with the electronic job planning system particularly well and his job plans were not approved on this platform. Updates on job plan engagement were brought to the attention of the Associate Medical Director and Medical Director, via our detailed job planning progress reports.

22.3 In relation to the efficiency and effectiveness of managing performance concerns within Urology – any concerns that were brought to HR attention, were supported with advice and guidance, such as those cases I have discussed under question 17. I was not aware of any ongoing concerns with regards to managing staff within Urology. Again I should add that I was [redacted] in 2015 and 2016 however I am aware now that governance concerns were known about in the specialty and discussed with Mr O'Brien in March 2016 but not discussed with HR at that time.

Personal Information redacted by the USI

22.4 Medical HR are not involved with appraisal and revalidation so I cannot provide a view on this process which is managed within the Medical Directorate.

Urology Services Inquiry

23. **Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?**

23.1 In my HR role, I would not inform or engage with Urology performance metrics or have any other patient or system data input within Urology.

23.2 The only relevant metric that I would have knowledge of would be the completion of Consultant Job Plans by Directorate and specialty across the Trust as previously referenced above question 12 and question 22. We would have provided summary information to the Medical Directors office and to Associate Medical Directors by directorate for sharing at various Job Planning task and finish groups. Below is just a sample of some of these reports that are shared with the MD office, as they have monthly meetings with the Associate Medical Directors. We can pull detailed information from our Electronic Job Planning software that would have been shared regularly with the Medical Director and Divisional Medical Directors. The Associate Medical Directors and Clinical Directors equally have access to this information for their own specialty on the e-job planning system that we have had implemented since 2012. *Please see:*

67. 01.2018 Rotas at Risk shared with MD

68. 08.2021 Rotas at Risk shared with MD

69. 11 6 14 Notes of Consultant Job Planning Steering Group Meeting FINAL

70. 13.10.17 Copy of JP update for amd forum and MD

71. 13.10.2017 Update email to MD office on Job planning

72. 18.7.2014 Copy of ProgressReport to MD office Surgery

73. 18.7.2014 Progress report of surgery job plans to MD

74. 23.8.2017 Medical Staff Management Task and Finish Group action notes

75. 24.5.2019 UPDATE CONSULTANT JOB PLANNING HEADLINES to MD

76. 30.4.2018 Task and Finish Job planning

77. 2009.10 HSCT TERMS OF REFERENCE - CONSULTANT CONTRACT STEERING GROUP

78. 21.9.22 Job Planning Dashboard shared with MD

79. 24.5.19 - PROGRESS REPORTS shared with MD

80. 30.4.2018 Job plans completed - CONSULTANTS

Urology Services Inquiry

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

(a) **Waiting times**

In my HR role, I would not have involvement with this area.

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

In my HR role, I would not have involvement with this area.

(c) **Letter and note dictation**

In my HR role, I would not have involvement with this area.

(d) **Patient care scheduling/Booking**

In my HR role, I would not have involvement with this area.

(e) **Prescription of drugs**

In my HR role, I would not have involvement with this area.

(f) **Administration of drugs**

In my HR role, I would not have involvement with this area.

(g) **Private patient booking**

In my HR role, I would not have involvement with this area.

(h) **Multi-disciplinary meetings (MDMs)/Attendance at MDMs**

In my HR role, I would not have involvement with this area.

(i) **Following up on results/sign off of results**

In my HR role, I would not have involvement with this area.

(j) **Onward referral of patients for further care and treatment**

In my HR role, I would not have involvement with this area.

(k) **Storage and management of health records**

In my HR role, I would not have involvement with this area.

(l) **Operation of the Patient Administrative System (PAS)**

In my HR role, I would not have involvement with this area.

(m) **Staffing**

24.1 In my Medical HR Role, I would have a role to provide HR support and guidance in the recruitment and employment of all medical staff, including those working

in Urology. I have provided a summary of staffing in Urology and recruitment efforts as evidence in Q1. The increase in consultant numbers would have been dependant on the Trust obtaining recurrent funding from the commissioners, to allow us to expand our numbers. It has been more recently when we have struggled to fill all our funded consultant posts. We continue to explore all avenues to do so, including re-advertisements, asking our contracted recruitment agency specialising in international recruitment to source doctors and seeking CV's from our normal contracted agency frameworks and non-contracted agencies.

24.2 In general we can find it more difficult to recruit to Consultant posts for several reasons. There continues to be a pay differential between what consultants are paid in N Ireland and what they can earn in the UK. This pay differential is primarily due to the cessation of our N Ireland local Clinical Excellence Awards Scheme in 2009. These schemes operate in England and Wales. In general terms, our on-call rotas will have more frequent on-call commitments (and possibly less tiers of junior doctors on beneath them) in comparison to larger hospitals such as Belfast. This makes our posts less attractive options for work/life balance reasons. We do also find that many doctors will relocate to the South of Ireland, given the earning potential is also greater. The ongoing difficulties with the pension taxation issues are also making NHS jobs less attractive and I believe more consultants are moving into the private sector.

(n) **Clinical Nurse Specialists (xv) Cancer Nurse Specialists**

(xvi) **Palliative Care Nurses**

(xvii) **Patient complaints/queries**

In my Medical HR role, I would not have involvement with this area.

Concerns

25. **Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.**

25.1 Given my role as an HR professional, I would be involved with offering support and guidance to managers when managing concerns about a doctor's performance. If there was a possible concern about the practice of an individual doctor around patient care, safety and governance; the procedure that we would be expected to follow would be the Department of Health (NI) "Maintaining High Professional Standards Framework".

25.2 In line with para 11 in Introduction of MHPS, this states *"All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures must reflect the framework in this document and allow for informal resolution of problems if deemed appropriate. Concerns about the performance of doctors and dentists in training should 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. The onus still rests with the employer for the conduct of the investigation any necessary action."*

25.3 I was involved with reviewing the local Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (based on the MHPS framework) in 2017/18 in response to this requirement. This updated an earlier version of Trust guidance which I believe had been completed by a colleague of mine (Mrs Siobhan Hynds) in 2010. I was off at this time [redacted] from March 2010 until 15 November 2010.

25.4 When I returned from [redacted] in March 2017, I recall being contacted by Mrs V Toal and Mrs S Hynds to ask if I would assist them in reviewing the Trust 2010 guidelines for handling concerns. I believe this was in light of learning from experiences with recent cases. The feeling at that time was that references within the earlier 2010 guidance to the Oversight Committee could be misleading and it was important to ensure it was clear that the decision maker in relation to MHPS cases, lies clearly with the Case Manager. However the Doctors/Dentist Oversight Group would still have a role to provide a support and oversight for the Case Managers. We were also keen at that time to ensure it was clear if and when it is appropriate for concerns to be handled informally and what the process should look like for this.

25.5 In addition to MHPS, the Trust is also expected to following the Early Alert System issued by the Department of Health. Whilst this hasn't been updated in some time, the Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department. This is a slightly different process to the HPAN system which operates in UK which is currently managed by NHS Resolution.

25.6 The Trust would also be expected to follow the process set out in the Trust "Right to raise a concern" policy, should there be a concern about an issue relevant to patient care, safety and governance.

25.7 I have worked over the years to try and improve the accessibility to the relevant information for our medical managers, so it is available as and when they need it. This led me to developing an online portal known as our Supporting Doctors in Difficulty HUB. This was circulated to all consultants in post in 26 March 2021 and remains accessible via the Trust Share-point pages.

25.8 I believe the Southern Trust was one of the first Trusts to develop guidelines for managing concerns about external locum agency doctors. I developed this guidance and shared it for comment with the Employment Liaison Adviser of the GMC Joanne Donnelly in 2019. A final copy was shared with the GMC advisor and I recall they commented that they were keen to use this to inform work they were undertaking to improve this risk area across the UK.

25.9 All the guidance continues to be accessible at any time on the Medical HR Hub. All our Medical HR Team include links to this HUB below their surnames in all emails and linked in Share point – again for easy access.

26. **Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.**

26.1 In relation to Staffing, whilst I was [redacted] during this time, I am aware that there were a number of key changes that took place in 2016 in relation to Medical Leadership posts. On reviewing the information, I can see the following changes:

(a) Clinical Director changed from Mr S Hall to Mr C Weir in June 2016;
(b) Mr E Mackle stood down as Associate Medical Director in April 2016 and Dr C McAllister was asked to cover this role in addition to his role as Divisional Medical Director for Anaesthetics from May 2016.

(c) The Assistant Director changed from Mrs H Trouton to Mr R Carroll in April 2016.
(d) The HR Director transferred from Mr Kieran Donaghy following his retirement to Mrs Vivienne Toal in 2016.

26.2 Such key changes over a short space of time is bound to have been difficult, as staff structures and interactions are crucial in an organisational system. I believe this may have had the potential for organisational memory to be impaired, particularly if any issues were being handled via informal ways of working. I also note that in May 2016 the Associate Medical Director Dr McAllister was asked to cover Surgery/Elective Care Directorate as AMD at the same time as his own area ATICS (Anaesthetics/Theatres/Intensive care), which can't have been easy, given he is also a full time clinician. There is a huge challenge in medical management posts, as often in my experience they cannot give up their clinical workload due to sheer workforce pressures (and not enough doctors to backfill them) and often don't want to, due to the deskilling that can occur if out of clinical practice for a period of time.

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1 As outlined in question 17, I have provided HR support to manage a number of concerns that were raised in the past regarding Urology practitioners. These included the following:

(a) Providing administrative support and HR guidance to a Surgery Clinical Director, Mr R Brown in a disciplinary investigation concerning Mr A O'Brien in 2011 relating to the disposal of clinical notes in a bin on the ward. This resulted in an informal warning. The full details and decision letter were shared with Mr O'Brien, Mr Mackle the Associate Medical Director, and Heather Trouton, Assistant Director at the conclusion. Further details included in question 17.

(b) Providing administrative support and HR guidance to Clinical Director Mr R Brown in completing an investigation concerning clinical concerns relating to a temporary LAT 'Dr Personal Information redacted' (Locum Appointment for Training) in Urology in 2012. Further details included in question 17.

(c) Advising on the necessary communications with a Locum Agency and Responsible Officer regarding an issue with a Urology locum consultant Dr Personal Information in 2020. Details included in question 17.

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern, on the provision, management and governance of urology services?**

28.1 In relation to the conduct concern that was investigated regarding the disposal of clinical notes by Mr O'Brien in 2011, the Case Manager's understanding was that this was an isolated incident. The full report was shared with the Associate Medical Director Mr Mackle and the Assistant Director Mrs H Trouton. Mr O'Brien apologised and agreed that disposal of the material concerned was inappropriate and that it would not happen again. He was issued with an informal warning under the Trust's Disciplinary procedure and I am not aware this practice was ever repeated and therefore the action taken seemed to address this issue. However I am concerned to read in the context of this public inquiry that there were ongoing issues with the management of patient charts with Mr O'Brien storing a large volume of these at home. I believe given the previous context, this should have been immediately escalated and dealt with in line with Trust policies and procedures.

28.2 In relation to the clinical concern in 2012 relating to the temporary LAT (Locum Appointment for Training) doctor, when concerns came to light, an initial screening was completed. This resulted in immediate restrictions being put into place. These included coming off the on-call rota, restricted practice with supervision and a period of time accompanied by the Urology SPR (Specialist Registrar) for Urology ward rounds. An investigation was undertaken in line with the Terms of Reference with full participation from the doctor and a number of witnesses. As this doctor was only on a temporary contract which ended during this period, the Case Manager (CM) followed Section VI para 7-9 of MHPS to take the investigation to its final conclusion wherever possible. Mr E Mackle as CM, concluded that on the balance of probabilities there was at least some evidence to substantiate some of the concerns in relation to the doctor's clinical performance. Had he remained in Trust employment, he would have recommended further formal consideration by NCAS and a likely action plan to address these deficiencies. However since he was no longer employed, the Trust could take no further action in this regard, but to

protect any possible risk to patients, referred the matter, with all of our information, to the General Medical Council.

28.3 In relation to the clinical concern relating to an Agency locum consultant in 2020, when concerns came to light, an immediate screening was completed by Mr M Haynes. For each of the clinical episodes reported, the appropriate action to safeguard patients was recorded in the screening report; e.g. contacted the patient, apologised and organised appropriate management; review of all consultation letters to ensure no further similar cases.

28.4 In line with our procedures for managing concerns involving Agency Locum doctors, preliminary enquiries were completed which included seeking the opinion of the doctor. These concerns resulted in an early termination of our locum agency contract with this doctor. As the concerns related to clinical decision making (which was felt to be below the standard expected of a consultant urologist) the full detail of our concerns and investigation was shared with the locum doctor's Responsible Officer and his Employment Locum Agency.

28.5 Whilst I would not be aware of any specific changes that were considered or implemented as a result of managing these concerns in Urology, I do believe in the cases I was involved with that the clinical managers understood the importance of immediately identifying the risk to patients and using the available policies and procedures to deal with these concerns at that time.

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

29.1 I believe I have addressed this question in Q28 above for the concerns that I was involved in providing HR guidance.

29.2 I was not involved with the management of the case concerning Mr AOB, as I was [redacted] from January 2015 – January 2016 and from March 2016 until March 2017.

30. **Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?**

30.1 For the concerns that I was involved with as outlined above in Q28, yes I believe there was the potential for there to be risk to patient safety. However I believe that the clinical managers I worked alongside at that time understood the importance of identifying the risk to patients, taking appropriate actions to mitigate the risk as outlined in Q28 above and using the available policies and procedures to deal with these concerns.

31. **Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.**

31.1 Yes for those limited concerns that I was involved with, as outlined in Q28, I do believe that appropriate action was taken. Two cases related to clinical concerns which happened to be locum doctors on temporary contracts. Action included immediate restrictions in practice being implemented, removal from out of hours/on-call work, a scoping of work to determine any wider concerns and additional supervision/support. In these cases restrictions continued until their employment ended.

31.2 There is currently no single agreed model to determine risk but a number of different models have been published that can help clinical managers in additional to their own professional judgement. To provide guidance in this area, I developed a document containing a selection of these risk matrix's to assist Clinical Managers entitled "Classifying Concerns and considering Risk" in 2021. This document is available from the Medical HR Supporting Doctors in Difficulty HUB referred to in question 25 above. We do plan to ensure this is incorporated into more widespread training for clinical and operational managers as set out in our new MHPS Training plan as referenced in Q13.

31.3 I was not involved in the management of the MHPS investigation relating to Mr O'Brien. I was however copied into an email from Mr M Haynes in May 2019 which refers to instances of the action plan (drawn up for Mr A O'Brien) not being met. I believe I was copied in given my role in Medical HR – but given my two superiors, Mrs S Hynds (Deputy Director HR)and Mrs Vivienne Total (Director of HR) who had knowledge of this case, were also in the email, I felt I didn't need to escalate or take any action. I didn't attend the oversight meetings, nor did I have the detail of these concerns but I knew that others were aware and as such I didn't need to take any further action. I wasn't copied into any further emails. *Please see:*

92. 17. May 19 Job plan re Mr Haynes and Mr OBrien correspondence

32. **In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice**

32.1 I understand it is the responsibility of the Medical Director and Operational Director to present formal MHPS cases to SMT Governance to promote learning and for peer review. This was set out with our Trust Guidelines for managing concerns both in 2010 and 2017.

32.3 I believe this is an area where we have not been as good as we should have been. The introduction of the monthly Oversight meetings in May 2020 as referenced in Q13i, has helped to provide a regular forum for discussion with the Medical Director. Divisional Medical Directors alongside their Operational Directors attend to discuss live informal or formal cases in their directorate. They are now also asked to highlight and take forward any wider systemic issues and learning coming from reported concerns.

32.4 For example, with the publication of the 2022 Shared Learning Policy, a Case Manager who recently completed a formal MHPS investigation has now been asked complete the template within this policy, (in collaboration with the relevant Associate Medical Director) which should provide a more formal mechanism for documenting actions to embed any necessary changes/learning. This will allow them to share thematic findings/recommendations in a more formal way to ensure information is relayed to appropriate staff/departments to encourage learning. The importance will be on sharing what happened, working out why it happened, and learning and being responsible for making changes for the future safety of staff and patients.

32.5 We also now have formal quarterly reports in place outlining all our formal MHPS cases to SMT Governance and a report is provided of all established concerns to the Chief Executive at the end of every month as evidenced earlier in my statement at Q13.

33. **Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?**

33.1 I was not alerted nor did I have concerns that clinical care or issues around risk were not being identified, addressed or escalated within Urology.

33.2 I was not contacted by anyone within Urology or otherwise with concerns around governance, clinical care or issues around risk. Given the wider clinical concerns that came to light from June 2020 regarding Mr. O'Brien's practise, it is not clear to me why clinical managers or systems of governance within Urology did not uncover and escalate these clinical concerns much earlier.

33.3 The one thing I would have been concerned about was the completion of online prospective job plans, however urology were not on their own. I would have raised this issue, with the Associate Medical Director and Medical Director via our Job planning progress reporting as referenced earlier in my statement in Q 13 and Q23.

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

34.1 Within my Medical HR Role, I would not have sight of what was included on the Urology/Acute Services Risk Register at departmental level.

34.2 I am aware that use of medical locums and medical staffing shortages continues to be included in Trust Corporate Risk Registrar. Whilst not relating specifically to urology; it does cover the actions taken by the Trust to try and mitigate these risks for hard to fill posts.

34.3 Referring back to a time in December 2013, I was asked to draft a risk assessment form on behalf of Urology to reflect some concerns we had around the working hours of the junior doctor registrars at that time. I escalated these concerns to the Director of HR, Mr K Donaghy and a meeting was arranged with the Associate Medical Director, Mr E Mackle so actions could be agreed. This was then passed to the specialty for consideration and ongoing management.

34.4 I am not aware of any clinical concerns or associated concerns with the performance of practitioners within urology being the subject of any governance documents or risk registrars, however this would have fallen

to the responsibility of the relevant Head of Service/Director for that area, so I would not normally have sight of this.

35. **What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?**

35.1 Ensuring we have an adequately resourced Medical HR unit to support more frequent and widespread training on handling concerns would increase effectiveness in carrying out my role. I have developed a Training Plan as referenced and evidenced at Q13. Medical HR is a specialist area and I do believe additional resources will help us raise awareness and facilitate pro-active training amongst clinical and operational managers on how to handle concerns. We need to continually strive towards a climate that emphasises organisational learning and explore how we can underpin our processes, systems, polices and regulatory frameworks with restorative principles and practices.

35.2 I have recently been given approval to recruit at risk for a new band 7 specialist MHPS case manager. This will be a dedicated MHPS role, something that we have not had in the past. In the past our support has always been in addition to an operational role carrying busy day to day responsibilities. This additional resource will also allow us to support the necessary continuous improvements in this field of work.

35.3 Developing Clinical Leadership induction training is essential. The challenge of being a clinical leader cannot be underestimated. Particularly, as most often these appointments are internal and one can end up managing colleagues who were once their senior or, at the least close contemporaries. Administrative support for clinical managers for their management role is also something that I believe should be considered as I know many rely heavily on Medical HR support which is finite due to our resources.

35.4 Ensuring enough time is allocated within Job Plans to facilitate clinical management is an ongoing challenge for Trusts when clinical commitments are ever increasing – however this is critical. It is not easy or straight forward for many reasons, not least the huge funding and staffing shortages faced by Trusts.

35.5 Continuing to build skills and competencies is important to promote a proactive coaching culture where all managers and staff know they have a clear responsibility to ensure and assure themselves of patient safety. I am not aware if there were adequate systems in place to allow for

regular peer review of clinicians work as part of supervision/management. Managers must continue to feel empowered to deal with any possible risk to patent safety at the earliest possible opportunity – with appropriate oversight to ensure action where necessary. Staff need to feel empowered and supported to raise concerns prior to any potential risk of patient harm, ensuring there are well communicated processes to address such concerns and systems in place to learn from good practice as well as what goes wrong.

35.6 Reviewing MHPS Framework to ensure processes do not serve to stifle or complicate pathways for correction. Most importantly ensuring patient safety remains at the core is critical – so greater clarity on the action to be taken when a concern first arises would help. The MHPS Framework does not give clear practical steps for clinical managers to follow for addressing concerns at the outset, ensuring matters are properly risk assessed, managed and documented very early before they reach a stage when more formal action is necessary.

35.7 There are other factors within the MHPS Framework that need greater clarity such as clear definitions of all the roles referred to in the document. The importance of having roles defined and clear lines of accountability around every aspect of the process cannot be overstated. The timeframes are also in need of review as they are not realistic within an over stretched busy NHS – albeit I appreciate they have to be reasonable. The MHPS Framework is silent in many areas such as whether a case manager can take soundings before reaching their decision and yet this would seem a sensible approach and in line with Baroness Harding advice. What constitutes a 'concern' is not well defined and yet it asks that "all" concerns are registered with the Chief Executive. Professional misconduct is not defined. At the end of an investigation, a Case Manager has to consider if there are 'intractable' problems and yet again, this term is not defined. In cases of misconduct, the document is also contradictory as it indicates in the introduction you can follow your own local disciplinary procedures and yet it has a Section 3 which states you can only apply conduct procedures when an investigation under section 1 shows there is a case of misconduct. Paragraph 39 talks about confidentiality but it is not clear how far this extends. Whilst I appreciate a complete rewrite may not be feasible given Case law has dealt with many issues – the sheer volume and complexity of the document in its current format is not helpful. General principles for Formal investigations are also right at the back of a 40+ page document when it would seem more sensible for a set of clear principles to be at the beginning of a

Framework document. As mentioned before, there are no practical steps within MHPS to provide consistent management guidance when managing informally in a fair, effective and safe way.

35.8 Consideration (potentially at Department of Health level) needs to be given to how Trusts can facilitate Case Investigations and Case Managers to undertake their formal roles under MHPS whilst also being expected to carry out their full time clinical roles. Almost all our Clinical Managers, Case investigators and Case Managers are also practicing clinicians (i.e. not full time managers). Trusts do not receive additional funding for their important management or MHPS roles. It is nearly impossible to complete even a straight forward MHPS investigation within 4 weeks, as invariably give the huge pressures on hospitals today, it is rarely possible to release consultants from clinical practice. There are a couple of examples where we have proactively tried to engage retiring consultants to be available for case investigator work which has been helpful.

35.9 Workforce plans that are not only completed regularly, but *fully funded* to ensure we have the right number of doctors and staff in the right place at the right time. Too often they are completed and then there is no funding to deliver them. It is essential that Clinical Directors/managers are clinically trained but often this means they are carrying the management role alongside their own busy clinical commitments. This needs to be considered by the Department of Health within workforce planning to enough doctors are commissioned and funded so that Trusts can facilitate clinician managers the time they need to properly manage. We need to ensure information gets to the right person who has the knowledge and ability to deal with it at the right time.

35.10 More regional collaboration and engagement for shared learning following cases would also be helpful. This will need resourced from the Department of Health.

35.11 Whilst not directly related to my HR role, IT Resources and the development of data skills to interrogate and triangulate information systems to ensure all relevant information in relation to a clinician's practice is easily available for their managers to spot issues/trends would increase effectiveness.

Staff

36. **As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within**

urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

36.1 My view of the working relationships between Urology staff and other Trust staff was good. I was not aware of any issues nor was I advised of any tensions or concerns. I consider my working relationships with those I interacted with in urology to be good. Again in all my interactions, I observed no relationship issues and there would have been no issues giving me any cause for concern. The team seemed to me to be working cohesively, I didn't witness, nor was I aware of any animosity. In the infrequent occasions I would have had to contact the Urology team, I feel I was able to obtain whatever information I needed in my HR role, from the relevant staff as outlined in question 20.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1 Yes. In my experience I felt there was a close working relationship between the operational (heads of service, assistant directors) and the clinical management team (i.e. Lead Clinicians, Clinical Directors, Divisional medical doctors). Whilst I cannot give specific examples, I feel like any advice I obtained was generally agreed jointly with the Head of Service/AD and Divisional Medical Director. I never picked up any cause for concern with working relationships between the clinical and operational managers.

Learning

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

38.1 Yes I am now aware of governance concerns arising out of the provision of urology service involving the MHPS investigation relating to Mr A O'Brien that I was not previously aware of. I am aware of these concerns given the sight I had to the various documents that were shared with me in 2020, as part of administering the Grievance process which resulted from Mr O'Brien's Maintaining High Professional Standards Investigation.

38.2 I am aware from reading the material in preparation for this public inquiry that a letter was issued to Mr O'Brien in March 2016 by his Clinical Management team raising concerns, particularly around administrative practice and current review backlog. I understand HR were not informed of these concerns at that time. I was [redacted] but I believe it would have been helpful to have sought specialist HR advice at that time.

38.3 I believe this initial concern should have prompted immediate preliminary enquiries by the clinical manager to take a deeper dive and scope to establish the full nature of the concern. The fundamental consideration within the MHPS Framework is the continued safety of patients and the public. Action when a concern first arises requires the clinical manager to consider if urgent action needs to be taken to protect the patients and if a precautionary restriction/exclusion on practice is required, until they can clarify the nature of the concern. The key Governance question I am asking is that no one seemed to understand or take accountability for determining the full extent of the problem, to ensure any necessary protective measures for patients could be put in place immediately and properly monitored.

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

39.1 On very first receipt of the prompt/concern, the response should have been for the clinical manager to very quickly ascertain what had happened. They needed to establish the facts, determine if there was a continuing risk and decide if there was action needed to manage any risk to ensure the ongoing protection of patients. It is not clear to me what action was taken following the meeting in March 2016. I note the request was to ask Mr O'Brien for an immediate plan to address the issues highlighted. I don't believe this was appropriate, given these were significant concerns which I believe met the threshold for formal investigation at that time. It may also have warranted an immediate interim review of Mr O'Brien's Job plan to ensure the necessary corrective reviews being asked of Mr O'Brien were possible.

39.2 More rigorous and robust action at this early stage may well have been a missed opportunity to ensure preliminary enquiries triangulated and documented all available data at that time. Had a robust review been undertaken, this may have allowed an earlier link between

administrative practices and impact on patient care, so protective measures could have been immediately implemented and monitored. From my experience over the years advising on cases, the role within MHPS for monitoring and managing risk (which is not well defined in the Framework) needs to lie with the immediate line manager to avoid any possible disconnect. They must remain accountable for ongoing line management and must update the case manager (in the context of formal MHPS investigations) on the actions they have taken. NHS Resolution can be very helpful in helping to draw up detailed action plans as necessary, I have attached a sample one into evidence that we have used previously as an example.

39.3 An assessment of an initial incident for its risk, so that the correct measures can be put in place to protect patients, has to take precedence over everything else. In my view this is the most critical aspect within MHPS. For example, by correctly identifying that a risk associated with a trigger event is low, sufficient reassurance can be gained that the issue is not a concern and can be dealt with as a learning incident. However as preliminary enquiries are undertaken and further events occur or information comes to light, the risk may vary, so a trigger initially classed as a low risk incident may rise to medium or high if other instances come to light or you have a doctor with little insight. Clinical Managers (taking advice when necessary) must continue to reassess risk as often as is necessary as part of their line management role. Case managers (as assigned under MHPS) should then seek the assurance they need from clinical line managers that all necessary protective measures are in place. We need to ensure managers are trained and supported to undertake this task.

39.4 I understand a screening report was completed in September but it is not clear why this was done by the Assistant Director in the Medical Directors office – this should have been the clinical manager who should have been responsible for retaining ongoing oversight. Input from NCAS (now NHS Resolution) could have provided additional support if this was needed to assist with the review of notes.

39.5 It is not clear to me why it took an SAI investigation in December 2016 to instigate formal action– I'm not clear if these were new concerns arising or if a closer review earlier would have uncovered them. Unfortunately it would seem the earlier inaction led to a delay to the formal investigation as there was still a need to determine the full extent

of the problem. I believe a more robust review at the outset may have avoided this.

39.6 I am aware that there were more difficulties encountered which prevented the completion of the MHPS process, however I was not in my post during 2015 and most of 2016 (Personal Information redacted by the USI) so I am not fully aware of all the factors that led to these delays. I do think that the key breakdown stems back to the fact an adequate and robust review, coupled with a risk assessment does not appear to have been completed and there were missed opportunities to address this as time went on. *Please see:*

93. Sample Action Plan NHS Resolution

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?**

40.1 The challenge for all managers is they are responsible for what is actually happening, regardless of what personal knowledge they hold at that time. Given what I know now; we need to ensure all managers are clear in their role and supported to undertake it fully and robustly. I do believe the governance systems need to be strengthened to triangulate data for clinical managers, so they are better aware how clinicians are performing in all aspects of their role. However there must also be a culture that where concerns arise (even if all information is not clear), the concern must be robustly evaluated to ensure the full extent of any concern is established and managed at the earliest possible opportunity. Clinical Managers must be clear in their role and supported to ensure this is the case.

40.2 The learning also has to be around fostering and encouraging a more open, transparent and fair culture for raising and managing all concerns, as soon as they arise. It is not appropriate to wait until one is sure there is a concern before escalating – that is the purpose of an investigation to uncover. Early escalation allows the necessary precautionary risk assessment to be undertaken immediately to prevent any possible harm to patients, clients or staff. When *possible* concerns are not escalated or enquiries not undertaken, this has the potential to undermine patient safety. Any perceived concerns should have resulted in decisive action and untoward behaviours should have

been tackled and addressed as they arose. This should have been a proactive process undertaken by the operational and clinical managers collectively, taking advice as necessary.

40.3 I do believe we failed to fully and robustly utilise the contractual tools of job planning at our disposal to ensure Mr O'Brien discussed and agreed a contractual annual job plan – even if this meant pursuing facilitation and appeal mechanisms. This may have helped inform a more cohesive model of management as a repeated failure to comply with such obligations (and perhaps others like appraisal) may have stone the light to indicate potentially a broader problem in other areas of the doctor's practice.

41. **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. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

41.1 In my Medical HR role, I have a very limited standpoint to address this question – as I was [redacted] when these concerns came to the attention of HR. However purely from rereading all the information that is available to me, I believe there may have been a failure to engage fully with the problems that arose within Urology Services to ensure they were fully and properly scoped out.

41.2 All consultants practice independently and are clinically responsible for their own patients. I believe this peculiar aspect to their role can mean there may be less emphasis in this profession and at this grade, on the typical methods for line management such as regular 1:1 supervision meetings. Whilst Clinical Directors and Associate Medical Directors are responsible and accountable for the medical staff within the Speciality and their role in the provision of services – I believe extensive consideration is needed right across the NHS (as opposed to being unique to the Southern Trust) on how best this model can work, so that they are fully supported, trained and motivated to carry out this important management role alongside their clinical practice.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

Urology Services Inquiry

42. **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?**

42.1 The immediate response under MHPS Framework is to manage risk to ensure patient safety is protected. I believe this should have been the key priority right at the outset. There needed to be greater triangulation of clinical data/performance indicators to provide assurance the Trust was fully aware of the nature of the concern at that time. However in the absence of that, the necessary risk assessment needed to be completed right at the outset to protect any ongoing risk of harm.

