I contacted Patient SUF by telephone on 02 January 2020, finding him to remain well. I advised him that his serum PSA level had remained relatively unchanged at 4.35ng/ml on 13 December 2019, and that the dose of Bicalutamide required to be increased to 150 mg daily. As he had just been dispensed a further, one month supply of 50 mg tablets, I advised him that he could increase the dose to 100 mg daily, by taking two 50 mg tablets each morning, to be reassured that he did not have any recurrence of breast tenderness by this incremental increase in dosage, and while awaiting receipt of 150 mg tablets.

I wrote to his GP on 2 January 2020 (the letter was incorrectly dated 02 January 2019) requesting that he next prescribe Bicalutamide 150 mg to be taken once daily. I also requested that the Practice Nurse facilitate Patient SUF having his serum PSA level repeated during the first week of March 2020, so that the result would be available when he would return for review later that month. I also wrote to Patient SUF confirming the increased dose of Bicalutamide and requesting that he arrange an appointment with the Practice Nurse to have his serum PSA level repeated during the first week of March 2020. I advised him that my secretary would arrange a review appointment for him nearer to that time.

I was confidently hopeful that taking Bicalutamide 150 mg daily would result in a further significant decrease in his serum PSA level, without gynaecomastia and hopefully with sustained improvement in his urinary symptoms, thereby enabling him to be referred for radical radiotherapy as intended. Nevertheless, I decided to review him in March 2020 to ensure that was so, and not least as I just retained a doubt as to whether he had experienced such a significant and sustained improvement in his urinary symptoms, as claimed. If I had found otherwise at review, I would instead have prescribed a LHRH agonist or antagonist, in addition to referral for radical radiotherapy.

Patient SUF did have a four week supply of Bicalutamide 150 mg daily prescribed by his GP on 17 January 2020, and again on 17 February 2020. There was no evidence from the ECR Medications Summary Record (updated in January 2021) of Bicalutamide having been prescribed thereafter. He also had similar quantities of Tamoxifen 10 mg daily and Oxybutynin MR 5 mg daily prescribed for the last time on 17 February 2020. It is worthy of note that he did not have Omeprazole prescribed by his GP until 17 January 2020 even though the GP had been requested to do so in November 2019. Omeprazole was again prescribed on 17 February 2020. None of these four medications had been prescribed after 17 February 2020.

On 02 January 2020, I could not have foreseen the global consequences of Covid-19. All review clinics had been suspended by mid-March 2020. The focus of the efforts of all at that time and during subsequent months was in preparing for an influx of patients suffering from Covid-19, redeployment of staff, providing an acute surgical service, developing a relatively safe, elective service for those most in need of it etc. As indicated above, Patient SUF did not have any medication prescribed again after 17 February 2020, and did not have his serum PSA level repeated in March 2020 as requested. As it had not been possible to review him as intended, I was unaware that he had not continued to be prescribed any medication, or that he had not had his serum PSA level repeated.

In September 2020, Mr Fel, Locum Consultant Urologist, noted that Patient SUF did not have his serum PSA level repeated in March 2020. He wrote to Patient SUF on 04 September 2020 requesting that he arrange an appointment to have his serum PSA level repeated.

Patient SUF was next reviewed by Mr Haynes, Consultant Urologist, on 02 October 2020. On doing so, he learned that Patient SUF had not collected a prescription for Bicalutamide 150 mg daily since February 2020, and as a consequence of which his serum PSA level had increased to 15ng/ml by September 2020. Mr Haynes did not record the reason for Patient SUF having failed to do so, and for having failed to have his serum PSA level repeated in March 2020. It may have been related to the pandemic, as he would not have been the only patient not to have attended a GP practice for fear of infection. Alternatively, he may have forgotten to do so, or he may have decided to discontinue treatment for whatever reason. In any case, Mr Haynes did not record an explanation.

In his letter to the GP, Mr Haynes related that he discussed with Patient SUF his prostate cancer diagnosis and the available treatment options. He related that Patient SUF did not recall having had any conversation about external beam radiotherapy as a radical treatment or discussion of surveillance as an option. I entirely refute the notion that I did not discuss with Patient SUF his management options, on 03 September 2019 and subsequently.

Mr Haynes then advised the GP that Patient SUF preferred no treatment at that time, to proceed with active surveillance, with a view to radiotherapy if his serum PSA levels increased or if there was evidence of progression. Mr Haynes advised the GP that he considered that active surveillance was a '*reasonable choice for a* Personal Information redacted by the *old man with intermediate risk prostate cancer'.* I find this view concerning in Patient SUF's case, as it does give the impression that the patient may have been advised that management by active surveillance was as reasonable as management with curative intent. For all of the reasons previously related, I do not believe this to be the case.

Mr Haynes proceeded to advise the GP that he had a conversation with Patient SUF about his initial treatment. He related that the *'initial treatment with a dose of 50 mg Bicalutamide is not the recommended treatment dose of Bicalutamide as an agent to treat prostate cancer as a single agent and there is concern that it may have a negative impact on the disease'.* He did not appear to appreciate that it had been prescribed in the first instance to prevent disease progression, that there had been biochemical evidence that it had continued to do so, and that increasing its dose earlier in preparation for radical radiotherapy had been contraindicated by worsening urinary symptoms, possibly attributable to Bicalutamide. He did not explain what that negative impact may have been in Patient SUF's case. Moreover, it is improbable that the Section of Oncology of the British Association of Urological Surgeons would have recommended in March 2020 that patients with low and intermediate risk, non-metastatic prostate cancer, could be prescribed Bicalutamide 50 mg to be taken once daily while awaiting further management, deferred due to CoVid 19, if there was a concern that so doing would negatively impact their disease. Mr Haynes then advised the GP that Patient SUF was aware that he would be monitoring his PSA and *'if required we will switch to a radical treatment'.*

There was no record of a review of Patient SUF's lower urinary tract symptomatic status, his upper gastrointestinal symptomatic status or of whether he had breast pain or tenderness, when he was reviewed by Mr Haynes on 02 October 2020. There was no record of these at his further review by

Mr Haynes on 12 May 2021 by which time Patient SUF's serum PSA levels had increased above 20ng/ml. Mr Haynes again discussed the options of radical treatment or surveillance. He reported that Patient SUF was clear that he did not wish to proceed to having radical radiotherapy, even if increasing serum PSA levels were accompanied by an increasing risk of metastatic disease, thereby excluding the possibility of curative treatment. Mr Haynes reported that the Patient was happy with continued surveillance.

Aidan O'Brien

Comments regarding the SAI Report of Service User F

A Root Cause Analysis report on the review of a Serious Adverse Incident including Service User F (SUF) was submitted to the Health and Social Care Board on 01 March 2021. The review was conducted following completion of a Datix IR1 form by Mr Mark Haynes, Consultant Urologist, following his review of SUF in October 2020. The following comments are related to the numbered sections in the report.

1.0 Executive Summary

The Summary makes two statements.

The first asserts that SUF was commenced on a low (sub-therapeutic) dose of Bicalutamide for prostate cancer.
This is incorrect as he was commenced on Bicalutamide 50 mg daily to relieve his concern regarding the risk of progression of any presumed prostate cancer while awaiting confirmation of its presence by biopsy.

The second asserts that there was no documentary evidence of any discussion of the radical treatment options for prostate cancer recommended by the Multidisciplinary Meeting (8 August 2020 [*sic*]).
This too is incorrect as there was no Multidisciplinary Meeting on 08 August 2019 (or 2020).

5.0 Description of Incident / Case.

On page 4 of the report, it states that SUF was discussed at the MDM on 08 August 2019 and that it was agreed that SUF had an intermediate risk but apparently organ confined prostate cancer.
In fact, there was no MDM on 08 August 2019. Instead, SUF's assessment and diagnosis to date was reviewed *on line* by Mr Mark Haynes as it had not been possible to hold a MDM due to lack of availability of other consultant urologists to attend. There was no discussion of SUF or agreement concerning his diagnosis.

The report also states that SUF was advised by me of the histological diagnosis at review on 03 September 2019 and that it was noted that his serum PSA level had decreased to 8.41ng/ml which I deemed acceptable.
This is incorrect as I reported to the GP on 27 October 2019 that I was pleased to find that his serum PSA level had already decreased to 8.41ng/ml when assayed at review on 03 September 2019. I was pleased by the biochemical evidence indicating that Bicalutamide 50 mg daily had prevented disease progression, the purpose for which it had been prescribed. I did not offer any view as to the acceptability of the decrease or of the level.

The report then states that SUF was of the impression that the [partial] androgen blockade may already have resulted in slight improvement in his urinary symptoms when he

attended again on 27 September 2019. This too is incorrect as I did not describe the androgen blockade as being partial in my letter of 27 October 2019 to the SUF's GP.

The report then gives the impression that I advised the GP to increase the dose of Bicalutamide to 150 mg daily at SUF's attendance on 13 December 2019.
I did so on 02 January 2020 in my correspondence to SUF's GP.

6.0 Findings

The report finds that the diagnostic pathway was rather prolonged.
In fact, the diagnostic pathway was quite compressed in this case as the waiting time for a first outpatient appointment following referral of a patient with a suspect prostate cancer had already exceeded two months during 2019.
If the referral had been triaged by a consultant urologist who had just requested that a Red Flag appointment be made for him at a New Patient Clinic, it could have been July 2019 before he would have attended as an outpatient for the first time.
The diagnostic pathway was shortened by my requesting ultrasound scanning at triage, by the scan having been appointed and performed one day later, and by my requesting an outpatient appointment be arranged following the date of the scan.
Taking the time to initiate assessment of his urinary tract by ultrasound scanning, and requesting an outpatient appointment following the date of the scan, resulted in the patient having a staged diagnosis of presumed prostatic carcinoma established by the time he would have had a first outpatient consultation otherwise.

The report finds that the MDM recommendation of 08 August 2019 was not followed.
This is incorrect as there was no MDM on 08 August 2019. There was a virtual review by a single urologist, Mr Mark Haynes.

The report additionally finds that the MDM recommendation of 08 August 2019 was surveillance or radiotherapy with curative intent.
This too is incorrect as the recommendation of Mr Haynes was to discuss management with curative intent or surveillance.

The report finds that the treatment did not conform to the 'NICAN Regional Hormone Therapy Guidelines for Prostate Cancer' 2016 and which was signed off by me as chair of the Clinical Reference Group.
The report does not specify in which manner the patient's treatment did not conform to the 'NICaN Regional Hormone Therapy Guidelines for Prostate Cancer 2016'.

The report finds that SUF was unaware that his care was at variance with regionally recommended best practice.
The report does not specify the manner in which his care was at variance with regionally recommended best practice.

The report finds that there was no evidence of informed consent to this alternative care pathway.
The report does not specify in which manner it was alternative.

The report finds that SUF stopped the Bicalutamide as it did not agree with his stomach.
It is worthy of note that Mr Haynes did not report such reason at his review of SUF in October 2020, or explore whether it was Bicalutamide which was responsible for any gastric upset, particularly in view of SUF having a hiatus hernia with oesophageal reflux and previously having been prescribed Omeprazole, or suggest alternative treatment options to mitigate such side effect.

The report finds that SUF was not referred to a Urology Cancer Nurse Specialist (CNS) to support and discuss treatment options, and that their phone number was not made available to him.
The report does not specify by whom it expected the patient be referred to a CNS and why their phone number was not made available to him.
It was the joint responsibility of the MDT Lead Clinician and the MDT Core Nurse Member to appoint or allocate a CNS to the patient.

The report finds that a CNS was available but that there was no record of SUF being referred to this support service.
It would appear that a CNS had not been appointed to SUF in accordance with the MDT Operational Policy and therefore failed to provide support to him though available.

The report finds that I provided uni-professional care despite multi-disciplinary input, and that this left the patient unsupported especially as their disease progressed.
This is incorrect as there was no multi-disciplinary input as there had not been a multidisciplinary discussion of his diagnosis at a MDM, as a CNS had failed to provide an input and as there was no evidence of disease progression while under my care.
Moreover, there was no evidence in provided documentation of involvement of a CNS in the care of SUF by 2021 when there was biochemical evidence of disease progression and when under the care of Mr Haynes, Consultant Urologist.

The report finds that there was no oncology referral.
This is correct as I considered it inappropriate to refer SUF for radical radiotherapy until he had undergone assessment and management of his severe lower urinary tract symptoms, in compliance with NICE Guidelines.

The report finds that there was no effective fail-safe mechanism due to the inadequate funding of the MDM and the absence of input by a CNS.
Both of these are true.
However, in addition, his management would have progressed if it had been possible to review him as intended in March 2020, had review clinics not have been suspended due to the Covid 19 pandemic.

The report finds that the use of Bicalutamide was known to the MDM, was challenged, was not minuted, was not escalated and was known externally within Oncology.
It is true that the use of Bicalutamide was known to the MDT and was certainly recorded in all cases at MDM when prescribed by me, such as would have been the case with SUF if he had been discussed at a MDM.

I certainly have no recollection of it ever having been challenged.
If it had been, I would certainly have been able to recall the challenge.
I believe the lack of challenge to be the reason it was neither minuted nor escalated.
It was certainly known within Oncology as the Cancer Centre has published its experience of its use in combination with radical radiotherapy.

7.0 Conclusions

The report concluded that *'a standard pathway for this man was followed up to and including the first MDM discussion'.*
Not only was there no discussion as there had been no MDM, though the documentation relating to the 'virtual MDM' conducted on 08 August 2019 gives the misleading impression that a MDM did take place at which SUF was discussed, it is concerning that a Root Cause Analysis did not discover that no MDM discussion of SUF took place.

The report then concluded that *'at that point, acceptable practice should have been to discuss the options available as recommended by the MDT'.*
Even though the options were not recommended by the MDT following discussion at a MDM, I did discuss both options recommended by Mr Haynes, though advising SUF that all of the features of his confirmed prostate cancer indicated that he would be best served by proceeding with management with curative intent.

The report also concluded that *'most urological centres would have requested a bone scan to complete staging'.*
For some years, our department has included MRI scanning of the lumbar spine and pelvis at the time of MRI scanning of the prostate gland, as was performed when SUF had MRI scanning performed.
In the absence of any evidence of extracapsular infiltration or of metastatic lymphadenopathy, we have found MRI scanning of the lumbar spine and pelvis to be more sensitive and specific for the detection of skeletal metastatic disease than radioisotope bone scanning.
It was for this reason that I did not request a bone scan.

The report completes its conclusion by stating that *'should the patient have chosen to pursue radical therapy, it would have been reasonable to start ADT (an LHRH analogue) as neo-adjuvant treatment at the same time as referring on for an opinion from a Clinical Oncologist'.*
I believe that this conclusion is concerning as it implies that prescription of a LHRH analogue was required to start ADT even though androgen deprivation had already begun as Bicalutamide had already been prescribed, though the dose initially prescribed was for the purpose of preventing disease progression while awaiting diagnostic confirmation of presumed prostate cancer, and was continued for that purpose while initiating investigation and management of the patient's lower urinary tract symptoms.
When it appeared that the patient had experienced a significant improvement in his urinary symptoms, presumably as a consequence of taking Oxybutynin, the initial dose of Bicalutamide was increased to 150 mg daily.

I believe that it would have been more reasonable to have achieved an optimal biochemical response prior to radical radiotherapy without the need for castration, with its increased risk of more severe adverse effects.

It is additionally concerning it was considered reasonable to initiate pharmacologically induced castration and referral to a Clinical Oncologist with a view to radical radiotherapy without first offering assessment and management of SUF's severe lower urinary tract symptoms, as recommended by NICE guidelines.

8.0 Lessons Learned

Five lessons were listed for learning.

The first of these was that the *'MDM should be chaired by a named clinician with responsibility for ensuring adequate discussion of every patient'.*

The Southern Trust's Urology MDT was established in April 2010 and the MDM was chaired each week by Mr M Akhtar, Lead Clinician of the MDT, until his departure in March 2012.
I was then appointed Lead Clinician in April 2012, and chaired the MDM each week until September 2014, in preparation for the introduction of 'Urologist of the Week', which necessitated the introduction of a rota of named chairs.
By then, it became necessary to limit the number of cases listed for discussion at each MDM to 40, so as to ensure that discussion was adequate over a three hour MDM.
Optimal discussion of each case necessitated the provision of a clinical summary adequately detailing previous clinical history, comorbidity, medications and performance status in addition to adequate detail of the condition to be discussed.
Optimal discussion then required detailed preparation of each case by the named Chair.
Preparation by the Chair for each MDM could take up to four hours, depending upon numbers to be discussed.
As numbers of cases to be discussed increased, as MDM time was consumed by additional regional discussion of organ specific cancers and due to the inadequacy of the urology service, we resorted to conducting *'virtual MDMs'* to avoid further cumulative delays in patient diagnosis and management.
As was the case with SUF, there was no discussion of him at a MDM.
The lack of discussion was further compounded by the apparent failure of Mr Haynes to circulate his recommendations of 08 August 2019 for scrutiny and amendment.
I would agree that the urology service should be enhanced to ensure adequate numbers of consultant members of MDT so as to ensure that all patients can be discussed at quorate MDMs.
MDMs falling on public holidays should be scheduled in advance to the next working day in lieu of usual clinical activity, to completely avoid having virtual MDMs.

The second lesson is that *'consideration should be given to ensuring that all patients and their GPs receive a plain English copy of the MDM discussion'.*

The entire MDM documentation, including clinical summary, updates and outcome of each case discussion at MDM, has always been sent to each GP, usually the day following MDM.

I would entirely agree with each patient being given a copy of the MDM documentation at his / her review following MDM.

The third lesson is that *'a Key Worker, usually a cancer nurse specialist, should be independently assigned to each patient with a new cancer diagnosis'.*

Even though every MDM has been attended by the MDT Core Nurse Member, or deputised by at least one Urology Cancer Nurse Specialist, there has been a failure to ensure that all newly diagnosed patients have been introduced to or contacted by a Nurse Specialist at or after their review following MDM.

Even though SUF was not actually discussed at a MDM, there was no reason why he could not have been assured of the support of a Nurse Specialist, as the Urology MDM Outcomes of 08 August 2019 were circulated by the Cancer Tracker by email on 12 August 2019 to all Urology Cancer CNSs, including the MDT Core Nurse Member.
I note the lack of any documentary evidence of involvement of a Key Worker in the management of SUF by 2021, even though there was biochemical evidence of disease progression by then.

The fourth lesson is that *'all patients and their families should be offered an outpatient or telephone consultation with their Key Worker to allow reflection on their options.*

While the above could be an inevitable consequence of involvement of a Key Worker in patient management, it should not be a substitute for similar review by the consultant urologist.

Indeed, I believe that it is concerning that this report concluded that it would be reasonable that a patient, such as SUF, should be advised of a confirmed diagnosis of intermediate risk, organ confined, prostate cancer, be informed of management options, be advised to proceed with management with curative intent, have castration pharmacologically initiated and referred to a Clinical Oncologist with a view to radical radiotherapy, all potentially at one outpatient review consultation, while ignoring severe urinary symptoms and without providing time and support for further consideration of those management options, as recommended above.

Lastly, the report advises that '*patients should be invited to a joint oncology outpatient appointment at which all the treatment options available should be explained by the most appropriate clinician'.*

While the above is laudable and long recommended, I believe that a greater priority should be having a Clinical Oncologist present at every MDM, a provision that has not be consistently achieved since 2010.

9.0 Recommendations and Action Planning

Recommendation 1

'A MDM chair's responsibilities must include regular quality assurance activity'.

I do not agree that this should be the responsibility of the chairs of MDM.
Instead, it should be the responsibility of the Lead Clinician of the MDT.

Recommendation 2

'The MDM should be quorate.'

There has been a persistent failure to provide a urological service led by consultant urologists adequate in number, a urological radiology service led by consultant radiologists adequate in number and a clinical oncology service adequate in number to ensure quorate Urology MDMs since 2010.

Recommendation 3

'The rationale for any decision to diverge from the MDM plan must be explained to the patient, documented in the communication with their GP, and subsequently validated by further MDM discussion.'

The MDM Plan to which Recommendation 3 refers is itself a recommendation.
I would agree that any divergence from the recommendations of the MDM must be explained to the patient and approved by the patient, documented in communication with their GP and subsequently reported to and discussed at a further MDM, with the caveat that divergences from recommendations following MDM discussion have often been a consequence of the informed decisions of patients.

Recommendation 4

'The MDM must have an open supportive culture allowing members to raise clinical concerns'.

I agree.

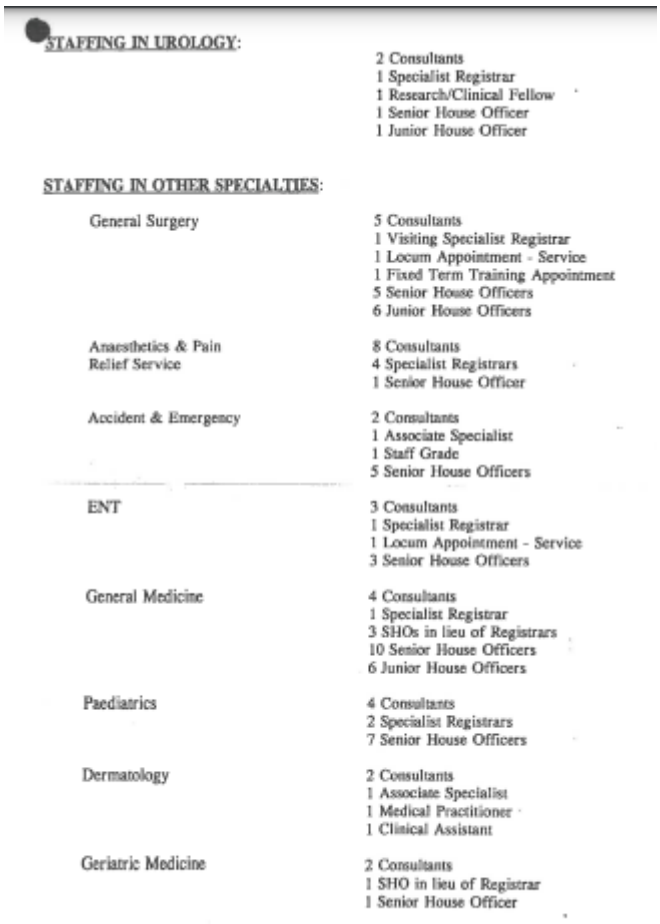
Recommendation 5

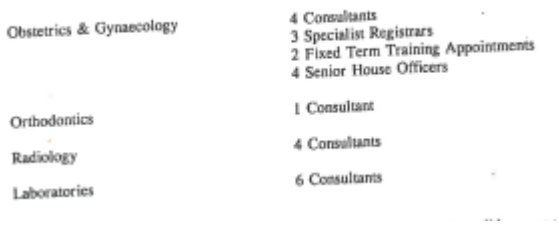
'The Southern Health and Social Care Trust must develop cancer service governance processes to identify deficits in care and to escalate these appropriately.'

The Southern Health and Social Care Trust has persistently failed over a period of 30 years to provide an adequate and safe urological service, including a urological cancer service, even though the deficits in its duty of care have been repeatedly escalated and brought to its attention. The development of even more governance processes in the absence of adequacy will only serve to have purpose further replaced by process.

Aidan O'Brien

CHRONOLOGY
UNDER RESOURCING
MR AIDAN O'BRIEN
3911.100
MPS REF: AP1/LEA/646528/N

Date	Document Name	Comments	Document No.
07.03.1996	Letter to Ms Helen Walker, Human Resources, Craigavon Area Hospital from Mr O'Brien	Notes resourcing issues in urology generally including the following statistics:- In Northern Ireland one Urologist for every 200,000 people. In Western Europe one for every 50,000. For AOB one for 300,000. UK average 1 for 130,000. Notes by 1992 the Trust should have had three Urologists according to UK standards and six by international standards. Notes lack of junior and administrative support. Notes how he was working 70/80 hours per week. Notes in four years he had only nine weeks off.	Doc File 1 pages 18 – 22 AOB-00018 - AOB-00022
1997	Consultant Urologist Job Description	Notes comparison in staffing:  STAFFING IN UROLOGY: 2 Consultants 1 Specialist Registrar 1 Research/Clinical Fellow 1 Senior House Officer 1 Junior House Officer STAFFING IN OTHER SPECIALTIES: General Surgery — 5 Consultants; 1 Visiting Specialist Registrar; 1 Locum Appointment - Service; 1 Fixed Term Training Appointment; 5 Senior House Officers; 6 Junior House Officers Anaesthetics & Pain Relief Service — 8 Consultants; 4 Specialist Registrars; 1 Senior House Officer Accident & Emergency — 2 Consultants; 1 Associate Specialist; 1 Staff Grade; 5 Senior House Officers ENT — 3 Consultants; 1 Specialist Registrar; 1 Locum Appointment - Service; 3 Senior House Officers General Medicine — 4 Consultants; 1 Specialist Registrar; 3 SHOs in lieu of Registrars; 10 Senior House Officers; 6 Junior House Officers Paediatrics — 4 Consultants; 2 Specialist Registrars; 7 Senior House Officers Dermatology — 2 Consultants; 1 Associate Specialist; 1 Medical Practitioner; 1 Clinical Assistant Geriatric Medicine — 2 Consultants; 1 SHO in lieu of Registrar; 1 Senior House Officer	TRU-101601 – TRU-101607

		 The Urological services is currently contracted to provide 1,110 inpatient episodes, 647 day case episodes and 3,857 outpatient episodes.	
2003	2010 Appraisal	Please see Mr O'Brien's appraisal of 2010. Within that is a section from Form 4 of the 2003 Appraisal completed on 23 December 2003 with Mr Stirling. In that the commentary notes that "*Care is provided to a population which probably exceeds the capacity of the service to provide."* That was "*To be assessed by process of review of the urology service".* It also notes there is no issue in relation to relations with patients although "*maybe a problem with time management."* It notes "*Major concern as to how service of urology is provided/ developed and is a frustration in lack of progress in assessing the service and future provision of same."*	2010 Appraisal pages 174-181 AOB-22175 – AOB-22182
?2005	2010 Appraisal	In Mr O'Brien's 2010 Appraisal there is a Form 4 included (which is undated). It includes reference to "*Ongoing concerns re volume of work and of the volume of work involved in on-call at weekend with no registrar – which involves consultant working as a registrar – with no monitory recompense. Still haven't got the extra 4 beds following MAU opening! Await with expectation the implementation of the urology review."*	2010 Appraisal page 187 AOB-22188
29.10.2005	Email from Sharon Glenny	Re: Cancelled Admissions .. I would ask that the request to formalise communication links with each other in terms of patients who have been cancelled on the day by the hospital for 1. Lack of beds 2. Over filled theatre list or 3. Medical reasons Is now actioned.	TL1 Page 149 AOB-82190
17.11.2005	Letter from Dr McCormick to Trust	Re: Review of Public Administration … These announcements will lead to the most significant change to the management of the HPSS in decades. It is in all our interests that the implementation of these reforms receives the maximum support and cooperation of HPSS staff from the outset. It is very important that we bring staff into the implementation process from the outset. … Let me emphasis that while there is no reason for the vast majority of HPSS staff to have any immediate concerns about their job security, it is probably inevitable that many will. This is a natural reaction to proposals for major organisational change… ..	TL1 Page 153 – 154 AOB-82196 - AOB-82197

		Finally, I want to take this opportunity to make the beginning of what will be a very challenging, but I believe a very worthwhile, period of innovation and change.	
17.11.2005	Letter from Dr McCormick to Trust	Re: Review of Public Administration : Health Decisions … The Minister's overriding aim is to improve the delivery of services for patients. He intends to streamline radically the HPSS management and set up a new structure that will have fewer, more effective bodies with a tighter focus on service delivery. These reforms will seek to provide more and improved frontline services and not an overall reduction. Any reduction in the number of HPSCC organisations will, of course, mean fewer posts at the very highest levels of management, but for most HPSS staff the most immediate difference will be a change of name by their employing organisation. … ..	TL1 Page 155 – 156 AOB-82198 - AOB-82199
10.07.2006	Letter to Mr O'Brien from Dr Orr	Offered 5.5 PAs in recognition of additional workload over and above his 10 PAs. Ex-gratia payment of Personal Information redacted by the USI in recognition of extra contribution during the period 1998 to the inception of the new contract.	Doc File 1 pages 39 - 40 AOB-00039 - AOB-00040
15.05.2007	Email from Lesley Leeman	Re: Urological Procedures for the Balmoral Clinic She advised me that they do not undertake complex major cases that would be associated with cancer. They do not undertake nephrectomies or radical prostatectomies. They will do PCNLs if there is a sufficient number of them and they will do general urology casemix such as TURPs, TURBs and ureteroscopies ..	TL1 Page 173 AOB-82214
09.07.2007	Email from Lesley Leeman	Re Waiting lists and transfers to Independent Sectors Email requesting AOB to look at his list and de-select patients not suitable for transfer to Independent Sector	TL1 Page 174 AOB-82215
19.07.2007	2010 Appraisal	In annual appraisal (extract from Form 4 is included in AOB's 2010 Appraisal) comments are made as follows:- "***Good medical care***. *External Services Review recommended a 4th consultant to take up post in 2007. The 3rd permanent post is starting this month. Concerns re meeting and [illegible] access targets."* **Any other points:** "*Still frustrated by lack of consultant expansion".*	2010 Appraisal page 188 and 192 AOB-22189 – AOB-22193
24.08.2007	Email correspondence between Jane	Re: Urology 6mth PTL Patient's surgery cancelled. Mr Young has no capacity to treat this patient in August and has scheduled him for surgery on 26 September 2007. This patient is then 6mth breach and needs surgery in August.	TL1 Page 175 – 176 AOB-82216 -

	Meredith, Mr Gibson, Mr Young and Mr O'Brien	… Spoke with Mr Young in theatres and has no capacity next week and patient not suitable for Balmoral. Mr Young no capacity next week, urgent patients booked also her advised that he thinks Mr O'Brien will not be doing list on Friday 31 August 2008, but maybe if we talk to Mr O'Brien sweetly… … Mr Young is taking a patient from Mr O'Brien's Friday afternoon list and doing it on his Tuesday afternoon list…. This has freed up Mr O'Brien's list on Friday afternoon to be able to fit in the three patients scheduled for Mr Batestones list on Friday morning … More bad news, I have received a phone call from Mary McGeough who advised that Dr Korda's theatre time has ran out and there are 3x6mth PTL patients who have not had surgery.	AOB-82217
09.09.2008	Email from Teresa Cunningham to Mr Gibson	Re Urgent Haematuria PTL for September As you know from my previous email, we are facing a shortfall in nurse led haematuria for September. Two of these patients were only added to the WL today. I thought this would be a simple matter of organising additional nurse led sessions but unfortunately it is not. To facilitate the clinics we need to have: 1. Ultrasound 2. Xray 3. Flexible Cystoscopies … We routinely have 3 ultrasound/xray slots per week. At a push we can get 4 but this is difficult (because we only have 3 flex cyst slots available). The most difficult issues however is access to flexible cystoscopies. We can access this service for our normal clinics, but if we run additional clinics, we will not have the capacity to do the additional flex cysts. Are transfers to DHH an option for these patients? … This will likely become a recurrent problem as we work our way down to 6 weeks by December. … Obviously given the current targets we are still significantly short and this may well deteriorate further unless we dedicate some time to discuss future plans ..	TL1 Page 177 AOB-82218
20.12.2008	Letter to Ms McNicholl from Mr O'Brien	"..reflected at length upon the direction of the Regional Review of Urological Services since attending the meeting at the Park Avenue Hotel on the 09th October 2008…. I still do have genuine and grave concerns regarding the future of urological services, particularly those outside of Belfast" …	SUP 1-6 AOB-03498 - AOB-03503

		"I really do regret this long narrative, but do believe it essential to ensure that you have a certain and complete grasp of the status quo, particularly that outside of Belfast. For me, the huge elephant in the room has always been service inadequacy, in recent times referred to as "capacity issues"." … "For all of these reasons, I would ask that the following recommendations be considered: # That any surgeon performing radical prostatectomies should perform a minimum of 10 per year # That any surgeon performing cystectomies for bladder cancer (usually radical) should perform a minimum of 10 per year # That radical prostatectomies be performed only at Altnagelvin Area and Belfast City Hospitals # That radical cystectomies be performed only at Belfast City and Craigavon Area Hospitals"	
Feb 2009	Extract taken from "Constitution for Northern Ireland Cancer Network (NICaN) Regional Network Groups"	Outlines Clinical Lead's responsibilities.	Doc File 1 pages 119 - 120 AOB-00119 - AOB-00120
March 2009	Review of Adult Urology Services in Northern Ireland: A Modernization and Investment Plan	Page 2 *"However, whilst reducing waiting times generally there have been some concerns about the capability of our urology services as they are currently arranged, to continue to deliver care of the highest standard while striving to meet increasing demand. The capacity within the HSC to deal with an increasing demand for urology services was the principal reason why this review was commissioned".* Page 8 *"A regional review of Adult Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services"* Page 13 – Catchment 3 Consultants – 305,000 (INPATIENT), 102,000 (PER CONSULTANT), 287,000 (DAY CASE), 96,000 (PER CONSULTANT) Page 22 *"The Increasing demand for Urology services in Northern Ireland is similar to that being experienced in the rest of the UK"* *"Demand for Urology Services is rising rapidly and the pattern of disease is changing"* *"New outpatient referrals and attendances have been increasing year on year"*	TL1 Page 320 – 382 AOB-82359 - AOB-82421