42.2 Clear, transparent and documented communication with the individual practitioner is also essential. Informal management within the specialty does not mean undocumented and therefore as soon as concerns were discussed in March, this should have been accompanied by a documented action plan with clear lines of responsibility, set and monitored by the local clinical management team.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically 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?**

43.1 I would have a limited standpoint to answer this question as I would not be familiar with the specific governance systems or clinical performance indicators in place within Urology that should pick up if things start to go wrong.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

Urology Services Inquiry

44.1 From working in Medical HR for quite some time, I am aware that MHPS Framework was to have been reviewed/updated by the Department of Health in the past (referenced in 2011 and 2018) but this has not happened to date. We continue to work with the original framework that was first issued to Trusts. There is a slightly different version in operation within the UK. The document is complex and given it is a different approach to how concerns are handled for other professional groups, I feel this has the potential to mislead those who have less experience using it, leading to a lack in confidence around handling concerns efficiently and compliantly in line with MHPS. *Please see:*

94. 00.11.2011 Revision to MHPS Changes DOH

95. 15.3.18 Response to DOH re mHPS review

96. 15.3.2018 SHSCT comments re revision MHPS to DOH

97. 15.4.2018 Review of MHPS response to DOH

98. 15.11.2011 Email re MHPS review with DOH

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.

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 17 November 2022

S21 102 of 2022

Witness statement of: Zoe Parks

Table of Attachments

Attachment	Document Name
1	2006 Mr A O'Brien transfer onto new contract
2	30.10.2006 A O'Brien external duties
3	14.08.09 Urology Team Analysis planning for Job Plans
4	18.2.2010 Email attachment D Burns presentation
5	18.2.2010 Email from D Burns re Urology
6	22.12.09 attachment with email 2
7	22.12.09 attachment with email 3
8	22.12.09 attachment with email D Burns
9	22.12.09 Attachment with email
10	22.12.09 Memo re Urology team analysis review
11	22.12.09 Urology Team Analysis for job plans Email HR to D Burns
12	22.12.2009 UROLOGY DRAFT TEAM ANALYISIS VERSION
13	22.12.09 Attachment with email 4
14	03.12.2009 Memo All Cons Waiting List Initiative
15	3.12.2009 Copy of New WLI Claim Form
16	9.12.2011 Memo to AMD and Directors re WLI Claims
17	18.11.10 reissue of WLI document agreed in Dec 09 to all AMD to ensure compliance
18	00.06.2011 Update on Consultant Job Planning for all Consultants
19	2.6.11 High level summary of Job planning to consultants
20	2.6.2011 Email issuing high level summary
21	01.06.2011 FINAL Disciplinary Report - A O'BRIEN
22	9.8.2011 Informal warning outcome Mr A O'Brien
23	5.12.11 Response to Mr AOB from Mr Mackle re Admin
24	10.11.2011 E re Job Plan Facilitation - 10.11.2011

25	16.11.2011 Email from Malcolm to AOB Clinical managers
26	28.09.11 Notes of Facilitation meeting M Clegg
27	E re Job Plan Facilitation A2 - 31.10.2011
28	2.10.13 Case Studies for Managing Concern Workshop
29	2.10.13 Handling Concerns Medical Staffing Presentation - Z PARKS
30	2.10.2013 Copy of concerns presentation to Mr C Weir
31	6.1.12 NCAS -Handling Concerns good practice
32	6.1.2012 Email to C Weir with Concern Guidance
33	22.9.15 Managing Concerns Presentation
34	6.3.2012 Email to payroll re outcome of wli claims
35	6.3.2012 Response to Mr AOB re WLI claims
36	24.2.12 Response to payroll for paying wli claims changed
37	30.1.2012 Mr O'Brien Grievance re WLI Claims
38	1.8.2014 urology reg Rota Actions
39	2.12.2009 Draft Risk Assessment Template
40	3.3.2014 Chaser email re registrar working patterns
41	4.2.14 - Response email from Mr Mackle indicating M Young was to reduce hours
42	4.2.14 memo to Mr Mackle re Urology
43	4.2.14 Response to memo re registrar urology working pattern
44	20.12.2013 Attachment EWTD Opt out form
45	20.12.2013 Meeting to discuss Urology Registrars Dir HR AMD
46	20.6.2011 M CORRGIAN REQUESTING CHANGES TO MR AOB JOB PLAN
47	24.1.14 Notification from Mr AOB re Job Plan via SouDocs
48	27.1.14 Response to changes to AOB Job Plan
49	27.1.2014 Email from Mr AOB t job plan online for first time
50	27.1.2014 Notification from Mr OB re Job Plan changes follow up
51	6.6.2017 Draft Medical urology Review report
52	6.6.2017 Urology Workforce Report MD View
53	15.6.16 Medical Workforce Planning for urology Appendix 1
54	15.6.2016 Medical Workforce Planning for Urology-Southern

55	26.05.17_Peter Barbour Urology Workforce Planning Report
56	26.5.2017 Urology Workforce planning report
57	2017 urology Workforce Planning Report
58	2021 050607 EMAIL TRAIL BETWEEN ZOE AND THERESE
59	Summary of Recruitment and Urology Numbers
60	00.04.2007 Medical Staffing Manager JD
61	001.01.2017 2018 Medical Workforce Plan
62	2019. 2010 Medical HR Action Plan
63	KSF Guidance Document
64	human-resources-profiles
65	Head of Service (Generic) Band 8a
66	21.4.2020 New Medical HR HUB 2020
67	01.2018 Rotas at Risk shared with MD
68	08.2021 Rotas at Risk shared with MD
69	11 6 14 Notes of Consultant Job Planning Steering Group Meeting FINAL
70	13.10.17 Copy of JP update for AMD forum and MD
71	13.10.2017 Update email to MD office on Job planning
72	18.7.2014 Copy of Progress Report to MD office Surgery
73	18.7.2014 Progress report of surgery job plans to MD
74	23.8.2017 Medical Staff Management Task and Finish Group action notes
75	24.5.2019 UPDATE CONSULTANT JOB PLANNING HEADLINES to MD
76	30.4.2018 Task and Finish Job planning
77	2009.10 HSCT TERMS OF REFERENCE - CONSULTANT CONTRACT STEERING GROUP
78	21.9.22 Job Planning Dashboard shared with MD. Q23
79	24.5.19 - PROGRESS REPORTS shared with MD
80	30.4.2018 Job plans completed - CONSULTANTS
81	01.5.2019 Regional Influence to Allocation to Trainees Report
82	1.11.2018 Q_008 Trust Level Locum Usage
83	10.5.2019 - REPORT FOR MEDICAL DIRECTOR

84	10.5.2019 Deep Dive into Medical HR issues report
85	8.9.2022 Governance Report Formal MHPS Case - Sensitive info
86	15.8.22 Training Plan MHPS 2022
87	20.9.2022 All Cases to CX - Sensitive info
88	20.10.2022 All cases to CX - Sensitive info
89	19.8.2011 Informal warning outcome Mr A O'Brien
90	2012 Summary of Evidence Gathered Personal Inform - Sensitive info
91	2.9.2020 Screening of Concern Personal Infor
92	17. May 19 Job plan re Mr Haynes and Mr O'Brien correspondence
93	Sample Action Plan NHS Resolution
94	00.11.2011 Revision to MHPS Changes DOH
95	15.3.18 Response to DOH re MHPS review
96	15.3.2018 SHSCT comments re revision MHPS to DOH
97	15.4.2018 Review of MHPS response to DOH
98	15.11.2011 Email re MHPS review with DOH

10 July 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Dear Mr O'Brien

Further to the discussions which we have had, I now wish to confirm the Trust's intention that you will be offered 5.5PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

The Trust is also making you an offer of an ex gratia payment of £ Personal Information redacted by the USI in recognition of your extra contribution during the period 1998 until inception of the new contract.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely

Dr I Orr
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

17 July 2006.

Mr. J. Templeton,
Chief Executive,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear John,

I do hope that you will have received a copy of my letter of 13 July 2006, addressed to Dr. Ian Orr, Medical Director, accepting the Trust's last New Consultant Contractual offer, and the *ex gratia* payment in recognition of my additionally working as a Registrar up to inception of the New Contract.

Now that both issues have been satisfactorily resolved, I would like to enquire again whether it would be possible to receive an advance payment. For a number of reasons, about which I would be happy to discuss with you, it would make an enormous difference if it were possible to receive an advance payment, of even a relatively small amount, before the end of July.

I would be most grateful if you would advise me whether this is possible

Yours Sincerely,

Personal Information redacted by the USI

Aidan O'Brien,
Consultant Urologist.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ

copied

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

3 July 2006.

Dr. Ian Orr,
Medical Director,
Office of the Medical Executive,
Craigavon Area Hospital Group Trust.

Dear Ian, JOHN

Re: New Consultant Contract Offer and *Ex Gratia* Payment.

Thank you for your letter of 10 July 2006. I write to confirm that I am pleased to accept the Trust's offer of 5.5 sessions of Programmed Activities, in recognition of additional workload over and above the 10 sessions that constitute my standard contractual duties under the New Consultant Contract. I also confirm my acceptance of your determination of my on-call category and commitment.

I also write to confirm my acceptance of the Trust's offer of an *ex gratia* payment of [redacted] in recognition of my extra contribution during the period from August 1998 until inception of the New Contract. Pursuant to Section 74 of the Finance Act 1988, I should be pleased if you would have confirmed that this amount shall be paid gross of all income tax, statutory or other deductions.

Lastly, I wish to avail of this opportunity to compliment you for the resolve with which you approached the above matters, and to thank you for the fair and balanced manner in which you conducted recent discussions. I do believe that the outcome is fair to both Trust and both consultant urologists. I do hope that the Trust also believes it to be so. I am pleased that these issues have been resolved to our mutual satisfaction, and that all can look forward to working together, with renewed vigour, to further develop urological services,

Yours Sincerely,

[redacted]

Aidan O'Brien,
Consultant Urologist.

Craigavon Area Hospital
13 JUL 2006
Chief Executive

Cc: Mr. J. Templeton, Chief Executive, CAHGT.
Mrs. M. Richardson, Director of Human Resources, CAHGT.
Mr. L. Stead, Director of Finance, CAHGT.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: [redacted]
Text No. [redacted]

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

10 July 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Dear Aidan O'Brien

Further to the discussions which we have had, I now wish to confirm the Trust's intention that you will be offered 5.5PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

The Trust is also making you an offer of an ex gratia payment of £[redacted] in recognition of your extra contribution during the period 1998 until inception of the new contract.

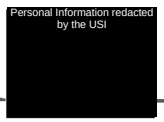
Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon BT63 5QQ
Tel: [redacted]

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely



Dr I Orr
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

SUMMARY OF PA OFFER

Name:	**Mr A O'Brien**
Specialty:	**Urology**
Contracted Programmed Activities:	**10 PA's**
Additional Programmed Activities:	**5.5 PA's**
Management Allowance (if applicable): Medical Director / Clinical Director	**N/A**
Total Programmed Activities:	**15.5 PA's**
On- Call Category:	**Category A**
On-call Frequency:	**1 in 2**

MR O'BRIEN

PREDICTABLE, ORGANISED DUTIES
MONDAY – FRIDAY

MONDAY

MORNING

9.00	WARD ROUNDS
11.30	MD WARD MEETING

(FIRST, SECOND AND FIFTH MONDAYS)

9.00	URODYNAMIC STUDIES
10.30	URODYNAMIC STUDIES
12.00	URODYNAMIC STUDIES

AFTERNOON

2.00	HISTOPATHOLOGY MEETING
3.00	HISTOLOGY REVIEWS/ADMINISTRATION
1.00	URODYNAMIC STUDIES
3.00	URODYNAMIC STUDIES
4.30	URODYNAMIC STUDIES

TUESDAY

MORNING

9.00	OPERATING, DSU

AFTERNOON

2.00	OUTPATIENT CLINIC

WEDNESDAY

MORNING

9.00	OPERATING THEATRE 2

AFTERNOON

1.30	OPERATING THEATRE 2

THURSDAY

MORNING

8.30	RADIOLOGY CONFERENCE
10.00	GRAND ROUND
12.00	DEPARTMENTAL MEETING

AFTERNOON

2.00	OUTLYERS EMERGENCY OPERATING ADMINISTRATION

FRIDAY

MORNING

~~9.00~~ 9.30 as per diary card		WARD ROUND
10.00		PRIVATE PATIENTS (3 per week)

AFTERNOON

1.00	DRUG REP APPT
2.00	WARD OR OFFICE REVIEWS
5.00	WARD ROUNDS

OTHER DUTIES

1. The above schedule is so full that the bulk of administration has had to be performed out of hours.

2. As over 50% of inpatient activity is due to emergency admissions, almost all resulting operating has had to be performed out of hours.

EXTERNAL DUITES/PRIVATE PRACTICE/MEDICO-LEGAL WORK

	DESCRIPTION OF EXTERNAL DUTY/PRIVATE PRACTICE/MEDICO-LEGAL WORK	FREQUENCY	TIME COMMITMENT * PLEASE INSERT TIMES	LOCATION
WEEKLY	PRIVATE PATIENT CONSULTATIONS	3 PER WEEK	1.5 HOURS PER WEEK	C.A.H.
	RELATED ADMINISTRATION	WEEKLY	1.5 HOURS	CAH
MONTHLY	PRIVATE INPATIENT AND DAY SURGERY	MONTHLY	2 HOURS	CAH
YEARLY	MEDICOLEGAL	YEARLY	12 HOURS (TOTAL)	CAH
	REGIONAL IN TRAINING ASSESSMENT	YEARLY	4 HOURS	BELFAST
	SpR SHORTLISTING	YEARLY	3 HOURS	BELFAST
	SpR APPOINTMENTS	YEARLY	4 HOURS	BELFAST
AD HOC	CHAIR OF CURE COMMITTEE	YEARLY TOTAL	10 HOURS	CAH

10 July 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Dear Mr O'Brien

Further to the discussions which we have had, I now wish to confirm the Trust's intention that you will be offered 5.5PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

The Trust is also making you an offer of an ex gratia payment of £ Personal Information redacted by the USI in recognition of your extra contribution during the period 1998 until inception of the new contract.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely

Dr I Orr
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

Mr O'Brien – Consultant Urologist

Original Offer

- Mr O'Brien was originally offered 14 PA's.
- 1.0 PA was allocated for unpredictable on-call and 1.0 PA for predictable on-call.
- The remaining 12 PA's was not detailed into elements of activity.

Job Plan

Monday	9.00am – 4.30pm
Tuesday	9.00am – *5.00pm* (Finishing time not specified)
Wednesday	9.00am – *5.00pm* (Finishing time not specified)
Thursday	8.30am – *5.00pm* (Finishing time not specified)
Friday	9.30am – 5.00pm (Finishing time not specified)

Note made that administration has to be performed out of hours. Also as 50% of inpatient activity is due to emergency admissions, almost all resulting operating has had to be performed out of hours.

External Duties Proforma

Private Patient Consultations:	3 per week (1.5 hours per week)
Related Admissions	Weekly (1.5 hours)
Private inpatient and Day Surgery	Monthly (2 hours)
Medicolegal	Yearly (12 hours per year)
Regional in Training assessment:	4 hours per year in Belfast
SpR Shortlisting:	3 hours per year in Belfast
SpR Appointments:	4 hours per year in Belfast
Chair of CURE Committee:	10 hours per year at Craigavon.

21 hours / 42 wks / 4 = 0.13 PA's

Diary Card Analysis

This is the unrefined spreadsheet analysis. The analysis includes everything that has been coded by the consultant and has not been refined to reflect the annualisation of on-call and out of hours phone calls have had to be input as a full ½ hour irrespective of the length of the call.

Completed: 15 March 2004 – 11 April 2004 (Averaged over 3.2 weeks)

Predictable on-call:	1.52PA's
Unpredictable on-call:	2.88 PA's
SPA's	0.26 PA's
Additional Duties:	0.10 PA's
DPC:	13.59 PA's (excluding on-call)
TOTAL	**18.36 PA's**

4.4

DPC (exc Emergency attendance) at Premium time = 8.49 PA's
Patient Admin equated to 6.5 PAs at Premium + 6 PA at normal over 3.2 weeks.
Other NON DPC work at Premium = 0.66 PA over 3.2 weeks.

Facilitation

Mr O'Brien was offered an additional 0.5PA at facilitation for supporting professional activities.

Calculations undertaken by Dr Gaston – Prior to Appeal

Direct Patient Care:	10.72 PAs
Premium Time DCC:	1.60 PA's
SPA's:	0.09 PA's
Allocation at Facilitation:	0.50 PA's
TOTAL:	12.91 PA's (excluding any on-call)

Review of on-call

It came to light that due to the late submission of Mr O'Brien's diary cards, the on-call was only calculated on the basis of Mr Young's diary cards.

The on-call included in Mr O'Brien's diary cards was therefore reviewed. Only emergency activity occurring outside normal working hours was counted – all other activity was included as part of the revised DPC allocation.

= **3.42 PA's** for predictable and unpredictable on-call.

The on-call included in Mr Young's diary cards was also reviewed. It was discovered that Mr Young had included an extra weekend of on-call. This was therefore excluded and the revised on-call allocation equates to:

= **0.42 PA's** for predictable and unpredictable on-call.

These allocations (3.84 for 2 consultants) were put through the "Short Method" for including prospective cover. The revised on-call figure equates to **2.38 PA's.** This does not however include the time for travel for emergency work. Therefore, it was accepted that an average of **2.5 PA's** may be a more acceptable figure.

This is an extra 0.5 PA over and above the original offer of 2PA's for on-call.

Possible New Offer

12.91 PA's
+ 2.5 PA's for on-call
= 15.41

Therefore, **15.5 PA's** (1 additional PA)

CONTENTS

MR A O'BRIEN

MR A O'BRIEN - MANAGEMENT STATEMENT

Background

- Mr O'Brien is employed as a Consultant Urologist with Craigavon Area Hospital Group Trust.

Original Offer

- Mr O'Brien was originally offered 14 PA's in September 2005. This was made up of:

- 12.0 PA's for Direct Patient Care
- 2.0 PA's for predictable and unpredictable on-call

- Following this initial offer Mr O'Brien requested facilitation highlighting that he felt the offer did not accurately reflect his workload.

- The Medical Director, Dr Humphrey took up another appointment outside the Trust following the communication of the original Trust offers and was, therefore, no longer available to take forward the job planning exercise.

- A facilitation meeting was undertaken on 10th October by the designated Medical Manager, Dr J Gaston.

Facilitation Meeting

Dr Gaston went through the Diary Card with Mr O'Brien to allow him to identify where he felt the diary did not accurately reflect his workload and also to allow Dr Gaston to clarify and refine activity. The following points were raised:

- It was agreed that time for breakfast would be deducted for the team.

- It was agreed that where Mr O'Brien had opportunities to undertake patient administration, particularly when he had undertake Private Practice during normal time, it could not be given in premium time.

- It was agreed that time would be deducted for his tea breaks at the end of the day.

Analysis undertaken following Facilitation

Emergency On-call

The emergency on-call was calculated prior to the original PA offer. Dr Gaston clarified that this had been calculated on a team basis. In line with terms and conditions of service, unpredictable on-call was limited to 1 PA until April 2005.

Review of Diary Cards

Following the discussion with Mr O'Brien at facilitation, it was possible for Dr Gaston to review the diary cards and refine the information recorded. A summary of his calculations has been included:

Direct Patient Care:		
Week	**Activity**	**PA's**
Week 1	Direct Clinical Care	9.50
Week 2	Direct Clinical Care	9.88
Week 3	Direct Clinical Care	11.25
Week 4	Direct Clinical Care	11.13
Total PA's		41.75
Average / Week		**10.44**

Supporting Professional Activities:		
Week	**Activity**	**PA's**
Week 1	SPA	0.13
Week 2	SPA	0.00
Week 3	SPA	0.00
Week 4	SPA	0.00
Total PA's		0.13
Average / Week		**0.03**

On-call Allocation:	**2.00**

Premium Time Workload:		
Week	**Activity**	**PA's**
Week 1	Premium Time	0.67
Week 2		1.00
Week 3		1.67
Week 4		2.67
Total PA's		6.00
Average / Week		**1.50**

TOTAL PA'S	**13.97**

CONSIDERABLE During the review of the diary cards, it became apparent that Mr O'Brien spent a ~~consideration~~ amount of time on Patient Administration. This was significantly above the average for his colleague and the other General Surgeons. Although no adjustment was made, it was felt that this should be addressed in the future.

Supporting Professional Activities

Dr Gaston reviewed the information provided by Mr O'Brien on supporting professional activity and external duties. It was felt that although this activity was not addressed in the diary, it would have been undertaken during the

course of the year. An assessment was made that this would equate to approximately 0.5 PA.

Recommendation following Facilitation

Dr Gaston recommended that the offer for direct patient care was fair. It was recommended however that Mr O'Brien should be offered an additional 0.5 PA in recognition of Supporting Professional Activities.

Mr Templeton advised Mr O'Brien in November 2005 that his offer had been revised and that this would result in 4.5 PA's over and above the 10 programmed activities. This was made up of:

- 12 PA's for direct patient care
- 2 PA's for emergency on-call
- 0.5 PA's for supporting professional activites

Request for Appeal

Following the outcome of facilitation, Mr O'Brien indicated that he wished to proceed to appeal and provided a copy of his diary cards including his manual calculation on each day.

This information was reviewed and a number of issues identified:

- Mr O'Brien counted all time attributed to emergency on-call. As he has already been allocated 2PA's for on-call, this would be double counting. On-call has to be calculated separately.

- Mr O'Brien counted all activity after 7pm as premium time. Although this is permitted, in some instances, particularly when he had undertaken private practice during the day, the Trust would feel it would be inappropriate to count this at premium time.

- A normal working day was transcribed when Mr O'Brien was on leave.

Conclusion

We would ask the panel to accept that:

- The direct patient care allocation (excluding on-call) of 12 PA's is a fair reflection of Mr O'Brien's workload, given that refinement of the diary cards indicated approximately 11.94 PA's.

- The on-call allocation of 2 PA's (predictable & unpredictable) has been calculated on a team basis. The unpredictable has been capped at 1 PA until April 2005. (((****TO CHECK****)

- The SPA allocation awarded at facilitation (0.5 PA) fairly reflects the workload undertaken retrospectively, based on the refined diary card information and considering additional duties.

- Where a clear lunch break was indicated in the diary, this time was deducted, in line with a consistent policy which applied to all consultants within the Trust. It was also agreed with Mr O'Brien that time for evening breaks should also be deducted.

- The Trust followed a fair and consistent approach to job planning including facilitation. Opportunities were given for discussion at all stages.

Calculations undertaken by Dr Gaston

Direct Patient Care:

Week	Activity	PA's
Week 1	Direct Clinical Care	10.00
Week 2	Direct Clinical Care	9.88
Week 3	Direct Clinical Care	11.50
Week 4	Direct Clinical Care	11.50
Total PA's		42.88
Average / Week		**10.72**

Supporting Professional Activities:

Week	Activity	PA's
Week 1	SPA	0.13
Week 2	SPA	0.25
Week 3	SPA	0.00
Week 4	SPA	0.00
Total PA's		0.38
Average / Week		**0.09**

Week	Activity	PA's
Week 1	Premium	0.75
Week 2		1.00
Week 3		1.67
Week 4		3.00
Total PA's		6.42
Average / Week		**1.60**

Allocation at Facilitation	**0.50**
TOTAL PA'S	**12.92**
On-call Allocation:	3.42
Average On-Call Allocation for Both Consultants	**2.36**

Mr A Obrien

Week 1:

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS		Time		On-Call
				DCC	SPA	Normal	Prem	
Mon	9.00 - 9.30	Waiting to operate in Theatre	CAH	0.5	0	9	0	1
	9.30 - 12.30	Ward Round	CAH	3	0			
	12.30 - 13.00	Diary Cards	CAH	0	0.5			
	13.00 - 13.30	Speak to relatives	CAH	0.5	0			
	13.30 - 14.00	Lunch Break not counted	/	0	0			
	14.00 - 18.00	Inpatient Care and Dictation	CAH	4	0			
	18.00 - 18.30	Tea Break not counted	/	0	0			
	18.30 - 19.00	Telephone Advice to hospitals and patients	CAH	0.5	0			
	19.00 - 20.00	Urgent Theatre Care	CAH	0	0			
Tue	9.00 - 12.30	Operating	CAH	3.5	0	9	0	0
	12.30 - 13.30	Organise Admissions	CAH	1	0			
	13.30 - 14.00	Lunch Break not counted		0	0			
	14.00 - 17.30	Outpatients Clinic	CAH	3.5	0			
	17.30 - 18.00	Coffee not counted		0	0			
	18.00 - 19.00	Emergency inpatient care	CAH	1	0			
	19.00 - 21.00	Dictation in premium time						
Wed	9.00 - 17.00	Bank Holiday - usually operating from 9 - 5	CAH	0	0		2	
Thurs	8.30 - 9.30	Radiology Meeting	CAH	8	0	8	0	0
	9.30 - 10.00	Breakfast (agreed at facilitation to deduct) not counted	CAH	1	0	9.5	0	2
	10.00 - 12.30	Clinic	CAH	0	0			
	12.30 - 13.30	Consultation with patient and relatives	CAH	2.5	0			
	13.30 - 14.00	Lunch Break not counted		1	0			
	14.00 - 14.30	Consultation	CAH	0	0			
	14.30 - 15.00	Performed IVP	CAH	0.5	0			
	15.00 - 19.00	Attended to in tray, correspondence re patients & dictation	CAH	0.5	0			
	19.00 - 21.00	Attended to acute admissions in premium time	CAH	4	0			
Fri	9.30 - 11.00	Ward Round	CAH	0	0	5	0	0
	11.00 - 11.30	Outpatient Consultation	CAH	1.5	0			
	11.30 - 12.00	Private Practice	CAH	0.5	0			
	12.00 - 12.30	Drug Rep	CAH	0	0			
	12.30 - 13.00	Telephone Advise to hospital	CAH	0	0			
	13.00 - 14.00	Lunch Break not counted		0.5	0			
	14.00 - 14.30	Private Practice	/	0	0			
	14.30 - 15.00	Outpatient Consultation	/	0	0			
	15.00 - 17.00	Private Practice	CAH	0.5	0			
	17.00 - 18.30	End of week ward round and telephone advise	/	0	0			
	18.30 - 19.00	Attended patient in A&E in normal time	CAH	1.5	0			
Sunday	16.30 - 16.45	Telephone Call (Counted in premium time)	CAH	0.5	0			
TOTAL HOURS				0	0	0	0.25	0
				DCC	SPA	Normal Total	Premium Total	On-Call
AVERAGE PA'S				40	0.5	40.5	2.25	3
				10	0.125	10.125	0.75	1

Week 2:

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS		Time		ON-Call
				DCC	SPA	Normal Time	Premium Time	
Mon	9.30 - 11.30	Ward Round	CAH	2	0	8.5	0	1
	11.30 - 12.30	Multidisciplinary meeting	CAH	1	0			
	12.30 - 13.00	Inpatient Consultation	CAH	0.5	0			
	13.00 - 14.00	Lunch Break not counted		0	0			
	14.00 - 15.00	Pathology Meeting	CAH	1	0			
	15.00 - 17.00	Outpatient Histology Review	CAH	2	0			
	17.00 - 18.30	Patient Admin	CAH	1.5	0			
	18.30 - 19.00	Urgent call from patient	CAH	0.5	0			
	19.00 - 20.00	Urgent attendance to patient in premium time)	CAH	0	0			
Tue	9.00 - 13.00	Day Surgery List	CAH	4	0	9.5	0	0
	13.00 - 14.00	Attendance to ill patients	CAH	1	0			
	14.00 - 17.00	Outpatient Clinic	CAH	3	0			
	17.00 - 18.00	Ward Round	CAH	1	0			
	18.00 - 18.30	Patient relatives	CAH	0.5	0			
	18.30 - 19.00	Tea not counted	CAH	0	0			
	19.00 - 22.00	Patient Admin	CAH	0	0		3	
Wed	9.00 - 19.00	Professional Leave - factored in normal working day	/	10	0	10	0	0
Thurs	9.00 - 19.00	Professional Leave - factored in normal working day	/	10	0	10	0	0
Fri	9.00 - 19.00	Professional Leave - factored in normal working day	/	10	1	11	0	0

TOTAL HOURS	DCC	SPA	Normal Time	Premium Time	On-Call
	39.5	1	40.5	3	1
AVERAGE PA'S	9.875	0.25	10.13	1	0.333333333

Week 3:

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS		Time		On-Call
				DCC	SPA	Normal	Premium	
Mon	9.00 - 11.00	Ward Round	CAH	2	0	9	0	1
	11.00 - 12.30	Urodynamic Studies	CAH	1.5	0			
	12.30 - 13.00	Consultation with relatives	CAH	0.5	0			
	13.00 - 13.30	Lunch Break not counted		0	0			
	13.30 - 16.30	Urodynamic Studies & meeting	CAH	3	0			
	16.30 - 17.30	Patient Administration	CAH	1	0			
	17.30 - 18.00	Telephone advise to Daisy Hill Hospital	CAH	0.5	0			
	18.00 - 18.30	Tea not counted		0	0			
	18.30 - 19.00	Emergency attendance to patients norm time	CAH	0.5				
	19.00 - 20.00	Emergency attendance to patients in premium time)	CAH	0	0			
Tue	8.30 - 9.00	Discussion with SPR	CAH	0.5	0	10	0	0
	9.00 - 13.00	Day surgery list	CAH	4	0			
	13.00 - 14.00	Patient Administration	CAH	1	0			
	14.00 - 17.00	Outpatient Clinic	CAH	3	0			
	17.00 - 18.00	Dictation and patient administration	CAH	1	0			
	18.00 - 18.30	Tea not counted	CAH	0	0			
	18.30 - 19.00	Attending to patients	CAH	0.5	0			
	19.00 - 21.00	Returning calls to patients	CAH	0	0		2	
Wed	9.00 - 17.00	Operating	CAH	8	0	10	0	0
	17.00 - 18.00	Emergency operating **in Normal Time**		1	0			
	18.00 - 19.00	Post op ward round	CAH	1	0			
	19.00 - 21.00	Emergency attendance to ill patients **(Counted in emergency on-call)**	CAH	0	0		1	3
	21.00 - 22.00	Patient Administration (PREM)	CAH	0	0			
	22.00 - 23.00	Emergency attendence to patient in A&E **(Counted in emergency on-call)**	CAH	0	0			
Thurs	8.30 - 9.30	Radiology Meeting	CAH	1	0	10	0	0
	9.30 - 10.00	Telephone advise to Daisy Hill Hospital	CAH	0.5	0			
	10.00 - 12.30	Grand ward round	CAH	2.5	0			
	12.30 - 13.00	Consultation with relatives	CAH	0.5	0			
	13.00 - 13.30	Lunch Break not counted		0	0			
	13.30 - 14.00	Patient Administration	CAH	0.5	0			
	14.00 - 15.00	Ward Round	CAH	1	0			
	15.00 - 15.30	IVP on patient	CAH	0.5	0			
	15.30 - 16.30	Radiological investigations	CAH	1	0			
	16.30 - 17.00	Emergency attendance to patient in A&E		0.5	0			
	17.00 - 19.00	Patient Admin	CAH	2	0			
	19.00 - 20.00	Patient Admin (PREM)	CAH	0	0		1	
Fri	9.30 - 11.00	Ward Round	CAH	1.5	0			
	11.00 - 12.30	Patient Consultations	CAH	1.5	0			
	12.30 - 13.00	Private Practice		0	0			
	13.00 - 14.00	Emergency Theatre	CAH	1	0			