		"The most recent analysis undertaken is estimating an 18% increase in predicted (GP) demand from 2007 to 2008. ….. notwithstanding the above difficulty, it has been accepted that there is a significant increase in demand, which is likely to be as a result of those factors outlined at the beginning of this section …" Page 23 *"Both the demand and activity in Urology is significantly greater than the current SBA volumes. Some of this is non-recurrent backlog created by the reducing waiting times since 2005/06 and the remainder is recurrent based on 2007/08 demand"* *"Both increased and additional capacity to assess and treat patients is urgently required in urology"* Page 32 *Craigavon Hospital is an outlier with regard to review ratios.."* *"It is disappointing to note that at the time of this review Trusts have reported a total of 9,386 patients for whom the date of their review has past (some by many months)…."* Page 34 *"Increasing demand and workload pressures which were understood to be as a result of an ageing population along with people living longer, increased cancer detection …"* *"Capacity pressures (staffing) with a workforce struggling to cope with the increasing workload and meet the current targets and quality/clinical standards"* *"Capacity pressures (infrastructure) on some sites, with regard to access to theatres and day surgery sessions which again results in transfer of work to independent sector"* Page 45 *"The key challenges currently being faced by the service were outlined. In summary, these related to the capacity to deliver a modern, quality service and the ability to achieve and sustain long term stability and viability.."* *"It has been recognised that investment in additional capacity and staff will not on its own resolve the challenges relating to long term service stability"*	
24.03.2009	Email correspondence between Ms Sloan and Mr Weir	Re: Endoscopy List and Ward Reconfiguration Mr Weir notes that the Ednoscopy session was not to be configured as a fixed daily session stating "*How on earth can SOW function with the juniors if we are tied up doing a morning endoscopy list? SOW work and seeing patients comes first. Unless it is reflected in job plans. I am not aware that any of us have had that negotiation. I don't mind if ward work has finished then we can utilise the session.* *I will not be doing PEG replacement or Colonoscopy.* *There is a widespread concern regarding ward reconfiguration. This is another example of how things are not negotiated anymore. We all have concerns how this will work. When did we have a detailed discussion about it? When did we talk through the implications of it? How are we going to do*	SUPOCT Page

		a ward round when everyone including urology are in attendance? Tell me what benefits are to quaity of care and how you see this working in the real world? Maybe I have missed those discussions too and I am sorry I have. *Maybe I'm out on a limb here but our team of nurses are not happy and neither am I."* **Ms Sloan notes:** ***"** Endoscopy. This has not been fully neotiated with those currently delivering the SOW service. I received a very short email asking if I would support or participate in this service. In principal it should improve patient care if we have access to urgent endoscopy rather than patients continually being bumped on the emergency list, but when did this materialise into three fixed 3.5 hrs half day sessions? How can the commitments of a consultant delivered SOW be delivered while covering this. The days of leaving a reg to do this are gone, especially as we have had three registrars unable to perform endoscopy this year alone. If these are actue bleeders needing intervention then they need appropriate staff to manage them safely.* *The physicians also have not been fully involved in the practicalities of delivering this service and have their own concerns.* *This appears to have been rushed in very quickly and needs to be formally staffed for it to run in conjunction with the SOW not instead off.* *Ward Re-configuration. The clinical staff both medical and nursing actually delivering the service and meeting the targets have not been involved in this area. It seems a backwards step in patient care, if mixed general wards were such a good idea why did every subspeciality move to subspeciality ward care many eyars ago. The idea of an emergency ward seems logical considering our workload but the changes to the other areas seem impractical. How will we run multiple ward rounds, this will potentially delay starting elective sessions in the am. The details of this have come more by chinese whispers than direct engagement, and have not invovled all those affected jointly including ENT & UROLOGY they would probably agree with the sentiments of Colin's email.* *Currently medical outlyers also impact on our surgical beds can we be sure this will be resolved?* *There has been no meeting that I am aware of were ENT/Urology/Surgery consultant staff have all been in attendnace and this has been discussed, we are mutually exclusive and changes to one service will impact on the delivery of otehrs. Perhaps this needs to be arranged so this can all be discussed inclusively."*	

May 2009	Response to Department of Urology to Trust's Proposals for Ward Reconfiguration	**Proposals** 1. The Trust should firstly explore the possibility of moving all elective flexible cystoscopies out of day surgical theatres and into outpatient procedure rooms. This would be particularly worthwhile at CAH, moving flexible cystoscopies from DSU to the Thorndale Unit. This alone would free up six theatre sessions per month for elective day surgical procedures. Similar possibilities should be explored at STH and DHH. 2. The Trust should maximise the provision of adequately resourced, elective, day surgical facilities at all sites, so as to minimise the inappropriate use of inpatient beds for day surgery. 3. With reservations, we commit to trying the elective admissions ward for elective day cases who cannot be accommodated elsewhere. They will be admitted to that ward, and will return to it following surgery, and be discharged from there. 4. With greater concerns regarding continuity of care, we commit to having elective, short stay patients admitted on the day of surgery to that elective admissions ward, but only on condition that they return postoperatively to the Urology Unit. 5. All longer stay, elective admissions will be admitted to the Urology Unit, and remain there until discharge. 6. All non-elective admissions will be admitted directly to, or transferred to, the Urology Unit. 7. The Urology Unit will be singular and distinct. Any compromise of its integrity would disable implementation of the Regional Review.	SUP 13 - 17 AOB-03510 - AOB-03514
01.06.2009	Letter from Ms Youart to Mr O'Brien	Re: Urology Services **Point 1** Both Mairead McAlinden and myself are committed to the transfer of flexible cystoscopies and the expanded use of both the Thorndale Unit and other Trust facilities. I know already the options regarding a link corridor are being explored as a matter of priority and see no barriers presently to this occurring in the short term. **Point 2** I feel we have all been striving to achieve this point and work is currently underway with all specialties, to maximise day surgical facilities. This is now part of an action plan. **Point 3** I am delighted that there is agreement to utilise Ward 3 South for elective day surgical patients. This I believe will be further facilitated by the development of care pathways in Urology. I have asked Heather Trouton and Robin Brown to support and assist your team in developing those care pathways. **Point 4** I acknowledge the commitment to admit all patients to Ward 3 South and could I suggest that the team liaise with Connie Connolly and Heather Trouton to facilitate this.	TL1 page 190 – 192 AOB-82230 – AOB-82233

		Point 5 I acknowledge there is a degree of flexibility required in utilis I am hopeful that by developing care pathways as outli determining the best area for post-operative management. I would like to suggest that the procedures that could utilise t work through the implementation of these over the next month **Point 6** The Urology Unit will provide care for long stay and non-ele am sure that the work to develop care pathways will assist w support for this to be taken forward. **Point 7** I can only reiterate my thanks to the team in accepting this pr be located in the ward area, to which all general surgica admitted. **Point 8** I would like to outline for you the role I have discussed w recognise the role she has played in co-ordinating the numer are much wider than a Ward Manager's role. This has bee and I feel we need to recognise and give her the time to unde With this in mind, I feel the role needs to expand to one of N for Urology Services. The role will encompass providing nur both the Urology Unit and the patients who are being admitted stay areas. The role will also cover the services in Urodynamics and the T supporting the areas outlined alone in Point 1.	
02.06.2009	Email correspondence from Mr Mackle, Mr Gibson and Ors enclosing slip from Mr Mackle	Important email	Doc File 1 page 131 AOB-00131

		Mackle, MR E **From:** Mackle, MR E **Sent:** 02 June 2009 13:10 **To:** 'Simon.Gibson [redacted] Youart, Joy; O'Brien, Aidan **Subject:** Request for leave to clear administration Simon Thanks for discussing with me Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork. I have several serious concerns regarding the request: 1. I think approximately 2 years ago the trust funded a similar exercise to allow Aidan to catchup. It was agreed then that this was a one off and it was his responsibility (as per consultant contract) to prevent such a baglog developing again. 2. There are already 3.87 PAs of admin time in his current job plan. This is way in excess of any other consultant in the trust and is excessive when compared to eg Mr AKhtar (Cons Urologist) who has 1.12 PAs in his job plan for admin. 3. To expect the trust to fund the shortfall in clinical activity in light of Aidan's baglog (despite an over generous allowance of PAs in his job plan) would thus be unreasonable. If his colleagues feel that the request from urology is reasonable then I would expect the sessions to be covered at no additional cost from within the speciality. 4. If as you state Aidan feels there is now a clinical risk because he has allowed the backlog to develop then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may also need to consult with the Medical Director regarding the performance issues raised. Eamon Eamon Mackle Associate Medical Director Surgery / Elective Care Southern Trust	
12.06.2009	Letter to Mr Mackle from Mr O'Brien	Mr O'Brien denies that he made a request to Mr Mackle to stop clinical duties to clear up administrative issues. Notes it had been very stressful months caused by:- 1. Imposed loss of the ward. 2. Fragmentation of urological services which pose to make existential threat. 3. Lack of information and consultation.	Doc File 1 page 133 AOB-00133
15.06.2009	Email from Ms Montgomery to Urology Consultants	Re; First appointments We currently have 8 patients who need to be appointed and we do not have the capacity so we were wondering if you would have any solutions in order for us to get these patients seen	TL1 Page 193 AOB-82234
17.07.2009	Minutes of Morbidity & Mortality Surgical, Anaesthetics, Radiology and A&E meeting	Re Discussion regarding review patients .. Main issue from urology perspective is that the Clinicians' recommended timescale for patients' review at OPD are not being adhered to. It was commented current waiting time for review within urology is 18 months. There are targets for new patients to be seen in OPD therefore review are suffering a backlog because there is no corresponding target for them. It was felt that there is a hierarchy of reviews – those patients needing review with investigations take priority.	TL1 page 306 – 313 AOB-82345 - AOB-82352
16.10.2009	Email from Ms Murphy to Ms Youart	Re: 5 Consultant Model As you are aware over the last few months Performance and Reform have been working with urology them looking at demand and capacity data to establish the requirements with regard to out patients, in patients and day case sessions to meet the complete activity demand for the urology service in Southern Trust. …	TL1 Page 383 – 384 AOB-82422 - AOB-82423

		The sessions required will be improved by a 5 consultant team model and will utilise all sites within the Southern Trust. .. After considerable discussions it is felt by the Urology Consultants that this would not be workable due to lack of junior medical staff in the team and that the following sessional activity would be required…	
20.11.2009	Letter to Ms Trouton from MRA Young	Refers to recent "*External review for Northern Ireland"*	Doc File 1 pages 134 – 135 AOB-00134 - AOB-00135
07.12.2009	Meeting re Urology	Action Notes **Key points of discussion:** **1.** The Trust expects in line with the N I Integrated Elective will be treated by clinical priority and chronological order. as clinically urgent may not be clinically urgent. No agreed and junior staff on what is urgent or routine. If juniors patient status is not amended to routine. Agreement to Monday 14th December. **ACTION: Mr O'Brien.** **2.** Agreed to put all urgent patients on to immediate lists. **AC** **3.** Current problems perceived in system: ➢ Patients are getting letters of offer from IS even thou an in-house appointment. ➢ Clinical management plans are not accurately put on planned for annual review is booked for 3 months. ➢ Suggestion of separation of dictation and onward ma **Review and process mapping of systems – Hea** **4.** Pooling of lists is acceptable if patient consents, and is awar quickly by another surgeon. Need to agree who has clinical (original surgeon or operating surgeon). **ACTION: Mr Ma** The Urologists need to agree which patients/conditions can **ACTION: Ur**	TL1 page 395 -397

		5. Red Flag System The N I Standard is that patients with potential cancer are t ensure they are seen within designated timescales. This sys mainly on principle because the system is blunt and does nc priority across all red flags; nor does it reconcile with non-ca The use of red flags is mandatory and reflects clinical evider Agreement to develop a sub-division of red flags for use in s **and Urologists.** **6.** Need to clarify what POA hold signifies against a patient on patient is not medically fit for a procedure the clock stops. **7. Pre-Op Assessment** Needs review as patients can be called unnecessarily. **8.** Confidence in Trust destroyed due to ward reconfiguration.	
2010	Annual Report for the year ended 30 April 2010	*"2010 continued to offer considerable challenge to the provision of urological services in Craigavon however greater stability was evident albeit against a worsening economic climate, something that contributed to make education efforts difficult this year…"*	TL3 page 48 – 57
2010	2010 Appraisal – Form 2 – Details of your current medical activities	Mr O'Brien notes how he is a Consultant Urologist in a Urological Department/Service providing for a population of approximately 340,000. The service is provided by three Consultant Urologists with the support of two registrars, two nurse specialists and one GP with a specialist interest in additional to other nursing staff and more junior medical staff. Notes the Emergency/Acute/On-Call Service provided by each Consultant in 1 in 3 rota.	2010 appraisal pages 12-13 AOB-22013 – AOB 22014
2010	2010 Appraisal	Mr O'Brien has printed out list of surgery performed in 2010. There is a very substantial list	2010 appraisal pages 84 – 103 AOB-22085 – AOB-22104
2010	2010 Appraisal	Annual appraisal includes the following comments for 2010:- *"Current rota is 1:3. The population base covered is geographically wide, and hence patients are from both urban and rural backgrounds. A log of individual list of operations performed for 2008, 2009 and 2010 is impressively long, defining a constant and hardworking pattern."* In relation to working relations with colleagues it is commented:	2010 appraisal pages 195-199 AOB-22196 – AOB-22200

		"Has been on a 1:3 rota for several years now and is an active member in the unit which has a team approach to delivering its service. Aidan has a good relationship with colleagues, nurses and ancillary staff. This has all been tested in recent times by ward reconfigurations." Any other points: *"Aidan has regarded the changes resulting from the ward reconfigurations of 2009 as particularly disruptive, since it had taken many years to build and had predicted the deleterious effects of such changes. Eventual restoration to a definitive urology unit has been a very important point, and for the Trust to recognise this precise point.* *A further major change in practice has been the centralisation of radical pelvic cancer surgery imposed by the Department of Health. This has resulted in the loss of this provision at Craigavon Area Hospital and negative consequences for patients. There is general discontentment in the decision making process conducted by the recent Regional Review of urology. Aidan has concerns that this will have a significant knock on effects for services in the area in the future."*	
18.01.2010	Letter to Dr Rankin from Mr O'Brien	Mr O'Brien expresses concerns in relation to the appointment of a locum without consultation with others. CV not appropriate. Expresses concerns in relation to ward re configuration and loss of radical pelvic surgery and impact on the status of the department and thus recruitment.	Doc File 1 pages 138 – 139 AOB-00138 - AOB-00139
25.01.2010 – 27.01.2010	Email from Martina Corrigan to consultants	Re Additionality Please find below lists that I have held for additionality for March. I need confirmation on these lists as soon as possible as I have got first call for urology and if I don't go back then they will release them for surgical/gynae … … "Dear Mr O'Brien, Please see below I have slotted these dates in for March for Mr Akhtar are you available to take any of the rest. I was also trying to get you earlier I have taken the three Saturday's in February for Urology and Mr Akhtar has agreed to do Saturday 13th. Can you advice is you can do any of the other Saturday's? Mary is organising all cover and once confirmed I will speak and organise from the ward's point of view. We really need to take on these Saturday's to meet the 17 week target at the end of March. There will also be the four Saturday's available in March if you can advise if any suit as I need to confirm this tomorrow…" ..	SUP page 18 – 21 AOB-03515 – AOB-03518
03.02.2010	Email correspondence between Mr O'Brien and Mr Young & other consultants	Re additionality enclosing list of Additional Urodynamic Studies 2009 -10 Email from Michael Young "Dear all March rota in advance of Thursday. Purple are the extra lists to divide up. I think it fair to list the extras you are prepared to cover and if they are doubled up then we can split them evenly – does that sound ok?	SUP page 22-25 AOB-03519 - AOB-03522

		Martina – Please check this – I believe there are more but the dates and days did not match"	
03.02.2010	Email correspondence between Mr O'Brien, Mr Young & Others	Re Additionality Email from Mr Young: "Dear all, February rota is as complete as I can get it to date. I have asked Judith to print in colour as the grey version looses the importance of the message. May I point out that Funso is doing a sterling job as he is on his own till 15th Feb from 15th Jan. We should be mindful of the volume of ward follow up etc. You will see there is a lot of red yellow and blue – this indicates either extra work, a different located of work for that session and also being on own to do work. Please ensure secretaries/consultants put this into respective diaries. There is a lot of extra work. I do not think all team members have been informed of the extra work – ie admin side to send for these extra patients – time in lieu is not the way to do this, it needs to be financed as staff will never get the time back…"	SUP page 26-27 AOB-03523 - AOB-03524
03.06.2010	Email from Ms Corrigan enclosing Benchmarking of Urology Service		TL1 Page 424 – 431 AOB-82463 - AOB-82470
07.06.2010	Email from Ms McSherry to Mr O'Brien and Mr Young	Re: Haematuria Patients Just a wee problem I'd like to run past you which you could maybe discuss at your next Urology meeting. There are now 4 haematuria patients on the Friday pm list along with usually 4 or so other patients. It would appear that the Haematuria patients are taking a long time to get through resulting in the other patient being considerably delayed. Last Friday these first 4 were not finished until 4.15 pm. The other patients complained. One patient refused to wait any longer and walked out at 4pm, one asked for formal complaints form, another complained but this was hopefully resolved at ward level. I spoke with Jenny this am and she can't understand why it is taking longer for these patients to have their procedures. DSU staff on duty on Friday say that a lot of time is taken up with the Dr having to chase up results etc. Would it be possible to discuss this at the meeting and air out what the problems are? ..	TL1 Page 433 AOB-82472
07.06.2010	Action Note from Project Meeting	Re: feedback on Meeting with the Southern LCG – discussed potential to appoint new consultant with special interest in female urology, the capacity gap and need to benchmark. Re: Elective Reform Programme – A benchmarking of Trust performance compared with British Association of day surgery had been carried out…	TL1 Page 436 - 438 AOB-82475 -

		New model of care, suitable locations for each of the procedures to be carried out was agreed. The timescales for improving the current rates was discussed, no potential to increase bed numbers, additional theatre instruments would have to be purchased to support the additional theatre sessions. Considerable debate about the numbers at outpatient clinics and stipulation in the review recommendations that clinic templates should be set at 7 new and 7 review for a single consultant clinic. Consultants felt that this was too high given the time needed to spend particularly with cancer patients …	AOB-82477
14.06.2010	Regional Review of Urology Services Team South Implementation Plan	Notes that Team South had a total catchment population of 410,000. To increase by two Consultants, giving a total of five, and two specialist nurses recommended and agreed by Minister. Noted in 2010 urology team at that stage included:- 3 Consultant Urologists 2 Registrars 2 Trust Grade Doctors 2 Urology Specialist Nurses On page 6 is provides an outline of Consultant activity. On page 7 it is noted "*There is a substantial backlog of patients awaiting review at consultant clinics. The total number of patients is 4037."* On page 7 it is also noted that MDM is a significant issue, no oncology input. Page 9 includes some regional benchmarking.	Doc File 1 pages 140 – 172 AOB-00140 - AOB-00172
17.06.2010	Minute of Urology/Primary Care Meeting	**NOTE AOB ABSENT FROM MEETING** 1. Management of review backlog 2. Patient Pathways 3. Prevention of Growth of Review Back Log: Agreed that the Urology team as a whole would be more proactive in discharging patients back to their GP with a management plan. 4. Other issues: suggestion of Locum Consultant to be recruited.	TL1 Page 485 – 488 AOB-82524 - AOB-82527
28.06.2010	Notice To all staff	Agreed Reconfiguration of Surgical beds In terms of bed numbers, this represents an additional 17 inpatient beds and a reduction of 4 day case beds in total. It has been agreed that during the peak mid week period, 4 additional beds in 1 West will be available for use for a very limited period of time by the Surgical Division when required. This reconfiguration of surgical services has represented a huge challenge to the Acute Services Directorate and staff within the Division have contributed positively and constructively to this challenge…	TL1 page 473 AOB-82512

05.07.2010	Letter to Ms Porter from Mr Akhtar	Re: Issues relating to the Urology MDM Meeting … Today we completed three months of MDM from the start date and the basic infrastructure and promises are still not in place which is going to create a lot of problems from clinical governance issues as well as patient management and safety. 1. Post MDM follow up/ co-ordination of these patients (a) There is no clinical formalised to see these patients at the moment each individual consultant whenever they get time will see them which could be next week or it could be in a couple of weeks (b) If these patients needs any investigations this is again an issues as to who is going to book them and where that is going to be booked. The problem of booking the investigation can be partially resolved if as we have been saying for a long time that a computer is made available in the MDM room as well as the positions already indicated around the hospital. Some of these patients have been neglected as there are not appropriate clinical slots available or their investigations were not booked because of the ownership of those patients and responsibilities 2. The availability of personnel when some specialities on holiday. I do agree that we need to take our annual leave but in the meantime we have to have access to some alternative arrangements like colleague cover. 3. There is an issue of availability of microscopy, I have been told that the microscope has been ordered but it is almost 3 months since the microscope has become available and this is a huge clinical governance issue 4. … There should be clear cut guidelines for those patients treatment and how they are going to be followed up because after the treatment it doesn't finish there and they need further follow-up cystoscopy. At the moment the patients are being left without any follow up arrangement so they get lost in the system When we started in April we were promised that all these issues would be resolved by the 1st June and I am adamant that up to now nothing has been resolved and it is getting very frustrating and I am thinking that there is no point to the MDM if there is no infrastructure in place and arrangements made for the above issues.	TL1 Page 482 – 483 AOB-82521 - AOB-82522
07.07.2010	Email from Malcolm Clegg to all staff	Re: intention to appoint Clinical Director for Surgery and Elective care & Clinical Director for Medicine and unscheduled care	TL1 Page 474 – 480 AOB-82513 - AOB-82519
26.07.2010	Ms Porter's response to Mr Akhtar's letter	1. MDM follow up of patients – previously patients requiring appointments for review, results etc have been made by the Consultants secretarial teams. This should still be the case as this is not a role of the MDT co-ordinator. You may be aware that a review of administrative services is ongoing and this is one of the many issues which will be discussed. 2. Ordering of onward investigations – as you will be aware this is the responsibility of the medical staff.	TL1 Page 490 – 491 AOB-82529 - AOB-82530

		3. As you are aware we do have a process for red flagging patients with suspected cancer and it would be helpful if this was used by all of the team members as this helps the tracking team and the partial bookers, appointment makers to prioritise appointments for these patients within radiology and pathology services. 4. Regarding staff holidays: If this is with regard to the medical staff, this does not come under my remit 5. During the week of your letter the camera arrived and is being set up 6. Regarding the management and guidelines of intravesical mitomycin and BCG. Guidelines are the responsibility of the clinical team within the MDT and do not fall under my direct remit. I would expect that the medical team are working closely with the nursing staff, pharmacy and urology managers etc to produce these …	
29.07.2010	Email from Mr Williams in response to Ms Porter email of 29 July 2010	One would have thought that addressing the huge backlog of plain films is more important than sitting doing nothing. However, I will mention to Stephen Hall that I need more time in my job plan for the MDT …	TL1 Page 494 AOB-82533
29.07.2010	Email from Mr Williams to Ms Porter	Re Urology MDT Agreed. We have huge issues with unreported examinations in xray and the more time I have to allocate for the MDT means the less time I have for reporting. ..	TL1 Page 498 AOB-82537
29.07.2010	Email from Martina Corrigan to Mr O'Brien	Re Review Backlog I just wanted to follow-up with you regarding our meeting at lunchtime today when we discussed briefly the review backlog issue. Whilst I do appreciate your concerns and also appreciate all the work you have done to date with Kate and Jenny to address this issue, I just wanted to confirm as discussed at our meeting that there is no funding available to hold additional clinics to see any review backlog patients.	TL1 page 500 AOB-82539
03.08.2010	Memo from Heather Trouton to Acute Directorate	Re: Outpatient Utilisation Audit It has been recognised that there has been a huge increase in demand for Outpatients Services across all sites within the Trust which has out pressure on the physical space which has remained largely static. … It is our intention to improve where possible the efficiency, effectiveness and utilisation of the Outpatient Departments as a whole and enhance the experience of everyone, patient and staff alike who come into contact with this frontline service ..	TL1 Page 512 – 513 AOB-82551 - AOB-82552

20.08.2010	Email from Ms Graham to Angela Montgomery	Re: Urology Tracking Update 31 day patient's current numbers 65 – I would imagine that 85-90% would be breaches 62 days patient's current number 82 . the numbers that have breached their target already are 17. Will be breaches in the month of August 22. … Flexible cystoscopy is the big delay	TL1 Page 507 AOB-82546A
20.08.2010	Email from Mr Akhtar to Ms Trouton	Response to above email from Ms Graham .. It is not the only list issue. It more than that, including the capacity also. Need to sit down and set the priorities right	TL1 Page 509 AOB-82548
27.09.2010	Letter to Dr Rankin from Mr O'Brien	Re Regional Review … "I found the events of last week profoundly shocking and traumatic. I could never have imagined that such decisions could be made by some who had once qualified as doctors. I believe that it was appalling to cancel the admissions of those who urgently needed their surgery. Personal Information redacted by the USI Personal Information redacted by the USI was in such symptomatic distress from a bladder full of tumour that he required acute admission to hospital. The cancellation of his planned elective admission caused him such additional mental distress as to have him cry, to express suicidal intent, wanting to go home to die! I could go on, but I wont as it is pointless as it was before. Suffice to say that last week changed everything for me, and my colleagues. It completely removed any remnant of the veneer of clinical validity from the thrust of the review. For all of the above reasons, and regarding the contents of your letter, I wish to avail of this opportunity to highlight the fact that I believe bound, first and foremost, and to the best of my ability, by the Hippocratic Oath that I professed in 1978. I believe that my duty is to provide the best possible care to the maximum number of those in most need of it. I did not need NICE or BAUS to tell me so, or guide me to that conclusion. I do not agree with the imposed application of Improving Outcome Guidelines in the manner proposed in the Regional Review. There has not even been an assessment of clinical outcomes following radical cystectomy in Northern Ireland in order to determine how best to improve outcomes. Even when that has been conducted as is the case of radical prostatectomy, centralisation may be directed to the centre with the worse outcomes! As I have indicated previously, I have found that the mean duration of consultation at my clinics has been approximately 18 minutes. I have found that the duration is not influenced by new to review ratios. On Tuesday 21 September 2010, it took 190 minutes for me to review 10 patients, and that did not include time required to dictate letters. I cannot agree to comply with BAUS guidance regarding outpatient templates. My inability has absolutely nothing to do with the fact that I believe that the guidance is both ridiculous and obsolete, or that I have no association with BAUS whatsoever, or that I do not feel any obligation to be compliant with	SUP 32-34 AOB-03529 - AOB-03531

		anything emanating from BAUS. My inability is simply due to my being unable to do what is for me impossible! … I find it remarkable that a clinician should be required to see new patients within 20 minutes slots and review patients within 10 minutes slots. So doing is to compromise or jeopardise the completion of a consultation, thereby once again, jeopardising clinical outcome. … Regarding the triaging of letters, I do indeed aspire to be able to complete the triaging of all letters within one week. In particular, I would like to have all referrals triaged in a manner so that they are dispersed to their various destinations at 9am each Monday morning. All "red flag" referrals are currently triaged by me on a daily basis. I undertake to have all referrals, irrespective of urgency, triaged within one week of referral, as above, by 1 November 2010. That undertaking is conditional upon maintenance of the current cohort of three consultants, and could not necessarily by maintained if our numbers were to decrease."	
30.09.2010	Email from Martina Corrigan to Consultants	Re: Additional Outpatient Clinics We have just had confirmation that we are allowed to proceed with additional outpatient clinics to see those new patients who are breaching the 17 week target which will be 27 clinics from now until the end of March. We have also got the go ahead to proceed with some review backlog clinics again about 40 clinics from now until March 2010 which is about 2 review clinics per week.	TL1 Page 522 AOB-82561
04.10.2010	Meeting re Implementation	Re: Regional Implementation meeting	TL1 Page 524 AOB-82563
04.10.2010	Email from Martina Corrigan enclosing Out Patient backlogs	Re: Outpatient Backlogs list Mr Young (CAH) **2008 –** 452 **2009 –** 415 **2010** – 371 **Urgent/top of list** – 79 **Total –** 1317 <u>Mr Young (ACH)</u> **2008-** 97 **2009 –** 79 **2010 –** 12 **Urgent/Top of list –** 4 **Total –** 192 <u>Mr Young (BBPC)</u> **2008 – 72** **2009 - 81** **2010 – 25** **Urgent/Top of list – 8** **Total – 186** <u>Mr O'Brien (CAH)</u>	TL1 Page 526 – 540 AOB-82565 - AOB-82579A

		2008 – 135 **2009 –** 435 **2010 –** 241 **Urgent/Top of list –** 21 **Total –** 832 <u>Mr O'BRIEN (ACH)</u> **2008 – 103** **2009 – 110** **2010 – 73** **Urgent/Top of List – 31** **Total – 317** <u>Mr O'BRIEN (BBPC)</u> **2008 – 59** **2009 – 155** **2010 – 74** **Urgent/Top of list – 32** **Total – 320** <u>Mr Akhtar (CAH)</u> **2008 – 32** **2009 – 465** **2010 – 319** **Urgent/Top of list – 143** **Total – 959**	
12.10.2010	Minutes of MDM	Re IV Fluids/IV Antibiotics …. It was agreed by the group that Shirley must stress to these patients that we are not abandoning them and they have her as a point of contact should they become unwell between the two week interim period…	TL1 Page 548 – 549 AOB-82587 - AOB-82588
15.10.2010	Email from Ms O'Neil to Martina Corrigan	Re: MDM Outcomes … took the opportunity to discuss current MDM process and how best to improve the running of same. … Since MDM and NICAN pathways have commended we have a significant issue with what we call Day 3 and Day 4 appointments and space within the Consultants timetable to be able to offer these in any timely sort of fashion or indeed if at all. 1. A Local agreement with consultants determined that local MDM discussion would occur prior to initial histology review appointment … 2. We currently have insufficient histopathology review spaces however this is further reduced when the Registrar on call the previous weekend as EWTD states he must finish on a Monday at 3pm. …	TL1 Page 550 AOB-82589
28.10.2010	Outpatient Backlog Review	<u>Mr Young (CAH)</u> **2008 – 414**	TL1 Page 558 -559

		2009 – 407 **2010 – 424** **Urgent/Top of List – 82** **Total – 1327** <u>Mr Young (ACH)</u> **2008 – 68** **2009 – 77** **2010 – 22** **Urgent/Top of List – 5** **Total – 192** <u>Mr Young (BBPC)</u> **2008 – 66** **2009 – 77** **2010 – 32** **Urgent/Top of List – 4** **Total – 179** <u>Mr O'Brien (CAH)</u> **2008 – 6** **2009 – 414** **2010 – 303** **Urgent/Top of list – 53** **Total – 776** <u>Mr O'Brien (ACH)</u> **2008 – 72** **2009 – 105** **2010 – 92** **Urgent/Top of List – 23** **Total – 292** <u>Mr O'Brien (BBPC)</u> **2008 – 55** **2009 – 153** **2010 – 90** **Urgent/Top of list – 36** **Total – 334** <u>Mr Akhtar (CAH)</u> **2008 – 31** **2009 – 450** **2010 – 359** **Urgent/Top of List – 141** **Total – 981**	AOB-82597 - AOB-A82598
29.10.2010	Letter to Dr Rankin from Mr O'Brien	Response to Dr Rankin's letter asking Mr O'Brien to reconsider the issues raised regarding outpatient clinics 1. Mr O'Brien cannot undertake to limit duration of outpatient consultations whether new or review to a particular period of time. 2. Difference in number of appointments in Armagh is due to nurses having to leave at 12.30 to return to Banbridge Polyclinic 3. Believes BAUS recommendations are inexplicable, irresponsible and obsolete. 4. Total number sof patients to be accommodated at clinics is almost entirely unrelated to the issue of new:review ratios, and	SUP 35 – 36 AOB-03532 - AOB-03533

		undertaking to reduce the numbers of patients to be reviewes. It is possible to markedly reduce the numbers of patients to be reviewed, provided that there is agreement by all concerned to bear responsibility. I do not undertake to reduce ratios unless and until those agreements have been sought and obtained. 5. Cannot undertake to limited duration of any outpatient consultation as it would be clinically irresponsible for me to do so. Secondly I cannot agree to the total numbers of consultations recommended by BAUS, as it would be impossible for me to satisfactorily complete such numbers. Lastly, I will not undertake to reduce the numbers of patients to be reviewed to any particular figure, until primary care has agreed.	
05.11.2010	Email from Martina Corrigan to Urology Consultants	Re: Additional Theatre Sessions I have been given the go ahead to organise a number of additional sessions for Inpatient, Day cases and Flexi lists from now until end of March.	TL1 Page 560 AOB-82599A
12.11.2010	Email from Mr Akhtar to Martina Corrigan	Re: Urology Theatre Utilisation information (September 2010) … There are a few things not clear as such 1. Who is responsible for data input? 2. How accurate and on time data is inserted? 3. Is there any mention about the cancellation by patient on the day of surgery or day before and you are let with no alternative OR PATIENT SENT TO WRONG HOSPITAL!! 4. As for main OT CAH I still have to wait for the day when I finish early, always overrunning. Then how can there be non utilisation on Friday for 41 min?	TL1 page 571 AOB-82610
19.11.2010	Outpatient Backlog Review	<u>Mr Young (CAH)</u> **2008 – 378** **2009 – 405** **2010 – 420** **Urgent – 84** **Total – 1287** <u>Mr Young (ACH)</u> **2008 – 84** **2009 – 76** **2010 – 22** **Urgent – 5** **Total – 187** <u>Mr Young (BBPC)</u> **2008 – 66** **2009 – 77** **2010 – 31** **Urgent – 4** **Total – 178** <u>Mr O'Brien (CAH)</u> **2008 – 3** **2009 – 408** **2010 – 290** **Urgent – 52** **Total – 753**	TL1 Page 583 – 584 AOB-82622 - AOB-82623