	14.00 - 14.30	Meeting with Medical Med		0	0	7	0	0
	14.30 - 15.30	Private Practice		0	0			
	15.30 - 16.00	Patient Consultations	CAH	0.5	0			
	16.00 - 16.30	Private Practice	CAH	0	0			
	16.30 - 17.00	Patient Consultations	CAH	0.5	0			
	17.00 - 18.30	Ward Round	CAH	1.5	0			
	18.30 - 19.00	Patient Admin	CAH	0.5	0			
	19.00 - 23.00	Travel to Carrickmacross not counted.		0	0			
Sat	15.00 - 16.00	Review of inpatients	CAH	0	0	0	1	0
Sun	16.30 - 21.00	Emergency attendencein premium time	CAH	0	0	0	0	4.5

	DCC	SPA	Total Normal	Total Prem	On-Call
TOTAL HOURS	46	0	46	5	8.5
AVERAGE PA'S	11.5	0	11.5	1.67	2.83333333

Week 4:

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS		TIME		
				DCC	SPA	Normal	Premium Time	On-Call
Mon	9.00 - 11.30	Urodynamic Studies	CAH	2.5	0	9.5	0	0
	11.30 - 12.00	Patient Consultation	CAH	0.5	0			
	12.00 -12.30	Urodynamic Studies	CAH	0.5	0			
	12.30 - 13.00	Patient Consultation	CAH	0.5	0			
	13.00 - 13.30	Lunch not counted		0	0			
	13.30 - 14.00	Urodynamic Studies	CAH	0.5	0			
	14.00 - 15.00	Uropathology Meeting	CAH	1	0			
	15.00 - 15.30	Patient Consultation	CAH	0.5	0			
	15.30 - 16.00	Urodynamic Studies	CAH	0.5	0			
	16.00 - 16.30	Patient Consultation	CAH	0.5	0			
	16.30 - 18.00	Ward Round	CAH	1.5	0			
	18.00 - 19.00	Emergency Theatre **in normal time**	CAH	1	0			
	19.00 - 20.00	Emergency attendance (Counted in emergency on-call)	CAH	0	0		2	1
	20.00 - 22.00	Patient Admin (Prem)	CAH	0	0			
Tue	9.00 - 13.00	Day Surgery	CAH	4	0	9.5	0	0
	13.00 - 14.00	Ward Work / relatives	CAH	1	0			
	14.00 - 17.30	Outpatient Clinic	CAH	3.5	0			
	17.30 - 18.30	Pre op assessment	CAH	1	0			
	18.30 - 19.00	Tea not counted	CAH	0	0			
	19.00 - 22.00	Patient Admin (Prem)	CaH	0	0		3	
Wed	9.00 - 17.30	Operating session	CAH	8.5	0	9.5	0	0
	17.30 - 18.00	Tea not counted	CAH	0	0			
	18.00 - 19.00	Post op ward round	CAH	1	0			
	19.00 - 21.00	Patient Admin (Prem)	CAH	0	0		2	
Thurs	8.30 - 9.30	Radiology Meeting	CAH	1	0	10	0	0
	9.30 - 10.00	Breakfast (agreed to deduct at facilitation) not counted	CAH	0	0			
	10.00 - 13.00	Grand ward round	CAH	3	0			
	13.00 - 14.00	Consultation with relatives	CAH	1	0			
	14.00 - 14.30	Outpatient Consultation	CAH	0.5	0			
	14.30 - 15.00	Telephone advice to ACH	CAH	0.5	0			
	15.00 - 16.00	Ward Round	CAH	1	0			
	16.00 - 17.00	meeting with radiologists	CAH	1	0			
	17.00 - 19.00	Patient Admin	CAH	2	0			
	19.00 - 20.00	Patient Admin (Prem)	CAH	0	0		1	

Fri	9.00 - 10.30	Ward Round	CAH	1.5	0	7.5	0	0
	10.30 - 11.30	Patient Consultation	CAH	1	0			
	11.30 - 12.00	Private patient	CAH	0	0			
	12.00 - 12.30	Patient Admin	CAH	0.5	0			
	12.30 - 13.00	Meeting with drug rep	CAH	0	0			
	13.00 - 14.00	Lunch not counted	CAH	0	0			
	14.00 - 15.00	Patient Admin & consultation	CAH	1	0			
	15.00 - 16.30	Private practice	CAH	0	0			
	16.30 - 17.00	Patient Admin	CAH	0.5	0			
	17.00 - 18.30	Ward Round	CAH	1.5	0			
	18.30 - 19.00	Patient Admin	CAH	0.5	0			
	19.00 - 20.00	Patient Admin (Not at prem time as PP)	CAH	1	0			
Sat/Sun	Weekend	Weekend emeregncy workload included in emergency on-call	CAH	0	0	0	1	27.5

TOTAL HOURS	DCC	SPA	Total Normal	Total Prem	On-call
	46	0	46	9	28.5
AVERAGE PA'S	11.5	0	11.5	3.00	9.5

3

Programmed activities calculated from the workload diary

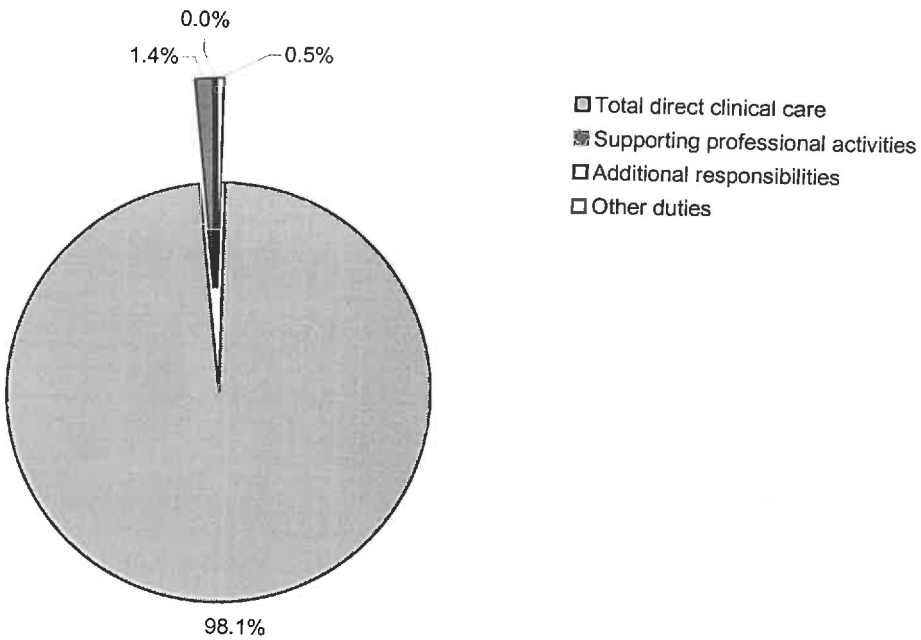
Name: **SU01**

Period: 15 March 2004 to 11 April 2004

Working weeks covered:	3.2

	Normal Time		Premium Time		TOTAL	
Mean Weekly (Adjusted)	**Hours**	**PAs**	**Hours**	**PAs**	**Hours**	**PAs**
Clinical care: predictable on call	1.09	0.27	3.75	1.25	4.84	1.52
Clinical care: unpredictable on call	1.09	0.27	7.81	2.60	8.91	2.88
Total direct clinical care	**45.94**	**11.48**	**19.53**	**6.51**	**65.47**	**17.99**
Supporting professional activities	**0.63**	**0.16**	**0.31**	**0.10**	**0.94**	**0.26**
Additional responsibilities	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Other duties	**0.00**	**0.00**	**0.31**	**0.10**	**0.31**	**0.10**
	46.56	**11.64**	**20.16**	**6.72**	**66.72**	**18.36**

Percentage of PAs Spent on Each Activity



Working week analysed by activity code

Name: **SU01**

Period: **15 March 2004 to 11 April 2004**

	Normal Time PAs	Premium Time PAs	Total PAs	Adjusted PAs per week	
Direct clinical care: 17.99 PAs per week					
C1	1.75	12.33	**14.08**	**4.40**	Emergency attendance
C2	3.75	-	**3.75**	**1.17**	Out-patient or other clinic
C3	8.00	-	**8.00**	**2.50**	Operating session (including anaesthetists)
C4	7.63	0.33	**7.96**	**2.49**	Ward round
C5	4.50	0.33	**4.83**	**1.51**	Other patient treatment or relative consultation
C6	0.88	1.33	**2.21**	**0.69**	Telephone advice to hospital
C7	2.00	-	**2.00**	**0.63**	Multi-disciplinary meetings about direct patient care
C8	2.25	-	**2.25**	**0.70**	Investigative, diagnostic or laboratory work
C9	-	-	-	-	Public health duties
C10	-	-	-	-	Travelling time between sites, not to usual place of work
C11	6.00	6.50	**12.50**	**3.91**	Patient administration
Supporting professional activities: 0.26 PAs per week					
S1	-	-	-	-	Training/Teaching
S2	-	-	-	-	Continuous Professional Development
S3	-	-	-	-	Audit / Clinical Governance
S4	0.13	0.33	**0.46**	**0.14**	Job Planning / Appraisal
S5	-	-	-	-	Research
S6	0.38	-	**0.38**	**0.12**	Clinical management
Additional responsibilities: 0.00 PAs per week					
A2	-	-	-	-	Audit lead or Clinical governance lead
A3	-	-	-	-	Clinical tutor
A4	-	-	-	-	Medical / clinical directors' and lead clinicians' PAs by substitution or additional remuneration
A5	-	-	-	-	Other additional responsibilities
Other duties: 0.10 PAs per week					
D1	-	-	-	-	Trade union duties
D2	-	-	-	-	AAC external member
D3	-	-	-	-	NCAA, GMC, CHAI
D4	-	-	-	-	Work for Royal Colleges
D5	-	0.33	**0.33**	**0.10**	Other
Additionally remunerated work: 0.65 PAs per week					
P1	1.75	0.33	**2.08**	**0.65**	Private practice
P2	-	-	-	-	Category 2 work
P3	-	-	-	-	Other additionally remunerated work
Non-work activity: 0.82 PAs per week					
N1x	-	-	-	-	Absent from work (annual/study leave)
N1y	-	-	-	-	Absent from work (sickness leave)
N2	2.63	-	**2.63**	**0.82**	Other (i.e. time spent not working)
On-call status (column 2)					
1	0.88	4.00	**4.88**	**1.52**	Predictable On-call
2	0.88	8.33	**9.21**	**2.88**	Unpredictable On-call

Worked weeks **3.2**

Consultant work diary

.5 March 2004

	Monday 15 Mar		Tuesday 16 Mar		Wednesday 17 Mar		Thursday 18 Mar		Friday 19 Mar		Saturday 20 Mar		Sunday 21 Mar	
	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?
7AM to 7:30														
7:30 to 8:00														
8:00 to 8:30														
8:30 to 9:00							C7							
9:00 to 9:30	C1	1	C3				C7							
9:30 to 10:00	C4		C3				N2		C4					
10:00 to 10:30	C4		C3				C4		C4					
10:30 to 11:00	C4		C3				C4		C4					
11:00 to 11:30	C4		C3				C4		C5					
11:30 to Noon	C4		C3				C4		P1					
Noon to 12:30PM	C4		C3				C4		S6					
12:30 to 1:00	S4		C11				C5		C6					
1:00 to 1:30	C5		C11		C1	1	C5		N2					
1:30 to 2:00	N2		N2		C1	1	N2		N2					
2:00 to 2:30	C7		C2		C11		C5		P1					
2:30 to 3:00	C7		C2		C11		C8		C5					
3:00 to 3:30	C5		C2		C11		C11		P1					
3:30 to 4:00	C5		C2		C11		C11		P1					
4:00 to 4:30	C5		C2		C11		C11		P1					
4:30 to 5:00	C11		C2		C11		C11		P1				C6	
5:00 to 5:30	C11		C2		C11		C11		C4					
5:30 to 6:00	C11		N2		C11		C11		C4					
6:00 to 6:30	N2		C1	1	C11		C11		C6					
6:30 to 7:00	C6		C1	1	C11		C11		C1	1				
7:00 to 7:30	C1	1	C11				C1	1						
7:30 to 8:00	C1	1	C11				C1	1						
8:00 to 8:30	D5		C11				C1	1						
8:30 to 9:00	D5		C11				C1	1						
9:00 to 9:30														
9:30 to 10:00														
10:00 to 10:30														
10:30 to 11:00														
11:00 to 11:30														
11:30 to midnight														
Midnight to 12:30														
12:30AM to 1:00														
1:00 to 1:30														
1:30 to 2:00														
2:00 to 2:30														
2:30 to 3:00														
3:00 to 3:30														
3:30 to 4:00														
4:00 to 4:30														
4:30 to 5:00														
5:00 to 5:30														
5:30 to 6:00														
6:00 to 6:30														
6:30 to 7AM														

CODES		Normal Time HOURS	Normal Time PA's	Premium Time HOURS	Premium Time PA's	TOTAL HOURS	TOTAL PA's
	Direct clinical care						
C1	Emergency attendance	3.00	0.75	3.00	1.00	**6.00**	**1.75**
C2	Out-patient or other clinic	3.50	0.88			**3.50**	**0.88**
C3	Operating session (including anaesthetists)	3.50	0.88			**3.50**	**0.88**
C4	Ward round	8.00	2.00			**8.00**	**2.00**
C5	Other patient treatment or relative consultation	4.50	1.13			**4.50**	**1.13**
C6	Telephone advice to hospital	1.50	0.38	0.50	0.17	**2.00**	**0.54**
C7	Multi-disciplinary meetings about direct patient care	2.00	0.50			**2.00**	**0.50**
C8	Investigative, diagnostic or laboratory work	0.50	0.13			**0.50**	**0.13**
C9	Public health duties						
C10	Travelling time between sites, not to usual place of work						
C11	Patient administration	11.50	2.88	2.00	0.67	**13.50**	**3.54**
	Supporting professional activities						
S1	Training/teaching						
S2	Continuous Professional Development						
S3	Audit / Clinical Governance						
S4	Job Planning / Appraisal	0.50	0.13			**0.50**	**0.13**
S5	Research	0.50	0.13			**0.50**	**0.13**
S6	Clinical management						
	Additional responsibilities						
A2	Audit lead or Clinical governance lead						
A3	Clinical tutor						
A4	MD / CD and LC' PAs by substitution or additional remuneration						
A5	Other additional responsibilities						
	Other duties						
D1	Trade union duties						
D2	AAC external member						
D3	NCAA, GMC, CHAI						
D4	Work for Royal Colleges						
D5	Other			1.00	0.33	**1.00**	**0.33**
	Additionally remunerated work						
P1	Private practice	3.00	0.75			**3.00**	**0.75**
P2	Category 2 work						
P3	Other additionally remunerated work						
	Non-work activity						
N1x	Absent from work (annual, study leave)						
N1y	Absent from work (sickness leave)						
N2	Other (i.e. time spent not working)	4.00	1.00			**4.00**	**1.00**
	On-call status (column 2)						
1	Predictable On-call	3.00	0.75	3.00	1.00	**6.00**	**1.75**
2	Unpredictable On-call						

Enter W or L in each box for work or leave on each half day - 'Not completed' until this is done.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
am	W	W	BH	W	W		
pm	W	W	BH	W	W		

Enter 'BH' for bank holiday

	Normal Time Recorded Hours	Normal Time Recorded PAs	Normal Time Adjusted Hours	Normal Time Adjusted PAs	Premium Time Recorded Hours	Premium Time Recorded PAs	Premium Time Adjusted Hours	Premium Time Adjusted PAs	TOTAL Recorded Hours	TOTAL Recorded PAs	TOTAL Adjusted Hours	TOTAL Adjusted PAs
Clinical care: predictable on call	3.00	0.75	3.75	0.94	3.00	1.00	3.75	1.25	6.00	1.75	7.50	2.19
Clinical care: unpredictable on call												
Total direct clinical care	**38.00**	**9.50**	**47.50**	**11.88**	**5.50**	**1.83**	**6.88**	**2.29**	**43.50**	**11.33**	**54.38**	**14.17**
Supporting professional activities	**1.00**	**0.25**	**1.25**	**0.31**					**1.00**	**0.25**	**1.25**	**0.31**
Additional responsibilities												
Other duties					**1.00**	**0.33**	**1.25**	**0.42**	**1.00**	**0.33**	**1.25**	**0.42**
	39.00	**9.75**	**48.75**	**12.19**	**6.50**	**2.17**	**8.13**	**2.71**	**45.50**	**11.92**	**56.88**	**14.90**

Worked	
4	days
0.8	weeks

NOTES

15/3/04 - 'waiting to operate in theatre' is C1x the correct code?

19/3/04 - 'consultation with Drug Rep' was D5, changed to S6

Consultant work diary

2 March 2004

	Monday 22 Mar		Tuesday 23 Mar		Wednesday 24 Mar		Thursday 25 Mar		Friday 26 Mar		Saturday 27 Mar		Sunday 28 Mar	
	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?
7AM to 7:30														
7:30 to 8:00														
8:00 to 8:30														
8:30 to 9:00														
9:00 to 9:30			C3											
9:30 to 10:00	C4		C3											
10:00 to 10:30	C4		C3											
10:30 to 11:00	C4		C3											
11:00 to 11:30	C4		C3											
11:30 to Noon	C7		C3											
Noon to 12:30PM	C7		C3											
12:30 to 1:00	C5		C3											
1:00 to 1:30	N2		C5											
1:30 to 2:00	N2		C5											
2:00 to 2:30	C7		C2											
2:30 to 3:00	C7		C2											
3:00 to 3:30	C2		C2											
3:30 to 4:00	C2		C2											
4:00 to 4:30	C2		C2											
4:30 to 5:00	C2		C2											
5:00 to 5:30	C11		C4											
5:30 to 6:00	C11		C4											
6:00 to 6:30	C11		C5											
6:30 to 7:00	C6		N2											
7:00 to 7:30	C1	2	C11											
7:30 to 8:00	C1	2	C11											
8:00 to 8:30			C11											
8:30 to 9:00			C11								S4			
9:00 to 9:30			C11								S4			
9:30 to 10:00			C11											
10:00 to 10:30														
10:30 to 11:00														
11:00 to 11:30														
11:30 to midnight														
Midnight to 12:30														
12:30AM to 1:00														
1:00 to 1:30														
1:30 to 2:00														
2:00 to 2:30														
2:30 to 3:00														
3:00 to 3:30														
3:30 to 4:00														
4:00 to 4:30														
4:30 to 5:00														
5:00 to 5:30														
5:30 to 6:00														
6:00 to 6:30														
6:30 to 7AM														

CODES		Normal Time HOURS	Normal Time PA's	Premium Time HOURS	Premium Time PA's	TOTAL HOURS	TOTAL PA's
	Direct clinical care						
C1	Emergency attendance			1.00	0.33	1.00	0.33
C2	Out-patient or other clinic	5.00	1.25			5.00	1.25
C3	Operating session (including anaesthetists)	4.00	1.00			4.00	1.00
C4	Ward round	3.00	0.75			3.00	0.75
C5	Other patient treatment or relative consultation	2.00	0.50			2.00	0.50
C6	Telephone advice to hospital	0.50	0.13			0.50	0.13
C7	Multi-disciplinary meetings about direct patient care	2.00	0.50			2.00	0.50
C8	Investigative, diagnostic or laboratory work						
C9	Public health duties						
C10	Travelling time between sites, not to usual place of work						
C11	Patient administration	1.50	0.38	3.00	1.00	4.50	1.38
	Supporting professional activities						
S1	Training/teaching						
S2	Continuous Professional Development						
S3	Audit / Clinical Governance						
S4	Job Planning / Appraisal						
S5	Research			1.00	0.33	1.00	0.33
S6	Clinical management						
	Additional responsibilities						
A2	Audit lead or Clinical governance lead						
A3	Clinical tutor						
A4	MD / CD and LC' PAs by substitution or additional remuneration						
A5	Other additional responsibilities						
	Other duties						
D1	Trade union duties						
D2	AAC external member						
D3	NCAA, GMC, CHAI						
D4	Work for Royal Colleges						
D5	Other						
	Additionally remunerated work						
P1	Private practice						
P2	Category 2 work						
P3	Other additionally remunerated work						
	Non-work activity						
N1x	Absent from work (annual, study leave)						
N1y	Absent from work (sickness leave)						
N2	Other (i.e. time spent not working)	1.50	0.38			1.50	0.38
	On-call status (column 2)						
1	Predictable On-call						
2	Unpredictable On-call			1.00	0.33	1.00	0.33

Enter W or L in each box for work or leave on each half day - 'Not completed' until this is done.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
am	W	W	L	L	L		
pm	W	W	L	L	L		

Enter 'BH' for bank holiday

	Normal Time Recorded Hours	Normal Time Recorded PAs	Normal Time Adjusted Hours	Normal Time Adjusted PAs	Premium Time Recorded Hours	Premium Time Recorded PAs	Premium Time Adjusted Hours	Premium Time Adjusted PAs	TOTAL Recorded Hours	TOTAL Recorded PAs	TOTAL Adjusted Hours	TOTAL Adjusted PAs
Clinical care: predictable on call					1.00	0.33	2.50	0.83	1.00	0.33	2.50	0.83
Clinical care: unpredictable on call												
Total direct clinical care	18.00	4.50	45.00	11.25	4.00	1.33	10.00	3.33	22.00	5.83	55.00	14.58
Supporting professional activities					1.00	0.33	2.50	0.83	1.00	0.33	2.50	0.83
Additional responsibilities												
Other duties												
	18.00	4.50	45.00	11.25	5.00	1.67	12.50	4.17	23.00	6.17	57.50	15.42

Worked	
2	days
0.4	weeks

NOTES

Wed 24 - Sat 27 'EAU, Vienna' - was coded as CPD, treated as Leave

Consultant work diary

March 2004

	Monday 29 Mar		Tuesday 30 Mar		Wednesday 31 Mar		Thursday 1 Apr		Friday 2 Apr		Saturday 3 Apr		Sunday 4 Apr	
	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?
7AM to 7:30														
7:30 to 8:00														
8:00 to 8:30														
8:30 to 9:00			C4				C7							
9:00 to 9:30	C4		C3		C3		C7							
9:30 to 10:00	C4		C3		C3		C6		C4				C6	
10:00 to 10:30	C4		C3		C3		C4		C4					
10:30 to 11:00	C4		C3		C3		C4		C4					
11:00 to 11:30	C8		C3		C3		C4		C5					
11:30 to Noon	C8		C3		C3		C4		C5					
Noon to 12:30PM	C8		C3		C3		C4		C5					
12:30 to 1:00	C5		C3		C3		C5		P1					
1:00 to 1:30	N2		C11		C3		N2		C1	2				
1:30 to 2:00	C8		C11		C3		C11		C1	2				
2:00 to 2:30	C7		C2		C3		C4		S6					
2:30 to 3:00	C7		C2		C3		C4		P1					
3:00 to 3:30	C8		C2		C3		C8		P1		C4			
3:30 to 4:00	C8		C2		C3		C11		C5		C4			
4:00 to 4:30	C8		C2		C3		C11		P1		P1		C6	
4:30 to 5:00	C11		C2		C3		C1	2	C5		P1			
5:00 to 5:30	C11		C11		C1	2	C11		C4				C1	2
5:30 to 6:00	C6		C11		C1	2	C11		C4				C1	2
6:00 to 6:30	N2		N2		C4		C11		C4				C1	2
6:30 to 7:00	C1	1	C5		C4		C11		C11				C1	2
7:00 to 7:30	C1	1	C5		C1	2	C11						C1	2
7:30 to 8:00	C1	1	C5		C1	2	C11						C1	2
8:00 to 8:30	C1	1	C11		C1	2							C1	2
8:30 to 9:00			C11		C1	2								
9:00 to 9:30					C11		C6							
9:30 to 10:00					C11								C6	
10:00 to 10:30					C1	2								
10:30 to 11:00					C1	2								
11:00 to 11:30														
11:30 to midnight														
Midnight to 12:30														
12:30AM to 1:00														
1:00 to 1:30														
1:30 to 2:00														
2:00 to 2:30														
2:30 to 3:00														
3:00 to 3:30														
3:30 to 4:00														
4:00 to 4:30														
4:30 to 5:00														
5:00 to 5:30														
5:30 to 6:00														
6:00 to 6:30														
6:30 to 7AM														

CODES		Normal Time HOURS	Normal Time PA's	Premium Time HOURS	Premium Time PA's	TOTAL HOURS	TOTAL PA's
	Direct clinical care						
C1	Emergency attendance	3.00	0.75	7.50	2.50	10.50	3.25
C2	Out-patient or other clinic	3.00	0.75			3.00	0.75
C3	Operating session (including anaesthetists)	12.00	3.00			12.00	3.00
C4	Ward round	10.00	2.50	1.00	0.33	11.00	2.83
C5	Other patient treatment or relative consultation	4.00	1.00	1.00	0.33	5.00	1.33
C6	Telephone advice to hospital	1.00	0.25	2.00	0.67	3.00	0.92
C7	Multi-disciplinary meetings about direct patient care	2.00	0.50			2.00	0.50
C8	Investigative, diagnostic or laboratory work	4.00	1.00			4.00	1.00
C9	Public health duties						
C10	Travelling time between sites, not to usual place of work						
C11	Patient administration	7.00	1.75	3.00	1.00	10.00	2.75
	Supporting professional activities						
S1	Training/teaching						
S2	Continuous Professional Development						
S3	Audit / Clinical Governance						
S4	Job Planning / Appraisal						
S5	Research						
S6	Clinical management	0.50	0.13			0.50	0.13
	Additional responsibilities						
A2	Audit lead or Clinical governance lead						
A3	Clinical tutor						
A4	MD / CD and LC' PAs by substitution or additional remuneration						
A5	Other additional responsibilities						
	Other duties						
D1	Trade union duties						
D2	AAC external member						
D3	NCAA, GMC, CHAI						
D4	Work for Royal Colleges						
D5	Other						
	Additionally remunerated work						
P1	Private practice	2.00	0.50	1.00	0.33	3.00	0.83
P2	Category 2 work						
P3	Other additionally remunerated work						
	Non-work activity						
N1x	Absent from work (annual, study leave)						
N1y	Absent from work (sickness leave)						
N2	Other (i.e. time spent not working)	2.00	0.50			2.00	0.50
	On-call status (column 2)						
1	Predictable On-call	0.50	0.13	1.50	0.50	2.00	0.63
2	Unpredictable On-call	2.50	0.63	6.00	2.00	8.50	2.63

Enter W or L in each box for work or leave on each half day - 'Not completed' until this is done.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
am	W	W	W	W	W		
pm	W	W	W	W	W		

Enter 'BH' for bank holiday

	Normal Time Recorded Hours	Normal Time Recorded PAs	Normal Time Adjusted Hours	Normal Time Adjusted PAs	Premium Time Recorded Hours	Premium Time Recorded PAs	Premium Time Adjusted Hours	Premium Time Adjusted PAs	TOTAL Recorded Hours	TOTAL Recorded PAs	TOTAL Adjusted Hours	TOTAL Adjusted PAs
Clinical care: predictable on call	0.50	0.13	0.50	0.13	1.50	0.50	1.50	0.50	2.00	0.63	2.00	0.63
Clinical care: unpredictable on call	2.50	0.63	2.50	0.63	6.00	2.00	6.00	2.00	8.50	2.63	8.50	2.63
Total direct clinical care	**46.00**	**11.50**	**46.00**	**11.50**	**14.50**	**4.83**	**14.50**	**4.83**	**60.50**	**16.33**	**60.50**	**16.33**
Supporting professional activities	**0.50**	**0.13**	**0.50**	**0.13**					**0.50**	**0.13**	**0.50**	**0.13**
Additional responsibilities												
Other duties												
	46.50	**11.63**	**46.50**	**11.63**	**14.50**	**4.83**	**14.50**	**4.83**	**61.00**	**16.46**	**61.00**	**16.46**

Worked	
5	days
1	week

NOTES

2/4/04 - 'meeting with med rep', was blank, suggest S6

Consultant work diary

5 April 2004

	Monday 5 Apr		Tuesday 6 Apr		Wednesday 7 Apr		Thursday 8 Apr		Friday 9 Apr		Saturday 10 Apr		Sunday 11 Apr	
	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?	Work code	On-call?
7AM to 7:30														
7:30 to 8:00														
8:00 to 8:30														
8:30 to 9:00											C6			
9:00 to 9:30	C8		C3		C3		C7							
9:30 to 10:00	C8		C3		C3		C7		C4		C1	2		
10:00 to 10:30	C5		C3		C3		N2		C4		C1	2		
10:30 to 11:00	C8		C3		C3		C4		C4		C1	1		
11:00 to 11:30	C8		C3		C3		C4		C5		C1	1		
11:30 to Noon	C5		C3		C3		C4		C5		C1	1		
Noon to 12:30PM	C8		C3		C3		C4		P1		C1	1	C1	1
12:30 to 1:00	C5		C3		C3		C4		C11		C1	1	C1	1
1:00 to 1:30	N2		C5		C3		C4		S6		C1	1	C1	1
1:30 to 2:00	C8		C5		C3		C5		N2		C1	1	C1	1
2:00 to 2:30	C7		C2		C3		C5		N2		C1	1	C1	1
2:30 to 3:00	C7		C2		C3		C5		C11		C1	1	C1	2
3:00 to 3:30	C5		C2		C3		C6		C5		C1	1	C1	2
3:30 to 4:00	C8		C2		C3		C4		P1		C1	2	C1	2
4:00 to 4:30	C5		C2		C3		C4		P1		C1	2	C1	2
4:30 to 5:00	C4		C2		C3		C8		P1		C1	2	C1	2
5:00 to 5:30	C4		C2		C3		C8		C11		C1	2	C1	2
5:30 to 6:00	C4		C5		N2		C11		C4		C1	2	C1	2
6:00 to 6:30	C1	2	C5		C4		C11		C4		C1	2		
6:30 to 7:00	C1	2	N2		C4		C11		C4		C1	2		
7:00 to 7:30	C1	2	C11		C11		C11		C11		C1	2		
7:30 to 8:00	C1	2	C11		C11		C11		C11		C1	2		
8:00 to 8:30	C11		C11		C11						C1	2		
8:30 to 9:00	C11		C11		C11						C1	2	C6	
9:00 to 9:30	C11		C11		C11						C1	2		
9:30 to 10:00	C11		C11								C11			
10:00 to 10:30											C11			
10:30 to 11:00											C11			
11:00 to 11:30	C6										C11			
11:30 to midnight											C1	2		
Midnight to 12:30											C1	2		
12:30AM to 1:00											C1	2		
1:00 to 1:30											C1	2		
1:30 to 2:00											C1	2		
2:00 to 2:30											C1	2		
2:30 to 3:00											C1	2		
3:00 to 3:30											C1	2		
3:30 to 4:00											C1	2		
4:00 to 4:30											C1	2		
4:30 to 5:00											C1	2		
5:00 to 5:30											C1	2		
5:30 to 6:00											C1	2		
6:00 to 6:30														
6:30 to 7AM														

CODES		Normal Time HOURS	Normal Time PA's	Premium Time HOURS	Premium Time PA's	TOTAL HOURS	TOTAL PA's
	Direct clinical care						
C1	Emergency attendance	1.00	0.25	25.50	8.50	26.50	8.75
C2	Out-patient or other clinic	3.50	0.88			3.50	0.88
C3	Operating session (including anaesthetists)	12.50	3.13			12.50	3.13
C4	Ward round	9.50	2.38			9.50	2.38
C5	Other patient treatment or relative consultation	7.50	1.88			7.50	1.88
C6	Telephone advice to hospital	0.50	0.13	1.50	0.50	2.00	0.63
C7	Multi-disciplinary meetings about direct patient care	2.00	0.50			2.00	0.50
C8	Investigative, diagnostic or laboratory work	4.50	1.13			4.50	1.13
C9	Public health duties						
C10	Travelling time between sites, not to usual place of work						
C11	Patient administration	4.00	1.00	11.50	3.83	15.50	4.83
	Supporting professional activities						
S1	Training/teaching						
S2	Continuous Professional Development						
S3	Audit / Clinical Governance						
S4	Job Planning / Appraisal						
S5	Research						
S6	Clinical management	0.50	0.13			0.50	0.13
	Additional responsibilities						
A2	Audit lead or Clinical governance lead						
A3	Clinical tutor						
A4	MD / CD and LC' PAs by substitution or additional remuneration						
A5	Other additional responsibilities						
	Other duties						
D1	Trade union duties						
D2	AAC external member						
D3	NCAA, GMC, CHAI						
D4	Work for Royal Colleges						
D5	Other						
	Additionally remunerated work						
P1	Private practice	2.00	0.50			2.00	0.50
P2	Category 2 work						
P3	Other additionally remunerated work						
	Non-work activity						
N1x	Absent from work (annual, study leave)						
N1y	Absent from work (sickness leave)						
N2	Other (i.e. time spent not working)	3.00	0.75			3.00	0.75
	On-call status (column 2)						
1	Predictable On-call			7.50	2.50	7.50	2.50
2	Unpredictable On-call	1.00	0.25	18.00	6.00	19.00	6.25

Enter W or L in each box for work or leave on each half day - 'Not completed' until this is done.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
am	W	W	W	W	W		
pm	W	W	W	W	W		

Enter 'BH' for bank holiday

	Normal Time Recorded Hours	Normal Time Recorded PAs	Normal Time Adjusted Hours	Normal Time Adjusted PAs	Premium Time Recorded Hours	Premium Time Recorded PAs	Premium Time Adjusted Hours	Premium Time Adjusted PAs	TOTAL Recorded Hours	TOTAL Recorded PAs	TOTAL Adjusted Hours	TOTAL Adjusted PAs
Clinical care: predictable on call	1.00	0.25	1.00	0.25	7.50	2.50	7.50	2.50	7.50	2.50	7.50	2.50
Clinical care: unpredictable on call	45.00	11.25	45.00	11.25	18.00	6.00	18.00	6.00	19.00	6.25	19.00	6.25
Total direct clinical care	0.50	0.13	0.50	0.13	38.50	12.83	38.50	12.83	83.50	24.08	83.50	24.08
Supporting professional activities									0.50	0.13	0.50	0.13
Additional responsibilities												
Other duties												
	45.50	11.38	45.50	11.38	38.50	12.83	38.50	12.83	84.00	24.21	84.00	24.21

Worked	
5	days
1	week

NOTES

9/4/04 - 'meeting with drug rep', was blank, changed to S6

NEW CONSULTANT CONTRACT FACILITATION

STRICTLY PRIVATE & CONFIDENTIAL

Date:	**10th October 2005**
Present:	Dr J Gaston: Designated Medical Manager for Facilitation. Mr A O'Brien: Consultant Urologist *In attendance - Miss Z Magee, Medical Staffing*

Mr A O'Brien

SUMMARY OF KEY POINTS / COMMENTS

Doctor Gaston:
I have gone through your diary and my calculations are similar to Dr Humphrey's.

Discussion about work included in diary cards

Mr O'Brien:
How has time spent on-call been calculated as 2PA's?

Doctor Gaston:
On-call is usually counted for the group and divided up to give an average for on-call. We will look at the emergency on-call for Mr Young and add this to your on-call and see what this equates to.

Mr O'Brien:
I will accept an offer that is fair and accurate. I want to be sure what was taken as emergency work and what was not. The emergency element of our work was calculated to be 6PA's per week between 2 consultants.

Mr O'Brien:
I want it all reconciled. In my letter, I couldn't accept an offer, which I felt, was not a fair and accurate reflection of my total time commitment. I am confused between the diary card analysis and the job plan.

Doctor Gaston:
That is the most difficult task to try and fit the diary card (retrospective) into a prospective job plan.

SUMMARY OF KEY POINTS / COMMENTS

Mr O'Brien:
Can I have a copy of my diary cards and job plan? I also wanted to know about backpay for maximum part time consultants and what the Trust's intention is?

Doctor Gaston:
I can advise you that the information from the DHSSPS in relation to abating has been changed.

Mr O'Brien:
It is an important issue, there appears to be a discrepancy between the job plan and the diary cards. I am not being offered any SPA's.

Time was spent going through the diary cards and discussing codes and Dr Gaston explaining what he would have given.

The following figures were discussed: DPC: 9 + 11.5 + 6 + 9.5 + 5 + 8.5 + 12.5 + 9 + 12 + 10+ 11 + 7.5 + 12.5 + 12.5 + 12.5 + 11.5 + 7.5 = 168

Doctor Gaston:
We will look at your colleague Mr Young and consider the issues highlighted.

END OF MEETING

SUMMARY AFTER MEETING

In addition Mr O'Brien has 3 days off during the diary card period. This meant the analysis divided the total over 3.2 – which distorted the figures.

E.g. 168 / 3.8 = 52.5/4 = **13.12 PA's**

If we factor in 3 normal working days:

168 + 3 days at 10 hours (average working day) = 198/4/4 = **12.37PA's.**

On-call allowance: **2 PA's**
SPA allowance: 0

Therefore:

DCC – 198/4/4 = 12.0 (Dr Gaston agreed to keep at 12 rather than 12.3)
+ on-call = 2.0
= 14.0

Facilitation - Propose to give 0.5 for SPA = 14.5 PA's.

Letter to Mr Young should include rationale for factoring in 3 normal working days at 10 hours, as opposed to dividing over 3.2.

CRAIGAVON AREA HOSPITAL GROUP TRUST

DIRECTORATE OF HUMAN RESOURCES

To: **Mr A O'Brien, Consultant Urologist**

From: **Miss Zoë Magee, Medical Staffing Support Officer**

Date: **26th April 2006**

Subject: **New Consultant Contract – Appeal**

Further to your letter dated 19th April and following our recent discussion, I would like to confirm that arrangements are now being put in place for an Appeal Hearing to be set up. Indeed, I can advise you that the independent panel member, supplied by the DHSSPS, to sit on your appeal panel is: **Prof P Hepper**, Non Executive Director, Ulster Community & Hospitals HSS Trust. Following notification of your panel nominee in your recent letter, I will now contact each panel member to determine their availability.

You have indicated that Mondays and Thursdays are the best days to avoid unnecessary disruption to your clinical duties and that you are not available on 15th and 16th May. I will consider this information when arranging the date for the hearing and do my very best to ensure the appeal is arranged at a convenient time for you.

I am attaching a copy of the relevant guidance for panel members in appeals as agreed between the Consultant Contract Implementation Team and the BMA. I will contact you as soon as I have a possible date to consider. In the meantime however if you require any further information, please do not hesitate to contact me on EXT Personal Information redacted by the USI

.....

Miss Zoë Magee
Medical Staffing Support Officer

Firbank House, CAH Extension: Personal Information redacted by the USI Email: Personal Information redacted by the USI

19 April 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist

Dear Mr O'Brien,

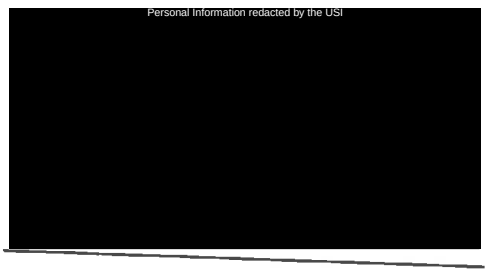
ASSIMILATION TO THE NEW CONSULTANT CONTRACT

Following my recent correspondence, I would advise you that the job planning process for 2004/05 has to be drawn to a conclusion.

Since you have not provided details of your nominee so that an appeal can be arranged I have to assume that you have decided not to transfer onto the new consultant contract and will therefore remain on your existing Terms and Conditions of Service. In order for your documentation to be finalised, I would ask you to confirm your decision to Miss Zoë Magee, Medical Staffing Support Officer, by Friday 28th April.

You will be aware that job plan reviews are an important feature of both the old and new contract. It is therefore intended that the 2006 review will take place at the earliest opportunity.

Yours sincerely,



Mr J Templeton
Chief Executive

21 March 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist

Dear Mr O'Brien,

ASSIMILATION TO THE NEW CONSULTANT CONTRACT

Further to my letter dated 12 December 2005, it is necessary at this stage for me to clarify what your intentions are, in relation to your assimilation onto the new consultant contract.

As you did not provide details of your nominee for the appeal panel, it has not been possible to arrange a date for your hearing. If you still wish to proceed to a formal appeal, I would be grateful therefore if you could provide details of your nominee to Miss Zoë Magee, Medical Staffing Support Officer, Firbank House, Craigavon Area Hospital as soon as possible. If however you have decided to accept your existing contract offer and proceed to the next stage i.e. receive financial calculations *or* decide not to transfer onto the new consultant contract, this should also be indicated.

As you appreciate this process has to be time limited since it involves a considerable amount of time to complete. It is therefore vitally important that this information is forwarded to Miss Magee as soon as possible.

Yours sincerely,

Mr J Templeton
Chief Executive

12 December 2005

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

Dear Mr O'Brien,

Further to your letter dated 28th November, I would like to provide clarification on a number of the points which you have raised.

I am sorry that you felt the facilitation meeting was rushed but I am aware Dr Gaston allowed 1 hour for each meeting, giving consultants the same opportunity to make use of the time available. You mentioned that you felt particularly disadvantaged as you did not have a copy of your diary cards or Trust analysis. It is my understanding, however, that you would have received a copy of these at the time of completion. Indeed, I am aware that a copy of the spreadsheet analysis was delivered to your secretary on 23rd September 2004. These documents have, of course, always been available via the Human Resources Department, which I understand provided you with a copy on 20th October, following your request after the facilitation meeting.

I'm sure you can appreciate that I cannot re-examine your diary card analysis at this stage since this is something which would have been dealt with by Dr Gaston and indeed will be dealt with by the Appeal Panel. I can, however, confirm that arrangements will now be put in place for an Appeal Hearing to be set up in accordance with Schedule 4 of the Consultant Terms and Conditions of Service (Northern Ireland) 2004 (copy attached). As you can see from the attached, you are required to nominate one member of the panel. I would be grateful if you would

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

Mr. J. Templeton,
Chief Executive,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5HQ.

28 November 2005

Dear John,

Thank you for your letter of 16th November 2005, and for the revised contractual offer contained therein. I regret to advise you that I am dissatisfied with the outcome of the facilitation process, and that I do wish to proceed to a formal appeal.

In doing so, I enclose for your information, a copy of my letter of response of 22nd September 2005, addressed to Mrs. Betty Williamson, following the initial contractual offer of 9th September 2005. As you will note from that letter, I felt then unable to accept the initial offer as I could not believe that it reflected fairly and accurately my total time commitment to HPSS work during 2004/5.

I met with Dr. Gaston for facilitation on 10th October 2005. I found Dr. Gaston courteous and genuine, but in retrospect, I found the meeting to be rushed. It may not have seemed so to Dr. Gaston, particularly as he was so au fait with all of the issues involved, whereas I felt relatively disadvantaged, particularly as I had not had a copy of my diary cards, or of the Trust's analysis. In essence, I did explain to Dr. Gaston that it had been my understanding that the analysis of the diary cards had calculated that I had committed 17.99 mean sessions weekly to total direct patient care, and that I was unable to understand how or why I was offered a contract of 14 sessions. Dr. Gaston then scrutinised my diary cards, and concluded that sessions of direct patient care totalled 13 plus 1 predictable on call plus 1 unpredictable on call. As this exercise resulted in yet another variation, I requested that I be provided with copies of my original diary cards so that I could arrive at my own calculation.

I enclose those copies. In making my own calculation, I have completely excluded, to the benefit of the Trust, all time allocated to telephone calls received at or made from home concerning patient care. I have also excluded, to the benefit of the Trust, all time allocated when periods of time included travel between hospital and home, in addition to patient care. I have made annotations in pencil. Calculations are made for a period of 3.2 weeks, as 4 days were spent attending annual meeting of the European Association of Urology in Vienna, from 24.03.04 to 27.03.04 (supporting professional activity).

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted by the USI
Text No.: Personal Information redacted by the USI

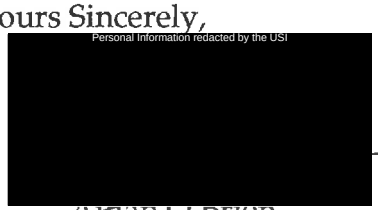
By so doing, I have calculated 140.5 hours in normal time in 3.2 weeks (43.9 hours per week = 11 sessions) and 64.5 hours in premium time in 3.2 weeks (20.2 hours per week = 6.5 sessions). Once again, this mean weekly total of 17.5 sessions corresponds quite accurately to the estimated total time commitment to HPSS work as indicated in my letter of 22nd September 2005.

One particular aspect of the contractual offer that I cannot understanding is that it would seem that total on call clinical care would appear to be limited to a total of 2 sessions, even if actual sessions worked while on call is significantly in excess of that number. I cannot understand how a contractual offer can be a fair and accurate reflection of total time commitment if a significant element is so limited in any offer. In the Trust's analysis, total weekly sessions in direct patient care while on call were calculated to be 4.4 sessions. It would appear to me that it is unjust and unfair that 2.4 sessions should have been worked without remuneration. Perhaps this is the unremunerated work performed as a Registrar from 1998 to 2004?

I do believe that it is both accurate and fair that 0.5 SPA sessions should be additionally offered in the contract, as 2 hours per week would have been a fair and accurate reflection of time committed to SPA, as evidenced by the four days spent attending the EAU.

Lastly, I do most sincerely and respectfully hope that proceeding to formal appeal will not take several more months to conclude. It is now one year since I was promised by Mrs. Richardson that contractual offers would be received by December 2004, and the entire process concluded by March 2005, at the latest,

Yours Sincerely,



Aidan O Brien,
Consultant Urologist.

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

16th November 2005

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

PRIVATE AND CONFIDENTIAL

Dear Aidan,

RE: OUTCOME OF THE FACILITATION PROCESS

I am writing to advise you that following your facilitation meeting on Monday 10th October, Dr Gaston has considered the issues you raised and reviewed all the necessary information. As a result, he has suggested that the Trust review the existing PA offer made to you. He has recommended that for 2004/2005, you should be offered an additional 0.5 PA. This will result in a total of 4.5 PA's over and above 10 programmed activities. This recommendation has been accepted by the Trust and has been reflected in the amended proforma attached.

On a more general note, he has highlighted that the allocation of supporting professional activities in a number of areas across the Trust is lower than what might be expected and will need to be addressed. It is planned that for the future, this will be adjusted through the prospective job planning process. This is likely to involve verification of SPA activity and agreed redistribution where appropriate. As part of the review of SPAs, the Trust will discuss the allocation of time given to the essential elements, in particular identifying appropriate allocation for clinical management, education, CPD and appraisal etc.

In the meantime, it is important for you to be aware that if you are not satisfied with the outcome of the facilitation process and wish to proceed to a formal appeal, you must notify me in writing by Tuesday 29th November 2005.

Personal Information redacted by the USI

Mr J W Templeton
Chief Executive

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted by the USI
Text No.: Personal Information redacted by the USI

NEW CONSULTANT CONTRACT FACILITATION MEETING

NAME: MR A O'BRIEN, CONSULTANT UROLOGIST
1. Letter requesting facilitation
2. Consultant Job Plan including copies of original diary cards
3. Computer analysis of individual diary cards
4. Computer summary of specialty analysis
5. Correspondence to/from Consultant. Includes prospective job plan and the offer from the Trust.

OUTCOME OF FACILITATION PROCESS

Name:	AIDEEN O'BRIEN
Directorate:	SURGERY
Specialty:	UROLOGY.

Breakdown Of PA's:

Emergency Work

- Predictable: 1 PA's
- Unpredictable: 1 PA's

Travelling Time: ____ PA's

Theatre Sessions: ____ PA's

Outpatient Clinics: ____ PA's

} 12

Ward Rounds: ____ PA's

Other: ____ PA's

Total Direct Clinical Care: 14 PA's

Supporting Professional Activities: 0.5 PA's *
(breakdown where appropriate)

Total no. of PA's: offered 14.5 **PA's**

* Offer additional 0.5 PA for SPA allocation

Specialty 101: Inpatient Activity Data by Hospital/Provider for Urology, 2003/2004

Hospital/Provider	Average Available beds	Average Occupied beds	Discharges and Deaths	Day Cases	% Occupancy	Throughput (Annual)	Average Length of stay	Turnover Interval	% Day Cases
Altnagelvin Area	8.6	7.2	646	1339	83.7	75.1	4.1	0.8	67.5
Altnagelvin Group HSS Trust	**8.6**	**7.2**	**646**	**1339**	**83.7**	**75.1**	**4.1**	**0.8**	**67.5**
Belfast City	51.5	36.5	2278	4371	70.9	44.1	5.9	2.4	65.7
Belfast City Hospital HSS Trust	**51.5**	**36.5**	**2278**	**4371**	**70.9**	**44.1**	**5.9**	**2.4**	**65.7**
Causeway	3.1	2.9	282	517	93.5	90.8	3.8	0.3	64.7
Causeway HSS Trust	**3.1**	**2.9**	**282**	**517**	**93.5**	**90.8**	**3.8**	**0.3**	**64.7**
Craigavon Area	24.2	20.6	1530	1043	85.1	63.1	4.9	0.9	40.5
Craigavon Area Hospital Group HSS Trust	**24.2**	**20.6**	**1530**	**1043**	**85.1**	**63.1**	**4.9**	**0.9**	**40.5**
Lagan Valley	0.1	0.1	16	301	100.0	253.9	2.3	0.0	95.0
Down Lisburn HSS Trust	**0.1**	**0.1**	**16**	**301**	**100.0**	**253.9**	**2.3**	**0.0**	**95.0**
Mater Infirmorum	6.8	5.5	512	826	80.9	74.6	3.9	0.9	61.7
Mater Infirmorum Hospital HSS Trust	**6.8**	**5.5**	**512**	**826**	**80.9**	**74.6**	**3.9**	**0.9**	**61.7**
Royal Victoria	0.0	0.0	0	175	0.0	0.0	0.0	0.0	100.0
Royal Group of Hospitals HSS Trust	**0.0**	**0.0**	**0**	**175**	**0.0**	**0.0**	**0.0**	**0.0**	**100.0**
Northern Ireland	**94.3**	**72.9**	**5264**	**8572**	**77.3**	**55.7**	**5.1**	**1.5**	**62.0**

Source: KH03A

Specialty 101: Outpatient Activity Data by Hospital/Provider for Urology, 2003/2004

Hospital/Provider	Clinic Sessions		Attendances				Private Patient Attendances	GP written Referral Requests Rec'd
			Referrals		Consultant Initiated			
	Held	Cancelled	Seen	DNA	Seen	DNA		
Altnagelvin Area	147	8	792	124	2194	218	5	1205
Roe Valley	42	9	338	54	477	45	0	270
Altnagelvin Group HSS Trust	**189**	**17**	**1130**	**178**	**2671**	**263**	**5**	**1475**
Belfast City	409	91	1540	235	4601	722	8	2473
Belfast City Hospital HSS Trust	**409**	**91**	**1540**	**235**	**4601**	**722**	**8**	**2473**
Causeway	62	14	530	45	562	34	1	510
Causeway HSS Trust	**62**	**14**	**530**	**45**	**562**	**34**	**1**	**510**
Banbridge	28	0	127	28	543	105	0	37
Craigavon Area	87	3	828	114	3055	381	5	873
Craigavon Area Hospital Group HSS Trust	**115**	**3**	**955**	**142**	**3598**	**486**	**5**	**910**
Lagan Valley	66	2	422	51	466	65	0	225
Down Lisburn HSS Trust	**66**	**2**	**422**	**51**	**466**	**65**	**0**	**225**
Mater Infirmorum	49	3	683	106	764	131	0	865
Mater Infirmorum Hospital HSS Trust	**49**	**3**	**683**	**106**	**764**	**131**	**0**	**865**
Royal Victoria	43	7	257	76	437	112	0	375
Royal Group of Hospitals HSS Trust	**43**	**7**	**257**	**76**	**437**	**112**	**0**	**375**
Northern Ireland	**933**	**137**	**5517**	**833**	**13099**	**1813**	**19**	**6833**

Source: KH09

Note: DNA = Did not attend.

CRAIGAVON AREA HOSPITAL GROUP TRUST
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20 October 2005

Please see enclosed a copy of your original diary cards and computer spreadsheet analysis, as requested.

Please note, as outlined in previous memos from Mrs Richardson at the time the analysis was first issued, there are a number of factors which should be considered when reviewing this information. The analysis includes everything that has been coded by the consultant and has not been refined to reflect:

- The annualisation of on-call
- Out of hours phone calls have had to be input as a full ½ hours irrespective of the length of call.

If you require any further information, please do not hesitate to contact me on EXT Personal Information redacted by the

Personal Information redacted by the USI

Zoë Magee (Miss)
Medical Staffing Support Officer

HUMAN RESOURCES DEPARTMENT

Firbank House
Craigavon Area Hospital Group HSS Trust
68 Lurgan Road, Portadown
Craigavon BT63 5QQ
Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Mrs. B. Williamson,
Directorate of Human Resources,
Craigavon Area Hospital Group Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

22 September 2005.

Dear Betty,

Re: New Consultant Contractual Offer.

I write in relation to the New Consultant Contractual offer for the year 2004/5, issued by Dr. Caroline Humphrey, former Medical Director, on 9 September 2005, and delivered by internal mail to my secretary's office on 15 September 2005. Dr. Humphrey confirmed that it was the Trust's intention that I would be offered 4 sessions of Programmed Activities in recognition of additional workload over and above the 10 sessions of Programmed Activities that constitute standard contractual duties under the New Consultant Contract. I write to advise you that I cannot accept the Trust's offer for the following reasons.

Dr. Humphrey stated in her letter of 09 September 2005 that the additional 4 sessions of Programmed Activities are reflected in my job plan schedule agreed between me and my Clinical Director, and submitted to her by the Clinical Director. I fail to see how the additional 4 sessions are reflected in the job plan schedule at all, as the schedule is none other than a record of programmed activities, during normal office hours, between approximately 9am and 5pm, Monday to Friday, during the year 2004/5. It is in fact mathematically impossible to have additional sessions of Programmed Activities reflected in a schedule that only records any activities that took place during the times of the standard 10 sessions.

Perhaps this has arisen due to a misunderstanding on my part of precisely that which was requested of me by my Clinical Director when he requested the job plan schedule. I never could fully understand the utility of a job plan schedule of arranged or programmed activities during normal working hours, Monday to Friday, only, particularly when only a proportion of the total time commitment took place during those hours, and when the Trust had a more useful and reliable record of the total time spent working in its own analysis of the diary card record conducted in March / April 2004. Perhaps therefore, I should have included all of the predictable, necessary work performed outside of normal office hours. If I had done so, then additional sessions would have been reflected in the schedule.

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Craigavon, BT63 5QQ
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Futhermore, though probably not of any significant relevance, the job plan schedule was not agreed between me and my Clinical Director, as Dr. Humphrey stated in her letter. There was neither agreement nor disagreement.

Most importantly, Dr. Humphrey stated in her letter that the proposed offer was based on the understanding that the job plan schedule was a fair and accurate reflection of the time commitment given by me to HPSS work during 2004/05, and that my acceptance of it would be taken as confirmation of this. For the reasons outlined above, the job plan schedule submitted to her is an inadequate, and therefore inaccurate, reflection of the time commitment given. As a consequence, the proposed offer is neither accurate or fair.

I honestly do believe that the most accurate and fairest assessment of the total time commitment given by me to HPSS work during 2004/05 was that of the Trust's analysis of the diary card record of work during March / April 2004. The record was entirely honest on my part, and as accurate as the diary card permitted. To the best of my knowledge, the only factors which could have had any inflationary effects were that the time slots available would have allocated inaccurately excessive times to consultations by telephone, that my analysis was conducted over a period of 3 weeks and 2 days due to my attending EAU conference in Vienna, and lastly, due to my having worked particularly long hours during one weekend during the period analysed. As I recall, and as I do not have a copy of the analysis to hand, it concluded that my total time commitment was in excess of 18 sessions. It is my honest view that a maximum reduction of one session could be considered appropriate for any such inflationary effects, and that an offer of a minimum of 7 sessions, in addition to the standard 10 sessions, would be a safely accurate and fair reflection of the total time commitment. Any less will certainly be inaccurate and unfair.

All of the evidence accessible to the Trust, accrued by it or presented to it in recent years, is entirely supportive of such a claim and of such an offer. We two urologists at Craigavon Area Hospital are providing a service for a population of over 310,000. This consultant / population ratio is lower than any one of the 30 member countries of the European Board of Urology. This ratio is not only a function of the inadequacy of the service, it also translates into overwork by those providing the service relative to the workload of those providing a better staffed service.

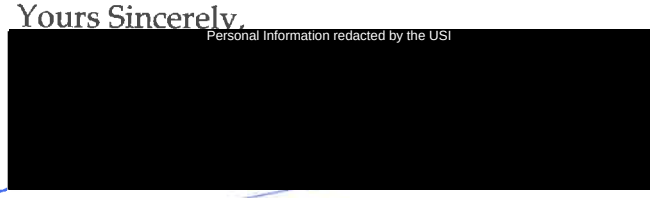
That this is true has been confirmed by the findings of the External Service Review conducted in 2004, and presented to the Trust then. When compared with urological services in Scotland, our throughput was equivalent to that provided by 3.7 consultants there, we each providing a throughput equivalent to 1.85 consultants in Scotland. Similar calculations are made when comparing throughputs with those

of other urologists in Northern Ireland. I have enclosed most recently available data from 2003/04. For example, there were a 1530 deaths and discharges at Craigavon Area Hospital during that year, a throughput of 765 per consultant. During that same year, there was a total of 3734 deaths and discharges in all other specialist urological departments in Northern Ireland, and provided with the 9 other consultant urologists: a throughput of 415 per consultant. Remarkably, but not surprisingly, our throughput per consultant was the equivalent of 1.8 consultants throughout the remainder of Northern Ireland. However, as in Scotland, our colleagues in Northern Ireland have already been offered contracts for totals of at least 12 sessions!

All of the comparative evidence that I know of wholly supports a claim that we would have been required to have committed total time of the order of 17.5 to 18.5 sessions in order to provide a service reflected in such throughputs. In fact, I find it quite remarkable that we should be considered able to have done so. In truth, the estimates and the claim has not taken into account all of the annual leave not taken, or the work done during annual leave. I write this letter towards the end of a week of supposed annual leave, and during which I have already done 17 hours of HPSS work, including 7 hours of operating!

Lastly, in any case, I cannot accept the proposed offer as it would be dishonest of me to do so, as it certainly and indisputably is neither a fair or accurate reflection of the total time committed to HPSS work during 2004/05. Moreover, it will also certainly not be possible to deliver current workload with a total of 14 sessions of Programmed Activities,

Yours Sincerely,



Aidan O'Brien,
Consultant Urologist.

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

9 September 2005

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien
Consultant Urologist
Urology Department
CAH

Dear Mr O'Brien

Further to the discussions which I have had with your Clinical Director, I now wish to confirm the Trust's intention that for the year 2004/05 you will be offered 4 PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job plan schedule agreed between you and your Clinical Director and submitted to me by your Clinical Director (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a fair and accurate reflection of the time commitment given by you to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

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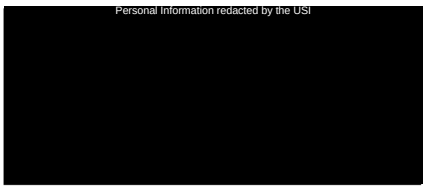
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted by the USI
Text No.: Personal Information redacted by the USI

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, enclosing a signed copy of the attached job plan, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely



C Humphrey
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

PREDICTABLE, ORGANISED DUTIES
MONDAY – FRIDAY

MONDAY

MORNING

9.00	WARD ROUNDS
11.30	MD WARD MEETING

(FIRST, SECOND AND FIFTH MONDAYS)

9.00	URODYNAMIC STUDIES
10.30	URODYNAMIC STUDIES
12.00	URODYNAMIC STUDIES

AFTERNOON

2.00	HISTOPATHOLOGY MEETING
3.00	HISTOLOGY REVIEWS/ADMINISTRATION
1.00	URODYNAMIC STUDIES
3.00	URODYNAMIC STUDIES
4.30	URODYNAMIC STUDIES

TUESDAY

MORNING

9.00	OPERATING, DSU

AFTERNOON

2.00	OUTPATIENT CLINIC

WEDNESDAY

MORNING

9.00	OPERATING THEATRE 2

AFTERNOON

1.30	OPERATING THEATRE 2

THURSDAY

MORNING

8.30	RADIOLOGY CONFERENCE
10.00	GRAND ROUND
12.00	DEPARTMENTAL MEETING

AFTERNOON

2.00	OUTLYERS EMERGENCY OPERATING ADMINISTRATION

FRIDAY

MORNING

9.00 9.30 as per diary card — WARD ROUND
10.00 — PRIVATE PATIENTS (3 per week)

AFTERNOON

1.00 — DRUG REP APPT
2.00 — WARD OR OFFICE REVIEWS
5.00 — WARD ROUNDS

OTHER DUTIES

1. The above schedule is so full that the bulk of administration has had to be performed out of hours.

2. As over 50% of inpatient activity is due to emergency admissions, almost all resulting operating has had to be performed out of hours.

To Be Completed For All Consultant Posts Requiring 10+ PA's To Deliver Current Workload

This pro forma forms part of the audit trail required to demonstrate that a thorough analysis has been carried out before confirming the requirement for additional PA's to the Southern Board / Department. It will also hopefully help you to work through the issues involved.