		Mr O'Brien (ACH) **2008 – 9** **2009 – 105** **2010 – 91** **Urgent – 20** **Total – 225** Mr O'Brien (BBPC) **2008 – 48** **2009 – 150** **2010 – 87** **Urgent – 36** **Total – 321** Mr Akhtar (CAH) **2008 – 31** **2009 – 444** **2010 – 346** **Urgent – 112** **Total – 933**	
10.12.2010	Email from Jenny McMahon	.. Mr O'Brien will do list on 28th despite annual leave	TL1 page 668 AOB-82707
14.12.2010	Email from Martina Corrigan to Mr O'Brien	Re: Update on number of patients waiting .. I am just sending through to each of you what you waiting times are like until end of January as these are the patients that need to be seen to help bring us in at 36 weeks by end of March 2011. 2 Patients waiting 38.37 weeks In patients – 27 patients waiting and longest patient waiting is 51.51 weeks I am happy to discuss and agree what additional sessions that you are able to do over the next few months	TL1 Page 671 AOB-82710
2011	2011 Appraisal	In his 2011 appraisal AOB comments including the following after stating that there were 3 Consultants from 2007:- "*The population served has also increased from 297,000 in 1992 to 340,000 by 2011. In some areas of subspecialist service provision, particularly stone management, the population served has been much greater. ….. It was the intent at last appraisal for 2010 that I would provide leadership in the development of services in lower urinary tract dysfunction as there remained long waiting lists for urodynamic assessment in particular, but the demands of general urology, and urological oncology in particular, have mitigated against that development.*" In relation to workload generally the 2010 had suggested a total consultant episodes be obtained. Comment is made under the heading "REPORT ON DEVELOPMENT ACTION IN THE PAST YEAR" as follows:-	2011 Appraisal page 8 AOB-22229

		"Information recording the total number of Finished Consultant Episodes, both acute and elective, day case surgery and inpatient surgery, and outpatient activity (new and review)on all three sites where outpatient clinics are conducted, has been requested from the Information Department, and will be filed when made available."	
2011	2011 Appraisal	Within the appraisal documentation there is a document entitled "*Number of Elective Finished Consultant Episodes (Operative and Non-Operative) to Mr A. O'Brien …… 01/01/2011 to 31/12/2011"*	2011 Appraisal Pages 57-64 AOB-22278 - AOB-22285
2011		Re Data displaying outpatient review backlogs in 2011.	SUP 66 – 72 AOB-03552 – AOB-03558
06.01.2011	Letter from Mr Mackle to Urology	Ongoing problems with Flu both seasonal and H1N1 2009. The demand is such that ICU in CAH now has to be staffed for 8 ventilated patients and at one stage on Tuesday we had 2 ventilated patients in a theatre. It is expected that we are in week 2 to 3 of a six week flue epidemic but it is expected that ICU pressures could last up to 3 further weeks One initial effect is that we are have had to cancel elective surgery e.g. next week between CAH and STH, we have had to cancel the equivalent of a whole theatre each day. We have also had to cancel some lists in main theatres block in CAH. If the demand for critical care beds continues to rise we will have to cancel further lists as the theatres will be used for ventilating patients. For the next few weeks we expect to be unable to allow elective surgery to take place if an ICU bed is required. If you have an urgent of cancer case, with a high risk of needing ICU and which you believe should go ahead despite the provisional ban then these cases need discussed and it should not be assumed that they will automatically be permitted to proceed. Where lists are cancelled the session will either be replaced by another clinical session..	TL3 page 1 – 2 AOB-05679 – AOB-05680
11.01.2011	Email from Ms Trouton to Mr O'Brien	Re: Waiting times *"Mr O'Brien* *I appreciate that there are important clinical considerations to be made when deciding who to schedule to your inpatient list on a weekly basis. However I have to stress that you currently have 34 patients who will be waiting greater than 36 weeks by the end of March who currently have no date for surgery. The longest waiter at the minutes with no date is currently waiting 54 weeks.* *Your list for tomorrow has 3 patients waiting 2 weeks, one waiting 14 weeks , one waiting 17 weeks and 1 waiting 19 weeks.*	TL3 page 9 AOB-05687

		Can I please ask if you would look at these 34 patients and either list them or if they do not require surgery take them off the waiting list particularly as some of these patients are actually categorised as urgent. *Urology has got special dispensation to go out from 13 weeks to 36 weeks as there is a recognition that we do have a capacity gap, however we cannot justify some patients being treated within 2 weeks while others wait 54 weeks.* *I appreciate that you have offered to do additional Saturday lists which is great, however as you know this is proving difficult to secure with theatre nursing staff and we really do need to use the core lists we have to treat these long waiters at least until we see what additionality, if any, we can secure.* *Can I ask that this gets your urgent attention and Sharon and Martina will be very happy to work with you to identify the patients needing listed before the end of March "*	
27.01.2011	Email correspondence between Mr O'Brien and Martina Corrigan	Re Additionality ".. It is my understanding that I am doing additional operating on Saturday 5 February and Saturday 26 February. I have already arranged the cases for Saturday 5 February. I have not yet arranged cases for 26 February. No decision yet made regarding March 2011."	SUP 49 – 50 AOB-03546 - AOB-03547
02.02.2011	Email from Ms McCorry to Ms Tedford	Re Mr O'Brien's Extras list for Saturday theatre session – 7 patients listed	TL3 page 10 – 11 AOB-05688 – AOB-05689
04.02.2011	Email from Ms Corrigan to Mr O'Brien	RE: Mr O'Brien waiting lists for March 20 patients listed with longest waiting of 55.35 weeks	TL3 page 12 – 18 AOB-05690 – AOB-05696
10.02.2011	Email from Ms Stinson to Urologist	Re: Re Implications of the Shortfall in Finance in Health *"You will be aware of the Minister's statement on the shortfall of £800 million over 4 years and £200 million in 2010/11 and there is no apparent strategic approach to addressing this. It is not clear therefore what each Trust will be asked to deliver from April"*	TL3 page 19 AOB-05697
18.02.2011	Email from Chief Executive to SHSCT	Re: Thank you *"This is undoubtedly an extremely challenging time for our service but I have every confidence in our ability and commitment to continue to provide a safe, responsive service to everyone who needs our help"*	SUPAUG Page 1
22.02.2011	Email from Ms Corrigan to Consultants	Re: Triaging letters *"Dear all* *I have been advised that there are 55 outstanding outpatient letters for triage that the booking centre are waiting on in order to book clinics. Can I ask that if you have any outstanding letters can you please action and return to the booking centre. I appreciate how busy you all are at the moment but I would be grateful if you could action this as soon as possible"*	SUPOct Page

04.03.2011	Urology Activity	2009/10 Elective FCEs **Mr Akhtar total – 319** **Mr O'Brien total – 513** **Mr Young total – 407** Day cases **Mr Akhtar total – 356** **Mr O'Brien total – 452** **Mr Young total – 704** Non- Elective FCEs **Mr Akhtar total – 186** **Mr O'Brien total – 210** **Mr Young total – 233** 2010/11 Elective FCEs **Mr Akhtar total – 244** **Mr O'Brien total – 312** **Mr Young total – 309** Day Cases **Mr Akhtar total – 352** **Mr O'Brien total – 505** **Mr Young total – 810** Non Elective FCEs **Mr Akhtar total – 184** **Mr O'Brien total – 177** **Mr Young total – 202**	TL3 page 23 – 25 AOB-05701 – AOB-05703
09.03.2011	Email from Ms McSherry to Urology	Re: Problem Tues Lists DSU Down 2 bed spaces due to 1 side room having to be taken out of action to store endoscopes. Impacts upon areas for consenting/discharge. Compounded further by Tuesday lists running over form am to pm resulting in congestion of patients trying to recover and those coming in. .. Ask that you all consider 1. Operating on the cases that takes the longest time to recover first (free up beds) unless there is a valid reason to do otherwise 2. If lists have been identified as late start due anaesthetic cover ECT, that lists are planned according 3. That nurse are not pressurised for issues beyond their control ie lack of space consenting/admitting 4. If am lists started on time there would be less change of overrun	TL3 page 28 AOB-05706
06.04.2011	Email from Ms Corrigan to Consultants	Re: Attendance at Cons Led Urology Clinics Oct Nov 2011 <u>4 month activity</u> **New Ops** **Mr Akhtar – Total 432** **Mr O'Brien – Total 501** **Mr Young – Total 327** **Review Ops** **Mr Akhtar – Total 564** **Mr O'Brien – Total 903**	TL3 page 30 – 32 AOB-05708 – AOB-05710

		Mr Young – Total 1119	
11.04.2011	Email complaint from patient	Re: Personal Information redacted by the USI *"The above named constituent has been waiting for a prostate operation at Craigavon Hospital and now informed a 6 month waiting list. He is in considerable pain and discomfort at present and grateful if this operation could be treated as a priority due to the discomfort he is experiencing. He is currently under* Personal Information redacted by the USI *."*	TL3 page 34 – 36 AOB-05712 – AOB-05714
24.05.2011	Email from Ms Corrigan to Consultants	Re: Additional Saturday Theatre List *"Dear All,* *I have had confirmation that there is funding available to do additional theatre lists in CAH June. This funding is to see long waiting patients as we now have a number that are waiting over 40 weeks. Can you let mw know by tomorrow evening if you would be able to do any of these lists, as there is anaesthetic and nursing cover available"*	TL3 page 60 AOB-05738
06.06.2011	Email from Ms Corrigan to Consultants	Re: Review Backlog 31 05 2011 **Mr Young CAH – Total 1016** **Mr Young ACH – Total 156** **Mr Young BBPC – Total 152** **Mr O'Brien CAH – Total 671** **Mr O'Brien ACH – Total 229** **Mr O'Brien BPPC – Total 272** **Mr Akhtar CAH – Total 844**	TL3 Page 79 – 81 AOB-05757 – AOB-05759
09.06.2011	Email from Ms Tedford to Consultants	Re: Total number of patients on ward enclosing table of bed occupancy We are staffed for 31 patients 12 of which are identified as urology beds. The figures calculate that over that period of time we had 30 patients of more on 36% of the time but more interestingly was that 81% of the bed days we had 12 or more urology patients. We clearly need more urology beds to cater for our patients	TL3 page 88 -92 AOB-05766 – AOB-05770
09.06.2011	Email from Ms McMahon to Ms Corrigan	Re: Haematuria Clinics There will be no flexible cystoscopy lists available in July for haematuria patients and unfortunately the service will have to be suspended form 22 June until flexi lists recommence. We had discussed the possibility of using Wed 27th July in day surgery as a full haematuria flexi list (which will be used for patients attending on the 15th & 22nd June as no other dates available) can you confirm if this is still available? Referrals outstanding: 6 red flags awaiting appt from 25th May 5 routine awaiting appt from 5th May	TL3 page 93 AOB-05771
14.06.2011	Email from Ms Corrigan to Mr O'Brien	Re: Letters for outpatient clinics Booking centre advised that waiting on letter back from Aidan O'Brien for sending for patients for July clinics	TL3 page 96 AOB-05774
01.07.2011	Memorandum between Mr O'Brien and Ms Trouton	Notes "*Heather Trouton to meet Mr O'Brien to discuss way forward in managing review backlog in a timely manner. Heather Trouton to set up meeting."*	Doc File 1 pages 255 – 256

		Discussion also in relation to communication with patients who have had their review appointment delayed due to the current backlog. Also discussion in relation to urodynamics. AOB to get 20 minutes per patient. "*Factor into workload but does not require a full dedicated urodynamic session."* Operational support to be given to Mr O'Brien to assist him "*managing the chronological booking process."*	AOB-00255 - AOB-00256
05.07.2011	Email from Mr Young to Ms Corrigan	Re: Job plan Our team is very restricted currently with leave [redacted].	TL3 Page 112 AOB-05790
19.07.2011	Email from Ms Rankin to Consultants	Re: Urology Development Trust received approval to proceed with the development of the urology service in line with the regional review and the activity levels agreed as our last proposal. This is good news and after much hard work, discussion and agreement it is good to get to this stage. However we still have much to do to implement the full service. 1. To discuss recruitment of new urologist 2. Finalise job plans	TL3 page 113 AOB-05791
20.07.2011	Email from Ms Corrigan to Consultants	RE: Review backlog Some further funding for additional review backlog clinics. **General Surgery – 1972** **Breast Surgery – 3** **Oral Surgery – 56** **Urology – 3329** **ENT – 2126** **Ophthalmology – 1837** **Orthopaedics – 455** **Thoracic surgery – 0**	TL3 page 114 – 115 AOB-05792 – AOB-05793
25.07.2011	Email from Ms Glenny to Mr O'Brien	Re: Waiting lists and scheduling *Dear Aidan* *I hope you are keeping well. Heather had spoken to me before the holidays about the above as she had met with you regarding setting up a process for dealing with waiting lists and scheduling. She has asked that Andrea and I take this forward and I was hoping that we could come to discuss this with you.."*	TL3 page 116 AOB-05794
26.07.2011	Email from Ms Cunningham to Mr O'Brien	Re: Review backlog *"Dear Mr O'Brien* *Please advise regarding dates you may be available for additional review backlog clinics during August/September"*	TL3 page 117 AOB-05795
26.07.2011	Email from Ms Stinson to Consultants	Re: Additional Endoscopy Lists *"Dear all,* *You will be aware that all Trusts have been asked to reduce the waiting time for a scope of 13 weeks…..*	TL3 page 118 AOB-05796

		However, there is still a significant number of people on the waiting list whom we will not be able to see and I am writing to see if each of you would be prepared to commit to a level of additionally at WLI rates between now and end of March 2012. *…*	
26.07.2011	Email from Ms Corrigan to Consultants	Re: Admission on day of surgery *"Dear all,* *Please see attached information on admission on day of surgery - I note from this information that we are starting to increase in our patients that are NOT being admitted on day of surgery.* *Can you give me any indication of why this might be occurring of if there is a trend of pattern that is causing this to happen? We are being monitored on this and I have to give an explanation if this is increasing and the possible reasons why so any information that you have would be appreciated"*	TL3 page 121 – 123 AOB-05799 – AOB-05801
27.07.2011	Email from Ms Corrigan to Consultants	RE: Backlog 30 June 2011 **Mr O'Brien CAH: 2009 total 216** **2010 total 277** **211 total 179** **Mr O'Brien ACH: 2009 total 70** **2010 total 105** **2011 total 40** **Mr O'Brien BBPC: 2008 total 2** **2009 total 87** **2010 total 88** **2011 total 60** **Mr Young CAH: 2008 total 86** **2009 total 330** **2010 total 401** **2011 total 174** **Mr Young ACH: 2008 total 24** **2009 total 64** **2010 total 23** **2011 total 18** **Mr Young BBPC: 2008 total 22** **2009 total 63** **2010 total 29** **2011 total 21** **Mr Akhtar CAH: 2008 total 1** **2009 total 222** **2010 total 347** **2011 total 229** **Mr Akhtar STH 0**	TL3 page 124 – 129 AOB-05802 – AOB-05807
25.08.2011	Email correspondence between Mr O'Brien and	Re consultants to review results and investigations as soon as result is available and that one does not wait until review appointment to look at them. Mr O'Brien response:	SUP 86 – 88 AOB-03583 -

	Martina Corrigan	Martina, I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons: • Is the consultant to review all results and reports relating to patients under his/ her care, irrespective of who requested the investigation(s), or only those requested by the consultant? • Are all results or reports to be reviewed, irrespective of their normality or abnormality? • Are they results or reports to be presented to the reviewer in paper or digital form? • Who is responsible for presentation of results and reports for review? • Will reports and results be presented with patients' charts for review? • How much time will the exercise of presentation take? • Are there other resource implications to presentation of results and reports for review? • Is the consultant to report/ communicate/ inform following review of results and reports? • What actions are to be taken in cases of abnormality? • How much time will review take? • Are there legal implications to this proposed action? I believe that all of these issues need to be addressed, .-Aidan.	AOB-03585
29.08.2011	Email correspondence between Mr O'Brien and Ms Trouton	Re: issue and actions from meeting held on 09 June 2011 which all three consultants were summonsed to. "I believe that your summary was not an accurate reflection of the discussions that day, as much for what it did not contain as for inaccuracies in what it did. Review backlog 1. New/review ration "off the wall" with no evidence for that claim 2. Negative clinical outcome for patient not being reviewed when intended was clinician's fault and responsibility 3. Told a patient that it was Trust's fault that he had not been reviewed when intended 4. Criticism of accepting back for review a patient who was under review at another hospital even though GP had requested to do so Urodynamics 1. Did not agree that 20 minutes would be required to review patients upon completion of urodynamic studies and to agree a management plan. 2. Reference to whatever not requiring "a full dedicated urodynamic session" requires clarification Pooled lists 1. Did not agree to manage all day case pateints in chronological manners. I did agree that the majority could be 2. Did not agree to pooling of lists. Did agree to operating on any of my colleagues day cases if waiting longer than mine, within categories of clinical priority Leadership Requirements	SUP 89 – 90 AOB-03586 - AOB-03587

		1. Lectured on how to give confidence to all nursing staff regarding patient care rather than being critical 2. Retain the right to be critical when believe justified 3. Ironic to be criticised for being negatively critical in a meeting largely devoted to negative criticism	
06.09.2011	Email from Ms Trouton to Consultants	Re: Appointing consultant with specialist interest *"… bear in mind the service needs with regard to demand and advise where you think the gaps of specialist interest will be which will need addressed…"*	TL3 page 140 – 141 AOB-05818 – AOB-05819
07.09.2011	Letter to Mr Young, Mr O'Brien and Mr Ahktar from Dr Rankin	Letter confirming that the Commissioner has required that all cystectomies are undertaken in a single unit in Northern Ireland i.e. in the Belfast Service on the basis that numbers in any year are very small in Northern Ireland and patients need to have the assurance that the surgeon is able to maintain the requisite skills.	Doc File 1 page 302 AOB-00302
11.09.2011	Email From Ms Corrigan to Mr O'Brien and Mr Young	Re: Backlog August 2011 **General surgery – total 1629** **Breast surgery – total 5** **Oral surgery – total 27** **Urology – total 3358** **ENT – total 2418** **Ophthalmology – total 1879** **Orthopaedics – total 578** **Thoracic surgery – total 0**	TL3 page 150 – 151 AOB-05828 – AOB-05829
13.09.2011	Email from Ms Corrigan to Consultants	Re: Clinic Outcome sheets *" it is hoped by the completion of these sheets during outpatient clinics that it will assist with Review patients being seen within the specified time frame and when we have addressed the review backlog that this will prevent a further backlog"* …	TL3 Page 152 – 154 AOB-05830 – AOB-05832
19.09.2011	Mr O'Brien's comments and concerns regarding proposed Job Plan	In AOB's Job Document in preparation for Job Plan facilitation in 2011 he provides a comprehensive summary of administration tasks and the lack of time allocated by way of paid PAs for them.	Doc File 1 pages 308 – 313 AOB-00308 - AOB-00313
27.09.2011	Email from Ms Corrigan to Consultants	Re: Urology August Speciality reports (Benchmark **77%** Actual **68.21%)** *"Dear all,* *Please see attached as you will see we are below the benchmark and I have been asked to work with yourselves in trying to address this so any thoughts and ideas would be welcome"*	TL3 page 155 – 157 AOB-05833 – AOB-05835
27.09.2011	Email correspondence between Mr O'Brien and	Re Additionality Martina Corrigan: "I would be grateful if you could indicate your availability for these Saturday's from November until end of March … the funding is to bring our waiting times back down to 36 weeks (currently sitting at 62 weeks)	SUP 109 AOB-03603

	Martina Corrigan		
28.09.2011	Facilitation Meeting with Mr O'Brien and Dr Murphy	At this meeting Mr O'Brien continues to contend that the administrative time being allocated in his Job Plan was "*ridiculously inadequate"*. He also refers to the fact that at that stage he had 436 patients on waiting list.	Doc File 1 pages 314 - 316 AOB-00314 - AOB-00316
29.09.2011	Demand Capacity Analysis	Re: Surgery **Mr O'Brien CAH –** Triage 1 (09.08.11).New Urgent 3 (30.08.11). Urgent Review 76 (08/11) **Mr O'Brien BBPC –** Triage 0. New Urgent 0. Urgent review28 (05/11) **Mr O'Brien ACH –** Triage 0. New Urgent 0. Urgent review 15 (06/11) **Mr Young CAH –** Triage 3 (11.08.11). Urgent 2 (25.08.11). Urgent review 36 (07/11) **Mr Young BBPC –** Triage 0. Urgent 0. Urgent Review 3 (07/11 – DNS Pt) **Mr Young ACH –** Triage 0. Urgent 0. Urgent Review 1 (06/11) **Mr Akhtar CAH –** Triage 0. Urgent 4 (11.08.11). Urgent Review 12 (10/11) **Mr Akhtar STH –** Triage 0. Urgent 0. Urgent Review 0	TL3 page 171 – 173 AOB-05849 – AOB-05851
Sept – October 2011	Demand Capacity Analysis	Re SurgeryMr O'Brien: 1 Triage 3 New Urgent & 76 Urgent review Mr Young: 3 Triage, 2 New Urgent & 36 Urgent review Mr Akhtar: 0 Triage, 4 New Urgent & 12 Urgent review	SUP 111 – 112 AOB-03608 - AOB-03609
Oct 2011 – Sept 2012	CHKS Consultant Level Indicator Programme	In 2012/13 Appraisal CHKS Consultant Level Indicator Programme completed. Reflective document indicates the following:- *"Whilst the overall performance in terms of FCEs is consistently satisfactory at1224 relative to previous years, and whilst the percentage of day cases is higher at 61% relative to the year 2012/13, it is still less than peer mean of 74.9%. The limited capacity of the Trust for day case surgery, and the methodof recording day case surgery, may be contributing factors.* *…… Outpatient performance is satisfactorily comparable to peer means, andnew:review ratio of 1:2.0 is comparable to peer mean of 1:1.9."*	2012/13 Appraisal Pages 62 – 68 AOB-22382 - AOB-22388
03.10.2011	Email correspondence between Mr O'Brien and Martina Corrigan	Re Urodynamic Studies Additionality Mr O'Brien querying and chasing when he is to be paid for this.	SUP 113 AOB-03610

03.10.2011	Email correspondence between Ms Corrigan and Consultants	Re: Urology & ENT Theatre speciality Reports - Wrong report sent out which did not take into account the Consultants filling the main theatre sessions	TL3 Page 166 – 170 AOB-05844 – AOB-05848
04.10.2011	Email correspondence from Mr O'Brien to Ms Corrigan	Re: Demand Capacity *You will see that we have a build-up of urgent reviews… I do have funding for additional review backlog clinics so if you are able to do some of these to see these urgent I would be grateful if you could advise and I will get them organised"*	TL3 page 171 AOB-05849
05.10.2011	Email correspondence between Mr Young, Ms Corrigan and Mr O'Brien	Re: Urology August Theatre Utilisation *"I note that others have concerns about this mechanism.* *Session time allocated to perform an event is different pending what you are recoding. A theatre session of operating is not the same as a doctor's clinical session. This is not fully factored into the schedule. The time lost in turnover and early finish to me looks unusual. We should relook at how this is recorded…."*	TL3 page 176 – 179 AOB-05854 – AOB-05857
05.10.2011	Email correspondence between Mr Young, Mr O'Brien and Ms Corrigan	Re: Urology August Theatre Utilisation Mr O'Brien raises the following points to which Mr Young agrees: -If I have a session on Friday afternoon, the first four patients attending will be Haematuria Clinic patients - They are asked to arrive at 1.30pm - The surgeon arrives at 1.30pm - All the patient processing and assessing begins at 1.30pm - I believe that the first cystoscopy would take place at 2pm -The entire, non-operative, clinical care and administrative time far exceeds operative time - I gather the session theoretically ends at 5.30pm - If last flexible cystoscopy were to end at 5.30om, what are the implications for finishing time for staff, medical and nursing. I think these and other aspects of theatre utilisation require consideration and discussion. Should theatre availability time be shortened to reflect or match real practice, or vice versa"	TL3 page 181 – 182 AOB-05859 – AOB-05860
05.10.2011	Email from Ms Cunningham to Consultants	Re: Additional Review Backlog Clinics *"Dear Mr Akhtar, Mr Young & Mr O'Brien* *I would be most grateful if you could advise regarding any dates you may be available for additional review backlog sessions October/November"*	TL3 page 183 AOB-05861
10.10.2011	Email from Ms Corrigan to Consultants	Re: Consultant dates for Saturday Theatre Sessions Request for Consultants to provide their availability for Saturday sessions in November – March. Trust received funding for these lists and includes increased beds and staff on ward. Funding is to bring waiting list times back down to 36 weeks (currently sitting at 62 weeks) so lists need to be used for long-waiting patients.	TL3 Page 184 – 185 AOB-05862 – AOB-05863
12.10.2011	Email correspondence between Mr	Re Amendments to Facilitation Meeting 1. AOB did not claim that his colleagues were allocated 4.25 PAS for admin.	SUP 117 – 118

	O'Brien and Mr Clegg	2. Purpose of raising issue on specialist clinics was not in notes. Issue was that job plan has AOB's clinic in Thorndale in same room as Mr Young on the same day. This is impossible and therefore renders the job plan impossible. 3. Did not claim that three consultants were inadequate for on-call 4. Notes of meeting should have been agreed prior to meeting with Mr Mackle	AOB-03614 - AOB-03615
25.10.2011	Email from Mr O'Brien to Ms Tedford and Ms Corrigan	RE: Extra Theatre Sessions **Ms Tedford –** *"The concerns we have are as listed,* *1. Patients are not clerked in or seen by medical staff or anaesthetist prior to attending theatre, resulting in no drug kardexs being completed or examination carried out to ensure there have been no changes since their pre-assessment.* *2. No consent form signed before leaving the ward* *3. Often bloods need repeated as it has been so long since they attended for pre-admission* *4. No recent ECG or chest x-ray available* *5. Drug kardexs not completed, and FY1 will not write up drug kardexs as they are instructed not to see these extra list patients resulting in patients not receiving their much needed medication eg cardiac drugs, epileptic drugs etc.* *Staff feel it is unsafe to send patients to theatre who have not been properly prepared….* *We as registered nurses have a duty of care to our patients and in that duty we must ensure that when we send patients to theatre we do so in the knowledge that they are prepared safely. With the current regime we feel vulnerable to accident waiting to happen…"* **Mr O'Brien –** *"I would agree that it would be prudent to formally meet prior to the commencement of additional operating sessions in November. I do believe that a formal agreement is required with regard to exactly what we will undertake to do on these patients following their admissions and preoperatively…. Would it be possible to use departmental meeting this Thursday for this purpose…."*	TL3 page 190 – 191 AOB-05868 – AOB-05869
Nov – December 2011	Demand Capacity Analysis	Re: For Surgery Mr O'Brien: Triage 1(6weeks), New urgent 0 & urgent review 97 Mr Young: Triage 8 (7 weeks), New urgent 0, Urgent review 39 Mr Akhtar: Triage 2 (7 weeks), new urgent 0, urgent review 0	SUP 125 - 126 AOB-03628 - AOB-03629
Nov – Dec 2011	Demand & Capacity Analyis (attached to above email from Ms Corrigan)	Re: Outstanding Triage/New Urgents/Urgent reviews **Mr O'Brien CAH –** Triage: 1 (6wks). New Urgent: 0. Urgent Review: 97 (09/11) **Mr O'Brien BBPC –** Triage: 0. New Urgent: 0. Urgent Review: 25 (06/11) **Mr O'Brien ACH –** Triage: 0. New Urgent: 0. Urgent Review: 8 (10/11) **Mr Young CAH:** Triage: 8 (7wks). New Urgent: 0. Urgent Reviews: 39 (08/11) **Mr Young BBPC:** Triage: 0. New Urgent: 0. Urgent Reviews: 1 (07/11 DNS PATIENT) **Mr Young ACH:** Triage: 0. New Urgent: 0. Urgent Reviews: 2 (11.11)	TL3 page 220 – 221 AOB-05898 – AOB-05899

		Mr Akhtar CAH: Triage: 2(7wks). Urgent: 0. Urgent Reviews: 0 **Mr Akhtar STH:** Triage: 0. Urgent: 0. Urgent Reviews: 0	
08.11.2011	Email from Ms Corrigan to Urology	Re: Total patients needed to be seen by end of March 2012 enclosing spreadsheet of backlog *"Dear all,* *I know that there has been some additionality in the system in October to try and start to bring the waiting times for urology back to 36 weeks by end of March 2012. I have looked this afternoon at the PTLs in detail and attached are the numbers that are currently waiting to be seen to bring this to within this timescale.* *It is imperative that all additional lists are booked with these "long waiters" and I have asked Sharon to provide each of your secretaries with a PTL that these patients must be selected from – there cannot be any exceptions as I am disappointed to note that there has been no decrease in waiting times at all.* *Also as you are aware I am working to secure inpatient/daycase and flexi lists during core working time for KJ and these must be used to schedule these long waiters. We will be monitoring this on a weekly basis and we need to see times reducing as currently the waiting times as you will see, are 67 weeks for flexis, 56 weeks for GA daycases and 67 weeks for inpatients. As you are aware the Board is funding this additionality and they are also monitoring us on a weekly basis.* *I would also remind you that Mr Brown in Daisy Hill has also offered to do daycases on a Tuesday afternoon so I would be grateful if you would identify patients that can be transferred to his waiting list so that he can organise to operate on these patients.* *I am happy to meet with each of you to discuss the best way of scheduling these patients to the lists that are available to us"* **Mr O'Brien:** *Inpatients to be seen: 106* *Longest Inpatient Wait: 61 weeks* *GA Daycases to be seen: 15* *Longest daycase wait: 35 weeks* *Flexible Cystoscopies: 49* *Longest Wait flexi: 47 weeks* **Mr Young:** *Inpatient to be sene: 79* *Longest Inpatient wait: 67 weeks* *GA Daycases: 62* *Longest Daycases: 110 (1 patient) then 51 weeks)* *Felxible Cystoscopies: 103* *Longest wait flexi : 67 weeks* **Mr Akhtar:** *Inpatients to be seen: 24* *Longest wait inpatient: 53 weeks* *GA daycases: 56* *Longest day case wait: 56 weeks* *Flexible cystoscopy: 121* *Longest flexi wait: 55 weeks*	TL3 page 210 – 211 AOB-05888 – AOB-05889

16.11.2011	Email correspondence between Ms Corrigan, Ms Trouton, Mr Clegg, Mr Mackle and Mr O'Brien dated 16 November 2011 enclosing Consultant Job Plan Review Template dated 01 September 2011	Email from Malcolm Clegg to Eamon Mackle in which he refers to the outcome of the facilitation and Mr O'Brien's acceptance of 10 November 2011 when in his email he indicated that "*I will spend only that time allocated, whilst believing it to be inadequate."* Mr Clegg comments "*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."*	Doc File 1 page 326 AOB-0032 6
28.11.2011	Email from Ms Matier to Urology Consultants	Re: Acute Urology GP Pathways Workshops *"Dear all,* *I am aware that a great deal of time has passed since we had our last GP pathways Workshop as it is proving impossible to align everyone's diary commitments to allow a further workshop to take place….."*	TL3 Page 222 – 235 AOB-05900 – AOB-05913
28.11.2011	Email from Ms Corrigan to Mr Young & Mr O'Brien	Re: Demand & Capacity Analysis. *"Dear all,* *Please see attached. I was wondering if you could have a look at the urgent reviews that you each have,* *The date in brackets is when these patients should have been seen by. For example, if you asked a patient to be seen urgently by September they are included in this figure. We need a plan of how we will get these patients seen and I am happy to discuss this with you.* *Also there are a few stragglers for triage can you have a wee look at these as well please."*	TL3 page 219 – 221 AOB-05897 – AOB-05899
05.12.2011	Email correspondence between Mr Mackle, Mr O'Brien and Ms McCorry	"*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 the need for Trust support then you obviously do not need to contact me to organise a meeting."*	Doc File 1 page 337 AOB-00337