Name:	**Mr A O'Brien**
Directorate:	**Surgery**
Specialty:	**Urology**

Total no. of PA's in Proposed Prospective Job Plan: _____14_____ PA's

Breakdown Of PA's:

Emergency Work

- Predictable: _____1_____ PA's
- Unpredictable: _____1_____ PA's

Travelling Time: _____ PA's

Theatre Sessions: _____ PA's

Outpatient Clinics: _____ PA's

Ward Rounds: _____ PA's

Other: _____ PA's

Total Direct Clinical Care: _____ PA's

Supporting Professional Activities: _____ PA's
(breakdown where appropriate)

12 PAs as per attached job plan

How could changes in work pattern improve efficiency?

PREDICTABLE, ORGANISED DUTIES
MONDAY – FRIDAY

MONDAY

MORNING

9.00	WARD ROUNDS
11.30	MD WARD MEETING

(FIRST, SECOND AND FIFTH MONDAYS)

9.00	URODYNAMIC STUDIES
10.30	URODYNAMIC STUDIES
12.00	URODYNAMIC STUDIES

AFTERNOON

2.00	HISTOPATHOLOGY MEETING
3.00	HISTOLOGY REVIEWS/ADMINISTRATION
1.00	URODYNAMIC STUDIES
3.00	URODYNAMIC STUDIES
4.30	URODYNAMIC STUDIES

TUESDAY

MORNING

9.00	OPERATING, DSU

AFTERNOON

2.00	OUTPATIENT CLINIC

WEDNESDAY

MORNING

9.00	OPERATING THEATRE 2

AFTERNOON

1.30	OPERATING THEATRE 2

1 Day

THURSDAY

MORNING

8.30	RADIOLOGY CONFERENCE
10.00	GRAND ROUND
12.00	DEPARTMENTAL MEETING

AFTERNOON

2.00	OUTLYERS EMERGENCY OPERATING ADMINISTRATION

FRIDAY

MORNING

9.00 9.30 as per diary card WARD ROUND
10.00 PRIVATE PATIENTS (3 per week)

AFTERNOON

1.00 DRUG REP APPT
2.00 WARD OR OFFICE REVIEWS
5.00 WARD ROUNDS

OTHER DUTIES

1. The above schedule is so full that the bulk of administration has had to be performed out of hours.

2. As over 50% of inpatient activity is due to emergency admissions, almost all resulting operating has had to be performed out of hours.

To Be Completed by All Consultants participating in External Duties/Private Practice/Medico-Legal Work

This pro forma is to help you record your average commitment to External Duties/Private Practice/Medico-Legal Work on an annual basis, which will be used to identify an agreed time within your job plan for this work. It may be difficult to quantify the amount of time spent on these duties, as the work may be irregular and unpredictable. Where it is predictable it should be set out and scheduled in the attached pro forma. However, where it is unpredictable, you should include an estimation of the amount of time required for these duties.

Name:	AIDAN O'BRIEN
Directorate:	SURGERY
Specialty:	UROLOGY

External duties are specific to individual consultants and usually support the wider work of the NHS by special responsibilities, usually external to the Trust, on a National basis. They include those activities which do not fall within the definitions of direct patient care, supporting professional activities or additional HPSS activities or within the definition of Fee Paying Services or Private Professional Services.

For example:

- Trade Union duties
- Commission for Health Improvement Inspections (or a Northern Ireland equivalent)
- Advisory Appointment Committee panel member
- National Clinical Assessment Authority Assessor
- Royal College work
- Government Department work
- GMC/GDC work

This list is not exhaustive.

EXTERNAL DUITES/PRIVATE PRACTICE/MEDICO-LEGAL WORK

	DESCRIPTION OF EXTERNAL DUTY/PRIVATE PRACTICE/MEDICO-LEGAL WORK	FREQUENCY	TIME COMMITMENT * PLEASE INSERT TIMES	LOCATION
WEEKLY	PRIVATE PATIENT CONSULTATIONS	3 PER WEEK	1.5 HOURS PER WEEK	C.A.H.
	RELATED ADMINISTRATION	WEEKLY	1.5 HOURS	CAH
MONTHLY	PRIVATE INPATIENT AND DAY SURGERY	MONTHLY	2 HOURS	CAH
YEARLY	MEDICOLEGAL	YEARLY	12 HOURS (TOTAL)	CAH
	REGIONAL IN TRAINING ASSESSMENT	YEARLY	4 HOURS	BELFAST
	SpR SHORTLISTING	YEARLY	3 HOURS	BELFAST
	SpR APPOINTMENTS	YEARLY	4 HOURS	BELFAST
AD HOC	CHAIR OF CURE COMMITTEE	YEARLY TOTAL	10 HOURS	CAH

INTERNAL AUDIT OF PRIVATE MEDICAL PRACTICE

Name (Please Print) AIDAN O'BRIEN

Specialty UROLOGY

I confirm that I have received your memo on internal audit of private medical practice.

I agree to comply fully with the Trust's Private Practice Procedures.

Signature [redacted]

Personal Information redacted by the USI

Date: 20.06.05

Please return to: -

Dr C Humprhrey
Medical Director
Administration Floor
CAH

MR O'BRIEN

CRAIGAVON AREA HOSPITAL GROUP TRUST

Caring Through Commitment

13TH September 2004

Mrs. Myrtle Richardson
Director of Human Resources
Craigavon Area Hospital Group Trust
Craigavon

Dear Myrtle,

It is with mixed emotions that I submit my diary cards and questionnaire so belatedly. I do so with guilt, embarrassment and a feeling of comparative inadequacy. However, I can assure you that the dominant, if not indeed the only, reason is that I fail to allocate time to such important matters, giving that time instead to the relentless need and demands of patient care.

Perhaps the External Service Review has indeed served one purpose. As I have been advised, perhaps it did require an External Review to confirm to the Trust that we have been working excessively to the extent that we had claimed for years, and that hopefully the Trust will believe that which it appeared not to do before.

Lastly, I would like to avail of this opportunity to advise you of the extent to which I have so greatly appreciated your understanding, empathy and patience over the past year or so. As I have advised you previously, I have felt for years that we and are patients have been abandoned by the Trust. I have greatly appreciated your capacity to listen and to care.

I do hope that all is in order with enclosed.

Yours sincerely,

Personal Information redacted by the USI

Aidan O'Brien FRCS
Consultant Urologist

ENCs

13 SEP 2004

Craigavon Area Hospital Group Trust, 68 Lurgan Road, Portadown, Co Armagh, BT63 5
Direct Line: Personal Information redacted by the USI Fax: Personal Information redacted by the USI E-mail: Personal Information redacted by the USI

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: Personal Information redacted

Consultant Job Plan Questionnaire

Parts 1 & 2 To be completed before or at the same time as the diary cards.

Part 3 Is an extraction from the diary cards and, therefore, must be filled out after completion of the diary cards.

Both parts of this questionnaire must be submitted to the Clinical Director by ***Friday 30th April 2004*** *at the latest.*

Irrelevant information redacted by the USI

Questionnaire – Part 1

Guidance

The following questionnaire has been prepared by the BMA (NI), DHSS&PS and HPSS employers.

The purpose of the questionnaire is to provide the Clinical Director with detailed information for the job planning process.

Completing the Questionnaire

Please ensure that you complete **all** sections of the questionnaire, providing as much detail as possible.

This part of the questionnaire relates to the consultant's **current** activities and responsibilities for 2003/04 and should be completed **before or at the same time** as the diary card, both of which must be submitted to the Clinical Director **Friday 30th April 2004** at the latest.

Part 1 of the questionnaire consists of the following sections:

Consultant Details

Section 1: Typical Job Plan in 2003/2004

Section 2: 2003/2004 Fixed Commitments

Section 3: 2003/2004 Flexible Commitments

Section 4: Other Commitments

Section 5: Additional Remuneration

Section 6: Resources and Support

Part 2 requires you to provide some Additional Information.

CONSULTANT DETAILS

Name: Aidan O'Brien

GMC/GDC registration number: 1394911

Main employer: Craigavon Area Hospital Trust

Other employer(s): None

Specialty: Urology

Contract type *(please tick)*:

Whole Time	☐
Maximum Part Time	☑
Part Time	☐
Locum	☐
Joint Appointment	☐

SECTION 1: Typical Job Plan in 2003/2004

Please provide details of your average working week to include fixed/flexible commitments in the last year. If you are a joint appointment, please indicate clearly the time allowed for university work. Similarly, if you are a joint appointment with another Trust, please indicate clearly the time and location at each Trust.

	Average Start Time	Average Finish Time	Type of Work (e.g. Fixed Outpatient Clinic)
Monday AM	9 AM	1.30 pm	WARD ROUNDS. WARD MEETING. URODYNAMIC STUDIES
Monday PM	2 PM	8 PM	UROPATHOLOGY MEETING. URODYNAMIC STUDIES. ADMIN.
Tuesday AM	9 AM	1.00 pm	DAY SURGICAL OPERATING
Tuesday PM	2 PM	8 PM	OUTPATIENT CLINIC. PREOP. WARD ROUND. DICTATION ETC.
Wednesday AM	9 AM	1.30 PM	OPERATING TO 5.30 pm PLUS
Wednesday PM	1.30 pm	10 pm	EMERGENCY SURGERY. POSTOP. ROUNDS AND ADMINISTRATION
Thursday AM	8.30 AM	1.30 pm	URORADIOLOGY MEETING GRAND WARD ROUNDS.
Thursday PM	2 PM	8 PM	OUTREACH CLINIC IN BANBRIDGE OR ARMAGH, OR EMERGENCY WORK ETC
Friday AM	9.30 AM	1 PM.	WARD ROUNDS. PATIENT CONSULTATIONS.
Friday PM	2 PM	7 PM	PATIENT CONSULTATIONS. 5PM WARD ROUND. ADMIN.
Saturday AM/PM	10 AM	TO ?	WARD ROUNDS ± THEATRE ON ALTERNATE WEEKENDS.
Sunday AM/PM	10 AM	TO ?	ONLY WHEN ON CALL AS REGISTRAR.
On –Call (Please give a brief description of your average on-call work)	ON CALL AS A CONSULTANT IN 1:2 ROTA. ON CALL AS REGISTRAR IN 1:4 ROTA APPROX., RESULTING IN 5.4 NHDs ON CALL PER WEEK. ON CALL WORK VARIES FROM VIRTUALLY ZERO HOURS TO MAXIMUM OF 28 HOURS OF INPATIENT MANAGEMENT, INVESTIGATION AND OPERATING AT WEEKEND WHEN ON CALL AS CONSULTANT AND REGISTRAR.		

SECTION 2: 2003/2004 Fixed Commitments.

1. How many fixed sessions do you currently work within NHS?

2 3 4 5 6 7 other ~ 7.5

If **other**, please provide details below:

MONDAYS : 1 SESS : WARD ROUNDS, MEETINGS + HIST. REVIEW
1 SESS : URODYNAMIC STUDIES + WARD. ATTENDERS
TUES : 1 SESS : DAY SURGICAL OPERATING
1 SESS : OUTPATIENT CLINIC
WEDNESDAYS : 2 SESSIONS : INPATIENT OPERATING.

2. What is the nature of activity in your fixed sessions?

Please provide a brief description:

THURSDAYS : 1 SESSION : URORADIOLOGY MEETING
GRAND ROUNDS.
0.5 SESSION : OUTREACH CLINICS ON
FIRST, SECOND AND FIFTH
THURSDAYS.

3. Are all your fixed commitments worked within this Trust? (YES)/NO

If **No**, please provide details including number of sessions, location of sessions, average time spent travelling to different site:

SECTION 3: 2003/2004 Flexible Commitments.

1. Please give a brief summary, including average time commitment per week, of the type of work you carry out during your flexible sessions:

THURSDAY PM: WARD ROUNDS OF OUTLYING PATIENTS
EMERGENCY / URGENT SURGERY
ARRANGEMENT OF IMAGING AND INTERVENTIONAL PROCEDURES
FRIDAY AM + PM: WARD ROUNDS. PUBLIC AND PRIVATE PATIENT CONSULTATIONS

2. How much study/professional leave did you take or will take in 2003/2004?

3-4 days.

Please provide details of the courses attended and the duration:

THE ONLY STUDY LEAVE THAT THE DEMANDS OF WORK PERMIT ME TO TAKE IS TO ATTEND ANNUAL MEETINGS OF EUROPEAN ASSOCIATION OF UROLOGY OR AMERICAN UROLOGICAL ASSOCIATION ON ALTERNATE YEARS, AS I DID TO EAU IN VIENNA 24-27 MARCH 2004 (AND HOPEFULLY SAN ANTONIO IN 2005)

3. Have you ever been granted discretionary leave, i.e. additional professional or study leave above the recommended 30 days over 3-year period, within or outside the United Kingdom? YES/NO

If **Yes**, please provide details including the reason and the time period, and whether or not you received pay and/or expenses.

4. Did you experience difficulty in getting the time off to attend any study or professional training? YES/NO

If **Yes**, please provide details:

I HAVE ALWAYS HAD DIFFICULTY IN TAKING TIME OFF FOR SUCH STUDY OR PROFESSIONAL EDUCATION, DUE TO THE EXPECTATIONS OF PATIENTS AND DEMANDS OF WORK. FOR EXAMPLE, I HAVE DECLINED ONCE AGAIN TO ATTEND IRISH SOCIETY OF UROLOGY MEETING IN GALWAY IN OCTOBER.

5. What Clinical Governance activities are you involved in?

Please provide details:

NONE, APART FROM ATTENDING MORTALITY AND MORBIDITY MEETINGS MONTHLY.

6. What percentage of audit meetings did you attend in 2003/2004? ~ 90%.

If less than 75%, please provide details:

7. Did you undertake an audit in the last year? YES/(NO)

8. If **Yes**, please provide details including the approximate time you spent undertaking the audit and the support you received from audit department and junior medical staff for example:

9. Do you have a regular teaching commitment, for example a college role or university role? (YES)/NO

If **Yes**, please provide details to include your role and your average weekly commitment:

POSTGRADUATE TEACHING OF SPECIALIST REGISTRARS IN UROLOGY. USUALLY 3 OR 4 HALF-DAYS OF PROGRAMMED TEACHING PER YEAR. REQUIRES AT LEAST 3-4 HALF-DAYS OF PREPARATION.

10. What management responsibilities do you have such as clinical directors role, chair of a Trust committee or rota co-ordinator?

Please provide details of your individual role and responsibility and average time you spend per week carrying out this role:

NONE.

11. Are you involved in a research project? YES/NO

If **Yes**, please provide details:
(to include your involvement, your average weekly commitment, the aim of the project, duration of project)

SUPERVISION AND ADVICE ON PROGRESS OF SUBSTANTIVE RESEARCH PROJECTS UNDERTAKEN BY RESEARCH FELLOWS. MAXIMUM TIME COMMITMENT OF ONE 1/2 DAY PER ACADEMIC TERM, OVER 3 YEAR DURATION PER FELLOWSHIP.

SECTION 4: **This section relates to the amount of time spent on various other commitments**

1. Do you have a regular private practice commitment? YES/NO

If **Yes**, please provide details (including average time commitment, the locations and when you undertake private practice):

I CONDUCT PRIVATE PATIENT CONSULTATIONS AT MY OFFICE IN THE HOSPITAL DURING FLEXIBLE SESSIONS ON FRIDAYS ONLY. AVERAGE NUMBER OF CONSULTATIONS IS 5 PER WEEK, EQUIVALENT TO 2.5 HOURS, PLUS APPROX. 1.5 HOURS ADMINISTRATION. IN ADDITION, APPROX. 1 DAY SURGICAL CASE OR INPATIENT CASE (SATURDAY MORNING) PER MONTH: 1-2 HOURS

2. Do you have any other regular commitments such as Medical-Legal work (e.g. Medical-Legal clinics held during HPSS time), Royal College work etc.? YES/NO

If **Yes**, please provide details (including your average time commitment and when you undertake the commitment:

3. Do you have fee paying service commitments? YES/NO

If **Yes**, please list the type of clinical work, detailing if this work is regular or non-regular, and the frequency/scheduled time commitments of such work.

SECTION 5: This section relates to the amount of remuneration associated with various activities

1. Are you currently in receipt of any remuneration for additional HPSS responsibilities for example, a clinical director's role or a postgraduate tutor role? YES/NO

   If **Yes**, please provide details including remuneration:

2. Is it expected that you will continue in this role during 2004/2005? YES/NO

3. Has this role been agreed with your clinical director/divisional director? YES/NO

4. Are you in receipt of remuneration for additional work, for example a waiting list initiative or covering for a long term absence of a colleague? YES/NO

   If **Yes**, please provide details including remuneration:

SECTION 6: **This section relates to the Resources and Support you require**

1. What support do you currently have to carry out your role, i.e. facilities, administrative, clerical or secretarial support, IT resources, etc.?

I HAVE AN OFFICE AND A PERSONAL SECRETARY WHO HAS SUPPORT OF AN AUDIOTYPIST SHARED BY OTHERS. I HAVE NOT BEEN PROVIDED WITH ANY IT SUPPORT, SUCH AS PC.

2. Do you have appropriate resources for your role? YES/(NO)

If **No**, please provide details:

1. I NEED A PC INSTALLED IN MY OFFICE
2. I NEED ADDITIONAL AUDIOTYPIST SUPPORT
3. I NEED INSTALLATION AND OPERATION OF A CLINICAL AUDIT SYSTEM TO FACILITATE AUDIT.

Questionnaire – Part 2
Additional Information

Please provide a list of your personal objectives, as agreed in the appraisal process.

1. TO BE RUMERATED FOR WORKING AS A SPECIALIST REGISTRAR, 5.4 SESSIONS PER WEEK, FROM AUGUST 1998 TO AUGUST 2004.
2. TO HAVE CLINICAL WORKLOAD REDUCED BY HAVING A THIRD CONSULTANT UROLOGICAL SURGEON APPOINTED AS SOON AS POSSIBLE.
3. TO HAVE NO MORE ELECTIVE REFERRALS SENT TO ME UNTIL BACKLOG HAS BEEN CLEARED.

Please provide details of CPD/CME requirements as specified by your Royal College.

A COMBINATION OF INTERNAL AND EXTERNAL CPD ACTIVITIES. I BELIEVE THAT I MEET CPD REQUIREMENTS.

Please provide details of your objectives with regard to clinical audit and clinical governance issues for the coming year. Please indicate what constraints you feel you face in meeting these.

IT IS IMPOSSIBLE TO UNDERTAKE CLINICAL AUDIT AND GOVERNANCE DUE TO EXCESSIVE CLINICAL WORKLOAD WHICH HAS BEEN DESCRIBED AND QUANTIFIED BY THE EXTERNAL SERVICE REVIEW. MY COLLEAGUE AND I HAVE EACH BEEN DOING THE WORK OF 2 CONSULTANTS AND THAT OF HALF AN SpR.

Please indicate what ideas you have for service improvements in your specialty.

I ENDORSE THE RECOMMENDATION CONTAINED IN THE REPORT OF THE EXTERNAL SERVICE REVIEW, WHICH ITSELF WAS ENTIRELY UNNEEDED AS ITS RECOMMENDATIONS WERE ALL THOSE RECOMMENDED AND REQUESTED SINCE 1999. THE ONLY SUBSTANTIDE RECOMMENDATION WITH WHICH I DISAGREED WAS THAT OF THE APPOINTMENT OF A LOCUM CONSULTANT UROLOGIST, WHICH WAS WRONG IN PRINCIPLE, AND PROVED TO BE YET ANOTHER WASTE OF TIME AND MONEY. THE SERVICE, WHICH HAS BEEN IN CRISIS FOR YEARS, REQUIRES URGENT IMPLEMENTATION OF THE REVIEW'S RECOMMENDATIONS.

Please indicate what you feel prevents you from working efficiently.

GROSS OVERBURDEN BY CLINICAL WORK, ADDED TO WHICH IS THE ADDITIONAL WORK AND STRESS RESULTING FROM DEMAND AND EXPECTATION WHICH THE EXCESSIVE WORK DOES NOT MEET.

Consultant Name: Aidan O'Brien **Date:** 15.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30		N	N2	
7:30 – 8:00		N	N2	
8:00 – 8:30		N	N2	
8:30 – 9:00	Travelling from home to work	N	N2	
9:00 – 9:30	Waiting to operate in theatre	Y	C1x	
9:30 – 10:00	Ward rounds - 2 South	Y	C4	
10:00 – 10:30	Ward rounds - 2 South	Y	C4	
10:30 – 11:00	Ward Rounds - 2 South	Y	C4	
11:00 – 11:30	Ward Rounds - 2 West	Y	C4	
11:30 – 12:00	Ward Rounds - 1 South	Y	C4	
12:00 – 12:30	Ward Rounds - ICU	Y	C4	
12:30 – 13:00	Obtained diary cards	Y	S4	
13:00 – 13:30	Called to speak to patient with renal tumour diagnosed	Y	C5	
13:30 – 14:00	Lunch	Y		
14:00 – 14:30	Uropathology meeting	Y	C7	
14:30 – 15:00	Uropathology meeting	Y	C7	
15:00 – 15:30	Inpatient care	Y	C5	
15:30 – 16:00	Inpatient care	Y	C5	
16:00 – 16:30	Inpatient care	Y	C5	
16:30 – 17:00	Organising TRUS biopsy reviews	Y	C11	
17:00 – 17:30	Dictation	Y	C11	
17:30 – 18:00	Dictation	Y	C11	
18:00 – 18:30	Tea	Y		
18:30 – 19:00	Telephone advice to hospitals and patients	Y	C6	

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Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	RESCHEDULED URGENT THEATRE CASE	Y	C1X	
20:00 – 21:00	PRESENTATION TO CURE	Y	D5	
21:00 – 22:00	Home	Y	N2	
22:00 – 23:00	Home	Y	N2	
23:00 – 24:00	Home	Y	N2	
24:00 – 1:00	Home	Y	N2	
1:00 – 2:00	Home	Y	N2	
2:00 – 3:00	Home	Y	N2	
3:00 – 4:00	Home	Y	N2	
4:00 – 5:00	Home	Y	N2	
5:00 – 6:00	Home	Y	N2	
6:00 – 7:00	Home	Y	N2	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 16.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	Y	N2	
7:30 – 8:00	HOME	Y	N2	
8:00 – 8:30	HOME	Y	N2	
8:30 – 9:00	TRAVELLING TO WORK	Y		
9:00 – 9:30	URGENT OPERATING	Y	C3	
9:30 – 10:00	OPERATING	Y	C3	
10:00 – 10:30	OPERATING	Y	C3	
10:30 – 11:00	OPERATING	Y	C3	
11:00 – 11:30	OPERATING	Y	C3	
11:30 – 12:00	OPERATING	Y	C3	
12:00 – 12:30	OPERATING	Y	C3	
12:30 – 13:00	ORGANISED ADMISSIONS FOR	Y	C11	
13:00 – 13:30	WEEK COMMENCING 29.03.04	Y	C11	
13:30 – 14:00	LUNCH	Y		
14:00 – 14:30	OUTPATIENT CLINIC	Y	C2	
14:30 – 15:00	OUTPATIENT CLINIC	Y	C2	
15:00 – 15:30	OUTPATIENT CLINIC	Y	C2	
15:30 – 16:00	OUTPATIENT CLINIC	Y	C2	
16:00 – 16:30	OUTPATIENT CLINIC	Y	C2	
16:30 – 17:00	OUTPATIENT CLINIC	Y	C2	
17:00 – 17:30	OUTPATIENT CLINIC	Y	C2	
17:30 – 18:00	COFFEE	Y		
18:00 – 18:30	EMERGENCY INPATIENT CARE	Y	C1X	
18:30 – 19:00	EMERGENCY INPATIENT CARE	Y	C1X	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	CLINIC DICTATION	Y	C11	
20:00 – 21:00	CLINIC DICTATION	Y	C11	
21:00 – 22:00	HOME	Y	N2	
22:00 – 23:00	"	Y	N2	
23:00 – 24:00	"	Y	N2	
24:00 – 1:00	"	Y	N2	
1:00 – 2:00	"	Y	N2	
2:00 – 3:00	"	Y	N2	
3:00 – 4:00	"	Y	N2	
4:00 – 5:00	"	Y	N2	
5:00 – 6:00	"	Y	N2	
6:00 – 7:00	"	Y	N2	

Direct Clinical Care - Code C

Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S

Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A

Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5

Non-work activity – Code N

Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2

Other duties – Code D

Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P

Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: AIDAN O'BRIEN **Date:** 17.03.04

ST. PATRICK'S DAY: USUALLY OPERATING FROM 09:00 TO 17:00

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	Y	N2	
7:30 – 8:00	"	Y	N2	
8:00 – 8:30	"	Y	N2	
8:30 – 9:00	"	Y	N2	
9:00 – 9:30	"	Y	N2	
9:30 – 10:00	"	Y	N2	
10:00 – 10:30	"	Y	N2	
10:30 – 11:00	"	Y	N2	
11:00 – 11:30	"	Y	N2	
11:30 – 12:00	"	Y	N2	
12:00 – 12:30	"	Y	N2	
12:30 – 13:00	TRAVEL TO HOSPITAL	Y		
13:00 – 13:30	REVIEW OF ILL INPATIENTS	Y	C1X	
13:30 – 14:00	REVIEW OF ILL INPATIENTS	Y	C1X	
14:00 – 14:30	PATIENT ADMINISTRATION	Y	C11	
14:30 – 15:00	PATIENT ADMINISTRATION	Y	C11	
15:00 – 15:30	"	Y	C11	
15:30 – 16:00	"	Y	C11	
16:00 – 16:30	"	Y	C11	
16:30 – 17:00	"	Y	C11	
17:00 – 17:30	"	Y	C11	
17:30 – 18:00	"	Y	C11	
18:00 – 18:30	"	Y	C11	
18:30 – 19:00	"	Y	C11	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	Y	N2	
20:00 – 21:00	"	Y	"	
21:00 – 22:00	"	Y	"	
22:00 – 23:00	"	Y	"	
23:00 – 24:00	"	Y	"	
24:00 – 1:00	"	Y	"	
1:00 – 2:00	"	Y	"	
2:00 – 3:00	"	Y	"	
3:00 – 4:00	"	Y	"	
4:00 – 5:00	"	Y	"	
5:00 – 6:00	"	Y	"	
6:00 – 7:00	"	Y	"	