19.12.2011	Letter from Patient	*Dear Sir/Madam* *I am writing to express my extreme disappointment at how I have been treated by whoever makes the appointment for Mr O'Brien's at the Urology Department in Craigavon Area Hospital.* *I was last seen on 6/5/2011 and was told I would be put on the next surgical list. After a couple of months I phoned his secretary since I had not received an appointment and was told I would be put on the next month's list, I phoned again and was told the same story and the next month and the next. The last time I phoned the lady said she would check and phone me back – I have still not heard from her.* *I also work for the Southern Trust so I understand how busy staff must be but I really need this surgery as the condition is having a very negative impact on my quality of like and I keep having my expectations raised that it won't be for much longer only to be disappointed month after month.* *I would like you to review my notes and please contact me as soon as possible to let me know when I can expect to be seen"*	TL3 page 241 – 246 AOB-05919 – AOB-05924
19.12.2011	Email from Ms Corrigan to Consultants	Re: Backlog *Trudy/Martina – can you speak to Consultants on 3 South and highlight backlog of results to be signed on 3 South.* *There are 1000 unsigned results that need filed"*	TL3 page 240 AOB-05918
28.12.2011	Email from Mr Young to Mr O'Brien and Mr Akhtar	Re: 5 Man Team Theatre Session Five sessions could be organized as such (with the Friday afternoon being an on call list ???) tues am + weds am, tues afternoon + pm, weds afternoon + pm, fri all day, fri afternoon. A five week cycle could be arranged with a degree of weekly familiarity to all. Diagrammatically the week of tues, weds would look like this and give each surgeon on a colour. This gives a focus for other job planning activities at defined other times.	TL3 page 247 – 251 AOB-05925 – AOB-05929
2012	Record of Attendance Morbidity and Mortality Meetings 2012	Record of Attendance Morbidity and Mortality Meetings 2012 for AOB – 4 out of 12 = 33% meetings attended	2012/13 Appraisal Page 86 AOB-22406
2012	Hospital Guide	Re: Fit for the Future/ Dr Foster Hospital Guide 2012 More relevant to Eng & Wales but demonstrates the demand and capacity issues experienced by the NHS	TL3 Page 608 – 647 AOB-06286 – AOB-06325
2012/13 Appraisal	2012/13 Appraisal	In the 2012/13 Appraisal Mr O'Brien notes in relation to current medical activities an extended, ten hour, inpatient operating session each week, in addition to two, elective, day surgical sessions each month. He also notes outpatient clinics at Craigavon Area Hospital, Armagh Community Hospital, Banbridge Polyclinic and South West Acute Hospital. Also notes that he conducts an Oncology Review Clinic at Craigavon Area	2012/13 Appraisal Page 3 AOB-22323

		Hospital eachweek in addition to providing a one-stop urodynamic service once weekly. He specifically notes:- *"Since assuming the Chair of Southern Trust Urology MDT in April 2012, the supervision and overview of the provision of urological cancer services has added significantly to my work. Each week, 35 cancer cases are discussed at MDM. All aspects of each case are previewed by me before each MDM, presented by me at MDM, and the plan for each case signed off by me after each MDM so that eachGP, and other specialists to whom a case may be referred, receives that communication one day later.*	
2012/13	2012/13 Appraisal	In AOB's 2012/13 Appraisal under ***"ADDITIONAL INFORMATION"*** he includes the following comment:- "*The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is on ongoing cause for concern."*	2012/13 Appraisal Page 5 AOB-22325
2012/13	Career Grade Medical Staff Appraisal Documentation	*In 2012/13 Appraisal - Career Grade Medical Staff Appraisal Documentation under the heading "**DOMAIN 2 – Safety and Quality"** AOB makes the following comments:* ***"Discussion*** *I always make every effort to deliver a safe level of care, and of the highest quality, to my patients. I believe that the factor which most threatens that level of quality and safety is the disjoint between demand and capacity. I have found that disparity to be an ongoing challenge…... Participation in Mortality and Morbidity Meetings, Grand Rounds and Multidisciplinary Meetings go a significant way to ensuring that is so. Independently conducted reviews can assist in improving performance, as demonstrated by the Antibiotic Ward Round Summaries (enclosed) confirming improved compliance.* *In March 2012, it was agreed by my multidisciplinary colleagues that I would assume the Chair of the Urology Multidisciplinary Team for the Southern Trust. It has been a heavy responsibility since, but one which has been very rewarding. Diagnosis, investigation, staging and management of patients with urological cancers can be complex and challenging. Preparation for Multidisciplinary Meetings is consuming for several specialists involved, particularly pathologists, radiologists and oncologists. I have made every effort to preview each case in a scrutinous manner and to chair meetings with the singular intent of optimizing diagnosis and prognosis. I did so in 1,530 cases from April 2012 to March 2013. Since April 2013, we have continued to discuss 35 cases each week, and so the numbers will be similar. I do hope that I have made a contribution to patient care. I have certainly learned to improve the care to my patients by doing so.* *I was appointed by the Department of Health to the post of Lead Clinician and Chair of the Northern Ireland Cancer Network Site Specific Group in Urology from 01 January 2013. During 2013, I chaired Regional Meetings with the sole purpose of achieving multidisciplinary consensus for new pathways of following up patients with prostate*	2012/13 Appraisal Page 94-95 AOB-22414 - AOB-22415

		cancer, and so that increased review would be conducted by Clinical Nurse Specialists, and which would remain compliant with EAU and NICE guidelines. As Lead Clinician, I also had the opportunity to be consulted and have input into the final NICE guidelines in Prostate Cancer Diagnosis and Treatment published in January 2014 (enclosed). By the end of 2013, we had agreed on 6 pathways which will be implemented throughout Northern Ireland during 2014 (document and pathways enclosed). The appraisal document also notes that attendance at M&M has been a problem for all urologists in Northern Ireland due to attendance at Regional Audit at the same time. Also notes "A*dditional time will be required for ongoing work as Lead Clinician and Chair of NICaN Urology, particularly in period to June 2015 when Urological Oncology Services in Northern Ireland are subjected to Peer Review."*	
January 2012	Complaint Letter from Patient to Mr O'Brien	1. Lack of communication and quality of care provided by the Trust 2. Complaint about being sent home with catheter and no review for a couple of weeks. Patient was told he would be reviewed in 2 weeks from discharge but in fact was not reviewed for 6 weeks 3. No support provided in relation to catheter 4. Was reviewed in October 2011 and was told he would need further investigation to take place in November 2011. However, was able to urinate normally for 4- 5 days in October 2011 once he had his catheter removed by GP. He later attended AE but still 3months later awaits review. Last spoke to secretary and she said waiting times were 36 weeks.	SUP 133 - 134 AOB-03630 - AOB-03631
19.01.2012	Minutes of M&M meeting		TL3 page 362 – 366 AOB-06039 – AOB-06044
24.01.2012	Email from Ms Corrigan to Urologists	Re: Urology, Flexi Cysto Dec 11 Theatre Utilisation You will note flexible cystoscopy utilisation is very poor in that it was only 29.81%. You will recall conversations when I have asked for extra patients to be added to CAH/STH lists as currently there are only 10 patients scheduled for CAH whilst DHH have at least 12 on their lists and as this has not happened I would like to progress this for future lists. As you are aware we have a large backlog of patients waiting for flexis so this poor utilisation is not good.	TL3 page 271 – 275 AOB-05949 – AOB-05943
25.01.2012	Email from Mr Akhtar to Ms Corrigan	Re: Urology Flexi Cysto Dec 11 Theatre Utilisation *"Dear Martina,* *In December I did one sth dpu list ie 13/12/2011. And I post the list below for your information. How come this list of 11 patients can be done in less than one hour? This list was booked for 13 patients 2 cancelled I question the technique/training of the person filling in the TMS. And this data also say late start of the list. What does that mean? I am there at before 9am*	TL3 page 276 – 281 AOB-05954 – AOB-05948

		and have to consent the patient before start? Don't agree with this particular data.	
30.01.2012	Email correspondence between Martina Corrigan and consultants	Re additionality and waiting list time "*As requested by the Board I have been profiling the current long waiters to determine the position that we need to be at by 31 March 2012, which is that NO patients can be waiting more than 36 weeks.* … Mr Young: 44 patients waiting on inpatient list that needs to be seen before 31 March (4 of which are PCNL) … This is 42 patients shortfall of 2 patients which I would hope may be sorted through ROTT/suspension on etc…. … Mr O'Brien: 63 patients waiting on the inpatient list that needs seen before 31 March … This totals 36 patients which leaves a shortfall of 27 patients which is approximately 9 lists … Mr Akhtar has only 8 inpatients to be seen on his PTL could some of his core lists be used in March to see some of these patients – I would suggest at least 27. … Flexis – there are 43 flexis waiting to be seen by end of March – there is no risk with these as KJ has 4 flexi lists in March and Mr Akhtar has agreed to do an all day Saturday flexi in March Daycases – There are currently 83 patients waiting on a GA that require being seen by end of March 2012. As per previous discussion Mr Brown has agreed to see some daycases in Daisy Hill and he has identified 20 patients from the current PTL and we have secured lists for him to do these in Daisy Hill which leaves a shortfall of 63 patients. Mr Young: 41 GA patients waiting (Mr Brown identified 4 of these that can be done in DHH) Mr O'Brien: 11 Gas waiting (Mr Brown identified 7 of these that can be done in DHH) Mr Akhtar: 25 GA waiting (Mr Brown identified 9 of these that can be done in DHH) …	SUP 136 – 140 AOB-03633 - AOB-03637
30.01.2012	Email from Ms Scott to Consultants	Re: Copy of Urology Triage of patient being transferred to Daisy Hill Hospital	TL3 page 285 – 291 AOB-05963 – AOB-05969
30.01.2012	Email from Ms	Re: PTL Lists	TL3 page 282 – 283

	Corrigan to Consultants	Long waiters position need to be at by 31 March 2012, which is that NO patient can be waiting more than 36 weeks. **Mr Young – Inpatients** Currently 44 waiting that need to be seen before 31 March. Ms Corrigan gave dates for when these patients could be listed **Mr O'Brien – Inpatients** 63 patients waiting that need to be seen before 31 March. Ms Corrigan gave dates for when these patients could be listed. **Flexis** There are 43 flexis waiting to be seen by end of March – there is no risk with these as KJ has 4 flexi lists in March and Mr Akhtar has agreed to do an all day Saturday flexi in March **Daycases** There are currently 83 patients waiting on a GA that require being seen by end of March 2012. **Mr Young** 41 GA patients **Mr O'Brien** 11 GA patients **Mr Akhtar** 25 GA patients	AOB-05960 – AOB-05961
01.02.2012	Email from Ms Corrigan to Consultants	Re: Urodynamics PTL target We have highlighted to the Board that we will not be able to meet the 9 week target. However we have 134 patients waiting with no dates and there are 7 waiting over 30 weeks if not seen by end of March will out to 46 weeks which will not be acceptable to the Board.	TL3 page 292 – 308 AOB-05970 – AOB-05986
02.02.2012	Email from Ms Corrigan to Consultants	Re: March Scheduling cancellation Scheduling cancelled today and we really need to be firming up sessions for March as per my precious email earlier in the week regarding meeting the 36 week target for inpatient and day patients, urodynamic and Thorndale sessions. Request for additionality	TL3 page 310 AOB-05988
03.02.2012	Email from Mr Young to Consultants	Re: March rota and annual leave	TL3 page 311 AOB-05989
07.02.2012	Email correspondence between Mr O'Brien and Martina Corrigan	Re: Patient complaint Mr O'Brien: "*Whilst not confusing communication with patient with response to complaint, just to let you know that I have nevertheless been in contact with patient's wife, to learn that the application of valved spigot to patient's catheter (the crux of the complaint) has been complicated by bypassing to the extent that the catheter has since been removed. I have therefore had patient removed from waiting list for admission, and instead have arranged*	SUP 144 AOB-03641

		for him to be reviewed at LUTs clinica. In any case will respond to complaint asap. There are just not enough hours in the day at present"	
07.02.2012	Email from Mr Young	March Rota	TL3 page 316 – 317 AOB-05994 – AOB-05995
09.02.2012	Email from Mr O'Brien	Re: March Roster Re carrying out additional lists. Mr O'Brien aware that he has the largest number of long waiters. Requests that KJ operate on Mr O'brien's patients when he is on leave and if Mr Akhtar would operate the following week	TL3 page 318 – 319 AOB-05996 – AOB-05997
09.02.2012	Email from Mr O'Brien to Ms Troughton	Re Lists *…."Lastly, having spent considerable time arranging above admissions which are certain, I want to take this opportunity to clarify for you (and Leanne acting for KJ) is that I will not accept any other surgeons taking patients off my list weeks in advance to preadmit etc. It only places entirely unnecessary pressure on me to do things out of order. I had other plans for my time yesterday evening. So, I will select all patients of mine for surgery by Mehmood and KJ during March. I will not compromise on that, and I will do it in my own good time"*	SUPOct page xxx
23.02.2012	Demand and Capacity Analysis Surgical Division	Outstanding Triage/ New Urgent/Urgent Review **Mr O'Brien CAH: Triage - 2 (8wks) New Urgent – 1 (1/2/12) Urgent Review 87 (09/11)** **Mr Young CAH: Triage - 6(10wks) New Urgent – 0 Urgent review 21 (01/12)** **Mr Akhtar CAH: Triage 1 (8wks) New Urgent – 2 (8/2/12) Urgent review 17 (11/11)** **Mr O'Brien BBPC: Triage 0. New Urgent – 0. Urgent review 16 (09/11)** **Mr Young BBPC: Triage 0 New Urgent -0 Urgent review 12 (11/11)** **Mr O'Brien ACH: Triage 0. New Urgent – 0 : Urgent review 2 (02/12)** **Mr Young ACH : Triage 0. New Urgent 0. Urgent review 0**	TL3 page 327 – 329 AOB-06005 – AOB-06006
28.02.2012	Email correspondence between Mr O'Brien, Martina Corrigan and Ms Trouton	Re: Urology waiting lists Ms Trouton: "*We have been advised on Friday past that we have to submit plans to have no in patient or day cases waiting any longer than 21 weeks by Sept 201 (we are currently struggling to meet 36 weeks as you know) and Outpatient waiting any longer than 17 weeks by end Sept 2012.* *This will inevitably mean that some work will need to go to the independent sector which is something that we as Trust and Clinical Team have tried to resist for a long time. It is with regret that it looks like we will have no alternative but to use them in the incoming months.* *Can I ask that you advise how you would want to use the IS for urology? It will be important that we are able to manage any cancer diagnosis in house while managing the set targets on the cancer pathway for example.*	SUP 150 – 153 AOB-03649 - AOB-03652

		…" Mr O'Brien response: *"Just a thought, if we were to continue to operate on Saturdays, what would waiting times be like come end of September?"*	
28.02.2012	Email correspondence between Mr O'Brien and Martina Corrigan	Re: Demand Capacity "Martina, Regarding the demand capacity analysis for outpatient, am I correct in understanding that there are 71 new patients to be seen as outpatients during March, and that there is the capacity to provide 79 with appointments, and that therefore there will be no problem? … Thirdly, I have been concerned to find patients appointed to my clinic at CAH these past 2 weeks and who were triaged by me and Michael Young to the Haematuria clinic in November 2011, and who have not been given an appointment at the Haematuria Clinic, but instead diverted to my consultant-led clinic 3 months later. I have since been advised that only those patients triaged to Haematuria and designated "red flag" are actually being appointed to the Haematuria Clinic…."	SUP 156 – 157 AOB-03653 - AOB-03654
29.02.2012	Transforming Cancer Follow Up (TCGU) Project	*"Clinics are often rushed and many patients report unmet information and support needs."* *"Services as currently configured will be unable to cope with the predicated increase in the number of people living with cancer or be able to address their survivorship need".*	SUP Oct Page xx
29.02.2012	Email from Ms Corrigan to Mr O'Brien	Re: PTL Waiting list PTL which require date before end of March. Problem with getting all of these scheduled and have highlighted this issue to board. Approx 26 patients with longest wait 55 weeks	TL3 page 336 – 338 AOB-06014 – AOB-06016
29.02.2012	Email from Ms Corrigan to Mr O'Brien	Re: Urology 3 Consultant Model Arranging to meet to discuss how best to meet the GAP and bring the target waiting times down to 21 weeks at the end of September. Intend to continue with Saturday Inpatient lists for the next 6 months with an agreement that will each do one all day Saturday session per month but the GAP will still remain of about 242 inpatients as well as a gap in: New outpatients gap of 441 (44 clinics) Daycases gap of 1512 (GA and Flexis with the 70% being flexis – 1058 = 106 flexi list and GA – 454 = 91 lists) IP gap – 242 = 81 lists Also need to bring in urodynamics to 9 weeks as it is a diagnostic and currently there are 140 on waiting list over 9 weeks with approx. 8-10 patients being added each week. Could do at least 1 Saturday additionality per month which would be 60 patients but ned plan to do rest as there are only about 5 patients per week being done in core clinics	TL3 page 339 – 343 AOB-06017 – AOB-06021
Feb-March 2012	Demand Capacity Analysis	Re: Surgery Mr O'Brien: Triage 2 (8wks), New Urgent, 1, Urgent Review 87 Mr Young: Triage 6(10wks), New Urgent 0, Urgent Review 21	SUP 154-155

		Mr Akhtar: Triage 1(8wks), New Urgent 2, Urgent Review 17	AOB-03644 - AOB-03645
March 2013	Consultant Urologist Job description	Notes current staffing in Urology and job description out for x2 consultant urologist positions **Consultants** Mr M Young Mr A O'Brien Mr M Akhtar (due to leave April 2012) 2 new posts 2 Specialist Registrars Supported by: 1 Lecturer Nurse Practitioners 2 Nurse Practitioners 1 GP with Specialist Interest in Urology	TRU-101608 – TRU-101620
01.03.2012	Email from Ms Corrigan to Urologists	Re: Haematuria criteria due to risk of being missed in the backlog	TL3 page 344 AOB-06022
01.03.2012	AGM Meeting of 01 March 2012	1. Majority of members in attendance with exception of oncologist 2. To be raised as an on-going risk area and not acceptable on an ongoing basis. Mr Young attended regional urology meeting and raised the lack of oncologist at that meeting. 3. Mr O'Brien – delays in dictating letters so that Vicki can get outcomes. Mr Akhtar suggests would be better if one clinic set up for MDT results patients, then dictated and typed immediately. 4. Mr O'Brien was appointed by Nomination to Chair 5.	SUP OCT Page
04.03.2012	Letter from Mr Young to Dr Rankin	Re: The proposed imminent advertisement for three consultant urological surgeons. *"In principle, it is found to be very unusual practice to advertise potential jobs within a department, without involving or even showing the job specification to the Lead Clinician of the Unit. I understand this would have been sent to press on Tuesday 6th March, unseen by myself, even though my name would have been used as the reference point. Would this have been tolerated in any other department? …"* Suggestions provided to make the job descriptions more accurate. *"In conclusion, there are several other erroneous points within most of the job descriptions, not least for instance, the "one-stop clinic approach" to the prostate diagnostic service, which is currently available. This appears to have been abandoned"*	TL3 page 349 – 351 AOB-06027 – AOB-06039

06.03.2012	Email from Ms Corrigan to Mr O'Brien	Re: PTL Reports 05 March 2012 Advised Board that we most likely will breach inpatients by 40 weeks Approx 27 patients with longest waiting 55 weeks on Mr O'Brien's inpatient list	TL3 page 352 – 353 AOB-06030 – AOB-06031
07.03.2012	Email correspondence between Mr O'Brien and Martina Corrigan	Re: PTL Reports Mr O'Brien: "*...I now have 19 patients on the PTL list awaiting dates. I would hope to be able to give dates to the majority of these cases. Bearing in mind that other patients are phoning every day requesting admission, I would hope to be able to offer admission dates to 15 of these patients by 31 March. SO, with inherent minor variability on that figure, you may assure the department that every effort will be made to offer dates to almost all of these patients. I am sorry that I cannot be more precise at this time.* *With regard to the numbers of patients on urgent waiting list for long periods, I believe that there is a rational explanation. The only category available for all patients who are not routine is "urgent". This is entirely due to the fact that there are only 2 categories of clinical priority available. When there were 4, we had available a much wider and more appropriate, 4 lane carriageway, along which to streamline patients. I believe that it was unwise to have dispensed with that years ago. I viced my opinion at that time, but found myself in the wilderness, as usual. However, the department should be reassured that those urgent patients waiting a long time are so because pateints much more urgent have since been attended to, but still have a greater clinical priority than those labelled as routine. Mind you, it would help greatly if one recurrently did not have to consume operating time to the routine and in chronological order, at the whim of the same department."*	SUP 166 – 169 AOB-03663 - AOB-03666
13.03.2012	Email from Ms Corrigan to Mr O'Brien	Re: Urodynamic PTL Had conversation about this previously and Mr O'Brien advised that some scheduling would meet 32 weeks at end of March. There are 3 patients to be seen in order to meet this target.	TL3 page 354 – 360 AOB-06032 – AOB-06038
15.03.2012	Email from Mr O'Brien to Ms Corrigan	RE: Urodynamics *"Just to give you update on impatient PTL.* *All patients have been contacted by me to be offered dates by end of March. Some patients were unable for admission for several reasons, such as current illness, other surgeries pending, abroad on holidays etc. All patients available and fit for admission by 31 March have had their admission arranged.* *Regarding urodynamic studies, I do not understand how some patients can suddenly appear on a PTL list. For example,* Personal Information redacted by the USI *I have been unaware of this patient being on my waiting list until I received your email. She certainly was not on my urodynamic waiting list as of 31/01/2012, and which I have in front of me. Your list indicates that she was placed on list on 04/07/11. It would appear that she attended my clinic in Banbridge, and I presume that she was placed on waiting list then. It just is all the more difficult to meet target times when patients can disappear from a waiting list for months, and only to reappear just when you think that all targets have been met"*	TL3 page 367 AOB-06045
16.03.2012	Email from Ms	Re: Urodynamics	TL3 page 368 – 369

	Corrigan to Mr O'Brien	*"… With regard to Urodynamics patients appearing I suspect this must be due to backlog in typing which when investigated in the past was the reasons for patients appearing on PTLs. I will investigate this patient and see if I can get PAS to do an audit trail on this and will let you know to see if this is the reason.."*	AOB-06046 – AOB-06047
20.03.2012	Email from Ms Corrigan to Consultants	Re: Saturday Urology Lists Saturday urology lists will be continuing from beginning of April until at least the end of September.	TL3 Page 370 AOB-06048
28.03.2012	Email from Mr Hawkins to Ms Mulholland	Re Image Problems – Urology Equipment *"I am sure you are aware we are experiencing recurrent problems with image quality of the Storz Endoscopic systems during urology cases. "*	SUP OCT Page
06.04.2012	Email from Mr Young	Re: May rota	TL3 page 381 – 384 AOB-06059 – AOB-06062
19.04.2012	Email from Ms Corrigan to Mr O'Brien	Re: Urology Escalations Patient waiting 3 weeks for a day 4 appointment with Mr O'Brien…..Mr Akhtar used to be able to see these patients the Monday after MDM but following his leaving we are concerned that patients are going to be delayed. Can you please advise if protected slots have been set up for Mr O'Brien for these patients following MDM?	SUP OCT Page
23.04.2012	Email from Ms Corrigan to Mr O'Brien	Re: Urology escalations 2 RF urology referrals that cannot get booked. Both triaged for Andrology clinic or consultant clinic. However no capacity	SUP OCT Page
02.07.2012	Email to Ms Parks from Mr Jong	Mr Jong resigns	TL3 page 429 AOB-06107
10.07.2012	Email from Ms Corrigan to Mr O'Brien	Re: patient query GP ringing re date for admission of patient. Patient previously under Mr Akhtar. GP concerned with delay in having this patient seen. Ms Corrigan quested Mr O'Brien advise on patient but noted that she understands how busy Mr O'Brien is and that he is basically on his own at the minute.	TL3 Page 434 – 435 AOB-06112 – AOB-06113
13.07.2012	Email from Ms Corrigan to Ms McGeough	Re: Urology day case list *"Unfortunately we are no longer able to use the Day Surgery list planned for Urology on 24 July 2012. As you may be aware KJ is leaving the Trust on 31 July 2012. He has advised us that he has quite a bit of Annual Leave still to take and is therefore to finish next Friday 20th July. We had hoped that the New Specialty Doctor would be able to do this list but he has advised us that he will be off on* Personal Information redacted by the USI *leave from 23rd July until 3rd August so I have no one to over this list.*	TL3 page 436 AOB-06114

		Apologies for the short-notice but there is nothing I can do about this"	
23.07.2012	Email from Ms Corrigan to Mr O'Brien and Mr Young	Re: Discharges to be dictated Spoken to secretaries and discussed current backlog of dictation of discharges. Advised they have been raising this issue with consultants. Advised that this backlog information should have been recorded on the backlog report as a risk to enable this problem to be escalated to you. Backlogs: **Ms McCorry – 60 backdated from April 2012** **Ms Dignam – 120 backdated from January 2012** **Ms Troughton – 60 backdated from January 2012** Very concerning from a governance point of view as we do not know what is among these discharges. I know that Sani is gone and John is going but I would appreciate a bit of guidance on how best to address this backlog. This has now been highlighted to me I will have to escalate but would prefer if you could advise a course of action.	TL3 page 439 – 440 AOB-06117 – AOB-06118
17.08.2012	Email from Ms O'Neill to Ms Troughton	Re: Additional Urodynamics Saturday lists 15th Sept	SUP OCT Page
11.09.2012	Email from Ms Corrigan to Ms Dignam and Ms McCorry	Re: Urology Inpatients. Patients appearing on the PTL with no dates for end of September. Raised with Board PCNL's and that will definitely have to wait 68 weeks at end of September. However, need Mr Young to have a look at the top 2 waiters 79 weeks and 24 weeks as they will either need to be given a date, discharged or suspended as this wait will not be accepted. **Mr O'Brien approx. total 74 patients with longest waiting 43 weeks** **Mr Young approx. total 41 patients with longest waiting 79 weeks** **Mr Akhtar approx. total 5 patients with longest waiting 29 weeks**	TL3 page 451 – 454 AOB-06129 – AOB-06132
11.09.2012	Email from Ms Corrigan to Ms Dignam and Ms McCorry	Re: Urology Daycases to be seen before end of September and October. Advised board that waiting time will be 63 weeks so I need to plan for the longer waiters. **Mr O'Brien approx. total 27 patients with longest wait 50 weeks** **Mr Young approx. total 46 patients with longest wait 67 weeks** **Mr Akhtar approx.. total 8 patients with longest wait 28 weeks**	TL3 page 455 – 459 AOB-06133 – AOB-06137
24.09.2012	Email from Ms Corrigan to Consultants	Re Activity and targets enclosing volumes of activity to deliver 2 Additional consultants and associated support staff would be appointed; The service would be expanded to encompass patients from the Fermanagh area; The 62 day cancer target would be achieved for all patients The Trust would be able to deliver the annual levels of service which are expected by the HSCB: 1. 3,948 new outpatient appointments 2. 5,405 review outpatient appointments 3. 5,585 inpatient FCEs/day cases	SUP OCT page
24.09.2012	Email from Mr Connolly to Ms Corrigan	Re: Activity and in response to Ms Corrigan's email about targets *"Clinics cannot just be booked to make these targets, otherwise the clinics will just run over on every single occasion. Is the original baseline activity that which was achieved with a 3 man team? If so, I do not see how the addition of 2 new consultants will increase activity by tripiling the number of new patients seen and doubling the number of review patients. In the few*	TL3 page 466 – 467 AOB-06144 – AOB-06146

		weeks that I have been here, it is clear that we have a massive backlog of reviews. The only solution to clearing these and seeing additional patients that I can see is increasing the number of clinics every week, not booking the current clinics with additional patients that cannot be realistically be seen. Have I misunderstood the figures?"	
October 2012 to September 2013	CHKS Consultant Level Indicator Programme	In 2012/13 Appraisal Reflective comments "*I have been satisfied to learn that my performances are very comparable to the mean of peer activity in all domains but two: my percentage day case rate was 49.9% (peer mean 75.7%) and my new:review outpatient ratio was 1:2.5 (peer mean 1:1.8).* *I believe that the explanation for the former is that the definition of a day case is determined by whether the intent at the time of commitment to admission is as a day case or otherwise, rather than whether the patient actually is admitted and discharged on the same day. I believe that that latter comprises a greater proportion of the total than is reflected in the CLIP report.* *I believe that my new:review outpatient ratio is a reflection of urological oncology being a significant portion of my practice. Indeed, if I did have the capacity to review all those patients who should have been reviewed when intended, the ratio would be 'worse'."*	2012/13 Appraisal Pages 69-79 AOB-22389 - AOB-22399
01.10.2012	Email from Mr Young to Urologists	Re: Urology Day Care Unit As AOB knows we had certain levels of need in the number of rooms pending what we were hoping to do in the unit. As always there has had to be compromise = I have held out for the acceptable compromise as I realize this will probably be out last chance. We need 4.3 consultants rooms and 2.7 treatment room sessions per week ideally 5 consulting and three treatment room are required but adding 4.3 and 2.7 will allow us to use one room as both consulting and treatment.	TL3 page 496 – 497 AOB-06174 – AOB-06175
03.10.2012	Email from Ms Clayton to Urology	Re: MDM cover Sept – Oct 12 The cancer trackers continue to experience pressures due to sick leave and annual leave…	TL3 page 498 – 499 AOB-06178 – AOB-06179
05.10.2012	Email from Ms Herron to Mr Young	Re: Specialty doctor in Urology Offered job but Mr Herron has turned down the post for following reasons: 1. Job descriptions for the above post says 10 PA, which I was in the impression half of the activity involve theatre sessions; as many specialties doctor urology does have a significant theatre time 2. This job is merely providing service to the trust but I have nothing to gain from this job, I mean from theatre experience point of view. 3. Wage for this job unfortunately does not meet my personal expectations.	TL3 page 501 AOB-06179
07.10.2012	Letter from Dept of Health	Re: "Who Care" discussion – Consultation on the future of Adult Care and Support *As you will be aware, adult care and support provision is increasingly coming under pressure for range of reasons, such as for example; an ageing population, increased expectations and a difficult financial climate.*	SUP OCT Page

		Given this situation, it is widely believed that our current care and support system will be unable to cope with the demands of future unless significant changes are made.	
15.10.2012	PTL Update list	Number of breaches	TL3 page 519 – 525 AOB-06197 – AOB-06203
18.10.2012	Email from Mr Young to Ms Corrigan	Re: Escalations Number of patients highlighted that need actioned. It was noted that Mr O'Brien should not send for any patients for this date as per scheduling meeting Mr O'Brien was organizing his own patients for Ajay. Mr Young highlighted that they were aware of the red flags and that Mr O'Brien would define the patients for the 2nd Nov and Mr Young for 9th Nov. Therefore lists will not be double booked yet taking into account red flag status	TL3 page 529 – 531 AOB-06207 – AOB-06209
18.10.2012	Email from Ms Corrigan to Mr O'Brien	Re Patient query – Personal Information redacted by the USI He advised that he is waiting for a ureteroscopy. He has been referred to 352 because of the waiting list but was recently informed by Sinead in Appointments at CAH that they could not do it because they did not have the equipment. He spoke with Mr O'Brien's secretary Monica about 3 days ago and she told him to ring back on Monday 17 September – but he is dubious about this as he contacted 352 on a number of occasions in response to their letter of 2 August offering him an appointment but he was unable to confirm a date.	SUP OCT Page
November 2012	Rota		TL3 page 570 – 576 AOB-06248 – AOB-06254
02.11.2012	Email from Ms Corrigan to Urology	Re: red flag patients requiring an urgent procedure Patients which were due to be given dates for beginning November but to date have no dates. Will be reported to Regional Board as breaches for cancer targets. Personal information added to WL 28/09/12 Personal information added to WL 30/08/12 Personal information redacted by USI added to WL 13/08/12 Personal information added to WL 01/10/12	SUP OCT Page
02.11.2012	Email from Ms Corrigan to Mr O'Brien	Re: Urology RF Referrals breaching 72 hour triage target 3 patients listed as breaching 72 hour target. The referrals were brought to Mr O'Brien's office but have not been returned therefore breaching the 72 hour target (6 patients).	TL3 page 535 – 536 AOB-06213 – AOB-06214
07.11.2012	Email from Mr Young to Urologists	Re: Rota and Proposed job plan	TL3 page 541 – 543
08.11.2012	Email from Ms	Re: Inpatient PTL	TL3 page 544 – 550

	Corrigan to Consultants	Patients need seen before end of November 2012. Need long waiters to be concentrated on as have been asked to be at 21 weeks by end of March 2013 62 Mr O'Brien with longest waiting 57 weeks 36 Mr Young with longest waiting 74 weeks 5 Mr Akhtar with longest waiting 37 weeks	AOB-06222 – AOB-06228
08.11.2012	Email from Ms Corrigan to Consultants	Re: Day case PTL Requesting that the patients are seen before end of November to ensure they meet the 21 weeks. Requesting that the patients are fitted into the rest of November/December lists. 4 are Mr O'Brien 24 are Mr Young 1 is Mr Akhtar	TL3 page 551 – 557 AOB-06229 – AOB-06235
19.11.2012	Email from Ms Corrigan to Urologists	Re: Theatre lists for December Can no longer get the following lists as the specialties that had given them up have actually covered them now with their own staff so we can longer get these: Tues 1st December 2012 – all day lists for Mr Connolly. Monday 10 December 2012 – AM CAH DSU Friday 14 December 2012 – AM but have been given PM instead Mr Glackin due in theatres all day, Mr Connolly was due all day but can do PM only and was going to see if Mr Pahuja can also do PM list? Tuesday 18 December 2012 AM – have been asked to convert to an LA list for Mr Connolly and advised that has already got anesthetic cover so can Gas please be sent for	SUP OCT Page
26.11.2012	Email from Mr Connolly to Urologists	Re: Emergency List **Mr Connolly –** *"Was anyone aware of the way that emergency lists are now running What I was told is that the Surgeon of the Week reviews the list and priorities it, giving time limits that the cases need to be performed in (1 hour, 4 hours, 12 hours, 24 hours etc). I did not receive any communication about this as far as I know but it appears to have been implemented from last week.* *I have just had a case bumped down the list without any communication from the surgical team – bilateral ureteric stones with hydro, luckily she is not septic and renal function is ok – but when I went down, I was told that their case had to be done within 4 hours so got priortised. Just slightly annoyed that this seems to have happened without any input from the other specialties which also use the emergency list"* **Mr Young –** *"What exactly is this = completely unaware of this. Will investigate"*	TL3 page 586 AOB-06264
27.11.2012	Email from Mr Williams to Urologists	*Re: CT urography* *"Dear all,* *We are struggling to keep up with the volume of CT urography which we are not actually funded for at all. When I set up this service, we agreed to restrict it to adults over 40 with macroscopic haematuria. I appreciate that CTU is the bes test for a number of indications but we do not simply have the capacity. Please therefore do not be surprised if your patient gets an IVP instead"*	TL3 page 589 AOB-06267

29.11.2012	Email from Ms Corrigan to Urologists	Re: Urology Inpatients needing to be seen by 31 March. Waiting time at end of March has to be 21 weeks. **Mr O'Brien: Total 85 patients with longest waiting time of 60 weeks.** **Mr Young: Total 62 patients with longest waiting time of 77 weeks** **Mr Akhtar: total 7 patients with longest waiting time of 40 weeks**	TL3 page 595 – 603 AOB-06273 – AOB-06281
04.12.2012	Email from Mr Williams to Mr O'Brien and Mr Young	Re: CT Urography *"Dear Aidan and Michael* *We have had a couple of patients come through recently for upper tract surveillance (as red flag requests (? appropriate)) in whom CT urography was requested. When this service was introduced (which is unfunded) we only agreed to perform CT urography on patients over 40 with macroscopic haematuria, from haematuria clinic. We simply don't have the capacity , or funding, to extend this to upper tract surveillance, which should be performed by IVP in Craigavon Area Hospital. In an ideal world, IVP would be scrapped entirely (as it has been in many centres) but we are some way off that here"*	TL3 page 604 AOB-06282
05.12.2012	Re Rota	Re: Jan Rota	TL3 Page 648 – 651 AOB-06326 – AOB-06329
06.12.2012	Email from Mr Glackin to Ms Troughton	Re: Mr O'Brien and Mr Glackin to switch Saturday Extra lists to avoid on call issues	SUP OCT Page
07.12.2012	Email from Mr Pahuja to Mr O'Brien and Mr Hennessy	Re: Thursday Team Schedule	TL3 page 659 – 660 AOB-06337 – AOB-06338
10.12.2012	Memorandum from Medical Director	Re: Waiting List Initiative & Waiting list initiative agreement	TL3 page 669 – 677 AOB-06347 – AOB-06355
10.12.2012	Email correspondence between Mr O'Brien and Mr Young	Re: Additionality "*I am sorry that you may have felt coerced into agreeing not to undertake additional elective operating lists on Saturdays when on call, and I do believe that you could retain the right to continue to do so, if that is your preference. Amongst all of the reasons for not doing so, I believe that the quantim of the urological morbidity and operative has increased to such a degree that it would indeed be quite useful for the on-call consultant to be free on Saturdays to undertake urgent operating without being encumbered with two sessions of elective operating.* *… "*	SUP 190 – 194 AOB-03687 - AOB-03691

12.12.2012	Jan Rota	Re: Jan Rota for consultants	TL3 Page 684 – 687 AOB-06362 – AOB-06365
26.12.2012	Email from Mr Pahjua to Mr Glackin	Re: Return to work *"Hi Martina/Michael* *Just to keep you posted regarding my plans. Sorry to have left at such short notice.* *As you know –* Personal information redacted by USI [redacted] *I intend to fly out to* Personal Informatio *and be in Belfast on Monday 17th late afternoon. I am happy to resume back work on 18th December tues.* *Apologise for all the disruption and appreciate the support from the whole team"*	SUP OCT Page
28.12.2012	Email correspondence between Ms Corrigan, Mr Young, Mr Carroll and Ms McAlinden	Re: Patient surgery cancellation Patient arrived for surgery at 730am (elective cystogram) and was told at 11am that she could not have procedure as no one had booked to do it. Mr Young confirmed that Dr McConville had been scheduled to do the surgery.	SUP OCT Page
31.12.2012	Email from Mr Connolly to Ms Corrigan	Re: Urology escalation Last minute cancellations – will bring up 2 haematuria patients. 4 patients escalated 1. Bladder surgery outstanding target date 04.01.13. Patient is now on day 17 of 31 target 2. Haematuria appt outstanding. Now on day 23 3. Haematuria referral. Seen on day 20 for 1st OPD – TCC identified and planned for surgery 21 12 12 but this not scheduled. 4. Haematuria referral. Patient offered appt but cancelled and now on day 22 and appt is outstanding	SUP OCT Page
2013	Record of Attendance Morbidity and Mortality Meetings 2013	Record of Attendance Morbidity and Mortality Meetings 2013 for AOB – 6 meetings attended	2012/13 Appraisal Page 87 AOB-22407

06.01.2013	Email From Mr Young to Consultants	Re: February rota.	SUP OCT Page
11.01.2013	Email from Ms Corrigan to Consultants	Re: Theatre Start and Finish Times Staring extended days to try and increase patient flow. Particularly concerned about flexi start times of Hirron as this is now a weekly issues when he is doing a list whilst the others can get the Day surgery on time and as reduced the flexis to 8, if were full time should be able to get back up to 10 patients	TL3 page 694 – 696 AOB-06372 – AOB-06374
23.01.2013	Email from Ms Corrigan to Consultants	Re: Urology PTL Inpatients should not be waiting any longer than 21 weeks. Daycases should not be waiting any longer than 21 weeks. Flexis should not be waiting any longer than 9 weeks. **Mr O'Brien Daycases – Approx. 26 patients with longest waiting 50 weeks** **Mr Young Daycases – Approx 80 patients with longest waiting 60 weeks** **Mr Akhtar Daycases – Approx 68 patients with longest waiting 23 weeks** **Mr O'Brien Inpatients – Approx. 119 patients with longest waiting 62 weeks** **Mr Young Inpatients (PCNL) – Approx. 21 patients with longest waiting 78 weeks** **Mr Young Inpatients – Approx. 54 patients with longest waiting 67 weeks** **Mr Akhtar Inpatients – Approx. 19 patients with longest waiting 49 weeks**	TL3 page 697 – 721 AOB-06375 – AOB-06399
25.01.2013	Email from Ms Corrigan to Consultants	Re: Availability to do additional Saturday Jenny has staff to work an all-day Saturday on 9 February in TDU and I was wondering would any of you be interested in doing an all day session to see review patients	TL3 page 722 AOB-06400
27.01.2013	Email from Mr Young	Re: Feb Rota	TL3 page 723 – 724 AOB-06401 – AOB-06402
28.01.2013	Email from Ms Lilburn to Urology	Re: Theatres *"Thanks for this. A bit of a crisis this week. 3 member of staff down. Only 1 CP left to cover lab and pacemakers/ICD reprog"*	TL3 page 725 AOB-06403
30.01.2013	Email from Ms Corrigan to Consultants	RE: Urodynamics capacity Re tender for more capacity. Currently have 180 patients waiting over 9 weeks and patients waiting up to a year need to be seen. The tender may help with long waiters	TL3 Page 733 – 735 AOB-06411-AOB-60413
11.02.2013	Email correspondence between Mr	Ms Trouton "Please can you discuss with AOB the following sessions Mr Glackin has capacity to see some of his patients …. If Mr O'Brien chooses patients for	SUP 195 – 196

	O'Brien and Ms McCorry	these sessions, in particular the February dates please can they be sent to me as soon as possible.." Mr O'Brien: "Please ask Liz to reserve this capacity as much as is possible. I will identify 5 cases for the 22 February and 23 February. You may reassure her that I will personally contact patients to ensure that they are able and willing to be admitted on particular dates, so that she does not need to worry about notifying patients at short notice"	AOB-03692 - AOB-03693
11.02.2013	Email from Ms Corrigan to Urologists	Re: PTL for end of March 2013 3 PTLs of patients (Mr Young = 32, Mr O'Brien = 44 and Mr Akhtar = 2 patients) that must be seen by 31 March 2013.	TL3 page 762 – 776 AOB-06440 – AOB-06454
12.02.2013	Email from Ms Dignam to Consultants	Re March rota	TL3 Page 778 – 781 AOB-06456 – AOB-06459
18.02.2013	Email from Ms Corrigan to Consultants	Re: Additionality Free all day main theatre list on Wednesday 27February in CAH. Query whether anyone interested in doing the list or the AM or PM session as additional.	TL3 page 813 AOB-06491
19.02.2013	Email from Ms Corrigan to Consultants	Re: PTL Mr O'Brien Inpatients 32 patients of Mr O'Brien's which are to be seen by 31 March. Michael Young only has 3 inpatients. Can the rest of patients be given to Tony, David and Ajay if they still have capacity on their March lists…. HSCB will not accept any patients waiting over 30 weeks at the end of March	TL3 page 814 – 819 AOB-06492 – AOB-06497
19.02.2013	Email from Ms Corrigan to Consultants	Re: PTL Daycases 6 Patients of Mr O'Brien's the first 2 have either DNA or CNA and the other 2 have been on waiting list for quite a while for flexible cystoscopy. 18 patients of Mr Youngs and some need done in Main Theatres.	TL3 page 820 – 824 AOB-06498 – AOB-06502
20.02.2013	Email From Ms Trouton to Mr O'Brien	Re: Urgent Red Flag requiring date *"Dear Aiden* *I do appreciate the demand for an urgent place on your lists and know you are currently working to fill same. Can I request that you give Martina nd the cancer team a date for this cancer patient. We are obligated to ensure that all cancer patients have a date for before day 85 of their pathway"*	TL3 page 834 – 835 AOB-06512 – AOB-06513
27.02.2013	Email From Ms Corrigan to Mr O'Brien	Re: PTL dates for end of March Mr O'Brien 42 Patients lonest wait is 67 weeks	SUP OCT Page
06.03.2013	Email from Ms Corrigan to Urology	Re: Haematuria .. We need a plan urgently for these patients and I am unsure how we are going to get these seen within a reasonable time, but as you will note form the spreadsheet there are some patients waiting for a long time to get their	TL3 page 844 – 847 AOB-06522 –

		appointment (some of these are not our fault as we received late referrals from SWAH – 4 letters) but we are still required to meet the target of 10 days for first appointment and we are well over this with most of patients and the next available clinic with spaces is not until 4 April. I also know that we aim to have these as a one-stop clinic but could we hold a few clinics just to get the patients started on pathway and I will work at getting some flexi lists secured? I think if we could get the backlog cleared and start off in April "clear" this may be more manageable?	AOB-06525
19.03.2013	Email from Ms Glenny to Consultants	Re: Total Planned Waiting List Until End December	TL3 page 1210 – 1218 AOB-06888 – AOB-06896
19.03.2013	Email from Ms Glenny to Consultants	Re: Urgent waiting list Mr O'Brien approx. 22 patients Mr Young approx. 98 patients Mr Akhtar approx. 1 patient Mr Glackin approx. 53 patient Mr Pahuja approx. 38 patients	TL3 page 1229 – 1242 AOB-06907 – AOB-06920
19.03.2013	Email from Ms Glenny to Consultanst	Re: In patients Mr O'Brien approx.. 143 patients Mr Young approx.. 72 patients Mr Akhtar approx. 0 Mr Glackin approx. 6 Mr Pahuja approx. 13 patients	TL3 page 1243 – 1252 AOB-06921 – AOB-06930
19.03.2013	Email from Ms Glenny to COnsultany t	Re: Day cases Mr O'Brien approx.. 46 Mr Young approx. 109 Mr Akhtar approx. 1 Mr Glackin approx.. 64 Mr Pahuja approx. 34	TL3 page 1219 – 1228 AOB-06897 – AOB-06906
22.03.2013	Email from Ms Corrigan to Urology	Re: PTL inpatient and day case 5 patients requiring a date by 30 March. Requesting space on consultants lists to see these patients. If not will have to declare these as breaching which after all the hard work and effort has went into getting all the long-waiters dates and sorted will be a shame.	TL3 page 865 – 866 AOB-06543-AOB-06544
26.03.2013	Email from Ms Corrigan to Consultants	Re: Outpatient Target Patients for March There are 170 on this PTL waiting an appointment with the longest waiting 87 weeks!! I know everyone has been working extremely hard but I really need a steer on what we should do about this waiting list…. Even if we were to run every Saturday which I know is not feasible we would need at least 17 Saturdays. .. I indicated to the board a few months ago that we would aim to be at, at least 40 weeks but on the PTL there are 67 breaching that target.	TL3 page 867 – 872 AOB-06551 – AOB-06556
26.03.2013	Email from Ms	Re: Haematuria	TL3 page 879 – 884

	Corrigan to Consultants	As you will see there are 85 patients on the haematuria waiting list with most now appointed albeit they are all breaching the 10 day target. There are another 15 waiting to be appointed but the next available date is not until June 2013 which means that we are going to be in a breach position for some time…"	AOB-06557 – AOB-06562
27.03.2013	Email correspondence between Ms Corrigan, Mr O'Brien and ors	Notes there are "*85 patients in haematuria waiting list with most now appointed albeit they are breaching the 10 day target. There are another 15 waiting to be appointed but the next available date is not until June.*" AOB proposes meeting between various stakeholders to discuss potential solutions including more selective triage of such patients.	Doc File 1 pages 411 - 412 AOB-00411 - AOB-00412
27.03.2013	Email from Mr O'Brien to Ms Corrigan	Re: Amended Urodynamics PTL *"The urodynamic issue is going to be much more difficult to resolve than is the Haematuria problem. I cannot think of any realistic way of tackling it without working on Saturdays. However, as suggested by Ajay, I think it would be useful to have a round table meeting where all of the work issues can be placed on the table: red flag operative work, long waiters, outpatient work, oncology reviews, urodynamics etc etc, and so that we could consider strategies to ensure that no area ends up so inappropriately neglected."*	TL3 page 890 AOB-06568
27.03.2013	Email from Mr Young	Re May rota	TL3 page 891 – 894 AOB-06569 – AOB-06572
28.03.2013	Email from Ms Corrigan to Mr O'Brien	Re: Urgent Urology Referral …"*Yes I agree with your comments below as I am worried there appears to be a lot triaged to them at the moment and with 2 clinics per months you are right they will become overwhelmed and we still have the same target of 9 weeks to meet…*"	TL3 page 897 – 898 AOB-06575 – AOB-06576
12.04.2013	Email from Ms Stinson (On behalf of Mr Carroll)	Re: Imaging slots for in-patients that can go home and come back *You will appreciate both our hospitals have been experiencing high numbers of patient admissions over the last number of weeks which has placed great pressure on all our staff & services.*	TL3 page 903 – 906 AOB-06581 – AOB-06584
17.04.2013	Email from Mr Young to Consultants	Re: Urology Dept Meeting To discuss Haematuria. Urodynamics will be next discussed. We will address: Current demand and how to record this volume. How patients are triaged to this service. Make clear the enter criteria to the service. Re-evaluate what is to be done at the clinc. Clinic design = one, two, three stop clinic locations.	TL3 page 939 AOB-06617
12.05.2013	Email from Ms Corrigan to Consultants	RE: Haematuria Spreadsheet Stating that really need to address this backlog and I would welcome any suggestions on how best to do this…. It is a result of this backlog that the overall Cancer Performance Target is not being met and I am under increasing pressure to try and bring forward solutions	TL3 Page 959 – 962 AOB-06637 – AOB-06640
14.05.2013	Email from Ms	Re: Performance issues	TL3 page 963 – 975

	Corrigan to Consultants	One action for us is that we cannot have anyone waiting longer than 30 weeks for either inpatients or daycases by end of May. 1. No patient must be waiting longer than the longest wait in March by End of May and should show recovery. Over waiting time Inpatients – 77 Daycases – 28 Mr Young IP – 41 with longest 87 weeks Mr O'Brien IP – 52 with longest 45.57 weeks Mr Akhtar IP – 3 with longest 55.285 weeks Mr O'Brien day case – 6 with longest 33 weeks Mr Young day case – 29 with longest 58 weeks Mr Akhtar day case – 15 with longest 33 weeks	AOB-06641 – AOB-06653
20.05.2013	Email from Ms Corrigan to Urology	Re: Urgent Information. Saturday Operating Lists *You may be aware that I had been using the funding from the vacant consultant's post to fund the additional lists during April and May. Since we have now employed a locum from today, there is currently no more funding for these additional lists during April and May. Since we have now employed a locum from today, there is currently no more funding for these additional lists. I have put in a bid for more funding but for now please do not send for any patients for Saturday's 8th, 15th, 22nd and 29th June. It is ok to go ahead with 1 June list and with the additional clinics that I have agreed for June, however I cannot agree to any more additionality for June."*	TL3 page 987 AOB-06665
29.05.2013	Email from Mr Young	Re: July rota	TL3 page 992 – 995 AOB-06670 – AOB-06673
06.06.2013	Urology Departmental Meeting	1. SWAH Referral Letters 2. Mr Glackin and Mr Pahuja concerned that outpatient clinics are being overbooked despite telling booking office to keep to the office template. PM clinic is three hours and this should be 12 patients – typically 14 or 15 patients are on clinic. In the interim this should be restricted until job plans can define clinic duration more precisely. If clinics overbooked then Consultants may ask booking office to cancel patients. 3. New consultants can not have their own codes for clinics and waiting lists 4. Mr Glackin and Mr Pahuja require more flexible cystoscopy slots. 5. Mr Jathar is locum consultant.	TL3 page 996 – 997 AOB-06674 – AOB-06675
25.06.2013	Email from Ms Stinson to Urology	Re: Urology Service We are all aware of the difficulties we are experiencing with both staffing in the Urology service as a whole and the impact this is having on service provision, particularly in the elective area.	TL3 page 1014 AOB-06692
05.07.2013	Email from Mr Pahuja to Urology	Re: Urodynamic plan & Mr Pahuja ideas	TL3 page 1043 – 1044 AOB-06721 –

			AOB-06722
11.07.2013	Email from Ms Corrigan to Urology	Re: PTL waits Monitoring 62 day pathway There are quite a few that have already breached the 62 day target.	TL3 page 1047 – 1052 AOB-06725 – AOB-06730
15.07.2013 – 16.07.2013	Email from Ms Corrigan to Consultants	Re: Urodynamics Independent Sector No longer going to send the long-waiting urodynamics patients out to the independent sector as was previously agreed. As you are aware I have agreed to run some all day Saturday Review Clinics for these long-waiting patients and then if required some urodynamic sessions over the next few months.	TL3 Page 1055 – 1059 AOB-06733 – AOB-06737
18.07.2013	Email from Ms Trouton to Consultants	Re: Urology Meeting *"I thought it might be good to take a moment to summarise the few actions that were agreed and discussed this afternoon as, as Aidan quite rightly states we often agree actions but often never get to implement due to many competing demands on our time.* 1. *It was agreed that we need to book our patients as far as possible in chronological order among the team of 5 consultants……* 2. *It was agreed that all vasectomy referrals will now be triaged to the vasectomy service led by Paul Hughes in DHH…* 3. *The cyrrent triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar to that used Wolverhampton and Guys hospital which we will take forward with our IT and booking centre colleagues* 4. *It was also suggested that, with good training we could develop and implement a pre triage system where clear referrals where triaged by a non consultant and only those more ambiguous would go daily to the consultant on call. This would really improve our turnaround time for triage and release consultant time...* 5. *I shared the correspondence from Mr Compton from the Regional Commissioning Board re underperformance on both Urology Outpatients and day cases and we know that this is largely due to the capacity gap in ICATS and our lack of junior doctors….* 6. *The Use of the emergency theatre was also brought up as an issue and I have undertaken to address this with Ronan and Charlie …"*	TL3 bundle 1070 AOB-06748
26.07.2013	Email from Ms Corrigan to Consultants	Re: Urodynamics Waiting List Reduced to 124 patients waiting over 9 weeks and waiting time reduced from 89 weeks to 78 weeks.	TL3 page 1073-1081 AOB-06751 – AOB-06759
26.07.2013	Email from Ms Dignam	Sept Rota	TL3 page 1082 – 1085 AOB-06760 –

			AOB-06763
29.08.2013	Email from Ms Corrigan to Consultants	RE: Urology PTL to meet 26 weeks **Mr O'Brien Inpatient approx. 87 patients with longest waiting 58 weeks** **Mr Young Inpatient approx. 33 patients with longest waiting 69 weeks** **Mr Glackin inpatient approx. 1 patients with longest waiting 31 weeks** **Mr Jathar inpatient approx. 2 patients with longest waiting 36 weeks**	SUP OCT Page
02.09.2013	Email from Ms Corrigan to Consultants	Re: Urodynamics 128 patients currently waiting to get an appointment and still very long-waiters. Longest waits: 1x76 1x69 2x67 1x64 2x61 1x60 1x56 1x54 Plan out Saturday additional clinics but if we are to meet 9 weeks by end of March 2013 we need to start doing these Saturday's again and I would welcome your thoughts on this. Also for core sessions during the week could the long waiters please be scheduled in so that we can start reducing the access waiting time.	TL3 page 1107 AOB-06785
06.09.2013	Email from Ms Corrigan to Mr Brown	Re: Flexible Cystoscopies and Vasectomies Re transfer of patients from CAH to DHH	TL3 page 1108 AOB-06786
10.09.2013	Email from Ms McCann to Urology	Re: Winter pressures … As we are approaching the winter months, we will be under extreme pressure though elective and emergency admissions and we will be tight for beds so I would really appreciate that we are made aware of all admissions, we don't want to be in a situation where we have to send patients home on arrival to the ward"	TL3 page 1109 AOB-06787
10.09.2013	Email from Ms Corrigan to Consultants	Re: Additional PA I had a meeting with the Board yesterday about our performance. This was a difficult meeting and they have now asked me to do a plan from now until end of December. I was wondering if any of you would be interested in temporarily taking on additional PA I propose to use the funding from the vacant post for this.	TL3 page 1110 AOB-06788
13.09.2013	Email from Ms Corrigan to Consultants	Re: Urodynamics 9 week PTL for September 110 currently sitting on this and whilst actual number is decreasing the waiting times are not…. Would appear patients are not being picked in strict chronological order and note that whilst there are a few long waiting patients on these clinics there is also patients either waiting longer or have only been waiting a few weeks which I cannot justify this..	TL3 page 1111 AOB-06792
13.09.2013	Email from Ms	Re Dec 26 week PTL	TL3 page 1114 – 1193

<table>
<tr><td></td><td>Corrigan to Consultants</td><td>Board focusing on long waiters and I have been asked to submit waiting times which needs to be at 26 weeks…. There is a lot of patients requiring to be seen and I am conscious that I am constantly asking to look at each area..

Mr O’Brien approx. 202 patients
Mr Young approx.. 197 patients
Mr Akhtar approx. 2 patients
Mr Glackin approx. 76 patients
Mr Pahuja approx.. 51 patients</td><td>AOB-06792 – AOB-06871</td></tr>
<tr><td>16.09.2013</td><td>Email from Ms McMahon to Consultants</td><td>Re: Urodynamics 9 week PTL

Due to limited registrar cover during the month of October only able to staff urodynamic clinics on 5 separate occasions</td><td>TL3 page 1202 – 1203

AOB-06880 – AOB-06881</td></tr>
<tr><td>19.09.2013</td><td>Email from Ms Glenny to Consultants</td><td>Re: Waiting list info

<table>
<tr><th></th><th>Hospital</th><th>Consultant Name</th><th>Waiting 0 to 6 weeks</th><th>Waiting 6+ to 13 weeks</th><th>Waiting 13+ to 21 weeks</th><th>Waiting 21+ to 26 weeks</th><th>Waiting more than 26 weeks</th><th>Total Waiting</th></tr>
<tr><td></td><td rowspan="6">CAH</td><td>Akhtar M Mr</td><td>0</td><td>1</td><td>0</td><td>0</td><td></td><td>1</td></tr>
<tr><td></td><td>Glackin A.J Mr</td><td>27</td><td>17</td><td>20</td><td>5</td><td>37</td><td>106</td></tr>
<tr><td></td><td>Jathar H L Mr</td><td>46</td><td>24</td><td>21</td><td>8</td><td>10</td><td>109</td></tr>
<tr><td></td><td>O'Brien A Mr</td><td>10</td><td>18</td><td>14</td><td>5</td><td>23</td><td>70</td></tr>
<tr><td></td><td>Pahuja A Mr</td><td>50</td><td>15</td><td>10</td><td>10</td><td>11</td><td>96</td></tr>
<tr><td></td><td>Young M Mr</td><td>74</td><td>71</td><td>42</td><td>7</td><td>45</td><td>239</td></tr>
<tr><td></td><td>CAH</td><td></td><td>199</td><td>142</td><td>105</td><td>35</td><td>117</td><td>621</td></tr>
<tr><td></td><td></td><td></td><td>207</td><td>146</td><td>107</td><td>35</td><td>126</td><td>621</td></tr>
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<tr><td></td><td></td><td></td><td>207</td><td>146</td><td>107</td><td>35</td><td>126</td><td>621</td></tr>
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<tr><th></th><th>Hospital</th><th>Consultant Name</th><th>Waiting 0 to 6 weeks</th><th>Waiting 6+ to 13 weeks</th><th>Waiting 13+ to 21 weeks</th><th>Waiting 21+ to 26 weeks</th><th>Waiting more than 26 weeks</th><th>Total Waiting</th></tr>
<tr><td></td><td rowspan="5">CAH</td><td>Glackin A.J Mr</td><td>13</td><td>12</td><td>4</td><td>0</td><td>1</td><td>30</td></tr>
<tr><td></td><td>Jathar H L Mr</td><td>6</td><td>8</td><td>2</td><td>0</td><td>2</td><td>18</td></tr>
<tr><td></td><td>O'Brien A Mr</td><td>33</td><td>34</td><td>26</td><td>18</td><td>92</td><td>203</td></tr>
<tr><td></td><td>Pahuja A Mr</td><td>18</td><td>9</td><td>5</td><td>2</td><td>2</td><td>36</td></tr>
<tr><td></td><td>Young M Mr</td><td>20</td><td>8</td><td>16</td><td>6</td><td>47</td><td>97</td></tr>
<tr><td></td><td>CAH</td><td></td><td>90</td><td>71</td><td>53</td><td>26</td><td>144</td><td>384</td></tr>
<tr><td></td><td></td><td></td><td>90</td><td>71</td><td>53</td><td>26</td><td>144</td><td>384</td></tr>
<tr><td></td><td></td><td></td><td>90</td><td>71</td><td>53</td><td>26</td><td>144</td><td>384</td></tr>
<tr><td></td><td></td><td></td><td>90</td><td>71</td><td>53</td><td>26</td><td>144</td><td>384</td></tr>
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<tr><td></td><td></td><td></td><td>297</td><td>217</td><td>160</td><td>61</td><td>270</td><td>1005</td></tr>
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</td><td>TL3 page 1208 – 1209

AOB-06886 – AOB-06887</td></tr>
<tr><td>23.09.2013</td><td>Email from Ms Dignam</td><td>Re: November rota</td><td>TL3 page 1255 – 1258

AOB-06933 – AOB-06936</td></tr>
</table>

<table>
<tr>
<td>October 2013 to December 2014</td>
<td>CHKS Consultant Level Indicator Programme</td>
<td>In 2012/13 Appraisal</td>
<td>2012/13 Appraisal pages 80 – 85

AOB-22400 - AOB-22405</td>
</tr>
<tr>
<td>16.10.2013</td>
<td>Email from Ms Glenny to consultants</td>
<td>Re: Urodynamics 9 week PTL for October

The longest wait on report has dropped to 56 weeks
There are 78 patients in total that we would be required to treat if we were to meet a 9 week waiting time target for October, none of which have a date for procedure in the month of October.</td>
<td>TL3 page 1296 – 1305

AOB-06974 – AOB-06983</td>
</tr>
<tr>
<td>16.10.2013</td>
<td>Email from Ms Glenny to Consultants</td>
<td>RE: Urology 26 week elective PTL October

In summary there are 261 patients on this report with no dates for the 26 week target at end of October. The longest waiter is now 69 weeks which is an improvement on last week.

Mr O’Brien Inpatients – Approx 110 patients
Mr Young Inpatients – approx. 40 patients
Mr Pahuja inpatients – approx. 5 patients
Mr Glackin inpatients – approx. 1 patient

Mr O’Brien day cases – approx. 21 patients
Mr Young day cases – approx. 44 patients
Mr Pahuja day cases – approx. 7 patients
Mr Glackin day cases – approx. 19 patients</td>
<td>TL3 page 1306 – 1327

AOB-06984 – AOB-07005</td>
</tr>
<tr>
<td>21.10.2013</td>
<td>Email from Ms Trouton to Consultants</td>
<td>RE: Urology 59 week PTL

They were still very concerned about the waiting times for surgery. We had given them an anticipated longest wait of 59 weeks at the very longest. To that end they have asked up to schedule the lists from now until the end of December to both ensure that we have absolutely no one waiting any longer than 59 weeks and to see if we can bring down that wait further.

<table>
<tr><th colspan="6">TOTAL ON 59 WEEK DECEMBER PTL = 61 PATIENTS</th></tr>
<tr><th colspan="3">In-Patients</th><th></th><th colspan="2">Day Cases</th></tr>
<tr><td colspan="2">Total</td><td>49</td><td></td><td>Total</td><td>12</td></tr>
<tr><td colspan="2">Booked</td><td>6</td><td></td><td>Booked</td><td>4</td></tr>
<tr><td colspan="2">Not Booked</td><td>43</td><td></td><td>Not Booked</td><td>8</td></tr>
<tr><td colspan="3">Split of Patients Not Booked:</td><td></td><td colspan="2">Split of Patients Not Booked:</td></tr>
<tr><td>Consultant</td><td>Volume to achieve 59 weeks</td><td>Current Longest Waiter</td><td></td><td>Consultant</td><td>Volume to achieve 59 weeks</td><td>Current Longest Waiter</td></tr>
<tr><td>AJG - Mr Glackin</td><td>0</td><td>32 weeks</td><td></td><td>AJG - Mr Glackin</td><td>0</td><td>45 weeks</td></tr>
<tr><td>AOB - Mr O'Brien</td><td>30</td><td>60 weeks</td><td></td><td>AOB - Mr O'Brien</td><td>0</td><td>47 weeks</td></tr>
<tr><td>APA - Mr Pahuja</td><td>1</td><td>50 weeks</td><td></td><td>APA - Mr Pahuja</td><td>0</td><td>33 weeks</td></tr>
<tr><td>HLJ - Mr Jathar</td><td>0</td><td>44 weeks</td><td></td><td>HLJ - Mr Jathar</td><td>1</td><td>33 weeks</td></tr>
<tr><td>MY - Mr Young</td><td>12</td><td>70 weeks</td><td></td><td>MY - Mr Young</td><td>7</td><td>56 weeks</td></tr>
</table>
</td>
<td>TL3 page 1339 – 1343

AOB-07017 – AOB-07021</td>
</tr>
<tr>
<td>21.10.2013</td>
<td>Email from Ms Glenny</td>
<td>Re: Urology 59 week PTL report

Potential slots for additionality.</td>
<td>TL3 page 1344 – 1348</td>
</tr>
</table>

	to consultant		AOB-07022 – AOB-07026
23.10.2013	Email from Mr Young	Re December rota	TL3 page 1349 – 1350 AOB-07027 – AOB-07028
28.10.2013	Email from Ms Glenny to Consultants	Re: Urology 59 week PTL report To set up formal 58 week PTL report so we can ensure we meet this target now and it wont be exposed to any "pop-ons" now that we have this agreed plan. I have also asked for a 50 week PTL to be set up. Mr O'Brien In patients – 31 patients Mr Young in patients – 13 patients	TL3 page 1360 – 1376 AOB-07038 – AOB-07054
07.11.2013	Email from Ms Glenny to Consultants	Re: Uro Dec Plan 9 patients with no date – Mr O'Brien 3 patients with no date – Mr Young	SUPAUG Page 189 – 190
14.11.2013	Email from Ms Glenny to Consultants	Re: Urodynamics 9 week PTL 9 week PTL for urodynamics which we will need to give some serious though to how we can start to bring the waiting times down for this group of patients. HSCB are expecting that the 9 weeks for urodynamics is met at the end of March. There are a total of 101 patients to meet 9 weeks by end of December already, 84 of which have no dates. Mr Akhtar – 2 Mr Connolly – 1 Mr Glackin – 2 Mr Jathar – 1 Mr Luts – 1 Mr O'Brien 60 Mr Pahuja – 3 Mr Young – 14	TL3 page 1377 – 1385 AOB-07055 – AOB-07063
24.11.2013	Email from Ms Corrigan to consultants	Re: Demand & Capacity Re Haematuria escalations. We have on average: Demand = 46-50 RF haematuria referrals per month Capacity = 36 slots (this is 1.5 sessions per week)	SUPOCT Page xx
27.11.2013	Email from Mr Young	Re Dec & Jan rota	TL3 page 1519 – 1525 AOB-07197 –

<table>
<tr><td></td><td></td><td></td><td>AOB-07203</td></tr>
<tr><td>16.12.2013</td><td>Email from Ms Corrigan to Consultants</td><td>Re: Haematuria clinic

Have an increase on 4 referrals per week we are slipping away behind again on first appointment for haematuria – day 51.</td><td>TL3 page 1531 – 1544

AOB-07209 – AOB-07222</td></tr>
<tr><td>16.12.2013</td><td>Email from Ms Trouton to Urology</td><td>Re: Scheduling

In mid October to meet 58 weeks by the end of December and we are still on schedule to meet that which is great.