Direct Clinical Care - Code C	
Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S	
Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A	
Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5
Non-work activity – Code N	
Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2
Other duties – Code D	
Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P	
Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: Aidan O'Brien **Date:** 18.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y	N2	
7:30 – 8:00	Home	Y	N2	
8:00 – 8:30	Travel to Work	Y		
8:30 – 9:00	Radiology conference	Y	C7	
9:00 – 9:30	Radiology meeting	Y	C7	
9:30 – 10:00	Breakfast	Y		
10:00 – 10:30	Grand ward round	Y	C4	
10:30 – 11:00	"	Y	C4	
11:00 – 11:30	"	Y	C4	
11:30 – 12:00	"	Y	C4	
12:00 – 12:30	"	Y	C4	
12:30 – 13:00	Consultation with patients	Y	C5	
13:00 – 13:30	and their relatives	Y	C5	
13:30 – 14:00	Lunch	Y		
14:00 – 14:30	Urgent outpatient consult	Y	C5	
14:30 – 15:00	Performed IVP	Y	C8	
15:00 – 15:30	Attended to inbox	Y	C11	
15:30 – 16:00	correspondence re: patients	Y	C11	
16:00 – 16:30	"	Y	C11	
16:30 – 17:00	"	Y	C11	
17:00 – 17:30	"	Y	C11	
17:30 – 18:00	Dictation	Y	C11	
18:00 – 18:30	Dictation	Y	C11	
18:30 – 19:00	Dictation	Y	C11	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	ATTENDED TO ACUTE ADMISSION	Y	C1X	
20:00 – 21:00	THEATRE FOR ABOVE PATIENT	Y	C1X	
21:00 – 22:00	TRAVEL TO HOME	Y		
22:00 – 23:00	Home	Y	N2	
23:00 – 24:00	"	Y	"	
24:00 – 1:00	"	Y	"	
1:00 – 2:00	"	Y	"	
2:00 – 3:00	"	Y	"	
3:00 – 4:00	"	Y	"	
4:00 – 5:00	"	Y	"	
5:00 – 6:00	"	Y	"	
6:00 – 7:00	"	Y	"	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 19.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y	N2	
7:30 – 8:00	Home	Y	N2	
8:00 – 8:30	Home	Y	N2	
8:30 – 9:00	Home	Y	N2	
9:00 – 9:30	Travel to work	Y		
9:30 – 10:00	Ward round	Y	C4	
10:00 – 10:30	Ward round	Y	C4	
10:30 – 11:00	Ward round	Y	C4	
11:00 – 11:30	Outpatient consultation	Y	C5	
11:30 – 12:00	Private patient consultation	Y	P1	
12:00 – 12:30	Consultation with drug rep.	Y	D5?	
12:30 – 13:00	Telephone advice to hospital	Y	C6	
13:00 – 13:30	Lunch	Y		
13:30 – 14:00	Lunch	Y		
14:00 – 14:30	Private patient consultation	Y	P1	
14:30 – 15:00	Outpatient consultation	Y	C5	
15:00 – 15:30	Private patient consult.	Y	P1	
15:30 – 16:00	Private patient consult.	Y	P1	
16:00 – 16:30	Private patient consult	Y	P1	
16:30 – 17:00	Private patient consult	Y	P1	
17:00 – 17:30	'End of week' ward round	Y	C4	
17:30 – 18:00	"	Y	C4	
18:00 – 18:30	Telephone advice to patient	Y	C6	
18:30 – 19:00	Attended patient in A+E	Y	C1X	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	TRAVEL TO HOME	Y		
20:00 – 21:00	Home	Y	N2	
21:00 – 22:00	"	Y	"	
22:00 – 23:00	"	Y	"	
23:00 – 24:00	"	Y	"	
24:00 – 1:00	"	Y	"	
1:00 – 2:00	"	Y	"	
2:00 – 3:00	"	Y	"	
3:00 – 4:00	"	Y	"	
4:00 – 5:00	"	Y	"	
5:00 – 6:00	"	Y	"	
6:00 – 7:00	"	Y	"	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 20.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y	N2	
7:30 – 8:00	Home	Y	N2	
8:00 – 8:30	Home	Y	N2	
8:30 – 9:00	On-call commitment	N	N2	
9:00 – 9:30	Taken over by Mr. Young	N	"	
9:30 – 10:00	until 7 pm to enable	N	"	
10:00 – 10:30	me to go to Rugby	N	"	
10:30 – 11:00	International in Dublin	N	"	
11:00 – 11:30	"	"	"	
11:30 – 12:00	"	"	"	
12:00 – 12:30	"	"	"	
12:30 – 13:00	"	"	"	
13:00 – 13:30	"	"	"	
13:30 – 14:00	"	"	"	
14:00 – 14:30	"	"	"	
14:30 – 15:00	"	"	"	
15:00 – 15:30	"	"	"	
15:30 – 16:00	"	"	"	
16:00 – 16:30	"	"	"	
16:30 – 17:00	"	"	"	
17:00 – 17:30	"	"	"	
17:30 – 18:00	"	"	"	
18:00 – 18:30	"	"	"	
18:30 – 19:00	"	"	"	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	Y	N2	
20:00 – 21:00	"	Y	"	
21:00 – 22:00	"	Y	"	
22:00 – 23:00	"	Y	"	
23:00 – 24:00	"	Y	"	
24:00 – 1:00	"	Y	"	
1:00 – 2:00	"	Y	"	
2:00 – 3:00	"	Y	"	
3:00 – 4:00	"	Y	"	
4:00 – 5:00	"	Y	"	
5:00 – 6:00	"	Y	"	
6:00 – 7:00	"	Y	"	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 21.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y	N2	
7:30 – 8:00	"	"	"	
8:00 – 8:30	"	"	"	
8:30 – 9:00	"	"	"	
9:00 – 9:30	"	"	"	
9:30 – 10:00	"	"	"	
10:00 – 10:30	"	"	"	
10:30 – 11:00	"	"	"	
11:00 – 11:30	"	"	"	
11:30 – 12:00	"	"	"	
12:00 – 12:30	"	"	"	
12:30 – 13:00	"	"	"	
13:00 – 13:30	"	"	"	
13:30 – 14:00	"	"	"	
14:00 – 14:30	"	"	"	
14:30 – 15:00	"	"	"	
15:00 – 15:30	"	"	"	
15:30 – 16:00	"	"	"	
16:00 – 16:30	"	"	"	
16:30 – 17:00	Telephone advice to SpR	Y	C6	
17:00 – 17:30	Home	Y	N2	
17:30 – 18:00	"	"	"	
18:00 – 18:30	"	"	"	
18:30 – 19:00	"	"	"	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	Y	N2	
20:00 – 21:00	"	"	"	
21:00 – 22:00	"	"	"	
22:00 – 23:00	"	"	"	
23:00 – 24:00	"	"	"	
24:00 – 1:00	"	"	"	
1:00 – 2:00	"	"	"	
2:00 – 3:00	"	"	"	
3:00 – 4:00	"	"	"	
4:00 – 5:00	"	"	"	
5:00 – 6:00	"	"	"	
6:00 – 7:00	"	"	"	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 22.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	N	N2	
7:30 – 8:00	"	N	N2	
8:00 – 8:30	"	N	N2	
8:30 – 9:00	"	N	N2	
9:00 – 9:30	TRAVEL TO WORK	N		
9:30 – 10:00	WARD ROUNDS	N	C4	
10:00 – 10:30	WARD ROUNDS	N	C4	
10:30 – 11:00	WARD ROUNDS	N	C4	
11:00 – 11:30	WARD ROUNDS	N	C4	
11:30 – 12:00	MULTIDISCIPLINARY WARD	N	C7	
12:00 – 12:30	MEETING	N	C7	
12:30 – 13:00	INPATIENT CONSULT. IN 4S	N	C5	
13:00 – 13:30	LUNCH	N		
13:30 – 14:00	LUNCH	N		
14:00 – 14:30	PATHOLOGY MEETING	N	C7	
14:30 – 15:00	"	N	C7	
15:00 – 15:30	OUTPATIENT HISTOLOGY	N	C2	
15:30 – 16:00	REVIEWS	N	C2	
16:00 – 16:30	"	N	C2	
16:30 – 17:00	"	N	C2	
17:00 – 17:30	PATIENT ADMINISTRATION	N	C11	
17:30 – 18:00	PATIENT ADMINISTRATION	N	C11	
18:00 – 18:30	PATIENT ADMINISTRATION	N	C11	
18:30 – 19:00	URGENT CALL FROM PATIENT	N	C6	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	URGENT ATTENDENCE TO PATIENT	N	C1Y	
20:00 – 21:00	TRAVEL HOME	N		
21:00 – 22:00	HOME	N		
22:00 – 23:00	"	N		
23:00 – 24:00	"	N		
24:00 – 1:00	"	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 23.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	N		
7:30 – 8:00	Home	N		
8:00 – 8:30	Home	N		
8:30 – 9:00	Travel to Work	N		
9:00 – 9:30	Day Surgical List	N	C3	
9:30 – 10:00	"	N	C3	
10:00 – 10:30	"	N	C3	
10:30 – 11:00	"	N	C3	
11:00 – 11:30	"	N	C3	
11:30 – 12:00	"	N	C3	
12:00 – 12:30	"	N	C3	
12:30 – 13:00	"	N	C3	
13:00 – 13:30	Attendence to ill patients	N	C5	
13:30 – 14:00	on ward	N	C5	
14:00 – 14:30	Outpatient Clinic	N	C2	
14:30 – 15:00	"	N	C2	
15:00 – 15:30	"	N	C2	
15:30 – 16:00	"	N	C2	
16:00 – 16:30	"	N	C2	
16:30 – 17:00	"	N	C2	
17:00 – 17:30	Ward Round	N	C4	
17:30 – 18:00	Ward Round	N	C4	
18:00 – 18:30	Patient's Relatives	N	C5	
18:30 – 19:00	Tea			

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	PATIENT ADMINISTRATION	N	C11	
20:00 – 21:00	(OUTPATIENT DICTATION AND	N	C11	
21:00 – 22:00	ORGANISATION OF ADMISSIONS)	N	C11	
22:00 – 23:00	TRAVEL HOME	N		
23:00 – 24:00	HOME	N		
24:00 – 1:00	"	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 24.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Travel to Airport	N	S2	
7:30 – 8:00	"	N	S2	
8:00 – 8:30	Belfast Int. Airport	N	S2	
8:30 – 9:00	Belfast to London	N	S2	
9:00 – 9:30	"	N	S2	
9:30 – 10:00	Heathrow Airport	N	S2	
10:00 – 10:30	"	N	S2	
10:30 – 11:00	"	N	S2	
11:00 – 11:30	"	N	S2	
11:30 – 12:00	"	N	S2	
12:00 – 12:30	London to Vienna	N	S2	
12:30 – 13:00	"	N	S2	
13:00 – 13:30	"	N	S2	
13:30 – 14:00	"	N	S2	
14:00 – 14:30	"	N	S2	
14:30 – 15:00	"	N	S2	
15:00 – 15:30	"	N	S2	
15:30 – 16:00	Vienna	N	S2	
16:00 – 16:30	"	N	S2	
16:30 – 17:00	"	N	S2	
17:00 – 17:30	"	N	S2	
17:30 – 18:00	"	N	S2	
18:00 – 18:30	"	N	S2	
18:30 – 19:00	"	N	S2	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	VIENNA	N	S2	
20:00 – 21:00	"	"	"	
21:00 – 22:00	"	"	"	
22:00 – 23:00	"	"	"	
23:00 – 24:00	"	"	"	
24:00 – 1:00	"	"	"	
1:00 – 2:00	"	"	"	
2:00 – 3:00	"	"	"	
3:00 – 4:00	"	"	"	
4:00 – 5:00	"	"	"	
5:00 – 6:00	"	"	"	
6:00 – 7:00	"	"	"	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 25.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Registration at EAU	N	S2	
7:30 – 8:00	Attending EAU	N	S2	
8:00 – 8:30	"	N	S2	
8:30 – 9:00	"	N	S2	
9:00 – 9:30	"	N	S2	
9:30 – 10:00	"	N	S2	
10:00 – 10:30	"	N	S2	
10:30 – 11:00	"	N	S2	
11:00 – 11:30	"	N	S2	
11:30 – 12:00	"	N	S2	
12:00 – 12:30	"	N	S2	
12:30 – 13:00	"	N	S2	
13:00 – 13:30	"	N	S2	
13:30 – 14:00	"	N	S2	
14:00 – 14:30	"	N	S2	
14:30 – 15:00	"	N	S2	
15:00 – 15:30	"	N	S2	
15:30 – 16:00	"	N	S2	
16:00 – 16:30	"	N	S2	
16:30 – 17:00	"	N	S2	
17:00 – 17:30	"	N	S2	
17:30 – 18:00	"	N	S2	
18:00 – 18:30	"	N	S2	
18:30 – 19:00	"	N	S2	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	VIENNA	N	S2	
20:00 – 21:00	"	N	S2	
21:00 – 22:00	"	N	S2	
22:00 – 23:00	"	N	S2	
23:00 – 24:00	"	N	S2	
24:00 – 1:00	"	N	S2	
1:00 – 2:00	"	N	S2	
2:00 – 3:00	"	N	S2	
3:00 – 4:00	"	N	S2	
4:00 – 5:00	"	N	S2	
5:00 – 6:00	"	N	S2	
6:00 – 7:00	"	N	S2	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 26.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Vienna	N	S2	
7:30 – 8:00	Attending EAU	N	S2	
8:00 – 8:30	EAU	N	S2	
8:30 – 9:00	EAU	N	S2	
9:00 – 9:30	EAU	N	S2	
9:30 – 10:00	EAU	N	S2	
10:00 – 10:30	EAU	N	S2	
10:30 – 11:00	EAU	N	S2	
11:00 – 11:30	EAU	N	S2	
11:30 – 12:00	EAU	N	S2	
12:00 – 12:30	EAU	N	S2	
12:30 – 13:00	EAU	N	S2	
13:00 – 13:30	Lunch	N		
13:30 – 14:00	Lunch	N		
14:00 – 14:30	EAU	N	S2	
14:30 – 15:00	EAU	N	S2	
15:00 – 15:30	EAU	N	S2	
15:30 – 16:00	EAU	N	S2	
16:00 – 16:30	EAU	N	S2	
16:30 – 17:00	EAU	N	S2	
17:00 – 17:30	EAU	N	S2	
17:30 – 18:00	Vienna	N		
18:00 – 18:30	Vienna	N		
18:30 – 19:00	Vienna	N		

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	VIENNA	N	N1x	
20:00 – 21:00	"	N	"	
21:00 – 22:00	"	N	"	
22:00 – 23:00	"	N	"	
23:00 – 24:00	"	N	"	
24:00 – 1:00	"	N	"	
1:00 – 2:00	"	N	"	
2:00 – 3:00	"	N	"	
3:00 – 4:00	"	N	"	
4:00 – 5:00	"	N	"	
5:00 – 6:00	"	N	"	
6:00 – 7:00	"	N	"	

Direct Clinical Care - Code C	
Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S	
Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A	
Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5
Non-work activity – Code N	
Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2
Other duties – Code D	
Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P	
Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: AIDAN O'BRIEN **Date:** 27.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	VIENNA	N		
7:30 – 8:00	EAU	N	S2	
8:00 – 8:30	EAU	N	S2	
8:30 – 9:00	EAU	N	S2	
9:00 – 9:30	EAU	N	S2	
9:30 – 10:00	EAU	N	S2	
10:00 – 10:30	EAU	N	S2	
10:30 – 11:00	EAU	N	S2	
11:00 – 11:30	TRAVEL TO AIRPORT	N	S2	
11:30 – 12:00	TRAVEL TO AIRPORT	N	S2	
12:00 – 12:30	VIENNA TO LONDON	N	S2	
12:30 – 13:00	"	N	S2	
13:00 – 13:30	"	N	S2	
13:30 – 14:00	"	N	S2	
14:00 – 14:30	"	N	S2	
14:30 – 15:00	LONDON HEATHROW	N	S2	
15:00 – 15:30	"	N	S2	
15:30 – 16:00	"	N	S2	
16:00 – 16:30	"	N	S2	
16:30 – 17:00	LONDON TO BELFAST	N	S2	
17:00 – 17:30	"	N	S2	
17:30 – 18:00	BELFAST INT. AIRPORT	N	S2	
18:00 – 18:30	TRAVEL TO HOME	N	S2	
18:30 – 19:00	"	N	S2	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	N	N2	
20:00 – 21:00	Completion of diary	N	S4	
21:00 – 22:00	Home	N	N2	
22:00 – 23:00	"	N	N2	
23:00 – 24:00	"	N	N2	
24:00 – 1:00	"	N	N2	
1:00 – 2:00	"	N	N2	
2:00 – 3:00	"	N	N2	
3:00 – 4:00	"	N	N2	
4:00 – 5:00	"	N	N2	
5:00 – 6:00	"	N	N2	
6:00 – 7:00	"	N	N2	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 28.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	N	N2	
7:30 – 8:00	"	"	"	
8:00 – 8:30	"	"	"	
8:30 – 9:00	"	"	"	
9:00 – 9:30	"	"	"	
9:30 – 10:00	"	"	"	
10:00 – 10:30	"	"	"	
10:30 – 11:00	"	"	"	
11:00 – 11:30	"	"	"	
11:30 – 12:00	"	"	"	
12:00 – 12:30	"	"	"	
12:30 – 13:00	"	"	"	
13:00 – 13:30	"	"	"	
13:30 – 14:00	"	"	"	
14:00 – 14:30	"	"	"	
14:30 – 15:00	"	"	"	
15:00 – 15:30	"	"	"	
15:30 – 16:00	"	"	"	
16:00 – 16:30	"	"	"	
16:30 – 17:00	"	"	"	
17:00 – 17:30	"	"	"	
17:30 – 18:00	"	"	"	
18:00 – 18:30	"	"	"	
18:30 – 19:00	"	"	"	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	N	N2	
20:00 – 21:00	"	"	"	
21:00 – 22:00	"	"	"	
22:00 – 23:00	"	"	"	
23:00 – 24:00	"	"	"	
24:00 – 1:00	"	"	"	
1:00 – 2:00	"	"	"	
2:00 – 3:00	"	"	"	
3:00 – 4:00	"	"	"	
4:00 – 5:00	"	"	"	
5:00 – 6:00	"	"	"	
6:00 – 7:00	"	"	"	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 29.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	N	N2	
7:30 – 8:00	HOME	N	N2	
8:00 – 8:30	HOME	N	N2	
8:30 – 9:00	TRAVEL TO WORK	N		
9:00 – 9:30	WARD ROUNDS	Y	C4	
9:30 – 10:00	WARD ROUNDS	Y	C4	
10:00 – 10:30	WARD ROUNDS	Y	C4	
10:30 – 11:00	WARD ROUNDS	Y	C4	
11:00 – 11:30	URODYNAMIC STUDIES	Y	C8	
11:30 – 12:00	URODYNAMIC STUDIES	Y	C8	
12:00 – 12:30	URODYNAMIC STUDIES	Y	C8	
12:30 – 13:00	CONSULT. WITH RELATIVES	Y	C5	
13:00 – 13:30	LUNCH	Y		
13:30 – 14:00	URODYNAMIC STUDIES	Y	C8	
14:00 – 14:30	UROPATHOLOGY MEETING	Y	C7	
14:30 – 15:00	"	Y	C7	
15:00 – 15:30	URODYNAMIC STUDIES	Y	C8	
15:30 – 16:00	"	Y	C8	
16:00 – 16:30	"	Y	C8	
16:30 – 17:00	PATIENT ADMINISTRATION	Y	C11	
17:00 – 17:30	(DICTATION ON URO. STUDIES)	Y	C11	
17:30 – 18:00	TELEPHONE ADVICE TO DHH	Y	C6	
18:00 – 18:30	TEA.			
18:30 – 19:00	ATTENDENCE TO A/E PTS.	Y	C1x	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	CALLED TO PATIENTS IN A/E	Y	C1x	
20:00 – 21:00	ATTENDED TO WARD PATIENTS + TRAVEL HOME	Y	C1x	
21:00 – 22:00	HOME	Y		
22:00 – 23:00	"	Y		
23:00 – 24:00	"	Y		
24:00 – 1:00	"	Y		
1:00 – 2:00	"	Y		
2:00 – 3:00	"	Y		
3:00 – 4:00	"	Y		
4:00 – 5:00	"	Y		
5:00 – 6:00	"	Y		
6:00 – 7:00	"	Y		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 30.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y		
7:30 – 8:00	Home	Y		
8:00 – 8:30	Travel to Work	Y		
8:30 – 9:00	Discussion with SpR re. pts	Y	C4	
9:00 – 9:30	Day Surgical List	Y	C3	
9:30 – 10:00	"	Y	C3	
10:00 – 10:30	"	Y	C3	
10:30 – 11:00	"	Y	C3	
11:00 – 11:30	"	Y	C3	
11:30 – 12:00	"	Y	C3	
12:00 – 12:30	"	Y	C3	
12:30 – 13:00	"	Y	C3	
13:00 – 13:30	Patient Administration	Y	C11	
13:30 – 14:00	"	Y	C11	
14:00 – 14:30	Outpatient Clinic	Y	C2	
14:30 – 15:00	"	Y	C2	
15:00 – 15:30	"	Y	C2	
15:30 – 16:00	"	Y	C2	
16:00 – 16:30	"	Y	C2	
16:30 – 17:00	"	Y	C2	
17:00 – 17:30	Outpatient clinic and	Y	C11	
17:30 – 18:00	dictation on patients.	Y	C11	
18:00 – 18:30	Tea.	Y		
18:30 – 19:00	Attending to patients on ND	Y	C5	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	RETURNING CALLS FROM PTS,	Y	C5	
20:00 – 21:00	AND ADDRESSING QUERIES FROM GP'S, HOSPITALS	Y	C11	
21:00 – 22:00	TRAVEL HOME	Y		
22:00 – 23:00	HOME	Y		
23:00 – 24:00	"	Y		
24:00 – 1:00	"	Y		
1:00 – 2:00	"	Y		
2:00 – 3:00	"	Y		
3:00 – 4:00	"	Y		
4:00 – 5:00	"	Y		
5:00 – 6:00	"	Y		
6:00 – 7:00	"	Y		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 31.03.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y		
7:30 – 8:00	Home	Y		
8:00 – 8:30	Home	Y		
8:30 – 9:00	TRAVEL TO WORK	Y		
9:00 – 9:30	OPERATING	Y	C3	
9:30 – 10:00	"	Y	C3	
10:00 – 10:30	"	Y	C3	
10:30 – 11:00	"	Y	C3	
11:00 – 11:30	"	Y	C3	
11:30 – 12:00	"	Y	C3	
12:00 – 12:30	"	Y	C3	
12:30 – 13:00	"	Y	C3	
13:00 – 13:30	"	Y	C3	
13:30 – 14:00	"	Y	C3	
14:00 – 14:30	"	Y	C3	
14:30 – 15:00	"	Y	C3	
15:00 – 15:30	"	Y	C3	
15:30 – 16:00	"	Y	C3	
16:00 – 16:30	"	Y	C3	
16:30 – 17:00	"	Y	C3	
17:00 – 17:30	EMERGENCY OPERATING	Y	C1y	
17:30 – 18:00	EMERGENCY OPERATING	Y	C1y	
18:00 – 18:30	POSTOPERATIVE WARD ROUND	Y	C4	
18:30 – 19:00	POSTOPERATIVE WARD ROUND	Y	C4	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	ATTENDING TO ILL PATIENTS	Y	C1y	
20:00 – 21:00	ON WARD AND DISCUSSION WITH PATIENTS RELATIVES	Y	C1y	
21:00 – 22:00	PATIENT ADMINISTRATION	Y	C11	
22:00 – 23:00	ATTENDED PATIENT IN A/E	Y	C1y	
23:00 – 24:00	Home	Y		
24:00 – 1:00	"			
1:00 – 2:00	"			
2:00 – 3:00	"			
3:00 – 4:00	"			
4:00 – 5:00	"			
5:00 – 6:00	"			
6:00 – 7:00	"			

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 01.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	Y		
7:30 – 8:00	HOME	Y		
8:00 – 8:30	TRAVEL TO WORK	Y		
8:30 – 9:00	RADIOLOGY MEETING	Y	C7	
9:00 – 9:30	RADIOLOGY MEETING	Y	C7	
9:30 – 10:00	TELEPHONE CALL FROM DHH RE: PATIENT	Y	C6	
10:00 – 10:30	GRAND WARD ROUND	Y	C4	
10:30 – 11:00	"	Y	C4	
11:00 – 11:30	"	Y	C4	
11:30 – 12:00	"	Y	C4	
12:00 – 12:30	"	Y	C4.	
12:30 – 13:00	CONSULTATION WITH INPATIENT + RELATIVES	Y	C5	
13:00 – 13:30	LUNCH	Y		
13:30 – 14:00	PATIENT ADMINISTRATION	Y	C11	
14:00 – 14:30	WARD ROUND OF OUTLYING	Y	C4	
14:30 – 15:00	INPATIENTS WITH SHO	Y	C4.	
15:00 – 15:30	ORGANISED IVP ON PATIENT	Y	C8	
15:30 – 16:00	ARRANGED VARIOUS RADIOLOGICAL	Y	C11	
16:00 – 16:30	INVESTIGATIONS FOR PATIENTS	Y	C11	
16:30 – 17:00	ATTENDED PATIENT IN A/E.	Y	C1Y	
17:00 – 17:30	PATIENT ADMINISTRATION,	Y	C11	
17:30 – 18:00	ARRANGING OUTPATIENT	Y	C11	
18:00 – 18:30	APPOINTMENTS AND DICTATION	Y	C11	
18:30 – 19:00	OF LETTERS	Y	C11	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	PATIENT ADMINISTRATION	Y	C11	
20:00 – 21:00	Home	Y	C11	
21:00 – 22:00	TELEPHONE ADVICE TO HOSP.	Y	C6	
22:00 – 23:00	Home	Y		
23:00 – 24:00	"			
24:00 – 1:00	"			
1:00 – 2:00	"			
2:00 – 3:00	"			
3:00 – 4:00	"			
4:00 – 5:00	"			
5:00 – 6:00	"			
6:00 – 7:00	"			

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 02.04.04.

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	Y		
7:30 – 8:00	HOME	Y		
8:00 – 8:30	HOME	Y		
8:30 – 9:00	HOME	Y		
9:00 – 9:30	TRAVEL TO WORK	Y		
9:30 – 10:00	WARD ROUND	Y	C4	
10:00 – 10:30	WARD ROUND	Y	C4	
10:30 – 11:00	WARD ROUND	Y	C4	
11:00 – 11:30	PATIENT CONSULTATION	Y	C5	
11:30 – 12:00	PATIENT CONSULTATION	Y	C5	
12:00 – 12:30	PATIENT CONSULTATION	Y	C5	
12:30 – 13:00	PRIVATE PATIENT CONSULT.	Y	P1	
13:00 – 13:30	EMERGENCY THEATRE	Y	C1Y	
13:30 – 14:00	EMERGENCY THEATRE	Y	C1Y	
14:00 – 14:30	MEETING WITH MED. REP	Y	?	
14:30 – 15:00	PRIVATE PATIENT CONSULT.	Y	P1	
15:00 – 15:30	"	Y	P1	
15:30 – 16:00	PATIENT CONSULTATION	Y	C5	
16:00 – 16:30	PRIVATE PATIENT CONSULT'N	Y	P1	
16:30 – 17:00	PATIENT CONSULTATION	Y	C5	
17:00 – 17:30	WARD ROUND	Y	C4	
17:30 – 18:00	WARD ROUND	Y	C4	
18:00 – 18:30	WARD ROUND	Y	C4	
18:30 – 19:00	PATIENT ADMINISTRATION	Y	C11	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	TRAVEL TO SALT (SOUTHERN	N	N2	
20:00 – 21:00	AREA LEARNING IN TEAMS)	N	N2	
21:00 – 22:00	MEETING IN CARRICKMACROSS	N	N2	
22:00 – 23:00	IN CARRICKMACROSS	N	N2	
23:00 – 24:00	"	N	N2	
24:00 – 1:00	"	N	N2	
1:00 – 2:00	"	N	N2	
2:00 – 3:00	"	N	N2	
3:00 – 4:00	"	N	N2	
4:00 – 5:00	"	N	N2	
5:00 – 6:00	"	N	N2	
6:00 – 7:00	"	N	N2	

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: AIDAN O'BRIEN **Date:** 03.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	IN CARRICKMACROSS	N	N2	
7:30 – 8:00	"	N	N2	
8:00 – 8:30	"	N	N2	
8:30 – 9:00	"	N	N2	
9:00 – 9:30	ADDRESSING AND PARTICIPATING	N	N2	
9:30 – 10:00	IN SALT MEETING, ON	N	N2	
10:00 – 10:30	ERECTILE DYSFUNCTION IN	N	N2	
10:30 – 11:00	DIABETIC PATIENTS	N	N2	
11:00 – 11:30	"	N	N2	
11:30 – 12:00	"	N	N2	
12:00 – 12:30	"	N	N2	
12:30 – 13:00	"	N	N2	
13:00 – 13:30	LUNCH	N	N2	
13:30 – 14:00	LUNCH	N	N2	
14:00 – 14:30	TRAVEL BACK TO CAH	N	N2	
14:30 – 15:00	"	N	N2	
15:00 – 15:30	REVIEW OF INPATIENTS	N	C4	
15:30 – 16:00	REVIEW OF INPATIENTS	N	C4	
16:00 – 16:30	PATIENT ADMINISTRATION	N	P1	
16:30 – 17:00	(PRIVATE)	N	P1	
17:00 – 17:30	TRAVEL HOME	N		
17:30 – 18:00	HOME	N		
18:00 – 18:30	"	Y		
18:30 – 19:00	"	Y		

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	Y		
20:00 – 21:00	"	Y		
21:00 – 22:00	"	Y		
22:00 – 23:00	"	Y		
23:00 – 24:00	"	Y		
24:00 – 1:00	"	Y		
1:00 – 2:00	"	Y		
2:00 – 3:00	"	Y		
3:00 – 4:00	"	Y		
4:00 – 5:00	"	Y		
5:00 – 6:00	"	Y		
6:00 – 7:00	"	Y		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 04.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y		
7:30 – 8:00	"	Y		
8:00 – 8:30	"	Y		
8:30 – 9:00	"	Y		
9:00 – 9:30	"	Y		
9:30 – 10:00	Telephone advice to hosp.	Y	C6	
10:00 – 10:30	Home	Y		
10:30 – 11:00	"	Y		
11:00 – 11:30	"	Y		
11:30 – 12:00	"	Y		
12:00 – 12:30	"	Y		
12:30 – 13:00	"	Y		
13:00 – 13:30	"	Y		
13:30 – 14:00	"	Y		
14:00 – 14:30	"	Y		
14:30 – 15:00	"	Y		
15:00 – 15:30	"	Y		
15:30 – 16:00	"	Y		
16:00 – 16:30	Telephone advice to hosp.	Y	C6	
16:30 – 17:00	Emergency travel to hosp	Y		
17:00 – 17:30	Attending to ill postop.	Y	C1Y	
17:30 – 18:00	patient in ITU	Y	C1Y	
18:00 – 18:30	"	Y	C1Y	
18:30 – 19:00	"	Y	C1Y	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	ATTENDING TO ILL PATIENT	Y	C1y	
20:00 – 21:00	TRAVEL + ARRIVAL AT HOME	Y		
21:00 – 22:00	TELEPHONE ADVICE TO HOSP.	Y	C6	
22:00 – 23:00	Home	Y		
23:00 – 24:00	"	Y		
24:00 – 1:00	"	Y		
1:00 – 2:00	"	Y		
2:00 – 3:00	"	Y		
3:00 – 4:00	"	Y		
4:00 – 5:00	"	Y		
5:00 – 6:00	"	Y		
6:00 – 7:00	"	Y		

Direct Clinical Care - Code C	
Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S	
Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A	
Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5
Non-work activity – Code N	
Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2
Other duties – Code D	
Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P	
Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: AIDAN O'BRIEN **Date:** 05.04.04.

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	Y		
7:30 – 8:00	HOME	Y		
8:00 – 8:30	HOME	Y		
8:30 – 9:00	TRAVEL TO WORK	Y		
9:00 – 9:30	URODYNAMIC STUDIES	N	C8	
9:30 – 10:00	URODYNAMIC STUDIES	N	C8	
10:00 – 10:30	PATIENT CONSULTATION	N	C5	
10:30 – 11:00	URODYNAMIC STUDIES	N	C8	
11:00 – 11:30	URODYNAMIC STUDIES	N	C8	
11:30 – 12:00	PATIENT CONSULTATION	N	C5	
12:00 – 12:30	URODYNAMIC STUDIES	N	C8	
12:30 – 13:00	PATIENT CONSULTATION	N	C5	
13:00 – 13:30	LUNCH	N		
13:30 – 14:00	URODYNAMIC STUDIES	N	C8	
14:00 – 14:30	UROPATHOLOGY MEETING	N	C7	
14:30 – 15:00	UROPATHOLOGY MEETING	N	C7	
15:00 – 15:30	PATIENT CONSULTATION	N	C5	
15:30 – 16:00	URODYNAMIC STUDIES	N	C8	
16:00 – 16:30	PATIENT CONSULTATION	N	C5	
16:30 – 17:00	WARD ROUNDS	N	C4	
17:00 – 17:30	WARD ROUNDS	N	C4	
17:30 – 18:00	WARD ROUNDS	N	C4	
18:00 – 18:30	EMERGENCY THEATRE	N	C1Y	
18:30 – 19:00	EMERGENCY THEATRE	N	C1Y	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	ARRANGED NEPHROSTOMY DRAINAGE FOR PATIENT	Y/N	C1y	
20:00 – 21:00	ADMINISTRATION : ORGANISED	N	C11	
21:00 – 22:00	ELECTIVE ADMISSIONS FOR WEEK COMMENCING 19.04.04	N	C11	
22:00 – 23:00	TRAVEL HOME	N		
23:00 – 24:00	TELEPHONE ADVICE TO HOSP.	N	C6	
24:00 – 1:00	HOME	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C	
Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S	
Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A	
Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5
Non-work activity – Code N	
Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2
Other duties – Code D	
Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P	
Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: AIDAN O'BRIEN **Date:** 06.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	HOME	N		
7:30 – 8:00	HOME	N		
8:00 – 8:30	HOME	N		
8:30 – 9:00	TRAVEL TO WORK.	N		
9:00 – 9:30	OPERATING SESSION IN	EN	C3	
9:30 – 10:00	DAY-SURGICAL UNIT	N	C3	
10:00 – 10:30	"	N	C3	
10:30 – 11:00	"	N	C3	
11:00 – 11:30	"	N	C3	
11:30 – 12:00	"	N	C3	
12:00 – 12:30	"	N	C3	
12:30 – 13:00	"	N	C3	
13:00 – 13:30	ATTENDING TO PATIENT ON	N	C5	
13:30 – 14:00	WARD AND DISCUSSION OF ILLNESS WITH RELATIVES.	N	C5	
14:00 – 14:30	OUTPATIENT CLINIC - CAH	N	C2	
14:30 – 15:00	"	N	C2	
15:00 – 15:30	"	N	C2	
15:30 – 16:00	"	N	C2	
16:00 – 16:30	"	N	C2	
16:30 – 17:00	"	N	C2	
17:00 – 17:30	"	N	C2	
17:30 – 18:00	ASSESSMENT PRE-OP. PATIENTS	N	C5	
18:00 – 18:30	"	N	C5	
18:30 – 19:00	TEA IN CANTEEN	N		

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	ATTENDING TO QUERIES RE:	N	C11	
20:00 – 21:00	PATIENT MANAGEMENT RAISED BY PATIENTS AND GPs	N	C11	
21:00 – 22:00	DURING DAY. DICTATION OF CLINIC LETTERS	N	C11	
22:00 – 23:00	HOME	N		
23:00 – 24:00	"	N		
24:00 – 1:00	"	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 07.04.04.