Martina has advised that the plan to get to 44 weeks by the end of March and on the way to get to 50 weeks by the end of January which I am realibly informed is doable.</td><td>TL3 page 1545

AOB-07223</td></tr>
<tr><td>16.12.2013</td><td>Email from Ms Glenny to Consultants</td><td>Re Scheduling 44 weeks

<table><tr><td></td><td colspan="3">IN-PATIENTS</td></tr><tr><td></td><td>BOOKED</td><td>NOT BOOKED</td><td>TOTAL</td></tr><tr><td>AJG</td><td>2</td><td>1</td><td>3</td></tr><tr><td>AOB</td><td>1</td><td>71</td><td>72</td></tr><tr><td>APA</td><td>1</td><td>3</td><td>4</td></tr><tr><td>HLJ</td><td>0</td><td>1</td><td>1</td></tr><tr><td>MY</td><td>2</td><td>24</td><td>26</td></tr><tr><td>RJB</td><td>0</td><td>3</td><td>3</td></tr><tr><td>TOTAL</td><td>6</td><td>103</td><td></td></tr><tr><td></td><td colspan="2">109</td><td></td></tr></table></td><td>TL3 page 1546 – 1568

AOB-07224 – AOB-07245</td></tr>
<tr><td>16.12.2013</td><td>Email from Ms Glenny to Consultants</td><td>Re: Scheduling 50 weeks

<table><tr><td></td><td colspan="3">IN-PATIENTS</td></tr><tr><td></td><td>BOOKED</td><td>NOT BOOKED</td><td>TOTAL</td></tr><tr><td>AJG</td><td>2</td><td>0</td><td>2</td></tr><tr><td>AOB</td><td>0</td><td>32</td><td>32</td></tr><tr><td>APA</td><td>1</td><td>0</td><td>1</td></tr><tr><td>HLJ</td><td>0</td><td>1</td><td>1</td></tr><tr><td>MY</td><td>2</td><td>14</td><td>16</td></tr><tr><td>TOTAL</td><td>5</td><td>47</td><td></td></tr><tr><td></td><td colspan="2">52</td><td></td></tr></table></td><td>TL3 page 1568 – 1576

AOB-07246 – AOB-07254</td></tr>
<tr><td>28.12.2013</td><td>Email from Mr Pahuja</td><td>Re: Leaving

Mr Pahuja resigns</td><td>TL3 page 1583

AOB-07261</td></tr>
<tr><td>30.12.2013</td><td>Email from Ms Glenny to Consultants</td><td>Re: 50 Week PTL

Mr O’Brien – 63pprox.. 33 patients
Mr Young – 63pprox.. 24</td><td>TL3 page 1584 – 1596</td></tr>
</table>

		Mr Glackin – 64 approx.. 1 Mr RJB? – 2 patients Mr HLJ – 3	AOB-07262 – AOB-07274
January 2014 to December 2014	CHKS Consultant Level Indicator Programme	CHKS Consultant Level Indicator Programme	2014 Appraisal pages 19 – 24 AOB-22564 - AOB-22569
2014	2014 Appraisal	2014 Appraisal notes: *"Outpatient activity changed during 2014 with the appointment of two more consultant urologists during the year. The outpatient schedule since September 2014 is detailed in Section 2.4 below."*	2014 Appraisal Page 4 AOB-22549
2014	2014 Appraisal	2014 Appraisal notes under heading Additional Information: *"The factors impacting upon the delivery of patient care have been the same for years. They have not changed from year to year, or perhaps more precisely, the only change has been that they impact more and more negatively. Even though I, like all of my colleagues, have increasingly long waiting lists for surgery and increasing numbers of patients waiting longer periods of time for review, the relentless expectation is to take us increasing numbers of new patients and do so in within stipulated time periods, and only to join the lengthening queues for surgery and review, and to the extent that the wait impacts negatively upon their care and outcomes. I work long hours every day,* *contracted or otherwise, paid and unpaid, in an attempt to mitigate the worst outcomes."*	2014 Appraisal Page 5 AOB-22550
2014	2014 Appraisal	2014 Appraisal states *"Discussion* *My main roles in this domain have been those of Lead Clinician of the Urological Cancer MDT for theSouthern Health and Social Care Trust, and as Lead Clinician and Chair of the Northern Ireland Cancer Network (NICaN) Urology Clinical Reference Group.* *As evidenced by the documentation above, the Southern Trust has had a progressive increase in thenumbers of referrals of patients suspected of having cancer, the numbers confirmed of having cancer and the numbers managed. This increase has been the case across all urological malignancies, but was most pronounced in relation to renal tumours. In spite of this increase, we made very significant progress during 2014 in assessing and managing increasing proportions of all cases within the 62 day pathway, until we reached 100% compliance by January 2015.* *During 2014, much of my effort was in constructing all of the organizational infrastructure and documentation in preparation for Peer Review in 2015.*	2014 Appraisal page 51 AOB-22596

<table>
<tr><td></td><td></td><td>Similarly, as Lead Clinician and Chair of NICaN Urology, I led the development of agreed Referral Guidelines, Clinical Management Guidelines and Patient Pathways in preparation for Regional Peer Review in 2015."</td><td></td></tr>
<tr><td>2014</td><td>2014 Appraisal</td><td>2014 Appraisal states

62 day performance (completed waits)
<u>62 day Performance for the 2014/15 year up to the end of January 2015 (Completed Waits)</u>

<table>
<tr><td>TRUST
Belfast</td><td>TUMOURSITE</td><td>Nov-14</td><td>Dec-14</td><td>Jan-15</td><td>2014/15YTD</td></tr>
<tr><td></td><td>Urological Cancer</td><td>54%</td><td>40%</td><td>38%</td><td>50%</td></tr>
<tr><td>Northern</td><td>Urological Cancer</td><td>50%</td><td>29%</td><td>0%</td><td>24%</td></tr>
<tr><td>South Eastern</td><td>Urological Cancer</td><td>36%</td><td>36%</td><td>56%</td><td>44%</td></tr>
<tr><td>Southern</td><td>Urological Cancer</td><td>87%</td><td>87%</td><td>77%</td><td>70%</td></tr>
<tr><td>Western</td><td>Urological Cancer</td><td>100%</td><td>100%</td><td>100%</td><td>94%</td></tr>
</table></td><td>2014 Appraisal page 56

AOB-22601</td></tr>
<tr><td>2014</td><td>2014 Appraisal</td><td>Regional Urology Referrals

Total Referrals between January 2013 to January 2015 inclusive - BY TRUST
Information sourced from PAS via DWH download on 23rd February 2015
Duplicate Referrals based on same HCN, korner speciality and referral date +/- 7 days have been removed
Information based on PAS box on which referral has been recorded
ICATS excluded
Belfast Trauma and Orthopaedics excluded (under development)

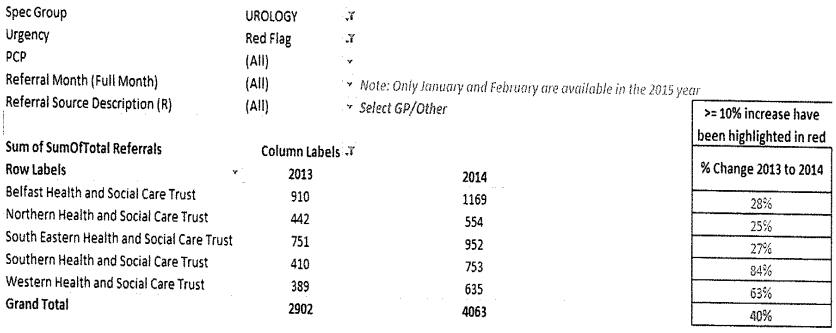
Spec Group: UROLOGY
Urgency: (All)
PCP: (All)
Referral Month (Full Month): (All) — Note: Only January is available in the 2015 year
Referral Source Description (R): (All) — Select GP/Other

<table>
<tr><td>Sum of SumOfTotal Referrals</td><td>Column Labels</td><td></td></tr>
<tr><td>Row Labels</td><td>2013</td><td>2014</td></tr>
<tr><td>Belfast Health and Social Care Trust</td><td>7724</td><td>7751</td></tr>
<tr><td>Northern Health and Social Care Trust</td><td>4256</td><td>3740</td></tr>
<tr><td>South Eastern Health and Social Care Trust</td><td>5140</td><td>5258</td></tr>
<tr><td>Southern Health and Social Care Trust</td><td>3987</td><td>4695</td></tr>
<tr><td>Western Health and Social Care Trust</td><td>3492</td><td>3961</td></tr>
<tr><td>Grand Total</td><td>24599</td><td>25405</td></tr>
</table>

<table>
<tr><td>>= 10% increase have been highlighted in red</td></tr>
<tr><td>% Change 2013 to 2014</td></tr>
<tr><td>0%</td></tr>
<tr><td>-12%</td></tr>
<tr><td>2%</td></tr>
<tr><td>18%</td></tr>
<tr><td>13%</td></tr>
<tr><td>3%</td></tr>
</table></td><td>2014 Appraisal page 57

AOB-22602

2014 Appraisal page 58</td></tr>
</table>

		Regional Red Flag  Spec Group: UROLOGY Urgency: Red Flag PCP: (All) Referral Month (Full Month): (All) Referral Source Description (R): (All) Note: Only January and February are available in the 2015 year Select GP/Other >= 10% increase have been highlighted in red Sum of SumOfTotal Referrals / Column Labels / 2013 / 2014 / % Change 2013 to 2014 Belfast Health and Social Care Trust / 910 / 1169 / 28% Northern Health and Social Care Trust / 442 / 554 / 25% South Eastern Health and Social Care Trust / 751 / 952 / 27% Southern Health and Social Care Trust / 410 / 753 / 84% Western Health and Social Care Trust / 389 / 635 / 63% Grand Total / 2902 / 4063 / 40%	AOB-22603
01.01.2014	Email from Mr Young to Consultants	Re: February rota	TL5 page 1 – 4 AOB-70163 – AOB-70166
06.01.2014	Email from Ms Glenny to Consultants	Re: Uro 50 week PTL January Patients scheduled to meet 50 week target. Noted that there are 61 patients in today on the report and only 4 have scheduled dates so far.	TL5 page 5 – 7 AOB-70167 – AOB-70169
07.01.2014	Email from Ms Stinson	RE: Update on Bed Pressures Notes that hospital has been under significant pressure over the weekend.	TL5 page 10 – 11 AOB-70172 – AOB-70173
07.01.2014	Email from Ms Corrigan to Consultants	Re: Additionality Noting the dates which the consultants had agreed to undertake additional theatre session	TL5 page 12 AOB-70174
10.01.2014	Email from Global Circular	Re: Emergency Dept Pressure	TL5 page 13 AOB-70175
14.01.2014	Email from Ms Corrigan to Mr O'Brien	Re: Patient late scheduling Patient went to Craigavon on 15th October 2013 to have a stint put in and was to go back 2 weeks later to have it removed but they haven't sent for him.	TL5 page 22 – 23 AOB-70184
14.01.2014	Email from Ms Corrigan to Mr O'brien	RE: Patient late for scheduling Patient was advised by Mr O'brien that he would be brought back in in October but has not yet been called for. Ms Corrigan noted that she was	TL5 page 21

		aware that this was one of the patients she was aware Mr O'brien has previously discussed	AOB-70183
21.01.2014	Email from Ms Glenny to Consultants	Re: Additionality List of dates provided for some additionality	TL5 page 103 AOB-70265
22.01.2014	Email from Ms Dignam to Ms McCorry	Re: Patient query Patient seen Mr O'Brien privately and is frustrated as has not got date for private surgery	TL5 page 104 AOB-70266
30.01.2014	Email from Ms Dignam to Consultants	RE: March rota	TL5 Page 150 – 153 AOB-70312 – AOB-70315
03.02.2014	Email from Ms Glenny to Consultants	Re: Elective & Non-Elective Activity for TURBT – TURPT Details how long patients were waiting before procedures were performed	TL5 page 154 – 170 AOB-70316 - AOB-70332
04.02.2014	Email from Mr Williams to Consultants	RE: CT Uro capacity Limited capacity for CTU and scanning indication would be restricted to investigation of macroscopic haematuria in patients over 40.	TL5 page 171 – 179 AOB-70333 – AOB-70341
05.02.2014	Email from Ms Corrigan to Mr O'Brien	Re: Patient query Patient's father been on waiting list for removal of stent since September 2013. Does not want to complain but patient has become very unwell. Ms Corrigan noted that she has explained to the Patient of the urology waiting times	TL5 Page 193 AOB-70355
06.02.2014	Email from Mr O'Brien to Ms McCorry	Re: Ms McCorry booking patients without Mr O'Brien approval. Concerns that patients with advanced malignancy will not be seen for weeks	TL5 page 194 AOB-70356
18.02.2014	Email from Ms Corrigan to Consultants	Re: Cancer Performance Continually not meeting either 31 day or 62 day cancer targets. Notes that there are a lot of competing demands coming from all directions. Main issue at the moment is resolving the timeliness of first appointments e.g. not enough slots etc.. and therefore patients not being appointed until for example, day 50… knows will not be addressed before end of March as have backlog to address. Need to address the immediate backlog and long waiters which are already long past their target date. Need plan to ensure that from 31 March, no more patients are breaching. This will mean moving patients already booked, bringing patients apppointments forward for outpatients, ins and day patients, so that we can meet the targets. It will also mean having to cancel non-urgent appointments.	TL5 page 200 AOB-70362

		Other clinical needs such as cancer recurrences, removal of stents etc	
19.02.2014	Email from Mr Glackin to Ms Corrigan	Re: above email on cancer performance. Mr Glackin notes that referrals for triage arrive in Trust but are not brought to consultant's attentions for a couple of days after and this is costing dearly in cancer pathway	TL5 page 216 – 218 AOB-70378 – AOB-70380
21.02.2014	Email from Ms Corrigan to Mr O'Brien	Re: Patient who id Day 61 but was discharged on PAS due to admin error	TL5 page 219 – 220 AOB-70381 – AOB-70382
24.02.2014	Email from Ms Corrigan to Mr O'Brien	Re: Cancer escalations – to give date urgently. Request to take routine/long waiters off to put these patients on as need to ensure do not breach at end of March	TL5 page 222 AOB-70384
28.02.2014	Email from Mr Young to Consultants	Re: April rota	TL5 Page 225 – 227 AOB-70387 – AOB-70389
13.03.2014	Email from Ms Corrigan to Ms O'neill and Ms McMahon	Re: Staffing in Thorndale	TL5 page 317 AOB-70479
14.03.2014	Email from Mr O'Brien to Mr Brown	Re: Patient query Mr O'Brien queries advice from Mr Brown but highlights his long waiting list has meant this patient had bladder resected in May 2013 and was supposed to have his GA cystoscopy done by July 2013 but waiting list so bad that Mr O'Brien only seeing him now in March 2014	TL5 page 324 AOB-70486
20.03.2014	Email from Ms Corrigan to Consultants	Re: Haematuria spreadsheet Shows that patient's 1st appointment is average to day43 which is a slight decrease in weekly demand	TL5 page 386 – 410 AOB-70548 – AOB-70572
26.03.2014	Email from Mr Young to Consultants	Re: May rota	TL5 page 413 – 415 AOB-70575 – AOB-70577
28.03.2014	Email from Ms Corrigan to Consultants	RE: NI cancer waiting times – include Northern Ireland Waiting Time Statistics – Cancer waiting times October – December 2013 *Last quarter performance (table 6) page 17* *Regional 62 day performance – means for this quarter are Belfast – 79.5% - North 83.4% - South 87.3% - SE 72.4%- WH 88.2% - for us Urology which*	TL5 page 416 – 442 AOB-70578 –

		we are working hard to turn around Table 8 Page 18 – regional 31 day performance – good table 10 page 19 – regional 14 day breast performance – working through both locally and regionally	AOB-70604
April 2014	Team South Response to Urology Review 2014	1. Difficulties with review (a) Lack of openness re agenda for review in first place (b) Fixed reference point, namely year 2000 document i.e. ten years behind (c) Not listened to our concerns that things moved on from this document; for instance same time span allocated to patients despite considerable added administration adjoining this for each patient (d) May have increased consultants but little resources or extra facilities 2. Issues of Craigavon (a) Variable employment of middle grade (b) Infrastructure of day surgery availability (c) Rural community (d) Defining how many theatre lists originally was a challenge due to diversity of procedures and target time (e) SABA was an historical document, uncompromising to changes in need (f) Demand and capacity changes (g) Administration time allocated inadequate (h) On call duties, like administration, runs in tandem (i) Turnover of consultants has been an instability (j) Matching demands or targets with patient slots needs significant fine tuning. (k) Revisit the question of bladder removal as part of non-oncology reconstructive urology. (l) Lack of engagement by GPs What we need to do An improved administrative flow of patients; this is not only ICT based but personnel working within unit e.g a clinic co-ordinator administrative person 1. Theatre capacity in CAH (bulk of work) needs enhancing. Original difficulty precisely defining needs. Should have two theatre lists per consultant 2. Enhanced day surgery and twenty three hour facilities within the main hospital would increase our scope 3. Appreciation that new BAUS recommendations will be available soon – understanding that there is a further improvement in consultant to population base and that there has been a shift in the age/expectation/ and procedures since last review. 4. A recognition that one shoe does not fit all; each department can have its policies to gain as much productivity 5. Stick to targets before moving on to the next one 6. A distinct focus on care pathway aiming for an enhanced triage, hot clinic principal with rapid access 7. Elimination of external factors such as wait limiting features as access to radiology	TL5 page 460 – 463 AOB-70622 – AOB-70625
01.04.2014	Email from Mr Glackin to Ms Corrigan	Re: Cancer patients needing update Mr Glackin noted that he does not have capacity due to existing red flags and the need for an assistant.	TL5 Page 452 – 454 AOB-70614 – AOB-70616
03.04.2014	Email from Mr Young	Providing an example for radiology cancellation	TL5 page 464

	to Mr O'Brien		AOB-70625
14.04.2014	Email from Ms Corrigan to Consultants	Re: Urology Departmental meeting Was scheduled for Thurs 17th April but due to unforeseen circumstances, Ms Corrigan can no longer attend and cannot complete piece of work which was due for this meeting	TL5 page 515 AOB-070677
18.04.2014	Email From Ms Corrigan to Mr Young	Re Waiting lists New outpatient waiting is 31 weeks with total of 1339 waiting *Mr Young – 236 longest wait is 23 weeks* *Mr O'Brien – 167 longest wait is 22 weeks* *Mr Glackin – 256 longest wait is 20 weeks* *Mr Suresh – 89 longest wait is 17 weeks* *Mr A – 16 longest waiting 20 weeks* Review backlog total waiting is 2803 and longest waiting is January 2011 *Mr Young – Urgent 129 (July 13) Routine 670 (Feb 12)* *Mr O'Brien – Urgent 348 (March 11) Routine 989 (Jan 11)* *Mr Glackin – Urgent 103 (Aug 2011) Routine 177 (Sept 12)* *Mr Suresh – Urgent 98 (May 13) Routine 64 (dec 12)* *AJAY – Urgent 54 (Aug 13) Routine 171 (May 13)* Inpatient – 364 longest wait 71 weeks *Mr Young – Urgent 62 longest 67 weeks. Routine 27 Longest 71 weeks* *Mr O'Brien – Urgent 126 longest 70 weeks Routine 89 longest 70 weeks*	TL5 page 543 – 544 AOB-70705 – AOB-70706

		Mr Glackin – Ugrent 17 longest 48 weeks Routine 4 longest 30 weeks. *Mr Suresh – Urgent 11 longest 30 weeks. Routine 13 longest wait 27 weeks* *AJAY – Urgent 8 longest wait 30 weeks. Routine 7 longest wait 52 weeks* Daypatients total 460 with longest wait 67 weeks *Mr Young – Urgent 73 longest wait 64 weeks. Routine 136 longest wait 67 weeks* *Mr O'Brien – Urgent 24 longest 61 weeks Routine 18 longest wait 61 weeks* *Mr Glackin – Urgent 29 longest 38 weeks. Routine 23 longest 37 weeks* *Mr Suresh – Urgent 73 longest 42 weeks. Routine 33 longest wait 56 weeks* *AJAY – Urgent 19 longest wait 31 weeks. Routine 32 longest wait 41 weeks*	
18.04.2014	Email from Ms Corrigan to Ms Farrell	Re: Complaint from Personal Information redacted by the Noted that Mr O'Brien is aware of this patient but the urology department are experiencing an increase in waiting times for non-cancer patients as currently concentrating on treating cancer patients	TL5 page 545 – 551 AOB-70707 – AOB-70713
22.04.2014	Email correspondence between Mr O'Brien and Ms McCorry	Re: Patient Response "*Hello Martina,* *I apologise for not having responded to so many of your emails. I have been so consumed by appraisal and revalidation. I have spent long days and nights preparing. It is such an enormous amount of work to complete all of the preparation for enhanced appraisal prior to revalidation. In any case, I had enhanced appraisal this afternoon with Michael, all successfully, and I will have revalidation on Friday. I am really happy with it all now.* *I have to let many other things take second place, including triage. I spent all day Sunday triaging. When complete, I will arrange with Leanne Brown an audit, to ensure that all referrals have been processed. Regarding [Patient] I contacted him at the weekend, and have arranged for him to be*	SUP 303 AOB-03799

		admitted on Tuesday 6 May for TURP on Wednesday 7 May. He actually lives alone [Personal Information redacted by the USI] *"*	
23.04.2014	Email from Mr Young to Mr O'Brien and Others	Re: June rota	TL5 page 552 – 554 AOB-70714 – AOB-70716
28.04.2014	Email from Ms Corrigan to Consultants	Re Funding Board agreed to fund 700 review backlog patients for quarter one and two	TL5 page 555 – 556 AOB-70717 – AOB-70718
May 2014	Narrative Report on the Stock Take for the Health and Social Care Board of Urology Services in Northern Ireland Feb – May 2014	Challenges: Belfast Trust 1. Specific problems of the Team East arrangements that the 2009 review has initiated, especially the on-call arrangements between the Ulster Hospital and BCH 2. Increasing workload especially from increasing numbers of cancer referrals to its cancer centre 3. Consultant changes and increasing emergency work resulting in significant reduction in workforce capacity and in the skills base in particular surgical reconstruction services. 4. Recruitment of clinical staff remains difficult 5. Growing waiting lists especially for core urology and outpatient services 6. Primary care catchment areas overlapping with other providers making allocation of referrals challenging 7. Limited space for day diagnostic services and limited theatre sessions, but helped by using the theatre at White Abbey Hospital to provide some diagnostic and day cases 8. The Trust raised the issue of the provision of Robotic Surgery 9. On ongoing problem with a small group of patients awaiting complex reconstructive surgery was described South Eastern Trust 1. Specific problems of the Team East arrangements that the 2009 review had initiated, especially the on-call arrangements between the Ulster Hospital and BCH 2. Currently 3 consultant team is overstretched; 4 peripheral sites covered as well as the main hospital; BCH provides clinical work at Lagan Valley 3. Rising demand for both cancer and core urology services Northern and Western Trusts 1. Waiting times for outpatients and surgical procedures remain high with significant numbers of patients on the operative waiting lists particularly for core urology procedures 2. The arrangements for cross cover on-call arrangements between the two sites are not yet fully operational. 3. The 2 new operating theatres on the Altnagelvin sites are not yet completed and do not have an agreed timescale for construction 4. The loss of the defined cancer operations to the cancer centre has not been backed up with clear annual outcome data to assess whether improvements have resulted	SUPOCT Page

		5. The costing of some of the Team NW proposals are not yet fully worked out and no clear decision taken 6. Recruitment of clinical staff has remained difficult Southern Trust 1. The waiting times particularly outpatient services have very long waiting times 2. Access to operating theatre sessions is limited resulting in waiting lists for operative procedures in particular core urology cases. 3. The commissioned service and budget agreement aims are based on the workforce capacity rather than the demand 4. Recruitment of clinical staff has until very recently been a problem. Recent consultant appointments are hoped will improve clinical services in time. The 3 funded specialty doctors remain vacant 5. Numerous outreach day surgery and clinics involve significant travel times and absence from Craigavon Hospital site 6. Engagement between primary and secondary care has been limited. The development of regionally agreed care pathways has not been fully instituted or adopted by referring services in primary care and A&e. 7. Administration time for consultants is significant and is not reflected in their job plans. There is a particular worry in delays in consultants to consultants referrals, MDT referrals and triage	
07.05.2014	Email from Ms Reddick to Consultants	Re: CT Delays Delays noted in red flag patient pathways due to no bloods being done prior to requests for CT chest, Colonoscopy and Urogram.	TL5 page 569 AOB-70731
12.05.2014	Email from Ms McMahon to Mr Young	Re Departmental meetings To give consideration to the following ahead of meeting: 1. Haematuria Service 2. Prostate Biopsy 3. LUTS service 4. General Outpatient/uro-oncology clinics 5. Improving appointments for review patients by reducing unnecessary visits 6. Uro-oncology review strategy	TL5 page 570 AOB-70732
13.05.2014	Email from Mr O'Brien to Ms Nelson	Re: Urology Staff meeting Mr O'Brien requests a meeting to consider and discuss the issues surrounding preoperative assessment and notification of admission	TL5 page 571 AOB-70733
17.05.2014	Email from Mr Suresh to Mr Williams	Re Delay in Reports Noticed a delay in receiving reports… more than 6 weeks after they were reported. I am sure you would agree that this delay is unacceptable	TL5 page 624 AOB-70786
21.05.2014	Email from Mr Young to Consultants	Re Urology Meeting Notes that he wants to discuss the following 1. Pathway for TROC within the trust 2. Define a pathway for the outstanding review Outline the set up for the future Thursday Meetings	TL5 page 625 AOB-70787
22.05.2014	Email from Ms Reddick	Enclosing *"A Guide for Northern Ireland Cancer Access Standards"* which highlights waiting time standards	TL5 page 626 – 659

	to Consultants		AOB-70788 - 70821
24.05.2014	Email correspondence between Mr Duggan and Others	Re: Urology Reconstruction Deeply disappointed that he is recommending that urology reconstruction is exported to England. He seems to think the numbers are small and we cannot provide a local service. … If we don't fight this draft document, we can say goodbye to surgical procedures that we have been doing successfully for many years. ..	SUP 307 – 308 AOB-03803 - AOB-03804
25.05.2014	Email correspondence between Mr O'Brien to Mark Fordham	Re Report of Stock Take of Regional Review of Adult Urological Services in Northern Ireland Mr O'Brien raised the following issues 1. Concept of ignoring or transgressing Trust Board boundaries did have merits and continues to do so e.g. Southern Trust assumed provision of urological services for County Fermanagh since January 2013…. Appreciate how critically distance is for a proportion of patients needing care – not fully appreciated by decision makers in Belfast. 2. Three team model simplistically and naively glossed over some significant inadequacies. The greatest inadequacy being the lack of urological services based at Antrim Area Hospital. 3. There has been a lack of urgency or commitment to the establishment of an adequate service based at Altnagelvin Area Hospital. Believe this too should be a funding priority. 4. Issue of amalgamated on-call arrangements by Team East is a no brainer. 5. The future provision of Female Urological, Reconstructive and prosthetic surgical services. 6. There is an inadequacy of theatre capacity everywhere. Utilisation of available theatres had been increased by ourselves and other specialities at Craigavon Area Hospital in recent years by extended days and operating on Saturdays. It has been my experienced that the balance between operating and other activities has changed remarkably over these past two decades… appointing new consultants will not necessarily solve the waiting times for surgery. I believe the Trust could increase theatre utilisation even further. 7. Radical prostatectomy shown to enhance operative ease, visulisation and perioperative outcomes, there has been no evidence to date of improved oncological outcomes. 8. Agree with your views on SABA etc. With current system, if it cannot be counted, it cannot be allowed to take place, and that does indeed stifle innovation…. Slavish adherence to BAUS recommendations made over a decade ago has been equally torturing and stifling of innovation 9. Clinical Research fellows to attract trainees to urology 10. Inadequacy of time within job plans for administration generally, and for leadership roles in particular. Results will not be achieved with goodwill and a shoe string alone.	SUP 312 – 314 AOB-03808 - AOB-03810
25.05.2014	Email from Ms	Re: Haematuria clinic	TL5 page 669 – 670

	Corrigan to Consultants	Average of 7 referrals per week from April and patients being booked into D14. Notes that this was good news and looked like referral work was paying off	AOB-70831 – AOB-70832
28.05.2014	Email from Mr Young to Consultants	Re July rota	TL5 page 673 – 675 AOB-70835 – AOB-70837
31.05.2014	Email from Mr Suresh to Consultants	Suggestion to bring in a "one stop haematuria clinic"	TL5 page 683 – 693 AOB-70845 – AOB-70855
June 2014	Cancer Performance Dashboard Report	**Day 62 Inter trust transfer breachers** Urology – 2 (in June) **Internal breaches – day 62** Urology – 8 (in June) **Day 31 breaches** Urology – 1 (in June) Describes delays due to waiting lists, delays in MRI reports, delay in MDM discussions etc **Referral suspect June 2013 – 2014 (62Day)** Urological cancer – 107 (June 2014) **Referral suspect June 2013 – 2014 (31 day)** Urological cancer – 44 (June 2014) **Confirmed cases – 62 Day** Urology – 17 (June 14) **Confirmed cases – 31 days** Urology – 13 (June 14)	TL5 page 1065 – 1104 AOB-71227 – AOB-71266

		Breach reasons – Delay in surgery, long waits for CTs, PETs etc, waiting lists,	
03.06.2014	Email from Ms Corrigan to Consultants	Re PTL cancer 62 day pathway Approx. 20 patients breaching 62 day.	TL5 page 638 – 701 AOB-70860 – AOB-70863
04.06.2014	Email from Ms Glenny to Consultants	Offering dates for additionality	TL5 page 703 – 705 AOB-70865 – AOB-70867
04.06.2014	Email correspondence between Martina Corrigan and others	Re Capacity and additionality Email from Martina Corrigan in relation to obtaining an up to date position of where anticipate will be regarding waiting times and SBA for end of September. Looking for confirmation of annual leave to work out capacity.	SUP 319 AOB-03815
06.06.2014	Email from Ms Corrigan to Consultants	Re: Follow ups from urology meeting to address backlogs 1. Looking at cancer targets and bringing patients back to within the 31/62 day pathway by end of July 2014 2. Look at where we will be by end of September with the long-waiting patients sitting on the PTL, the aim is that we should be in the same position as we were at end of March which was 69 weeks, however as discussed today we will be sitting with 77 patients over this time frame. I am going to validate these patients to ensure that they are fit and if they need their surgery etc and then we need to start giving dates to the longest waiting patients, so at least we can give Debbie and the Board an idea of where we will be at the end of September 3. Review backlog. The target is that by the end of September all 2011 and 2012 patients will have an outcome.. I have started on 2011 and I am going through these for "admin" errors… Once I have this finished I will look at 2012 for Aidan and Michael's in the first instance and do the same exercise for this. Just to advise on what I have done to date I have a 10% discharge due to admin errors so I do feel this has been a worthwhile exercise 4. Can you please let Sharon and I know your availability for Saturday's during July/August and September to see patients Innovation and Implementation of ideas...	TL5 page 706 – 707 AOB-70868 – AOB-70869
09.06.2014	Letter from Trust in response to patient	Re Complaint from Mr [redacted] Notes that Mr O'Brien is aware of the patient but at present patients in urology who are not categorized as very urgent patients are regrettably having to wait longer for their procedures.	TL5 page 1192

10.06.2014	Email correspondence between Mr Carroll, Ms Corrigan and Mr Young	Re: Nursing assistants in theatres Issue with not having juniors available to assist in theatres e.g. holding cameras etc.	TL5 page 758 – 764 AOB-70920 – AOB-70926
12.06.2014	Email from Ms Corrigan to Consultants	RE: 62 day active LW & Breaches Urology longest wait SHSCT (02 April : 138) (28 May: 126). No. over 62 days SHSCT (02 April : 20) (28 May: 15)	TL5 page 767 – 770 AOB-70929 – AOB-70932
12.06.2014	Email correspondence between Ms Corrigan, Ms McVey, Ms Burns, Ms Trouton, Ms Stinston, Mr Caldwell and Ms Corrigan	AOB sends Sharon Glenny and Martina Corrigan list of patients on his waiting list for "*cancer or investigation of possible cancer."* List includes 36 patients from 19 April 2013 to 30 May 2014. Martina Corrigan write to Debbie Burns advising her that Aidan is "*fully supportive of the direction that we are trying to achieve."* She notes that he is "*now put this in writing (not like him)."*	Doc File 1 pages 720 – 721 AOB-00720 - AOB-00721
13.06.2014	Email from Ms Corrigan enclosing letter from Acute Services Directorate Management Review	Notes the capacity and demand issues and the challenges the Trust are facing	TL5 page 771 – 791 AOB-70933 – AOB-70953
19.06.2014	Urology MDT Operational Policy Brief for the AGM enclosing draft Operational Policy for Urological Cancer Service	This includes a historic review of urology cancer service. Points arising from it include the following:- 1. In 2011 the Trust covered a population of 362,711. 2. Team South for urology services had an increased population of 423,885. 3. An MDT had been established in 2010 (following review of adult urology services in 2009). 4. Clinical Lead was initially Mr Akhtar from April 2010 to March 2012. Since 2012 the Clinical Lead for the MDT and Chair of the MDT has been Mr O'Brien. 5. Bullet points are noted of the various improvements made under the MDT. On page 12 there is a detailed of responsibilities for MDT Lead.	Doc File 1 pages 734 – 757 AOB-00734 - AOB-00757

		Confirms that there are "*currently two clinical nurse specialists"* and outlines their roles and responsibilities (pages 14 and 15).	
23.06.2014	Email from Ms Corrigan to Consultants	Re: Urgent waiting list and requesting whether anything consultants can do to reduce these waiting lists Mr Young – 49 pts (24/2/14) Mr O'Brien – 26 pts (15/1/14) SWAH – 38 pts (12/12/13) Mr Glackin – 51 pts (14/2/14) Mr Suresh – 24 pts (27/1/14) Mr Haynes – 2 pts (31/5/14) Prostate – 16 pts (23/1/14) LUTS – 14 pts (13/2/14)	TL5 page 868 AOB-71030
26.06.2014	Email from Ms Corrigan to Consultants	Re: Haematuria Spreadsheet showing that referral demand has been down the last couple of weeks and 1st appointment is approx. day 18-20	TL5 page 880 – 910 AOB-71042 – AOB-71072
26.06.2014	Email from Ms Dignam to Consultants	Re August rota	TL5 page 911 – 914 AOB-71073 – AOB-71076
27.06.2014	Email from Mr Haynes to Consultants	Re: Follow up from meeting with Dean Sullivan "*It is clear that we cannot work to meet demand as it is at present without huge capacity expansion."* *Mr Haynes thoughts on demand and capacity management and what is needed ASAP to deliver an adequate vision* 1. *Demand management – Male LUTS, Female Luts, UTIs, Loin Pains, Peno-Scrotal, ED, Fertility, Red flags* 2. *Capacity management*	TL5 page 915 – 917 AOB-71077 – AOB-71079
02.07.2014	Email from Ms McMahon to Mr O'Brien	Request for Mr O'Brien to reschedule his clinic as no nursing staff available	TL5 page 933 AOB-71095

03.07.2014	Email from Ms Glenny to Consultants	Re: Urology Long waiters at 02 July 2014 List reports patients greater than 80 weeks by end of September if don't get them scheduled. 21 patients of AOB 14 patients of MY 1 patient of AG	TL5 page 935 – 937 AOB-71097 – AOB-71099
04.07.2104	Letter from Debbie Burns	RE: Urology Moderinsation Notes the ongoing challenges faced to deliver timely patient-centered urological care. Requests the trust to bring forward proposals for 1. Maximising potential of all clinical job plans 2. Maximising the potential for skill mix between clinical groups 3. Introducing more effective and streamlined service delivery arrangement through the application of process mapping and service improvement techniques 4. Ensuring that all other aspects of best practice are appropriately reflected 5. Maximising linkages to primary care to raise awareness, ensure appropriate referrals and patient pathways "without prejudice" to the proposals to be brought forward by the Trust	TL5 page 939 – 941 AOB-71101 – AOB-71103
06.07.2014	Email correspondence between Mr O'Brien, Mr Haynes and others	Email exchange between Southern Trust Urologists in relation to resourcing and trying to get more work carried out at GP level. Some debate in relation to the number of new referrals per year either 4,900 or 5,900.	Doc File 1 page 771 – 772 AOB-00771 - AOB-00772
06.07.2014	Email from Mr O'Brien	Mr O'Brien raises issues 1. Greatest challenge is to implement changes designed to reduce referrals so that our capacity has some chance of meeting it. 2. First priority is to have general practitioners investigate and management much greater numbers of patients in primary care 3. Should not be considering the one-stop clinic as an alternative to maximising the investigation and management of patients in primary care. 4. Have GPs carry out investigations before referral e.g. if 60 year old man presents to GP reporting frank haematuria, then the GP will request a CTU amongst other investigations.	SUP 324 – 326 AOB-03820 - AOB-03822

		5. Lower some of your suggested thresholds for referral e.g. would hope that no man would have to have a residual volume of 500mls before having the benefit of balder outlet.	
07.07.2014	Email from Ms Corrigan to Consultants	Request to help other Trust who are struggling with capacity issues. Ms Corrigan notes that the SHSCT urology department are already having problems meeting their own targets	TL5 page 942 – 944 AOB-71104 – AOB-71106
07.07.2014	Email from Ms Glenny to Consultants	Re Top 10 longest waiters urology cancer patients pathway	TL5 page 945 – 960 AOB-71107 – AOB-71122
08.07.2014	Email from Mr O'Brien to Mr Haynes	Mr O'Brien provides his views and comments on Mr Haynes emails in relation to Debbie Burns "Vision for urology"	TL5 page 966 – 968 AOB-71128 – AOB-71130
08.07.2014	Email correspondence between Ms Corrigan, Mr O'Brien and ors	Email from Martina Corrigan to Urologists at Southern Trust. "*Dear All* *You will have seen an email from Debbie that Dean has requested for a follow-up meeting for the end of July, beginning of August, to discuss the way forward and our 'vision' so it is very important that we take time out to discuss all the points raised by Mark and Aidan (Michael I do not have a copy of your thoughts) so that we are fully prepared for this meeting.* *As per Mark's suggestion can we use as much of this and next Thursday AM as possible for this work?* *Can you advise what time we can start and I will organise a room?"*	Doc File 1 pages 773 – 775 AOB-00773 - AOB-00775
10.07.2014	Email from Ms Reddick to Ms Boyd and Others	Delays in suspect cancer patient pathway (62 day) due to unavailability of up to date GFR prior to CT Scan	TL5 page 974 AOB-71136
11.07.2014	Email from Ms Corrigan to Consultants	Re: 62 Day active Longest waiters Urology SHSCT – Longest wait (02 April: 138), (28 May: 126), (25 Jan: 111). Number over 62 day (02 April: 20), (28 May: 15), (25 Jan: 20)	TL5 page 976 – 980 AOB-71138 – AOB-71142
12.07.2014	Email from Ms Corrigan to Consultants	RE: Cancer Performance Update Notes that the dept are going in the right direction.	TL5 page 983 – 990 AOB-71145 – AOB-71152
13.07.2014	Email from Mr Suresh	Enclosing his "vision for urology"	TL5 page 991 – 993

	to Consultants		AOB-71153 – AOB-71155
16.07.2014	Email from Ms Elliot to Mr O'Brien	Re: PATEINT QUERY Patient wanted date for surgery has been on waiting list from March 2013	TL5 page 1001 AOB-71163
17.07.2014	Email from Ms Corrigan to Consultants	Request to carry out additionality as Mr Suresh is off and his patients should not be allowed to wait	TL5 page 1002 – 1004 AOB-71164 – AOB-71166
17.07.2014	Email from Ms Corrigan to Consultants	Re: Her "vision for Urology" Noted that always concentrated and getting sucked into detail of a few areas and then other areas suffered and ended up getting nothing right. 1. Looking at ways to do things differently to reduce our capacity requirement and as discussed this can be through referral management 2. Looking at our service delivery management for elective and emergency care 3. Elective – how to deliver inpatients and daycases within the constraints of the current available theatre space and this includes looking at all sites 4. Non-elective as discussed this is challenging and a model needs to be implemented that will help with this challenge 5. Need to ensure that the model in place has on-going capacity management and planning to ensure that once implemented we continue to meet demand and that we clear and don't go back into a backlog situation Will need to consider infrastructure and staffing requirement s	TL5 page 1005 – 1006 AOB-71167 – AOB-71168
17.07.2014	Email from Ms Corrigan to Mr O'Brien and Mr Young	RE: LUTS clinic noting that when referring for Kathy to see a patient as a joint consultation/LUTS, it will be at least March 2015 before they will be offered an appointment due to patients currently on waiting list	TL5 page 1008 – 1010 AOB-71170 – AOB-71172
18.07.2014	Email from Mr Haynes enclosing minutes of Urology Meeting re "vision"	Meeting dated 10 July 2014 Main challenge is that patients are waiting too long for their care. Receive an average of 416 new outpatient referrals per month while we are only currently delivering 366 new OP appointments per months. For inpatients/day case surgery we list approx. 160 hours of operating per month while capacity to deliver is 140 hours per month. The demand vs capacity is therefore 50 new referrals per month and 20 hours operating.	TL5 page 1016 – 1022 AOB-71178 – AOB-71184

		This does not account for follow up outpatient reviews or the ESWL, flexible cystoscopy or urodynamics waiting lists. The current total backlog stands at: 1390 new outpatients without appointments 802 patients listed for IP or day case procedure 3600 FU appointments pending Tasked by the board to do the following: 1. Deliver a sustainable service 2. Is based on efficient models of care 3. Maximises available capacity 4. Maintains acceptable, equitable waiting times 5. Incoorporates planning for delivery of increasing demand 6. Identifies what additional resource is required to deliver this service 7. Identifies risk which pose a threat to delivery of the vision Notes that previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed that the board want us to look to re-examine the entire urology service and redesign but that the board expects us to fail to deliver its requests and anticipates us to return with one or two ideas that ultimately fail to deliver real change.	
18.07.2014	Email from Mr Young to Ms Corrigan	Re Urology Vision Pathway Draft of pathway - notes the capacity and resource issues	TL5 page 1023 – 1024 AOB-71185 – AOB-71186
18.07.2014	Email from Mr O'Brien to Mr Haynes	Response to Urology vision Mr O'Brien queried whether the principal challenge facing SHSCT urology is that patient are waiting too long their care. Mr O'Brien noted that he would have thought that is was a consequence of its causes, which could include a disparity between demand and capacity as well as inefficiencies in the use of capacity.	TL5 page 1026 – 1027 AOB-71188 – AOB-71189
18.07.2014	Email from Ms	Organising an additional session for Mr O'Brien to see his patients	TL5 page 1028 – 1030

	Corrigan to Mr O'Brien		AOB-71190 – AOB-71192
21.07.2014	Email from Ms Corrigan to Mr O'Brien	Re Patient surgery red flag Patient queried when his date for surgery would be as has been on waiting list from Jan 2014. It was explained to him that the demand of the urology service and have been scheduling extra sessions to address the lengthy waiting times. Ms Corrigan wondered if Mr O'brien could fit patient in or whether another consultant should fit him in	TL5 page 1032 – 1033 AOB-71194 – AOB-71195
24.07.2014	Email from Ms Corrigan to Mr O'Brien	Re 40 day cancer PTL lists Approx 104 patients with longest waiting 157 (?weeks/days)	TL5 page 1044 – 1060 AOB-71206 - AOB-71222
24.07.2014	Email from Ms Corrigan to Consultants	Re Cancer Performance at end of month shows that the department are improving	TL5 page 1107 – 1110 AOB-71269 – AOB-71272
29.07.2014	Email from Ms Dignam to Mr O'Brien	Re: Patient query Patient wanted date for surgery as been on waiting list from May 2013. Ms Dignam advised that all urology waiting lists are significantly behind	TL5 page 1120 AOB-71282
29.07.2014	Email from Mr O'Brien to Ms Corrigan	Re: Additionality Mr O'Brien noted that he had to carry out an additional session in Thorndale. He had not previously passed it by Ms Corrigan	TL5 page 1122 AOB-71284
31.07.2014	Email from Ms Corrigan to Consultants	Re: Hamaturia Clinic Spreadsheet Sets out the breachers and how far along their pathway. Also notes reasons for delay causing breach e.g. Late triage	TL5 page 1124 – 1155 AOB-71286 – AOB-71317
01.08.2014	News Release BBC Talk Back	Urology Patient complaint – BBC Talkback *"The Trust recently advised this patient that her surgery would take place in September and that a final letter would be sent confirming the exact date as soon as the schedule had been finalized.*	TL5 Page 1159 – 1161 AOB-71321 – AOB-71323

		The September schedule is currently being finalized and letter will be issued to patients confirming surgery dates today. *As our Urology Service is experiencing very high levels of demand, we are having to prioritise cancer cases at this time.* *We apologise to any patients who are waiting longer than we would wish for their procedure"*	
01.08.2014	Email from Ms Corrigan to Consultants	Re: Cancer Performance update Longest waiter (day) for 1st appointment week ending 31 July 2014 **Urology cons led = 20** **Urology Haematuria = 29** **Urology prostate = 15**	TL5 Page 1162 – 1165 AOB-71324 – AOB-71327
01.08.2014	Email from Ms Glenny to Mr O'Brien	Re Urology Longest Waiter as of 31 July 2014 Approx. 64 patients of Mr O'Brien with longest wait from December 2012 Approx 43 patients of Mr Young with longest wait from September 2012	TL5 page 1166 – 1184 AOB-71328 – AOB-71346
02.08.2014	Email from Ms Corrigan to Mr O'Brien	Re: Capacity planning Mr Corrigan lists a number of questions to work out capacity for each clinic	TL5 page 1185 – 1187 AOB-71347 – AOB-71349
05.08.2014	Email from Ms Dignam to Mr O'Brien	Re: Patient queries X 4 patients querying for dates for surgery/review. Longest waiting from May 2013	TL5 page 1195 AOB-71357
07.08.2014	Email from Ms Glenny to Mr O'Brien	RE: Carrying out an additional theatre session	TL5 page 1206 AOB-71368
08.08.2014	Email from Ms Glenny to Consultants	Re: Urology Elective Waiting Lists	TL5 Page 1208 – 1285

		Issue raised re patients "missing" from some patient centre waiting lists. This email also sets out the waiting list positions 52 week PTL: In total there are 116 patients waiting greater than one year. 66 of these patients, 4 patients have dated for surgery, 62 patients have no dates for surgery. The longest waiting urgent patient without a date is 86 weeks 50 of these patients are routine. 6 patients have dates for surgery, 44 patients have no dates for surgery and the longest waiting routine patient without a date is 81 weeks Total urgent waiting list: There are 547 patients waiting for an urgent elective procedure. 102 patients have a date for surgery. 445 patients do not have a date for surgery and the longest waiting patient without a date for surgery is 86 weeks. Note on urgent waiting list – 64 of patients are marked with method of admission as suspect cancer. May well be that not all of these patients are being tracked by the red flag team. However 24 of the patients marked as suspect cancer do not currently have a date for surgery and the longest waiter is 42 weeks. There are 241 patients on the planned waiting list for urology procedure with an expected date of admission of September 2014 or less. 75 Patients have a date for surgery (4 of these are now in the past and need updated by secretary) and 166 patients have no date for surgery with 100 of these patients for flex cycstocopy and 66 are for other urology procedures. **Planned Patients – Approx 56 patients of AOB** **Urgent waiting list – approx. 160 patients of AOB** **Longest waiters waiting over one year – Approx 31 patients of AOB**	AOB-71270 – AOB-71447
10.08.2014	Email from Mr O'Brien to Ms Corrigan	Discusses the benefit in responding to offering help to the Northern Trust but notes that SHSCT have enough on their plates	TL5 Page 1286 – 1287

	and Consultants		AOB-71448 – AOB-71449
12.08.2014	Email from Ms Dignam to Consultants	Re September rota	TL5 page 1291 – 1298 AOB-71453 – AOB-71461
14.08.2014	Email from Ms Corrigan to Consultants	Re: Capacity – enclosing document prepared by Mr Haynes re capacity planning of SHSCT Urology Dept	TL5 page 1303 – 1315 AOB-71465 – AOB-71477
17.08.2014	Email from Mr Young to Ms Corrigan and Consultants	Re: Capacity response Notes that the review backlog is historical and not a continuing issue. This was DOH main issue with SHSCT.	TL5 page 1320 – 1321 AOB-71482 – AOB-71483
17.08.2014	Email from Mr O'Brien to Consultants	Re: Capacity & reflections on the Sullivan Challenge. 1. Believe we should firstly wholly appreciate the potential significance of our Department/Service being given this opportunity to advise/influence/perhaps even dictate how it could/should be …. For 22 years it has been most difficult to impress upon authority the notion that those who provide the service may also be those best equipped to know what is required, and how it should be or could be provided. 2. I believe that we have been given a responsibility to design a service which will ensure that urological pathology and morbidity can be managed in future in an effective, safe and efficient manner, achieving outcomes which are better all around than they are today. 3. I believe the future design should therefore be based upon three conceptual planks: • Demand Management • Advanced triage • New clinic	TRU-01534 – TRU - 01539
17.08.2014	Email correspondence between Mr O'Brien, Ms Corrigan and Ors	Mr Young forwards an email to Martina Corrigan and others (including the Urologists) referring to the following:- 1. Information gathering a process which has been carried out. 2. A meeting with Mr Sullivan for fresh ideas to improve urology delivery on a timely basis which has been interpreted as new ways of being more efficient.	Doc File 1 pages 779 – 784 AOB-00779 - AOB-00784

		3. Notes that there is no new money. 4. Notes that major topics had to be discussed over summertime period for presentation to the Board which was not ideal. 5. Notes a fairly consistent "*monthly referral rate of 400+/- 50 cases."* 6. Considers that the data should be presented "*as it is"* rather than assumed demand reduction of 20%. 7. Suggestion that a one stop shop clinic was being put forward. Query what was it to include. 8. Suggests further analysis of statistics as he would "*hope that this would show the DOH that the review backlog is historical and not a continuing ongoing issue. This was one of their main issues with us."* 9. Notes a number of practical suggestions for work patterns. AOB responds in an email of 17 August including the following points:- 1. This is the first opportunity since 1992 for input into how the service should be. Notes how previous plans were "*undermined by Clinical Director, Medical Director, Director of Acute Services, Chief Executive Director of Public Health and Board."* 2. Notes that the purpose is to design a service which will be provided by both primary and secondary care. 3. Notes the need for the design to include the "*need for sanity of care."* 4. Considers that "*the management"* is a foundation in which the service can be sustained. 5. Comments on the possibilities of a new clinic and limitations in relation same. "*I believe that advance triage will be the essential bridge between successful demand management and the successful, effective, safe and efficient delivery of outpatient consultation and procedural assessment/investigation such as flexible cystoscopy, biopsies and urodynamic studies.* *I also believe that if we are capable to determining pathways for assessment and management in primary care, we should also be equally capable of designing pathways for effective, safe and efficient triage, so that the bulk? all of triage could be conducted by Nurse Specialists, rather than consultants, one of the latter always available whilst urologist of the week to advise."* *"…. I hope I have made myself clear; demand management and advanced triage will have ensured that all that can be done as an outpatient prior to arrival at our Department will already have been done……."* *"I am passionately of the view that we have not yet grasped the potential impact of demand management, advanced triage and then single visit assessment could have on our Department.* *I do believe that it could certainly stall and hopefully reverse the mitigation of consultant time being increasingly consumed in outpatient services,*	

		rather than operating, and which has occurred progressively over the past twenty years…….. *The first and overriding priority of every clinician of the week is the provision of round the clock emergency care. It is therefore impossible to provide emergency care if you have a fixed commitment elsewhere in the hospital or in any other place."* Makes a number of comments in relation to how to manage this service. Notes how "*we have been talking about Urologist of Week for years".*	
18.08.2014	Email from Mr O'Brien/Mr Glackin to Ms Corrigan and Consultants	Re: Capacity response Mr O'Brien provides his comments and concerns for the capacity plan. He also highlights the he believes triage should involve initial contact with the patient by telephone to advise the next steps. He notes that he believes advanced triage will be the essential bridge between successful demand management and the successful, effective, safe and efficient delivery of outpatient consultation and procedural assessment/ investigation. Mr O'Brien also notes the expectations on urologist of the week and how he argued against this notion years ago and does still for the same reasons.	TL5 page 1322 – 1329 AOB-71484 – AOB-71491
19.08.2014	Email from Ms Dignam to Mr O'Brien	RE: Patient query Patient's mum called re surgery which he has been on waiting list from June 2014. Ms D explained to patient that Mr O'Brien's waiting lists are extensive. Patient's mum demanded to talk with Mr O'Brien	TL5 page 1330 AOB-71492
19.08.2014	Email from Ms Burns to Ms Corrigan and Consultants	Re: Capacity plan Reference to presentation of the capacity plan from Urology. Notes that it is exciting and will throw up some big challenges from the NI system which absolutely need tackled	TL5 page 1331 AOB-71493
20.08.2014	Email from Ms Corrigan to Consultants	Last minute additional all day theatre session for Saturday	TL5 page 1333 AOB-71495
22.08.2014	Email from Mr Suresh to Mr O'Brien	Notes that Mr O'Brien is on annual leave but is "working even harder during holidays"	TL5 page 1336 AOB-71498
26.08.2014	Email from Mr O'Brien to Mr Haynes and Consultants	Re: Response to Mr Haynes email re day case surgery and urologist of the week. Mr O'Brien notes that he will not agree to any kind of elective, fixed commitment whilst on call.	TL5 page 1338 – 1346 AOB-71500 – AOB-71508
26.08.2014	Email from Mr Haynes	Re: Response re Day surgery and urologist of the week	TL5 page 1347 – 1357

	to Mr O'Brien		AOB-71509 – AOB-71519
28.08.2014	Email from Ms Glenny to Mr O'Brien	Re: Transferring long waiting patients to Mr O'Donoghue who has now started	TL5 page 1358 – 1370 AOB-71533 - AOB-71539
31.08.2014	Email from Ms Corrigan to Consultants	RE 62 Day active longest waiters Notes that they are doing really well. **Urology SHSCT** July longest wait: 154 August longest wait: 88 Num over 62 days July : 6 Num over 62 days August: 4	TL5 page 1374 – 1377 AOB-71536 – AOB-71539
03.09.2014	Email from Ms Corrigan to Consultants	Re Meeting To discuss the pilot on 3 doctor clinic and move urologist of week to being all day. Want to meet to discuss the logistics of this.	TL5 page 1380 AOB-71542
03.09.2014	Email from Mr O'Brien to Ms Corrigan and Consultants	Re: Meeting Mr O'Brien notes that he is concerned at the lack of implementing the Transforming Cancer Follow Up pathways. He highlights that the long backlog in prostate cancer reviews needs to be addressed asap.	TL5 page 1381 AOB-71542
03.09.2014	Email from Mr Young to Consultants	Re October Rota	TL5 page 1382 – 1386 AOB-71544 – AOB-71548
04.09.2014	Trust 2014/2015 Financial Contingency Plan	Notes the financial pressures and asks to minimize travel and training. Highlights the extensive media coverage of the extreme financial pressures facing the health service.	TL5 page 1390 – 1394 AOB-71550 – AOB-71556
09.09.2014	Email from Ms	Re: Extended theatre days	TL5 page 1404

	Corrigan to Consultants	Wanted to organise to discuss these as cannot have 12 hour operating days and the extended days will need to be split	AOB-71566
11.09.2014	Email from Ms Corrigan to Mr O'Brien	Notes that she knows Mr O'Brien is under so much pressure with admin work but highlights that the outstanding triage is being escalated	TL5 page 1427 AOB-71589
11.09.2014	Email from Ms Corrigan to Consultants	Re: New Urgent urology waiting lists Notes the following on urgent waiting lists **Mr Young = 44 (4/3/14 longest waiter)** **Mr O'Brien = 18 (10/2/14 longest waiter)** **Mr Glackin – 56 (24/3/14 longest waiter)** **Mr Suresh = 27 (11/4/14 longest waiter)** **Mr O'Donoghue = 10 (7/7/14 longest waiter)** **Mr Haynes = 19 (2.6.14 longest waiter)** **LUTS = 11 (26/6/14 longest waiter)**	TL5 page 1428 – 1429 AOB-71590 – AOB-71591
16.09.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient on waiting list from September 2013 and has had catheter in since July 2014 and would like to be seen as soon as possible	TL5 page 1433 AOB-71595
17.09.2014	Email from Ms Elliot to Mr O'Brien	Request for overbooking clinic	SUPOCT Page
03.10.2014	Email from Mr Hall to Ms Clayton	Re: Imaging waiting times USS waiting lists – 13 weeks (routine), 8 weeks (urgent), 4 weeks for ultrasound with biopsy & 1.5 weeks without biopsy Mr Hall notes that that 4 weeks for a red flag is outside of the guidelines	TL5 page 1479 – 1494 AOB-71641 – AOB-71656
03.10.2014	Email from Mr McKeveney to Ms Clayton	Re Imaging waiting times Notes that he would be embarrassed to tell my patient this is the best the Southern Trust can do. I don't buy the argument that money is tight – we all know the consequences of a delayed diagnosis: it inevitably leads to increased expenditure.	TL5 page 1484 – 1487 AOB-71646 – AOB-71649
06.10.2014	Email from Mr McKeown	RE: Imaging waiting times	TL5 page 1501 – 1503

	to Ms Clayton	Notes that this is simply unacceptable. Cannot keep patients in plaster for 12 weeks, give them enoxaparin and find out 12 weeks later that they had no fracture. If cannot get imaging in a timely fashion as an outpatient, we shall have to admit these type of patients	AOB-71663 – AOB-71665
07.10.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient's mother rang re date for surgery which patient has been on since March 2013	TL5 page 1512 AOB-71674
08.10.2014	Email from Ms Corrigan to Consultants	Re Haematuria clinics Currently 12 patients on haematuria waiting list and Ms Corrigan requests that the Consultants consider a way to address that as will go back to appointing over day 27 and not meeting targets	TL5 page 1513 – 1514 AOB-71675 – AOB-71677
12.10.2014	Email from Mr Hall to Ms Corrigan	Re issues with E-Discharge and noting that whole system needs reviewed	TL5 page 1524 – 1528 AOB-71689– AOB-71690
13.10.2014	Theatre start time audit		TL5 page 1541 – 1543 AOB-71703 – AOB-71705
13.10.2014	Email from Mr Haynes to Consultants	Re Fluid Management System and TURPS Notes that equipment is not fit for purpose	TL5 page 1544 – 1547 AOB-71706 – AOB-71709
14.10.2014	Email from Ms Elliot to Mr O'Brien	Re: patient query Patient awaiting date for surgery which was due in January 2014.	TL5 page 1564 AOB-71726
15.10.2014	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re removal of stent which should have been done in April 2014	TL5 page 1568 AOB-71730
15.10.2014	Email from Mr O'Brien	Query if Mr Young can see a patient as Mr O'Brien is at full capacity	TL5 page 1570

	to Mr Young		AOB-71732
16.10.2014	Email from Ms Corrigan to Consultants	Re: Haematuria escalations Notes that there are 14 patients outstanding appointments	TL5 page 1572 – 1578 AOB-71834 – AOB-71740
16.10.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient on waiting list from October 2013 and wanted to know if there was a date for him	TL5 page 1579 AOB-71741
16.10.2014	Email from Mr O'Brien to Ms Corrigan	Mr O'Brien provides a suggestion on how to add some haematuria clinic patients to the admission lists	TL5 page 1581 – 1587 AOB-71743 – AOB-71749
20.10.2014	Email from Mr McMahon to Consultants	Re: Scheduling Highlights that need a new strategy to scheduling clinics and diagnostic services for Thorndale to maximize productivity. At times clinics are half booked or not booked at all or patients turn up.	TL5 page 1590 AOB-71752
22.10.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient wanted her CT scan referral changed to urgent as was advised of 24 week wait for CT scan	TL5 page 1591 AOB-71753
22.10.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient on waiting list from October 2013 and is now getting more symptoms	TL5 page 1593 AOB-71755
23.10.2014	Email from Ms Corrigan to Ms McAloran	Re patient query for date for surgery Ms Corrigan noted that waiting times are continuing to increase for non cancer patients	TL5 page 1596 – 1598 AOB-71758 – AOB-71760
24.10.2014	Email from Ms Corrigan to Consultants	Re: Longest red flag waiters Urology cons led – 14	TL5 page 1600 – 1602 AOB-71762 –

		Urology Haematuria – 18 Urology prostate – 15	AOB-717764
24.10.2014	Email from Ms Corrigan	Re Haematuria Clinic Spreadsheet	TL5 page 1603 – 1632 AOB-71765 – AOB-71794
26.10.2014	Email from Ms Corrigan to Consultants	Re Dictation Backlogs	TL5 page 1643 – 1644 AOB-71805 – AOB-71806
26.10.2014	Email from Ms Corrigan	Notes that extended theatres are to start from 01 December 2014	TL5 page 1651 AOB-71813
27.10.2014	Email from Mr O'Brien to Ms Corrigan	Re Backlog of discharges applicable to all consultants Mr O'Brien highlighted that he as not got access to e-discharge and does not know what IMMIX is.	TL5 page 1678 – 1687 AOB-71840 – AOB-71849
28.10.2014	Email from Ms Cox to Mr O'Brien	Re Patient queries X9 patient messages re dates for surgeries. Some dates back to March 2013 for waiting times	TL5 page 1740 AOB-71902
31.10.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient on waiting list from October 2013 and wondering when would get a date	TL5 page 1744 AOB-71906
31.10.2014	Email from Ms Cox to Consultants	Re November Rota	TL5 page 1745 – 1748 AOB-71907 – AOB-71910
Oct – Dec 2014	Northern Ireland Waiting Time Statistics	Generally waiting times are not meeting targets	TL5 Page 767 – 812 AOB-72959 – AOB-73007

03.11.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient's NOK ringing as patient was due to have check cystoscopy following 6 week course of BCG which was due in July 2014	TL5 page 1749 AOB-71911
04.11.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient ringing as on waiting list from December 2013 and would like a date as PSA rising	TL5 page 1750 AOB-71912
04.11.2014	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's GP ringing re date as on waiting list and due review appointment in June 2014 and noted that MDM said she would be reviewed in May 2014 but neither has happened	TL5 page 1751 AOB-71913
05.11.2014	Email from Ms Trouton to Consultants	Re: URO 80 week PTL Highlighting that whilst making great strides in cancer targets, all other waiting times are going out. Sitting at 80 – 85 weeks for sometime but this has now gone to 90 weeks and if don't address this the waiting times for urology will soon be over 2 years which is not great. Total 39 patients Mr Glackin – 1 Mr O'Brien – 28 Mr O'Donoghue – 1 Mr Young – 9	TL5 page 1752 – 1759 AOB-71914 – AOB-71921
07.11.2014	Email from Ms Burns to Consultants	Reference to trying to obtain funding to address uro 80 week PTL	TL5 page 1762 AOB-71924
12.11.2014	Email from Ms Corrigan	Re Few thing – Ms Corrigan notes some matters of concern for her 1. Another meeting planned with GPs on 4 December and haven't finalized guidance 2. Talked about pros and cons of consultant of the week but need Aidan and John's thoughts 3. Areas that would like feedback re changes – Consultant of week, ward rounds, triage, new clinics, acute clinics, extended theatre day	TL5 Page 1798 - 1799 AOB-71960 – AOB-71961