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	N		
7:30 – 8:00	"	N		
8:00 – 8:30	"	N		
8:30 – 9:00	Travel To Work	N		
9:00 – 9:30	Operating Theatre Session	N	C3	
9:30 – 10:00	"	N	C3	
10:00 – 10:30	"	N	C3	
10:30 – 11:00	"	N	C3	
11:00 – 11:30	"	N	C3	
11:30 – 12:00	"	N	C3	
12:00 – 12:30	"	N	C3	
12:30 – 13:00	"	N	C3	
13:00 – 13:30	"	N	C3	
13:30 – 14:00	"	N	C3	
14:00 – 14:30	"	N	C3	
14:30 – 15:00	"	N	C3	
15:00 – 15:30	"	N	C3	
15:30 – 16:00	"	N	C3	
16:00 – 16:30	"	N	C3	
16:30 – 17:00	"	N	C3	
17:00 – 17:30	"	N	C3	
17:30 – 18:00	Tea	N		
18:00 – 18:30	Postop. Ward Round	N	C4	
18:30 – 19:00	"	N	C4	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	PATIENT ADMINISTRATION.	N	C11	
20:00 – 21:00	LETTERS. DICTATION.	N	C11	
21:00 – 22:00	ARRANGED OUTPUT. APPS ETC. AND TRAVEL HOME	N	C11	
22:00 – 23:00	Home	N		
23:00 – 24:00	"	N		
24:00 – 1:00	"	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 08.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	N		
7:30 – 8:00	"	N		
8:00 – 8:30	Travel to Work	N		
8:30 – 9:00	Uroradiology meeting	N	C7	
9:00 – 9:30	"	N	C7	
9:30 – 10:00	Breakfast	N		
10:00 – 10:30	Grand Ward rounds	N	C4	
10:30 – 11:00	"	N	C4	
11:00 – 11:30	"	N	C4	
11:30 – 12:00	"	N	C4	
12:00 – 12:30	"	N	C4	
12:30 – 13:00	"	N	C4	
13:00 – 13:30	Consultations & Referrals	N	C5	
13:30 – 14:00	"	N	C5	
14:00 – 14:30	Outpatient consultation	N	C5	
14:30 – 15:00	Telephone advice to ACH	N	C6	
15:00 – 15:30	Round of outliers	N	C4	
15:30 – 16:00	"	N	C4	
16:00 – 16:30	Organised radiological inv.n	N	C8	
16:30 – 17:00	with radiologists	N	C8	
17:00 – 17:30	Patient administration	N	C11	
17:30 – 18:00	"	N	C11	
18:00 – 18:30	"	N	C11	
18:30 – 19:00	"	N	C11	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	PATIENT ADMINISTRATION	N	C11	
20:00 – 21:00	Home	N		
21:00 – 22:00	"	N		
22:00 – 23:00	"	N		
23:00 – 24:00	"	N		
24:00 – 1:00	"	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C	
Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S	
Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A	
Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5
Non-work activity – Code N	
Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2
Other duties – Code D	
Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P	
Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: AIDAN O'BRIEN **Date:** 09.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	N		
7:30 – 8:00	"	N		
8:00 – 8:30	"	N		
8:30 – 9:00	TRAVEL TO WORK	N		
9:00 – 9:30	WARD ROUND	N	C4	
9:30 – 10:00	"	N	C4	
10:00 – 10:30	"	N	C4	
10:30 – 11:00	PATIENT CONSULTATION	N	C5	
11:00 – 11:30	PATIENT CONSULTATION	N	C5	
11:30 – 12:00	PRIVATE PATIENT CONSULT N	N	P1	
12:00 – 12:30	PATIENT ADMINISTRATION	N	C11	
12:30 – 13:00	MEETING WITH 'DRUG REP'	N		
13:00 – 13:30	LUNCH	N		
13:30 – 14:00	"	N		
14:00 – 14:30	PATIENT ADMINISTRATION	N	C11	
14:30 – 15:00	PATIENT CONSULTATION	N	C5	
15:00 – 15:30	PRIVATE PATIENT CONSULT N	N	P1	
15:30 – 16:00	PRIVATE PATIENT CONSULT N	N	P1	
16:00 – 16:30	PRIVATE PATIENT CONSULT N	N	P1	
16:30 – 17:00	PATIENT ADMINISTRATION	N	C11	
17:00 – 17:30	WARD ROUND	N	C4	
17:30 – 18:00	"	N	C4	
18:00 – 18:30	"	N	C4	
18:30 – 19:00	PATIENT ADMINISTRATION	N	C11	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	ADMINISTRATION	N	C11	
20:00 – 21:00	TRAVEL HOME	N		
21:00 – 22:00	Home	N		
22:00 – 23:00	"	N		
23:00 – 24:00	"	N		
24:00 – 1:00	"	N		
1:00 – 2:00	"	N		
2:00 – 3:00	"	N		
3:00 – 4:00	"	N		
4:00 – 5:00	"	N		
5:00 – 6:00	"	N		
6:00 – 7:00	"	N		

Direct Clinical Care - Code C	
Emergency attendance:	
Predictable on-call	C1x
Unpredictable on-call	C1y
Outpatient or other clinic	C2
Operating session	C3
Ward round	C4
Other patient treatment or relative consultation	C5
Telephone advice to hospital	C6
Multi-disciplinary meetings about direct patient care	C7
Investigative, diagnostic or laboratory work	C8
Public Health duties	C9
Travelling time between sites	C10
Patient administration	C11

Supporting activities – Code S	
Training/Teaching	S1
Continuous Professional Development	S2
Audit/Clinical Governance	S3
Job planning & appraisal	S4
Research	S5
Clinical management	S6

Additional Responsibilities - Code A	
Audit lead or clinical governance lead	A2
Clinical Tutor	A3
Medical/clinical directors/ lead clinician	A4
Other additional responsibilities	A5
Non-work activity – Code N	
Absent from work	
Annual/study leave	N1x
Sickness	N1y
Other (time spent not working)	N2
Other duties – Code D	
Trade union duties	D1
AAC external member	D2
NCAA/GMC/CHAI	D3
Work for Royal Colleges	D4
Other	D5

Addition remunerated work – Code P	
Private Practice	P1
Category 2 work	P2
Other remunerated work	P3

Consultant Name: Aidan O'Brien **Date:** 10.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	N		
7:30 – 8:00	"	N		
8:00 – 8:30	Telephone advice to Hosp.	N	C6	
8:30 – 9:00	Travel to Work	N		
9:00 – 9:30	Attending to ill patient in	Y	C5	C1y
9:30 – 10:00	ward	Y	C5	C1y
10:00 – 10:30	Ward rounds, discharging	Y	C4	C1x
10:30 – 11:00	patients and seeing	Y	C4	C1x
11:00 – 11:30	new admissions, all	Y	C4	C1x
11:30 – 12:00	done as Registrar	Y	C4	C1x
12:00 – 12:30	"	Y	C4	C1x
12:30 – 13:00	"	Y	C4	C1x
13:00 – 13:30	"	Y	C4	C1x
13:30 – 14:00	"	Y	C4	C1x
14:00 – 14:30	"	Y	C4	C1x
14:30 – 15:00	"	Y	C4	C1x
15:00 – 15:30	Doing IVP's on newly	Y	C8	C1y
15:30 – 16:00	admitted patients with	Y	C8	C1y
16:00 – 16:30	ureteric colic	Y	C8	C1y
16:30 – 17:00	Inpatient management	Y	C1y	
17:00 – 17:30	"	Y	C1y	
17:30 – 18:00	"	Y	C1y	
18:00 – 18:30	"	Y	C1y	
18:30 – 19:00	"	Y	C1y	

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	INPATIENT MANAGEMENT	Y	C1y	
20:00 – 21:00	"	Y	C1y	
21:00 – 22:00	PATIENT ADMINISTRATION	Y	C11	
22:00 – 23:00	"	Y	C11	
23:00 – 24:00	EMERGENCY OPERATING	Y	C1y	
24:00 – 1:00	"	Y	C1y	
1:00 – 2:00	"	Y	C1y	
2:00 – 3:00	"	Y	C1y	
3:00 – 4:00	ACUTE EMERGENCY ON WARD	Y	C1y	
4:00 – 5:00	EMERGENCY OPERATING	Y	C1y	
5:00 – 6:00	OPERATING AND TRAVEL HOME	Y	C1y	
6:00 – 7:00	HOME	Y		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Consultant Name: Aidan O'Brien **Date:** 11.04.04

	Work Commitment	On-Call Y/N	Code	Office Use
7am – 7:30	Home	Y		
7:30 – 8:00	"	Y		
8:00 – 8:30	"	Y		
8:30 – 9:00	"	Y		
9:00 – 9:30	"	Y		
9:30 – 10:00	"	Y		
10:00 – 10:30	"	Y		
10:30 – 11:00	"	Y		
11:00 – 11:30	Travel to hospital	Y		
11:30 – 12:00	Ward rounds, inpatient	Y	C1X	
12:00 – 12:30	management, discharging	Y	C1X	
12:30 – 13:00	patients, attending	Y	C1X	
13:00 – 13:30	to new admissions	Y	C1X	
13:30 – 14:00	and doing IVPs on	Y	C1X	
14:00 – 14:30	and new admissions	Y	C1Y	
14:30 – 15:00	with colic (all work	Y	C1Y	
15:00 – 15:30	undertaken as	Y	C1Y	
15:30 – 16:00	registrar, as no	Y	C1Y	
16:00 – 16:30	registrar on call)	Y	C1Y	
16:30 – 17:00	"	Y	C1Y	
17:00 – 17:30	"	Y	C1Y	
17:30 – 18:00	Travel home	Y		
18:00 – 18:30	Home	Y		
18:30 – 19:00	"	Y		

Time	Work Commitment	On-Call Y/N	Code	Office Use
19:00 – 20:00	Home	Y		
20:00 – 21:00	Telephone advice to Hosp+	Y	C6	
21:00 – 22:00	Home	Y		
22:00 – 23:00	"	Y		
23:00 – 24:00	"	Y		
24:00 – 1:00	"	Y		
1:00 – 2:00	"	Y		
2:00 – 3:00	"	Y		
3:00 – 4:00	"	Y		
4:00 – 5:00	"	Y		
5:00 – 6:00	"	Y		
6:00 – 7:00	"	Y		

Direct Clinical Care - Code C		**Additional Responsibilities - Code A**	
Emergency attendance:		Audit lead or clinical governance lead	A2
Predictable on-call	C1x	Clinical Tutor	A3
Unpredictable on-call	C1y	Medical/clinical directors/ lead clinician	A4
Outpatient or other clinic	C2	Other additional responsibilities	A5
Operating session	C3		
Ward round	C4	**Non-work activity – Code N**	
Other patient treatment or relative consultation	C5	Absent from work	
Telephone advice to hospital	C6	Annual/study leave	N1x
Multi-disciplinary meetings about direct patient care	C7	Sickness	N1y
Investigative, diagnostic or laboratory work	C8	Other (time spent not working)	N2
Public Health duties	C9	**Other duties – Code D**	
Travelling time between sites	C10	Trade union duties	D1
Patient administration	C11	AAC external member	D2
		NCAA/GMC/CHAI	D3
		Work for Royal Colleges	D4
		Other	D5
Supporting activities – Code S		**Addition remunerated work – Code P**	
Training/Teaching	S1	Private Practice	P1
Continuous Professional Development	S2	Category 2 work	P2
Audit/Clinical Governance	S3	Other remunerated work	P3
Job planning & appraisal	S4		
Research	S5		
Clinical management	S6		

Additional Activities

Please provide details of any additional commitments/duties that you are involved in throughout the year which are not reflected in this 4-week period, e.g. participation on interview panels, attendance at meetings, etc.

Nature of Activity/Duty	Time Commitment
VICE CHAIR OF CURE COMMITTEE	12 HOURS OF COMMITTEE MEETINGS PER YEAR.
DIRECTOR OF CURE	12 – 20 HOURS OF ADMINISTRATION PER YEAR
CURE FUNDRAISING EVENTS	12 HOURS PER YEAR
POSTGRADUATE TEACHING OF SpRs IN UROLOGY	3 HALF-DAYS PER YEAR
PREPARATION FOR ABOVE	3 HALF-DAYS PER YEAR
RITA ASSESSMENTS, SHORTLISTINGS + INTERVIEWS	3 HALF-DAYS PER YEAR.
SUPERVISION AND MEETINGS TO MONITOR RESEARCH BY RESEARCH FELLOWS	3 HALF-DAYS PER YEAR.
CME BY READING OF UROLOGICAL LITERATURE	2 HOURS PER WEEK (100 HRS PER YEAR)

UROLOGY DEPARTMENT

Telephone: Personal Information redacted by the USI
Fax:

30 October 2006

Mr E Mackle
Clinical Director of Surgical Services
Craigavon Area Hospital Group Trust

Dear ~~Eamon~~ JOHN,

Re: External Duties

The only external functions or duties to which I am committed are those of Director of CURE and member of the CURE Committee. I would anticipate that both will continue indefinitely. In the context of inquiry, I would not consider that either compromise my obligations to the Trust as its employee.

Yours sincerely

Personal Information redacted by the USI

AIDAN O'BRIEN
CONSULTANT UROLOGICAL SURGEON

copy to Mr J Templeton, Chief Executive, CAHGT

Parks, Zoe

From: Burns, Deborah <[redacted]>
Sent: 14 August 2009 12:49
To: McAlinden, Mairead; Youart, Joy; Donaghy, Kieran
Cc: Clarke, Paula; Tally, Paula; Mackle, Eamon; Parks, Zoe
Subject: FW: TEAM UROLOGY JOB PLAN - SECOND DRAFT 13.8.09
Attachments: TEAM UROLOGY JOB PLAN - SECOND DRAFT 13.8.09.doc

Importance: High

Hi all
Please find attached below a first work up of the DCC and Spa sessions for the urology team and what will be left to meet the demand in clinical sessions. This is based on a very good model - Eamons suggestion of a SOW model where that person still maintains clinical sessions in the morning. However as you can see we will still only have 26 clinical sessions per week to meet demand if all 5 consultants available and probably will only have 4 available at any one time due to annual leave therefor will on a 52 week year have only 20.75 clinical sessions avaialable every week.

I am working on the demand currently - this is proving difficult as currently the decisions to admit look very high - this should be available next week but without adding in the western work and still assuming 5 consultants - based on the attached we will find it difficult to meet demand. Therefore there probably needs to be some consideration given at a corporate level to the number of PA's taken up as attached and if any further corporate guidnace can be given to the AMD etc in this area?

Any comments let me know
Thanks
D
Debbie Burns
Assistant Director Performance Improvement Southern Trust
Email: [redacted]
Tel: [redacted]

From: Parks, Zoe
Sent: 14 August 2009 11:29
To: Burns, Deborah
Cc: Mackle, MR E
Subject: TEAM UROLOGY JOB PLAN - SECOND DRAFT 13.8.09
Importance: High

<<TEAM UROLOGY JOB PLAN - SECOND DRAFT 13.8.09.doc>>

For your comments

Zoë Parks
Medical HR Mgr
Southern Trust
Direct Line: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Southern Health and Social Care Trust

Urology Service Review

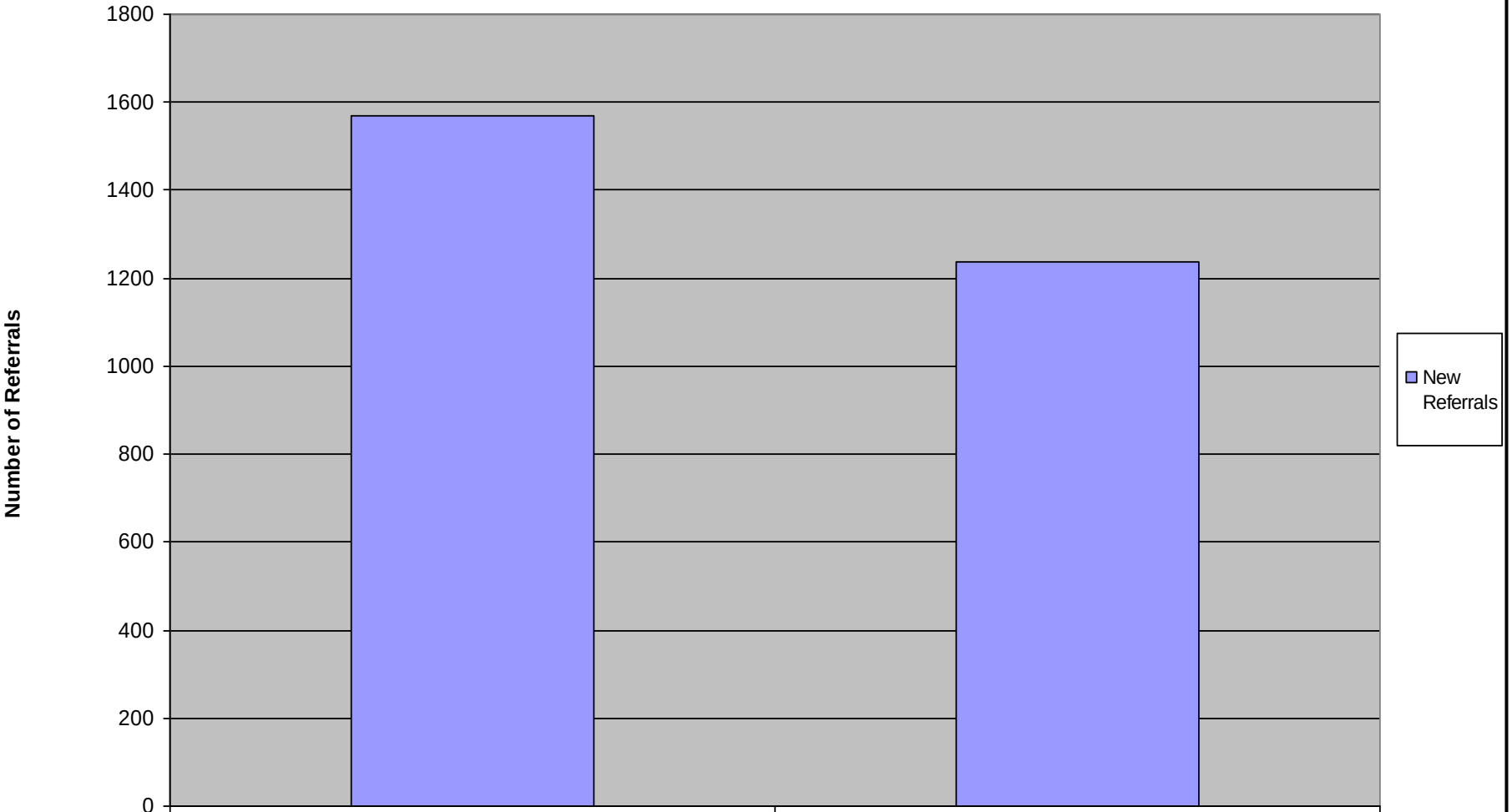
Demand & Capacity Planning

Paula Tally – Head of Reform

7 September 2009

SOUTHERN HEALTH & SOCIAL CARE TRUST
Number of New Outpatient Referrals to Urology CAH Team
2007/08 & 2008/09

Surgical Team is based on - CAH, BBPC, STH and ACH = CAH Team



Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Demand & Capacity Planning

- Additional 400 referrals per year WHSCT
- Chronic cases (14%)
- Consultant Initiated Referrals (50 per wk)
- 45% Conversion from New - Reviews

SHSCT Out-Patient Demand

- 20 referrals per wk (after rott) x 52 = 1040
- 1040 x 45% x 3 reviews = 1404
- 1040 x 14% chronic x 2 reviews = 291
- Consultant I. Referrals 50 x 52 = 2600
- Total Reviews = 4295

New Demand = 1040/52 = **20 new per wk**

Review Demand = 4295/52 = **83 rws per wk**

Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

Fermanagh Out-patient Demand

- 400 annual referrals
- 400/52 = **7 new per wk**
- 400 x 45% x 3 reviews = 540/52 = 10
- 400 x 14% chronic x 2 reviews/52 = 2
- Total Reviews = **12 Reviews per wk**

Total New Demand = 27 new per wk

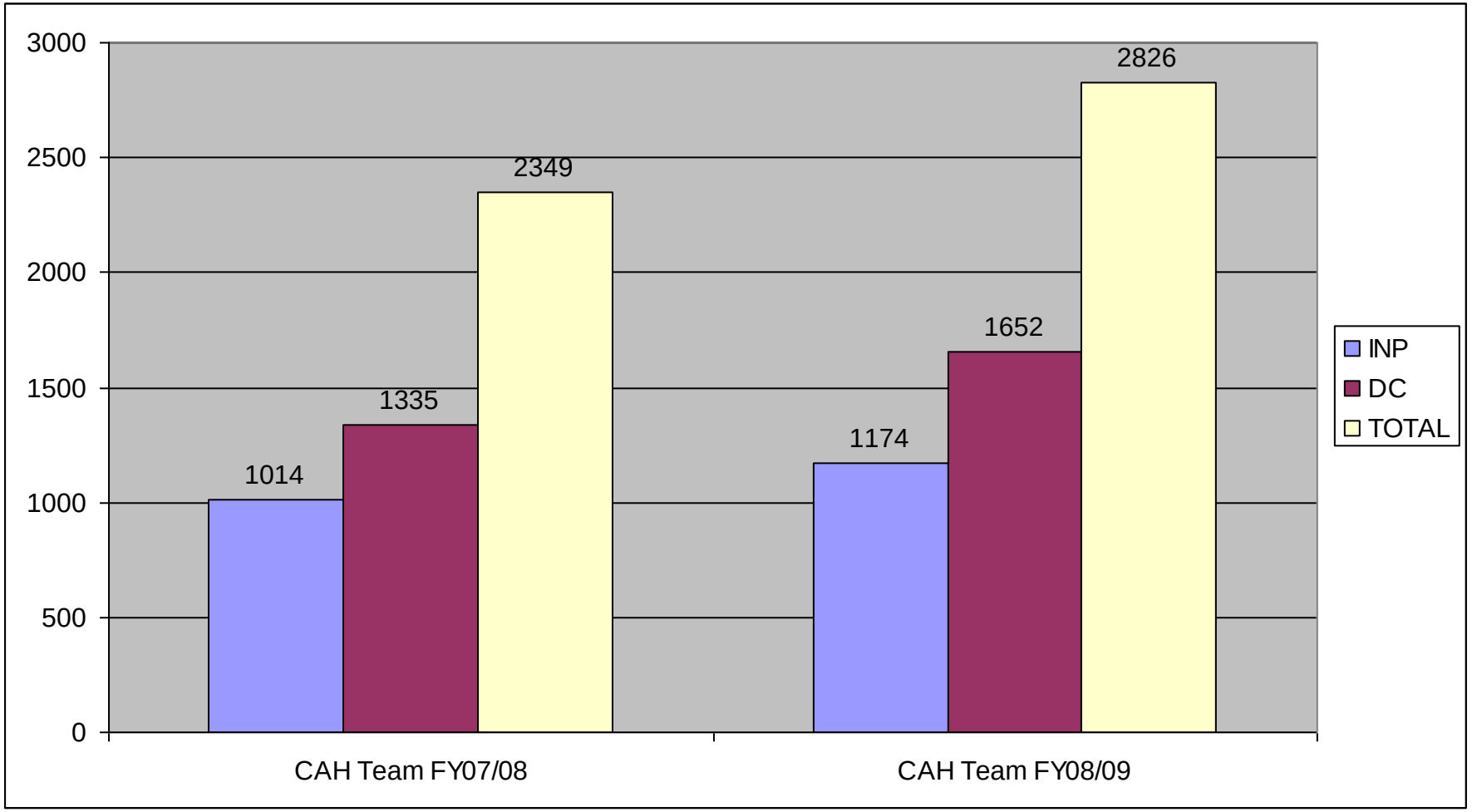
Total Review Demand = 95 rws per wk

Southern Health and Social Care Trust

In-Patient Demand

SOUTHERN HEALTH AND SOCIAL CARE TRUST

UROLOGY ANNUALISED DTA'S (EXCLUDING PLANNED ADMISSIONS) - INPATIENTS/DAYCASES/TOTAL



Received from SHSCT on 22/11/2022. Annotated by the Urology Services Inquiry.

DTA's Generated From Out-Patients

- Total 2008/09 2826
- 28% DTA (New) 27 x 28% = 8 per week
- 15% DTA (Rw) 95 x 15% = 14 per week
- Total = 22 pts x 52 = 1144

DTA's Split by In-Patients/Daycases

22 x 42% In-pts = 9 patients

22 x 58% D-cases = 13 patients

DTA's Generated From Other Sources

- 2826 – 1144 = 1682
- 1682 x 42% = 706/52 = 14 In-patients
- 1682 x 58% = 976/52 = 19 Daycases

Total Weekly In-Patient Demand

23 In-Patients, 32 Daycases

Southern Health and Social Care Trust

DISCUSSION

How can we devise a team job plan to meet the service needs identified?

Parks, Zoe

From: Burns, Deborah <[redacted]>
Sent: 18 February 2010 12:12
To: Parks, Zoe; Mackle, Mr E; Clegg, Malcolm
Subject: FW: Urology Information
Attachments: SUMMARY OF ACTION TO DATE - 11 Nov 09 (2).doc; Urology Service Review Presentation 7 Sept 09.ppt

Hi
see attached word document which outlines the split of the DCC sessions against outpatients, ins and days - and the differing views on how many sessions required for number of patients - if you remember main issues were time required to see new and review outpts - we thought 7 new and 23 review with doctor support - 2 docs at 3.5 clinic = 14 mins for new and review

Urology were proposing 5 new and 16 review - this would be 20 mins per patient!

Also day cases including mainly cystoscopy - we thought 6.4 per list on average the survey said! 5 per list??

DO we want to meet again?
D

Debbie Burns
Assistant Director Performance Improvement Southern Trust
Email: [redacted]
Tel: [redacted]

From: Tally, Paula
Sent: 12 February 2010 10:14
To: Burns, Deborah
Subject: FW: Urology Information

See email below.

Paula Tally

Best Care Best Value Project Manager
Directorate of Mental Health & Disability Rosedale
10 Moyallen Road
Gilford
BT63 5JX

Tel: [redacted]

From: Tally, Paula
Sent: 12 February 2010 10:14
To: 'debbie.campbel[redacted]'
Subject: Urology Information

Debbie

I have attached the brief summary and a copy of last presentation. Hope this is helpful.

Paula Tally

Best Care Best Value Project Manager
Directorate of Mental Health & Disability Rosedale
10 Moyallen Road
Gilford
BT63 5JX

Tel: [redacted]

UROLOGY DEPARTMENT

Telephone: Personal Information redacted by the USI
Fax:

30 October 2006

Mr E Mackle
Clinical Director of Surgical Services
Craigavon Area Hospital Group Trust

Dear ~~Eamon~~ JOHN,

Re: External Duties

The only external functions or duties to which I am committed are those of Director of CURE and member of the CURE Committee. I would anticipate that both will continue indefinitely. In the context of inquiry, I would not consider that either compromise my obligations to the Trust as its employee.

Yours sincerely

Personal Information redacted by the USI

AIDAN O'BRIEN
CONSULTANT UROLOGICAL SURGEON

copy to Mr J Templeton, Chief Executive, CAHGT

Northern Ireland
Medical & Dental Training Agency

Beechill House
42 Beechill Road
Belfast
BT8 7RJ

Tel: Personal Information redacted by the USI
Fax:
Web: www.nimdta.gov.uk
Email: Personal Information redacted by the USI

10 January 2008

Ms Betty Williamson
Medical Personnel
Craigavon Area Hospital
Lurgan Road
CRAIGAVON
BT63 5QQ

CRAIGAVON AREA HOSPITAL GROUP TRUST
14 JAN 2008
HUMAN RESOURCES DEPARTMENT

Dear Ms Williamson

Re: Payment of Training Programme Directors

I am writing to advise you of an adjustment that needs to be made in regard to payment of the Agency's Training Programme Director who is on your payroll. The Agency will be funding the following number of PA's, which should be backdated to 1 April 2007:

- Mr M Young - TPD for Urology, 0.25 PA

If you require anything further, please do not hesitate to contact Gillian Kirk on Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

Roisin Campbell BLS MSSc MCIPD
Human Resources Manager

22.12.09
Confirmed with NIMDTA this role finished on 30 Nov 09.

Southern Health and Social Care Trust

SUMMARY OF ACTION TO DATE

Urology Review Position

Demand & Capacity Analysis

A demand and capacity planning exercise has been undertaken, which has determined the demand on the Southern Trust Urology Service, based on 2008/09 figures. In addition information provided by Western Health & Social Care Trust regarding demand for urology services from Enniskillen/Omagh localities has also included in the demand/capacity exercise to determine the full service requirements based on the outcome of the regional urology review.

Demand & Capacity Findings

Service Area	Future Demand per Week
Outpatients New Review	27 new per wk 95 review per wk
In-patient	23 per wk
Day-cases	32 per wk

Proposed Urology Medical Team

Mr Michael Young
Mr Aidan O'Brien
Mr Mehmood Akhtar
2 x additional Consultant posts.

Summary Position

Directorate of Performance and Reform have undertaken extensive consultation with the Urology Specialty, regarding the development of a Service Specification to meet the identified future demand following full implementation of the recommendations of the regional urology review, based on a 5 Consultant Model. This is outlined below, in addition the proposed required which has been advised by Consultant Team has also been included.

Service Area	Demand		Proposed Total Sessions
Outpatients	27 new 95 review	Reform Urology	4 6
In-patients	23 per wk	Reform Urology	9 9
Daycase	32 per wk	Reform Urology	5 6
Total		**Reform** **Urology**	**18** **21**

Team Job Plan

The above sessions will be for DCC time only. Assuming that all 5 Consultants will be working on an 11 PA job plan, based on the figures provided by the Urology Team, this would leave 34 PA's to undertake all of the following;

Ward Rounds
Grand Ward Rounds
Patient Administration
SPA
Predictable On-call
MDT Meetings
Team Meeting
X-Ray Meeting
Travel between sites etc.
Surgeon of the Week?

Southern Health and Social Care Trust

Medical Directorate

Memorandum

Our ref:	PL/AB/lw	**Your ref:**	
To:	Zoe Parks, Medical Staffing		
From:	Dr Patrick Loughran, Medical Director		
c.c.	Simon Gibson, AD of General Surgery & Elective Care Sharon Glenny, Administrator Surgery Dept Eamon Mackle, AMD for Surgery/Elective Care		
Date:	15th September 2008		
Subject:	**Mr Akhtar – TRUS Biopsy Session**		

Dear Zoe

Could you please arrange for Mr Akhtar's job plan to be amended to include an additional ½ PA per week to reflect the work he is undertaking for TRUS Biopsy.

This would be effective from 1st June 2008.

Yours sincerely

Personal Information redacted by the USI

_____

Dr Patrick Loughran
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Fax: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

Parks, Zoe

From:	Parks, Zoe
Sent:	28 October 2022 19:45
To:	Parks, Zoe
Subject:	FW: UROLOGY DRAFT TEAM ANALYISIS VERSION 22 12 09
Attachments:	UROLOGY DRAFT TEAM ANALYISIS VERSION 22 12 09.doc; aobrien_externalduties.pdf; 20080915_Memo_ZoeParks_MrAkhtar_PLAB.doc; Payment of Training Programme Director - Mr M Young.pdf
Importance:	High

-----Original Message-----
From: Parks, Zoe [redacted]
Sent: 22 December 2009 12:31
To: Chambers, Rachel [redacted]; Burns, Deborah [redacted] Tally, Paula [redacted]
Cc: gillian.rankin [redacted] Clegg, Malcolm [redacted]
Subject: UROLOGY DRAFT TEAM ANALYISIS VERSION 22 12 09
Importance: High

22 December 2009

Debbie,

Re: Urology Team Analysis

Dr Rankin has asked, given the many discussions regarding urology services and the requirement from early January for them to attend MDT meetings regionally which takes out 3 outpatient clinics every week, if we can review the Urology Job plans and advise her of a timescale for completion.

I was meeting with Mr Mackle yesterday afternoon in the context of the ENT Job Plan analysis and I asked him about Urology. He was keen to meet up again with you and I to review the Team Urology analysis we had undertaken in August with a view to getting this right – which we could then present to the Urologists as a formal offer. If they don't accept they would then have to go through the normal process for job plan facilitation/appeal but would at least this would encourage some movement away from existing PA levels.

I had a further look at our previous analysis this morning and I have set in out slightly differently to show the team analysis clearly.

Also in terms of external duties – these are the only ones I am aware of – see attached. Some of these however may be historical now, Mr Mackle will hopefully be able to confirm this. I

can confirm that Mr Young is no longer Training Programme Director for NIMDTA –he held this role from 1 April 2007 until 30 November 2009 and was funded 0.25 PA from NIMDTA.

In terms of Junior Medical Staffing, there are 2 training doctors allocated to the training programme at CAH (although there are some indications that this may revert to 1 SpR post from August 2010 as the other ST3 post may revert back to surgical training – Mr Mackle is aware of this.) The SpR's work a fixed night on-call and 1 weekend in five. Currently these doctors are not working below 48 hours per week which is required for EWTD. There are ongoing discussions with Belfast to consider the development of a joint regional rota. Historically there were also 2 additional posts. However there is a query over the amount of time Mr Young gave to these doctors to undertake Research. We have not sought to fill these posts from February as per Dr Rankin/Mr Mackle, as moving forward there needs to be agreement that these will be "pure" service posts with no research element.

I am finishing today on leave and won't be back until 4 January, so unfortunately I won't be able to attend the meeting tomorrow. However I can update Malcolm Clegg and he is happy to attend in my absence if required. I can also be contactable on my mobile if there are any queries.

In the meantime, please let me know if you require anything else. Many thanks

Zoe

Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 22 December 2009 12:31
To: Chambers, Rachel; Burns, Deborah; Tally, Paula
Cc: gillian.rankin[redacted]; Clegg, Malcolm
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Attachments: UROLOGY DRAFT TEAM ANALYISIS VERSION 22 12 09.doc; aobrien_externalduties.pdf; 20080915_Memo_ZoeParks_MrAkhtar_PLAB.doc; Payment of Training Programme Director - Mr M Young.pdf

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In the meantime, please let me know if you require anything else. Many thanks

Zoe

DRAFT UROLOGY TEAM ANALYSIS – 22.12.O9

NORMAL WEEK – 4 WEEKS IN 5:

Programmed Activity DCC	Mr Young	Mr O'Brien	Mr Akhtar	New Consultant	New Consultant	Total Team PA's
Outpatient Activities **Theatre Sessions including Pre/Post** **Stones Clinic** **ESWL** **Travel between sites for DCC**	***5.25? Debbie - does this meet demand?***	5.25?	5.25?	5.25?	5.25?	**26.25**
Ward Rounds	1.25	1.25	1.25	1.25	1.25	**6.25**
MDT Session (Thurs 4 hrs)	0.5	0.5	0.5	0.5	0.5	**2.5**
Patient Administration	1	1	1	1	1	**5**
Emergency On-call	1	1	1	1	1	**5**
SpA required for revalidation	1.5	1.5	1.5	1.5	1.5	**7.5**
Extra SPA						
Additional HPSS Responsibility						**0.25**
External Duties						
TOTAL PA's	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**	**52.5**
BREAKDOWN						
DCC	**9**	**9**	**9**	**9**	**9**	
SPA	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	
Extra SpA/ APA or EPA						
Weekly PA Total	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**	

On-call: 11.4 hours /3 = 3.8 PA's x 52wks/42 wks = 4.70 PA's / 5 consultants on rota = 0.94 PA's

22 December 2009

DRAFT UROLOGY TEAM ANALYSIS – 22.12.O9

SURGEON OF THE WEEK: (1 WEEK IN 5)

Programmed Activity DCC	Mr Young	Mr O'Brien	Mr Akhtar	New Consultant	New Consultant	Total Team PA's
1 week in 5 only						
Surgeon of the Week PM 1 pm to 5pm SOW	5	5	5	5	5	25
Outpatient / Theatre Activities AM 9am – 1pm DCC Activity	4.5	4.5	4.5	4.5	4.5	22.5
Stones Clinic	0	0	0	0	0	0
ESWL	0	0	0	0	0	0
Travel between sites for DCC	0	0	0	0	0	0
Ward Rounds	1.25	1.25	1.25	1.25	1.25	6.25
MDT Session	0	0	0	0	0	0
Patient Administration	?	?	?	?	?	?
Emergency On-call	1	1	1	1	1	5
SpA required for revalidation	0.5	0.5	0.5	0.5	0.5	2.5
Extra SPA	0	0	0	0	0	0
Additional HPSS Responsibility	0	0	0	0	0	0
External Duties	0	0	0	0	0	0
TOTAL PA's	12.25	12.25	12.25	12.25	12.25	61.25
BREAKDOWN						
DCC						
SPA						
Extra SpA/ APA or EPA						
Weekly PA Total						

On-call: 11.4 Hhours /3 = 3.8 PA's x 52wks/42 wks = 4.70 PA's / 5 consultants on rota = 0.94 PA's

22 December 2009

DRAFT UROLOGY TEAM ANALYSIS – 22.12.O9

WEEK 1 – 4	**10.75**
WEEK 5	**12.25**
AVERAGE PER WEEK	**11**

22 December 2009

DRAFT UROLOGY TEAM ANALYSIS – 22.12.O9

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Ward Rounds	1.25	1.25	1.25	1.25	1.25	**6.25**
MDT Session (Thurs 4 hrs)	0.5	0.5	0.5	0.5	0.5	**2.5**
Patient Administration	1	1	1	1	1	**5**
Emergency On-call	1	1	1	1	1	**5**
SpA required for revalidation	1.5	1.5	1.5	1.5	1.5	**7.5**
Extra SPA						
Additional HPSS Responsibility						**0.25**
External Duties						
TOTAL PA's	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**	**52.5**
BREAKDOWN						
DCC	**9**	**9**	**9**	**9**	**9**	
SPA	**1.5**	**1.5**	**1.5**	**1.5**	**1.5**	
Extra SpA/ APA or EPA						
Weekly PA Total	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**	

On-call: 11.4 hours /3 = 3.8 PA's x 52wks/42 wks = 4.70 PA's / 5 consultants on rota = 0.94 PA's

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ESWL	0	0	0	0	0	0
Travel between sites for DCC	0	0	0	0	0	0
Ward Rounds	1.25	1.25	1.25	1.25	1.25	6.25
MDT Session	0	0	0	0	0	0
Patient Administration	?	?	?	?	?	?
Emergency On-call	1	1	1	1	1	5
SpA required for revalidation	0.5	0.5	0.5	0.5	0.5	2.5
Extra SPA	0	0	0	0	0	0
Additional HPSS Responsibility	0	0	0	0	0	0
External Duties	0	0	0	0	0	0
TOTAL PA's	12.25	12.25	12.25	12.25	12.25	61.25
BREAKDOWN						
DCC						
SPA						
Extra SpA/ APA or EPA						
Weekly PA Total						

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22 December 2009

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WEEK 1 – 4	**10.75**
WEEK 5	**12.25**
AVERAGE PER WEEK	**11**

22 December 2009

Southern Health and Social Care Trust

Medical Directorate

Memorandum

To: All Consultants

From: Dr P Loughran, Medical Director

Date: 3 December 2009

RE: **Waiting List Initiatives**

I am writing to advise you that new rates for waiting list initiative sessions have now been agreed within the Southern Trust. **These new rates will be £[redacted] per session for weekdays and £[redacted] per session for weekends**. In agreeing an increase to the current rates, the Trust has set out a number of principles, accompanied by a more robust system for requesting and authorising this extra contractual work. These principles and the new claim form have been approved by the Trust Local Negotiating Committee. A copy of these documents will be available from the left hand column on the Trust Intranet site under Directorates, HR & Organisational Development & HR Medical and Dental.

To satisfy audit, a robust system for this work will be introduced setting out when the extra contractual work will be undertaken, what activity level the Trust expects within the sessions, specific activity delivered during the session and clarification on any impact on the contracted job plan. This underpins the principle that no consultant should be paid twice for the same period of time.

The rates for waiting list initiative work will only be paid to existing consultant medical staff and will not be offered or paid to locum consultants employed by the Trust on locum rates or locum consultants engaged through a locum agency. Associate Specialists working independently, who are not under supervision from a consultant, can be paid the same rates as consultant staff however this must be authorised by the Associate Medical Director. Staff Grades, Specialty Doctors and Training doctors are not permitted to work independently and must work under supervision. **Payment**

rates for non consultant staff working under supervision will be £Personal Informatio per session for weekdays and £Personal Informatio per session for weekends.

This agreement will be reviewed on an annual basis and will be subject to any negotiations on a regional basis which may impact on same. As agreed with the Local Negotiating Committee, these new rates will be effective from 1 April 2009 and Finance will now be asked to process any outstanding payments due. In future all medical staff must use the new claim form.

Please also ensure these new arrangements are also brought to the attention of all non consultant medical staff within your specialty. I hope this clarifies the position for you however if you have any queries on the above please contact me at Personal Information redacted by the USI or your Associate Medical Director.

Yours sincerely,

Personal Information redacted by the USI

_____

Dr Patrick Loughran
Medical Director

ENC: Claim form for Medical Staff for Extra Contractual Work e.g. WLI

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Fax: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

Southern Health and Social Care Trust

CLAIM FORM FOR MEDICAL STAFF FOR EXTRA CONTRACTUAL WORK (e.g. WLI)

Personal details:	
Name of doctor:	Grade: Consultant ☐ Other ☐ If other, please state:
Speciallty/Directorate:	Location/Hospital Site:
Staff Number:	Contact Number:

Details of additional work:

Day	Date	Hospital Site	Type of workload / session	Agreed Level of Activity with AD	Activity delivered/ Number of cases completed	Start Time	*Rate per session

**** The Rate paid must be in accordance with the SHSCT Local Agreement Policy***

As waiting list payments are paid in accordance with the principle that a consultant cannot be paid twice for the same period of time - please confirm the following:

☐ TOTAL PA's in your existing job plan including DCC, ON-CALL, SPA etc.

I confirm that the above extra contractual work does not take place at a time I am paid by the Trust. (Please circle)

Yes **No**

If no, please state reason:

The Trust currently permits consultants to undertake a MAXIMUM of one waiting list initiative session per week during normal working hours (9am-5pm). This must be undertaken at a time not currently paid by the Trust (i.e. outside job plan).

Please confirm:

Will the waiting list session replace an SPA session? (Please circle) **Yes** **No**

If yes please state the nature of the SPA activity and how and when the activity will be redelivered. The suggested alternative time and method of delivery of the work within this SPA should be endorsed by the AMD/Director.

Comments from AMD/Director:

Southern Health and Social Care Trust

CLAIM FORM FOR MEDICAL STAFF FOR EXTRA CONTRACTUAL WORK (e.g. WLI)

Please confirm, considering all your Trust and non HPSS commitments, if by undertaking the extra contractual work outlined above, you will be working in excess of an average of 48 hours per week (averaged over a 26 week period)? (Please circle)

Yes **No**

If Yes - Please confirm that a signed derogation form, confirming your agreement to opt out of the EWTD maximum 48 hours per week (averaged over a 26 week period) has been forwarded to the Chief Executive.

Yes **No**

Please note that all consultants have an individual responsibility for the number of hours worked and for ensuring that you do not work additional hours which would prevent you from delivering a safe level of patient care.

I declare that the above entries are a true record and claim for the additional sessions worked; as detailed above.

Signed: _____ **Date:** _____

Please forward this form to your Assistant Director for verification

Verified by Assistant Director/Director of POC:

Signed: _____ **Date:** _____

Please forward this form to the Associate Medical Director for final authorisation

Authorised by Associate Medical Director:

Signed: _____ **Date:** _____

Please send original to Financial Management Department, Lurgan Hospital, Sloan Street, LURGAN and copied to The Medical Staffing Manager, Trust Headquarters, Craigavon Area Hospital, BT63 5QQ

Southern Health and Social Care Trust

Memorandum

To:	All Associate Medical Directors
Copy:	Service Directors
From:	Zoe Parks, Medical Staffing Manager
Date:	9 December 2011
RE:	**Waiting List Initiative Claims**

I have been asked to clarify with you that all claims for waiting list initiative work undertaken by yourselves should be approved and signed by the Director of Service as opposed to being signed by another Associate Medical Director which I understand may have occurred in the past.

I would also like to highlight a number of other issues that have been raised with me from Payroll regarding WLI forms that have been submitted recently for payment. Most of these queries relate to the times specified on the claim forms. I would be grateful if you ask all consultants when completing these claim forms to bear the following points in mind, to assist Payroll in processing these claims whilst satisfying their audit requirements. This will also hopefully avoid any unnecessary delay in processing payment for this extra contractual work.

- On occasions, start and end times have been included on WLI forms which are less than the expected 4 hours e.g. 1 WLI claimed for 9.00am to 12noon or 2 WLI claimed for 1.45pm to 5.00pm & 5.00pm with no end time. It is not clear in these examples if the payment should be reduced to reflect a pro rata rate or if the full rate is appropriate as the activity undertaken reflects what is expected in 4 hours. This should be explicit on the form to avoid any confusion regarding payment. Also if the session extends beyond 4 hours, it should be clear if a pro rata rate should be applied for the extended session or not.

- Some forms have indicated a start time of 1pm with no end time but have claimed two sessions. To satisfy audit I would be grateful if you could ensure that it is explicit that the end time is 9pm or that it is stated that the activity levels reflect

what is expected in 8 hours and the rate for two WLI sessions is therefore appropriate.

- Some claim forms just state AM or PM with no specific times. It would be helpful if specific times could always be included. For example a claim was recently submitted for 4 WLI sessions with a start time of “AM” on a Friday with no end time.

- It should always be explicit if the WLI rate is not applicable i.e. if the claim form is being used to claim for non WLI work where a consultant’s PA should be paid.

If you require any further details, please do not hesitate to contact me.

Many thanks

Mrs Zoë Parks
Medical Staffing Manager

Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 18 November 2010 12:35
To: Hall, S DR; Murphy, Philip Dr; Mackle, Mr E; Aljarad, Bassam; Simpson, John; Chada, Dr; Brown, Robin; Charles McAllister; McAllister, DrC Email Account managed by DSLAINE; OBrien, Charles; Convery, RP DR; Fawzy, Mohamed Dr; McCusker, Grainne; Damani, Nizam DR; O'Reilly, S MR; McCaffrey, Patricia DR; Heasley, Noel; Smith, Mike DR; McGuinness, Dr Joan; Sloan, Samantha Ms
Cc: Rankin, Gillian; Walker, Helen
Subject: Waiting List Initiatives - Important information for AMD's and CD's
Attachments: SHSCT LNC APPROVED - WLI CLAIM FORM FOR EXTRA CONTRACTUAL WORK.pdf; SHSCT LNC APPROVED - WLI LOCAL AGREEMENT Extra Contractual Payments JULY 09.pdf

18 November 2010

Associate Medical Directors

Clinical Directors

Re: Waiting List Initiatives

As you are aware a new process for waiting list initiatives was agreed within the Southern Trust late last year. The new documentation was forwarded to all consultants and the Senior Management Team in December 2009.

I have been asked to re-issue this documentation to all Associate Medical Directors and Clinical Directors and ask that you please ensure that all consultants are reminded of the process and the requirement to comply with the agreed principles set out in the attached document. All of these documents are also available via the Trust Intranet site under Directorates, HR & Organisational Development, HR Medical & Dental. (http://shsctintranet.hpss.n-i.nhs.uk/HTML/HR/Information.html).

<<SHSCT LNC APPROVED - WLI CLAIM FORM FOR EXTRA CONTRACTUAL WORK.pdf>> <<SHSCT LNC APPROVED - WLI LOCAL AGREEMENT Extra Contractual Payments JULY 09.pdf>>

Mrs Zoë Parks

Medical Staffing Manager

Southern Health & Social Care Trust

Direct Line: [redacted]

Email: [redacted]

Southern Health and Social Care Trust

CONSULTANT JOB PLANNING UPDATE

1.0 Consultant Job Planning Steering Group

In November 2009, a Consultant Job Planning Steering Group Meeting was established within the Trust, chaired by the Chief Executive and attended by the Trust Senior Management Team, Associate Medical Directors and Clinical Directors responsible for job planning.

This group is responsible for maintaining a strategic overview of the job planning process, acting as the decision/approval body for Trust issues raised and also for approving local Trust guidance developed to assist clinical managers with job planning.

2.0 Trust Guidance

The Trust Guidance developed to date is available from the Trust Intranet at:
http://shsctintranet.hpss.n-i.nhs.uk/HTML/HR/Information.html

- Local Trust Framework on Job Planning for Medical Managers – Approved by SMT 3.6.09 Tabled at LNC 8.10.09.
- Consultant Job Plan Template – Tabled at LNC 8.10.09
- Consultant Job Planning Statement of Intent – Tabled at LNC 8.10.09
- Consultant Working Hours EWTD Opt out - Tabled at LNC 7.1.10
- Claim form for extra contractual work (WLI) – Tabled at LNC 8.10.09

3.0 Summary of Job Planning Steering Group Meetings

25 November 2009	• The Terms of Reference for the Consultant Job Planning Steering Group were approved. • Discussion took place on SPA's, External Duties and Additional HPSS Responsibilities. A SHSCT approval proforma for APA's and EPA's was agreed and AMD's/CD's were asked to ensure this was completed on an annual basis for all consultants undertaking these duties, including all retrospective arrangements. • It was agreed the Medical Director would review all un-formalised additional roles within the Trust for discussion at future meetings. • A new claim form for waiting list initiatives was approved for implementation.
27 January 2010	• Updates were provided by each AMD in relation to job planning in their specialty. • An update was given by the Core Working Group regarding the demand and capacity exercise that had commenced across all specialties in the Trust. • Discussion took place regarding legacy on-call PA allocations and some areas were identified that needed to be reviewed by AMD's. • AMD's were requested to submit details in relation to additional SPA roles within their teams for consideration at the next meeting.

Southern Health and Social Care Trust

CONSULTANT JOB PLANNING UPDATE

24 March 2010	• Updates were provided by each AMD in relation to job planning in their specialty. • An update was provided by the Core Working Group on the demand/capacity work undertaken by specialty which should indicate the DCC sessions required in job plans • Medical Director, HR Director and AD for each division to meet with AMD to discuss their proposed additional SPA requirements. • It was confirmed that any job plan in excess of 12 PA's should be presented at the Job Plan Steering Group and an EWTD opt form should be completed. • Discussion took place on reviewing the Medical Study Leave policy • The Medical Director was asked to define the role of an Associate Specialist so this could be factored into the demand/capacity work. • AMD's were asked to ensure all consultants were aware of and complied with the annual leave guidance and notice required.
9 June 2010	• Updates were provided by each AMD in relation to job planning in their specialty. • The Medical Director provided an update on the on-going review of additional Supporting Professional Activities. • It was confirmed that the EWTD opt out form had been placed on the Intranet and should be completed by all Medical staff working in excess of EWTD hours. • A copy of the Guidance on the application of Root Cause Analysis Techniques for adverse incident and compliant investigation was circulated.
29 September 2010	• Updates were provided by each AMD in relation to job planning in their specialty. • The Medical Director discussed the agreements that had been reached with AMD and Director for each specialty in respect of additional SPA. These agreements had been approved by the AMD and Director as part of the review process. • Discussion took place with regards to the agreed allocations of additional SPA's and AMD's were asked to submit further comments to the Medical Director • The Medical Director provided an update on the review of AMD job plans • A document was circulated outlining the role of an Associate Specialist which was agreed.
17 November 2010	• Updates were provided by each AMD in relation to job planning in their specialty. • The Medical Director presented the final considered view in respect of the allocation of additional SPA activities and this was approved. • The Chief Executive asked AMD's to ensure the job planning process was taken forward, since guidance had now been agreed to address the main barriers. • It was confirmed that a responsibility allowance accompanied with role descriptors had been issued to all AMD's • The Medical Director provided an update on the Medical Study leave policy and advised that this would be circulated to AMD's and then brought to SMT for approval.
2 March 2011	• Updates were provided by each AMD in relation to job planning in their specialty. • The Chief Executive asked Operational Directors to consider short term measures to ensure AMD's would have the time to take job planning forward • It was confirmed that a responsibility allowance and role descriptors would be issued to all Clinical Directors. • Discussion took place on a review of the WLI principles and it was agreed that a revised WLI claim form should be developed and implemented over next few months. • The Chief Executive asked that a high level summary of the Job Planning Steering Group meeting would be shared with all consultants as a means to improve communication throughout the Trust.
13 May 2011	• The Trust purchased a one year contract with the electronic consultant job planning internet based system operated by Zircadian. This is currently used by almost 60 Trusts in the UK and offers improved job plan management with standardised job plans and data collection in a clear and efficient process. Set up and roll out is hoped to take place over the summer months.

Southern Health and Social Care Trust

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Southern Health and Social Care Trust

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Parks, Zoe

From: Parks, Zoe <[redacted]>
Sent: 02 June 2011 09:31
To: Loughran, Patrick; Donaghy, Kieran; Rankin, Gillian; Clarke, Paula; McNally, Stephen; McVeigh, Angela; Hogan, Martina; Heasley, Noel; Mackle, Eamon; McCaffrey, Patricia; McAllister, Charlie; Hall, Stephen; Simpson, John; Carroll, Ronan; Conway, Barry; McVey, Anne; Toner, Roisin; Magwood, Aldrina; Morton, Jacqueline T; Lappin, Lynn; Walker, Helen; Leeman, Lesley
Cc: Clegg, Malcolm
Subject: Update on Consultant Job Planning for all consultants - June 2011
Attachments: Update on Consultant Job Planning for all Consultants - June 2011.pdf

Importance: High

2 June 2011

At the last Job Planning meeting, it was agreed by the Chief Executive that a high level summary of the Consultant Job Planning Steering Group meetings would be circulated to all consultants to improve communication and transparency in the process. I have attached the document for your information that we will be circulated to all consultants shortly.

Zoë Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: [redacted]
Mobile: [redacted]
Fax: [redacted]
Email: [redacted]

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

CONTENTS

Appendices

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

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:

[redacted]
Personal Information redacted by the USI

Lily Kerr, Staff Side Secretary

[redacted]
Personal Information redacted by the USI

Kevin McAdam, Staff Side Secretary

Date: 14th September 2007.

Signed on behalf of Trust:

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

19 August 2011

STRICTLY PRIVATE AND CONFIDENTIAL

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

Dear Mr O'Brien

RE: ISSUE OF INFORMAL WARNING

I refer to our meeting on 23 June 2011 with regard to the following concern:

1. You disposed of a large section of patient filing in a bin, which was later found and retrieved by an auxiliary on the ward. The filing consisted of fluid balance charts, mews charts, TPN prescription forms, Aminoglycosides prescription forms and prescription Kardex for an inpatient on the Ward.

I now write to confirm to you that as part of the Trust's Disciplinary Procedure, you will be issued with an informal warning in respect of this concern. This warning will remain valid for a period of six months. It is noted that during our meeting, you confirmed that you accepted your action was wrong and that it would not occur again.

You have the right to appeal this decision. Should you wish to appeal you must write to Mr E Mackle, Associate Medical Director within seven working days of receipt of this letter, stating the grounds of your appeal.

Yours sincerely

Mr R Brown
Surgical Clinical Director

Copy to: Mr E Mackle Associate Medical Director

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

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

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

Kind Regards

Yours Sincerely

Eamon Mackle

Clegg, Malcolm

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

Malcolm,

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

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

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

Aidan O'Brien

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

Mr O'Brien,

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

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

I trust this helps to clarify your queries.

Regards

Malcolm

Malcolm Clegg

Medical Staffing Department

Southern Health and Social Care Trust

Craigavon Area Hospital

BT63 5QQ

Tel: Personal Information redacted by the USI

From: aidanpobrien Personal Information redacted by the USI [mailto: Personal Information redacted by the USI]
Sent: 03 November 2011 12:10
To: Clegg, Malcolm
Subject: Re: Amended 2011/12 Job Plan

Hello Malcolm,

Just noted your email this morning.

I would be grateful if you would clarify or explain why amended job plan attracts a total of 12.63 PAs when it should be 12.75 PAs?

Could you also explain for me how the job plan can have been effective from 01 September 2011, when it hasn't?

Thanks,

Aidan O'Brien

-----Original Message-----
From: Clegg, Malcolm < Personal Information redacted by the USI >
To: aidanpobrien < Personal Information redacted by the USI >
CC: O'Brien, Aidan < Personal Information redacted by the USI >; Murphy, Philip < Personal Information redacted by the USI >
Sent: Mon, 31 Oct 2011 14:01
Subject: Amended 2011/12 Job Plan

Dear Mr O'Brien,

Following your Facilitation meeting on 28 September you were advised by Dr Murphy that he felt it appropriate to offer you an additional 0.75 PA per week for administration until 28 February 2012; however from 1 March 2012 you would then reduce to 12 PAs per week.

I have attached an amended 12.75 PA job plan which reflects the additional 0.75 PA per week until the end of February 2012 and your request to have lunch breaks

included in the job plan. Your specialist clinic has also been moved from Friday morning to Friday afternoon.

I would be grateful if you could sign the amended job plan and return this to me

by Friday 4 November 2011. If I do not hear from you by Friday 4 November, I will assume you have accepted this job plan.

Regards

Malcolm

Malcolm Clegg

Medical Staffing Department

Southern Health and Social Care Trust

Craigavon Area Hospital

BT63 5QQ

Tel: Personal Information redacted by the USI

Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department Irrelevant redacted by the USI

Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department Irrelevant redacted by the USI

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

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

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

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

Regards

Malcolm

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

Tel: [redacted]

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

Malcolm,

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

completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate.

Aidan O'Brien

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

Mr Aidan O'Brien – Facilitation Meeting on 28 September 2011

Dr Philip Murphy welcomed Mr O'Brien and outlined the purpose of the Facilitation meeting.

Mr O'Brien was then asked to outline his position on the proposed job plan.

1. Admin time

Mr O'Brien stated that the substantive issue for him was admin time. There was an inadequate allocation of admin time in the proposed job plan. This was grossly detached from reality for him and his colleagues.

He had been allocated 4.25 hours for admin, however ½ hour of this relates to MDT specific admin and ½ hour for Thorndale queries. This leaves 3.25 hours per week, which is unrealistic.

Dr Murphy informed Mr O'Brien that some aspects of his administrative work are done by his support staff e.g. where contact with patients is required, he organises his secretary to do some of this. Mr O'Brien stated that his secretary could not organise ultrasounds, etc.

Dr Murphy then asked Mr O'Brien to explain what happens at the specialist clinic in the Thorndale Unit. Mr O'Brien explained that this was an ICATS clinic which included for example

- Outpatient /+diagnostic – "One stop clinic"
- Specialist assessments
- LUS
- Prostate diagnostic
- Haematuria

Assessments are done by Nurse Specialist / SPRs / GPsWSI e.g. prostate cancer cases. If positive, SPRs will organise scans and the Consultants would review these.

Whilst the other consultants in Urology have agreed their jobs plans, they are not happy but they have accepted this. In some ways they felt pressurised to sign e.g. Mr Young was going on leave and accepted on the Friday afternoon before going on leave.

Mr Akhtar intends to keep a diary card to quantify what admin time is actually required. He believes there is a deal whereby if the diary card indicates that greater admin time is required, this will then be allocated. Part of this acceptance is avoidance of more hassle and arguments – avoidance of confrontation. Mr O'Brien explained that he had thought about doing the same.

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Dr Murphy asked Mr O'Brien if he was aware of any guidance on the allocation of admin time from the specialist body for Urologists. Mr O'Brien stated that he was not sure about this.

Mr O'Brien stated that management's attitude was to expect things to be done in zero time. He did feel that certain aspects of work could be done more efficiently e.g. introduction of virtual clinics, but other aspects of the job could not been done any quicker.

Mr O'Brien explained that he had 436 patients on waiting lists. This was a large quantum of work. The times he had listed on his submission were nominal (bare minimum). He did feel that this was about a sense of justice.

2. Lunch Breaks

Mr O'Brien explained that early on in the discussions he was adamant he did not require lunch breaks as he doesn't go to canteen, however he now felt that lunch breaks should be included in his job plan as eating lunch eats into admin and travel time. Mr O'Brien understood that breaks will be unpaid.

3. Specialist Clinics

Mr O'Brien also raised the issue of specialist clinics. He wanted to highlight that his job plan includes conducting a specialist clinic each Friday morning in the Thorndale Unit in the same room and at the same time as Mr Young. Mr Young's specialist clinic is also scheduled for each Friday morning in Thorndale and Mr O'Brien felt this was unworkable.

Mr O'Brien stated that he was entirely happy with the Specialist clinic on Friday mornings although there was a time pressure associated with these.

He went on to explain that consultants would review the combination urodynamic studies. It was acknowledged by management that these take longer than routines. They would like urological cancer completely separated. Mr Akhtar is the Urological Cancer Lead and is therefore disinterested in urodynamics assessment but would like Mr O'Brien to take a lead on this.

4. On-call availability

Mr O'Brien then raised the issue of on call. He wished to draw attention to the fact that a consultant cannot be available to respond to emergencies when unavailable e.g. they should not be on-call for emergencies on this site while doing a clinic in Banbridge. The physical unavailability needs to be addressed. The physical, safe availability is not appropriate. They are so short on the ground and currently only have one Registrar.

Mr O'Brien advised that he was not concerned about the PA allocation for on call.

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Summary:

In summary Mr O'Brien stated that the admin time (4.25 PAs) in his proposed job plan was ridiculously inadequate.

His colleagues are not happy with it although they have accepted it.

This is not a reason for him to be offered less.

Notes agreed:_____ Date:_____