		4. Funding for nursing staff in Throndale. 5. PTL long waiters – had a difficult meeting with Debbie and Heather. Want the list addressed and a plan put in place for longest waiters. Understand the pressures everyone is under and knows that there is a big emphasis on cancer patients but need these lists back to 80 weeks. Notes the financial constraints of the health service and whilst there is no money for additionality or patients to be sent to independent sector, there is still a monitoring of waiting times and therefore chronological management will be a big focus with HSCB now. Important that address long waiters.	
12.11.2014	Email from Ms Elliot to Mr O'Brien	Notes that a patient's admission was cancelled as no bed was available	TL5 page 1802 AOB-71964
14.11.2014	Email from Ms McMahon to Ms Corrigan	Noting that urodynamics equipment had stopped working and have had to cancel all patients	TL5 page 1805 AOB-71967
14.11.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient querying for date of surgery as been on waiting list since July 2014	TL5 page 1806 AOB-71968
14.11.2014	Email from Ms Corrigan to Consultants	Re December Schedule	TL5 page 1808 – 1812 AOB-71970 – AOB-71974
14.11.2014	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient querying date for surgery as been on waiting list since October 2013	TL5 page 1822 AOB-71984
26.11.2014	Email from Ms Browne to Mr O'Brien	Request for overbooking his clinic as it is at full capacity but Mr O'Brien declined this	TL5 page 1859 AOB-72021
27.11.2014	Email from Ms Glenny to Consultants	Re Urology Planned patients – expected admission date on year in past X2 patients of AOB 1x MY 1x JOD	TL5 page 1867 – 1869 AOB-72029 – AOB-72031

28.11.2014	Email correspondence between Mr O'Brien and Ms Corrigan	Re Urodynamics equipment Mr O'Brien raised his concerns over the purchase of this equipment and Ms Corrigan provided her reasoning for how the equipment was purchased.	TL5 page 1874 - 1882 AOB-72036 – AOB-72044
02.12.2014	Email from Mr O'Brien to Mr Young	Re Rota for on call Mr O'Brien notes that he is on call 10 days, Mr Suresh, 9 days, Mr O'Donoghue, 5 days, Mr Haynes, 4 days, Mr Glackin, 3 days and Mr Young 0 days. In 6 months July – December Mr O'Brien was on call 37 days, Mr Suresh, 37 days, Mr Haynes, 33 days, Mr Young 31 dyas, Mr Glackin, 27 days and Mr O'Donoghue 19 days Mr O'Brien believes that there is a pattern which needs addressed	TL5 page 1887 AOB-72049
02.12.2014	Email from Mr Young to Consultants	Re December rota	TL5 page 1888 – 1893 AOB-72050 – AOB-72055
03.12.2014	Email from Mr O'Brien to Mr Young	Mr O'Brien notes that he finds it difficult to justify the oncall rota for Jan	TL5 page 1098 AOB-72070
03.12.2014	Email from Mr Young to Mr O'Brien	Mr Young responds to Mr O'Brien's oncall concerns	TL5 page 1909 – 1912 AOB-72071 – AOB-72074
11.12.2014	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list since Feb 2014 and now attending A&E due to blockage with catheter	TL5 page 1931 AOB-72093
11.12.2014	Email from Ms Corrigan to Consultants	Re Haematuria Spreadsheet Noted that average of 8 haematurias per week for month of Nov with a booking to day 9.	TL5 page 1932 – 1966 AOB-71094 - 72128

15.12.2014	Email from Ms Dignam to Consultants	Re Jan Rota	TL5 page 1972 – 1976 AOB-72134 – AOB-72138
15.12.2014	Emal from Ms Glenny to Consultants	Re Uro 9 week PTL for Dec Total of 141 patients on report with only 3 patients dated for procedure. Target for diagnostic tests is 9 weeks but Urology struggle with this and managed to get wait down to 52 weeks. However longest wait could potentially now be outside of this if patients highlighted are not seen by end of December. 6 in total to be scheduled to hold 52 weeks – 5 Mr O'Brien's and 1 Mr Pahujas	TL5 page 1977 – 1983 AOB-72139 – AOB-72145
16.12.2014	Email from Ms Glenny to Consultants	Re Uro planned patients – expected admission date Jan 2015 There are 226 patients in total. 12 patients have dates in the past and need urgently updated on PAS. 156 patients have no dates for procedure and 58 patients have date **Consultants** Mr Glackin – total patients: 156. Flexi: 9. GA: 6. Longest wait: Nov 14 Mr O'Brien – Total patients: 54. Flexi: 14. GA: 40. Longest wait: Oct 2013 Mr O'Donoghue – Total patients: 2. Flexi: 0. GA: 2. Longest wait: Sept 2013 Mr Suresh – Total patients: 20. Flexi: 9. GA: 11. Longest wait: May 2014 Mr Haynes – Total patients: 13. Flexi: 6. GA: 7. Longest wait: Nov 2104 Mr Young – Total patients: 52. Flexi: 29. GA: 23. Longest wait: Oct 2013	TL5 page 1986 – 2006 AOB-72148 – AOB-72168
16.12.2014	Email from Ms Elliot to Mr O'Brien	Re Patient query	TL5 page 2007 AOB-72169

		Patient's GP calling for date for surgery as been on waiting list since April 2014. Symptoms are affecting his work	
19.12.2014	Email from Ms Corrigan to Consultants	Patient who is day 31 and triaged for consultant clinic but there is no where to book him.	TL5 page 2014 AOB-72176
22.12.2014	Email from Ms Neilly to Mr O'Brien	Re Patient query Patient's Dr rang to note that patient was seen in June 2013 and was due review in December 2013 but this has not yet happened	TL5 page 2020 AOB-72182
31.12.2014	Email from Ms Glenny to Mr O'Brien and Ms Elliot	RE Uro planned patients -expected admission date one year in past Notes that 2 patients remaining on waiting list who were to be seen by December 2013.	TL5 page 2028 – 2033 AOB-72190 – AOB-72195
2015	2015 Appraisal	In 2015 Appraisal AOB notes *"Additional Information* *The issues which have impacted upon the delivery of optimal patient care have remained unchanged from those recorded in previous appraisals. I have a waiting list of over 280 patients waiting up to almost three years for admission for surgery. More patients are added to that waiting list each week than can be removed from it. Within the totality, there are patients with clinical urgencies waiting so long that their clinical conditions are worsened by doing so. My waiting list has been up to ten times greater than those of some of my colleagues. A similar situation pertains to outpatient reviews, and particularly those of cancer patients. Yet the situation has not been addressed in a durable and effective manner, whilst there persists an expectation that I will continue to accommodate new referrals."*	2015 Appraisal page 5 AOB-22655
January 2015 to December 2015	CHKS Consultant Level Indicator Programme	January 2015 to December 2015 CHKS review is included in 2015 Appraisal.	2015 Appraisal pages 18-24 AOB-22668 - AOB-22674

<table>
<tr>
<td>January 2015 to December 2015</td>
<td>CLIP (Consultant Led Indicator Programme) Report structured reflective template</td>
<td>
Southern Health and Social Care Trust
Quality Care - for you, with you

CLIP (Consultant Led Indicator Programme) Report structured reflective template
Requirement: One annually

Name of doctor: Aidan O'Brien GMC No: 1394911
Date of report:
January 2015 to December 2015
What issues can I identify from the report?

There was an apparent decrease in the total number of finished consultant episodes from 1003 in 2014 to 830 in 2015.
There was an increase in the total number of outpatient attendances from 899 in 2014 to 1109 in 2015. Most of this increase was due to an increased number of new patient attendances from 285 in 2014 to 462 in 2015.
The number of patients attending as outpatients and having a procedure as doubled, from 39 in 2014 to 81 in 2015.
The new / review ratio has decreased from 2.2 in 2014 to 1.4 in 2015

What actions will I undertake?

I would like to significantly reduce the numbers of new patients attending as outpatients as a proportion are added to waiting lists for admission as inpatients, only to languish there for periods so long as would be considered untenable in other parts of the UK. The situation is so bad that many patients have diminishing prospects of ever being admitted.
I also believe that it is inappropriate for me to spend time seeing new patients when urological cancer patients are waiting years beyond their review dates for review.

Final outcome after discussion at appraisal:
(Complete at appraisal)
• Notes the changes in 'Numbers' and sets out the Trusts objectives.
Concerned that Trust is not providing facilities to deal with issue. This is outside his Control
Regards the balance of provision as wrong issues to be discussed at Trust level.
</td>
<td>2015 Appraisal pages 25

AOB-22675</td>
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<tr>
<td>January to December 2015</td>
<td>Medical Appraisal Documents & Checklist</td>
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<table>
<tr><td>2.7.1 List any non-clinical work that you undertake which relates to management</td><td>As Lead Clinician of the Urological cancer MDT, I liaised with the Cancer Coordinator and Tracker each week to ensure that the management of all urological cancer patients was progressed during the 31 and 62 day timelines.
Having achieved 100% compliance during the year of Peer review in 2015, I ensured that remained the case during 2016.
I held Urology MDM Business meetings in preparation for the Annual Report to the National Cancer Plan in September 2016.</td></tr>
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ADDITIONAL INFORMATION

The only change in all of the factors which have impacted negatively upon the delivery of care to patients, particularly those most urgently in need, has been that they have worsened. My main concerns during 2016 were

the suboptimal care delivered to acute admissions and referrals, due to lack of beds and lack of emergency operating capacity, the lack of elective operating
the lack of elective operating capacity resulting in waiting lists becoming larger and longer
the increasing number of patients waiting longer periods beyond expected review dates.

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<td>2016 Appraisal Page 7

AOB-22837</td>
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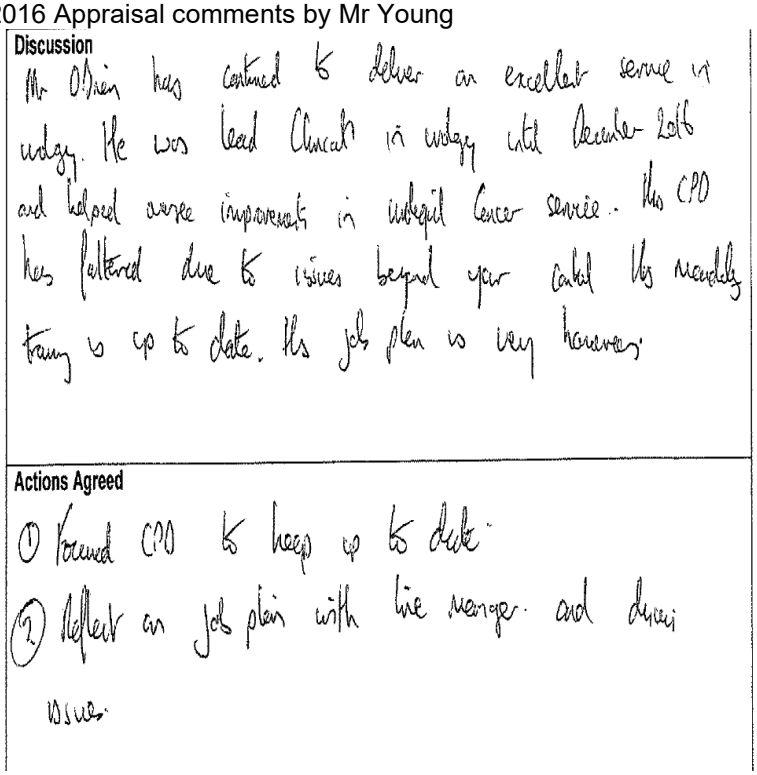
January to December 2015	Medical Appraisal Documents & Checklist	2016 Appraisal comments by Mr Young  **Discussion** Mr O'Brien has continued to deliver an excellent service in urology. He was lead Clinician in urology until December 2016 and helped oversee improvements in integrated Cancer service. His CPD has faltered due to issues beyond your control. His mandatory training is up to date. His job plan is very heavy. **Actions Agreed** 1) Forward CPD to keep up to date. 2) Reflect on job plan with line manager and discuss issues.	2016 Appraisal Page 8 AOB-22838
02.01.2015	Email from Ms Glenny to Consultants	Re: Uro 9 week PTL for Jan 2015 165 patients. 17 patients have dates, 148 have no dates. The longest waiter is 55 weeks. **Consultant** Mr ?AJA : 1 Patient waiting 55 weeks Mr Glackin: 9 patients, longest waiting 20 weeks Mr O'Brien: 73 patients, longest waiting 51 weeks	TL5 page 1 – 19 AOB-72196 – AOB-72214

		Mr O'Donoghue: 37 patients, longest waiting 20 weeks Mr Suresh: 8 patients, longest waiting 18 weeks Mr Haynes: 8 patients, longest waiting 24 weeks Mr Young: 12 patients, longest waiting 11 weeks	
02.01.2015	Email from Mr Young to Consultants	Re response to uro 9 week PTL waiting lists	TL5 page 20 – 22 AOB-72215 – AOB-72217
02.01.2015	Email from Ms Glenny to Consultants	Re Uro Elective waiting lists, 26 weeks PTL & expected admission & Total urgent 1. Total urgent – total of 432 patients. 79 patients have dates, 353 have no dates. *Mr Glackin: 25 patients with longest waiting 39 weeks* *Mr O'Brien: 141 patients with longest waiting 79 weeks* *Mr O'Donoghue: 28 patients with longest waiting 71 weeks* *Mr Suresh: 41 patients with longest waiting 67 weeks* *Mr Haynes: 11 patients with longest waiting 12 weeks* *Mr Young: 107 patients with longest waiting 91 weeks* 2. Red Flag patients without dates *Mr Glackin: 1 patient with longest waiting 8 weeks* *Mr O'Brien: 8 patients with longest waiting 63 weeks*	TL5 page 23 – 82 AOB-72218 – AOB-72277

		Mr O'Donoghue: 0 *Mr Suresh: 2 patients with longest wating 4 weeks* *Mr Haynes: 3 patients with longest waiting 7 weeks* *Mr Young: 1 patient with longest waiting 11 weeks* 3. Planned patients without dates *Mr Glackin: 13 patients with longest waiting from Nov 2014* *Mr O'Brien: 47 patients with longest wating from Oct 2013* *Mr O'Donoghue: 4 patients with longest waiting from Dec 2013* *Mr Suresh: 9 Patients with longest waiting from Sept 2014* *Mr Haynes: 3 patients with longest waiting from Dec 2014* *Mr Young: 38 patients with longest waiting from Feb 2014* 4. 26 week PTL patients without dates *Mr Glackin: 8 patients with longest wait of 51 weeks* *Mr O'Brien: 177 patients with longest wait of 79 weeks* *Mr O'Donoghue: 7 patients with longest wait of 76 weeks* *Mr Suresh: 29 patients with longest wait of 67 weeks* *Mr Haynes: 8 patients with longest wait of 71 weeks* *Mr Young: 94 patients with longest wait 91 weeks*	
06.01.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list for TURP since April 2014 and younger brother recently diagnosed with prostate CA so patient is anxious	TL5 page 94 AOB-72289
07.01.2015	Email from Mr Young to Consultants	Re Feb Rota	TL5 page 95 – 103 AOB-72290 – AOB-72298
08.01.2015	Email from Ms Glenny to Consultants	References the ongoing pressures with beds	TL5 page 104 AOB-72299
08.01.2015	Email from Ms Reddick	Re 62 day active longest waiter Breaches	TL5 page 105 – 115

	to Consultants	Urology – Longest wait in Jan 15: 146. Number over 62 days in Jan 15: 3	AOB-72300 – AOB-72310
09.01.2015	Email from Ms Glenny to Consultants	Received funding to do additional main theatre sessions during February and March to address long waiters.	TL5 page 121 – 122 AOB-72316 – AOB-72317
12.01.2015	Email from Ms Glenny to Consultants	Weekend additionality is no longer available due to bed pressures	TL5 page 121 – 122 AOB-72316 – AOB-72317
13.01.2015	Email from Ms Glenny to Consultants	Re Uro 9 week PTL for January Longest waiter still at 55 weeks. 3 patients to be scheduled in Jan to hold maximum waiting time of one year. All 3 patients are Mr O'Brien's but he does not have any slots left in January to do these. Mr ?AJA – 0 patients Mr Glackin – 7 patients at longest waiting 21 weeks Mr O'Brien – 71 patients at longest waiting 55 weeks Mr O'Donoghue – 36 patients at longest wating 19 weeks Mr Suresh – 6 patients at longest waiting 14 weeks Mr Haynes – 0 Mr Young – 7 patients at longest wating 13 weeks	TL5 page 123 – 140 AOB-72318 – AOB-72335
14.01.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's wife called re date for surgery as been on waiting list from March 2014	TL5 page 142 AOB-72337
14.01.2015	Email from Ms Corrigan to Consultants	Re PTLS Day 62 cancer pathway Notes that still maintaining a good performance with longest waiter at day 52	TL5 page 143 – 152 AOB-72338 – AOB-72347
15.01.2015	Email from Ms Glenny to Consultants	Re Uro Long waiters Notes that it is the surgeon's responsibility who has taken the patient for scheduling to ensure that the patient is fit for surgery and scheduled for February X 34 AOB patients with longest waiting 80 weeks X10 MY patients with longest waiting 89 weeks X 5 JOD patients with longest waiting 78 weeks	TL5 page 166 – 171 AOB-72361 – AOB-72366

		X1 KS patients with longest waiting 69 weeks	
20.01.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list since April 2014 and would like a date as he has been deteriorating	TL5 page 181 AOB-72376
21.01.2015	Email from Ms Elliot to Mr O'brien	Re Patient query Patient on waiting list for left ureteroscopy? TURBt planned for November 2014 following Mitomcycin C completed in October 2014	TL5 page 182 AOB-72377
21.01.2015	Email from Ms Elliot to Mr O'brien	Re patient query Patient on waiting list for TURP since April 2014 and wondering when will get date for surgery	TL5 page 183 AOB-72378
21.01.2015	Email from Ms Corrigan to Consultants	Re Urology Departmental meeting Agenda 1. Haematuria 2. Glycine 3. Swah OP waiting list 4. Flexible scopes – SWAH 5. Triage patients – ownership of patients 6. Urodynamics 7. Meeting (12 Feb) with secretaries and Katherine Robinson re process 8. Any other issues	TL5 page 184 AOB-72379
24.01.2015	Email from Ms Corrigan to Consultants	Re Urology Interim Plan Notes the postcodes that the SHSCT are to cover	TL5 page 188 – 215 AOB-72383 – AOB-72410
24.01.2015	Email from Mr Glackin to Consultants	Re Urology Interim Plan Notes his concerns about the postcode areas in which SHSCT are supposed to cover due to these areas being closer to alternative hospitals	TL5 page 216 – 221 AOB-72411 – AOB-72416
25.01.2015	Notes of Functional Support Servives Managers Meeting Acute Services Directorate	Notes that there is an issue with additionality and pressures on secretaries	TRU-22176 – TRU-22178
25.01.2015	Email from Mr O'Brien to Ms Corrigan	Re Urology Interim plan Notes that he feels it is insensible to consider sending all of the referrals from Mid Ulster to one provider Mr O'Brien proposes that redistribution of areas of responsibility by post code or ICP areas are not necessarily the most refined, sensitive or indeed sensible ways of doing so. I would have thought that, if broad areas of	TL5 page 227 – 233 AOB-72422 – AOB-72428

		agreement are reached, GPs in marginal areas could be consulted regarding their preference.	
28.01.2015	Email from Mr O'Brien to Mr Young and Ms Corrigan	Mr O'Brien notes that he has a significant amount of work to do in relation to the local and regional preparedness for Peer Review. Mr O'Brien noted that if it were not possible to have a week off from clinical work, he will take his annual leave to work on the peer review	TL5 page 250 AOB-72445
29.01.2015	Email from Mr Young to Consultants	Re March rota	TL5 page 251 – 259 AOB-72446 – AOB-72454
29.01.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re surgery. Has been on waiting list since 25 November 2013	TL5 page 260 AOB-72455
04.02.2015	Email from Mr Young to Consultants	References theatre start and finish times being delayed due to other consultants	TL5 page 272 AOB-72467
05.02.2015	Email from Ms Glenny to Consultants	Re Urology Review Backlog Have had 80 patient recorded validated. 50 of which have been discharged without requiring face to face review (63%).	TL5 page 326 AOB-72521
09.02.2015	Email from Ms Neilly to Mr O'Brien	Re Patient query Patient was last seen in June 2013 and was due for review in Jan 2014 but has not been seen. GP has wrote 4 times to advise of PSA increase and cough.	TL5 page 370 AOB-72565
09.02.2015	Email from Ms Glenny to Mr O'Brien	Notes that there is an additional theatre session free to give a long extended day operating	TL5 page 372 AOB-072567
10.02.2015	Email from Ms Dignam to Consultants	Re: Feb Schedule	TL5 page 376 – 378 AOB-72571 – AOB-72573
10.02.2015	Email from Ms Browne to Mr O'Brien	Query of whether to overbook SWAH clinic to fit in patient	TL5 page 379 AOB-72574
12.02.2015	Email from Ms Corrigan to Ms Robinson and Others	Re Urology meeting with admin Agenda 1. Process Map Urology Admin from receipt of referral 2. Use of triage forms & clinics outcomes forms, OC referrals, review referrals 3. Rota, hot clinic, agree who requests charts	TL5 page 387 – 388 AOB-72582 – AOB-72583

		4. Jenny/Kate – information to RBC re any activity they are carrying out that needs recorded 5. Release of red flag slots & PR slots – rules re timescale 6. Missing referrals from triage 7. Any other business	
13.02.2015	Email from Ms Elliot to Mr O'brien	Re Patient query Patient wanted a date for surgery as been on waiting list from February 2014	TL5 page 392 AOB-72587
16.02.2015	Email from Ms Glenny to Consultants	Re Review Backlog validation process encloses letter to go to patients Notes that this process is starting and letters will be sent to patients waiting over 6 months for their appointment. Notes that is there is no response after 2nd letter, will check address details are correct and if so, will remove patient from the OPWL and close the episode on PAS	TL5 page 393 - 402 AOB-72588 – AOB-72597
16.02.2015	Email from Mr O'Brien to Ms Glenny	RE Validation process Mr O'Brien notes that two weeks is too short for response. However, Mr O'Brien believed that the letters were ok provided that they include adequate and reasonable safeguards	TL5 page 403 – 404 AOB-72598 – AOB-72599
22.02.2015	Email from Ms Corrigan to Ms Dignam and Others	Re March Schedule	TL5 page 444 – 450 AOB-72639 – AOB-72645
23.02.2015	Email to Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list for removal of stent and right ureteroscopic laser lithotripsy since July 2014.	TL5 page 451 AOB-72646
23.02.2015	Email from Ms Glenny to Consultants	Re additional review clinic to address backlogs	TL5 page 452 AOB-72647
25.02.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list for stent removal since jUly 2014	TL5 page 457 AOB-72652
25.02.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient wondering when date will be as been on waiting list since November 2013. Was offered date for surgery in December 2014 but this was cancelled as he had fallen the day before	TL5 page 458 AOB-72653

26.02.2015	Urology Dept Governance Meeting	In attendance Mr O'Brien Mr Young Mr Glackin Mr Suresh Mr Haynes Mr O'Donoghue Sr McMahon Ms Martin Apologies None 1 Minutes of last meeting 16 December 2014 Agreed as accurate. Matters arising: Mr Glackin to write to Mr Mackle AMD for Surgery to agree details of daily handove between general surgery and urology. 2 Presentation of Urology Notes Audit Ms Martin Action arising from Audit 1 Greater scrutiny by Consultants of note making on ward rounds. 2 Share this audit presentation with all surgical FY1s. Action Ms Martin 3 Re-audit in 2 months Action Ms Martin This audit raised discussion regarding the quality of note keeping in terms of accurately reflecting th clinical care provided to our patients and how we as a team can improve this. 3 Morbidity & Mortality since 16 December 2014 No deaths noted between 1 December 2014 and 31 January 2015. Consultants require training for IMMIX to complete Mortality proformas- Action Mr Glackin. Mr Haynes suggested that we should choose 3 common urological procedures to prospectively audi surgical morbidity outcomes i.e. TURBT. Mr O'Brien suggested that acute stone admissions would be appropriate for audit. It was further agreed that each registrar would be responsible for presenting one such audit to the group twice per year. Action Mr Haynes Mr Glackin will provide a template before the next meeting to audit surgical morbidity outcomes in in patient elective cases staying in the hospital for more than 24 hours in line with trust patient safet suggestions. Action Mr Glackin. 4 Complaints & Compliments Discussion included presentation at this meeting of learning from SAIs involving Urology department once investigation was completed. Sharing of learning from complaints addressed by Trust on behalf of Urology Department. Take forward a patient experience survey for those attending the New Patient Clinic at the Thorndal Unit- Action Ms Randhawa. 5 Any other Business : Other issues relating to Clinical Governance. The team expressed the view that a multi-disciplinary approach to the meeting was desirable. It was agreed that Band 7 nurses and the Head of Service would be included as key participants in addition to the medical staff. 6 Date for next meeting 17 April 2015	TL5 page 574 AOB-72768 – AOB-72769
26.02.2015	Email from Mr Young to Consultants	Re: April rota	TL5 page 459 – 465 AOB-72654 – AOB-72660
26.02.2015	Email from Ms Glenny to Consultants	Re Planned Check Flexible Cystoscopy Patients without dates Mr Glackin: 18 patients with longest waiting from March 2015 Mr O'Brien: 13 patients with longest wating from Jan 2015 Mr O'Donoghue: 0 Mr Suresh: 13 patients with longest waiting from December 2014 Mr Haynes: 12 patients with longest waiting from December 2014 Mr Young: 36 patients with longest waiting from February 2015	TL5 page 495 – 502 AOB-72690 – AOB-72697
26.02.2015	Email from Ms Glenny	Re Uro Planned patients – EDA April 2015 or less (Excluding Flex cystoscopy)	TL5 page 503 – 516

	to Consultants	Mr Glackin: 8 patients with longest waiting from March 2015 Mr O'Brien: 43 patients with longest waiting from Jan 2014 Mr O'Donoghue: 0 Mr Suresh: 3 patients with longest waiting from March 2015 Mr Haynes: 9 patients with longest waiting from February 2015 Mr Young: 16 patients with longest waiting from February 2014	AOB-72698 – AOB-72711
26.02.2015	Email from Ms Glenny to Consultants	Re Diagnostic Cystoscopy waiting lists Mr Glackin: 9 patients with longest waiting 17 weeks Mr O'Brien: 12 patients with longest waiting 56 weeks Mr O'Donoghue: 72 patients with longest waiting 26 weeks Mr Suresh: 32 patients with longest wating 36 weeks Mr Haynes: 4 patients with longest waiting 17 weeks Mr Young: 30 patients with longest waiting 39 weeks	TL5 page 517 – 542 AOB-72712 – AOB-72737
02.03.2015	Email from Ms Mcmahon to Mr O'Brien	Re Uro waiting list 26 patients with dates 153 patients without dates 179 patients in total on waiting list	TL5 page 586 – 595 AOB-72781 – AOB-72790
04.03.2015	Email from Ms Corrigan to Consultants	Re Departmental meeting Notes that tomorrow's meeting will be to discuss Amended Glycine Paper and the following week will be the Urology MDT Business meeting	TRU-01518
05.03.2015	Email from Ms Waddell to Consultants	Re Urology daycase Notes that there is approx. 17.3% of activity currently recorded as a daycase requiring theatre	TL5 page 606 – 611 AOB-72801 – AOB-72806
05.03.2015	Email from Ms Glenny to Consultants	Re Review backlog validation process Well under way and a greater response that expected. However will require additional face to face sessions	TL5 page 612 AOB-72807
09.03.2015	Email from Ms Corrigan to Consultants	Re issues with contacting Urology consultants between 9am – 5pm.	TL5 page 618 – 619 AOB-72813 – AOB-72814
12.03.2015	Email from Ms Elliot to Mr O'Brien	Re patient query Patient ringing re date – has been on waiting list from October 2013	TL5 page 690 AOB-72885

18.03.2015	Email from Ms Elliot to Mr O'Brien	RE Patient Query Patient wanted date for surgery as been on waiting list from September 2014	TL5 page 694 AOB-72889
22.03.2015	Email from Ms Corrigan to COnsltants	Re Urology review backlogs Mr O'Brien & Mr Young have highest numbers of backlogs	TL5 page 712 – 719 AOB-72907 – AOB-72914
25.03.2015	Email from Ms Corrigan to Consultants	Re PTL day 62 waiting lists	TL5 page 738 – 750 AOB-72933 – AOB-72945
26.03.2015	Email from Mr Young to Consultants	RE May Rota	TL5 page 751 – 759 AOB-72946 – AOB-72954
29.03.2015	Email from Ms Corrigan to Consultants	RE Profile of Urology Urgent Elective Waiting Patients *"As you are aware there doesn't seem to be any additional money available to do additional work in the new financial year."* *"Mr O'Brien and Mr Young's urgent waiters are waiting an unacceptable time"* *"I know you are concentrating on a number of areas at the moment but I suppose one of the things that we need to reassure ourselves of is firstly those urgents that are waiting the long time are they still requiring a procedure and secondly are they definitely in the urgent category"* Mr Glackin has 26 patients waiting longest 30 – 39 weeks Mr O'Brien has 144 patients with 12 waiting over 70 weeks Mr O'Donoghue has 41 patients with longest waiting 50 -59 weeks Mr Suresh has 53 pateints with longest waiting 50 – 59 weeks Mr Haynes has 23 Patients with longest wating 20 – 29 weeks Mr Young has 110 patients with 3 waiting over 70 weeks	TL5 page 845 – 848 AOB-73040 – AOB-73043
30.03.2015	Email from Mr O'Brien	Re Profile on Urology urgent elective Notes that it is a waste of time to validate patients. Notes that is risky to ask patients whether they still want their operations. Highlights that having urgents done first supersedes long waiters. Mr O'Brien notes how to tackle to problem 1. Decide what priorities are. Cannot have a dozen priorities running at the same time. Operating should be priority 2. Michael and Mr O'B should no longer participate in new clinics until no longer have patients on urgent waiting lists waiting longer than other consultants	TL5 page 851 – 853 AOB-73046 – AOB-73048

		3. Consideration given to allowing MY and Mr O'B add patients to list of others 4. Greater urgencies are operated on instead of longest waiters	
April 2015	Urology MDT Annual Report for 2014/15	In Urology MDT Annual Report for 2014/15 the following comment is made: **Appointment of Consultant Urologists** Whilst the previous year of 2013/14 had begun with 5 Consultant Urologists in post, two subsequently left during that year, the resulting vacancies partially mitigated by the appointment of Mr. Suresh in late 2013. The resultant reduction in service capacity had impacted negatively on the ability of the MDT to meet demand and deliver cancer services within agreed target times. That negative impact has been eliminated by the appointments of Mr. Haynes and Mr. O'Donoghue during 2014, bringing the consultant compliment to six by August 2014.	2015 Appraisal pages 73 AOB-22723
April 2015	Urology MDT Annual Report for 2014/15	In Urology MDT Annual Report for 2014/15 the following comment is made: **Red Flag Referrals** There has been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past year, up from 2902 in 2013 to 4063 in 2014. The greatest increase has been to the Southern Trust, with an increase of 84% from 410 in 2013 to 753 in 2014. This has occurred in the context of the Southern Trust having the greatest percentage increase in all urological referrals, with an 18% increase from 3987 in 2013 to 4695 in 2014.	2015 Appraisal pages 73-74 AOB-22723 - AOB-22724
April 2015	Urology MDT Annual Report for 2014/15	In Urology MDT Annual Report for 2014/15 the following comments are made: However, challenges and failures persist. The main inadequacies have remained the absence of a consultant urological radiologist at too many meetings. The MDT is cognisant of the current problems regarding the provision of experienced radiological cover and will encourage the Trust to address this issue. Whilst the presence of clinical and medical oncologists has improved significantly in recent years, it is still not complete. Both of these inadequacies have resulted in a MDM quoracy of 23% for 2014, as evidenced by the MDT Attendance Spreadsheet.	2015 Appraisal page 76 AOB-22726

April 2015	Operational Policy Urology Cancer Service Southern Trust	Operational Policy Urology Cancer Service Southern Trust includes the following comments in relation to resource **1.1 Southern Trust Urology Services** The Southern Health and Social Care Trust has provided a Urology service for patients living the southern area of Northern Ireland since 1992, when one consultant urologist was appointed. A second consultant urologist was appointed by Craigavon Area Hospital Group Trust in 1996. Since then, the service has increased incrementally in size and capacity, with a sixth consultant urologist appointed in 2014. Particular features of the service has been the provision of Extracorporeal Shock Wave Lithotripsy at the Stone Treatment Centre at Craigavon Area Hospital since 1998, and the provision of all outpatient services at a dedicated unit, the Thorndale Unit, since 2007. This unit moved to a new location within the hospital in 2013, with increased capacity, to enable all outpatient consultations to be conducted there, in addition to ultrasound scanning, prostatic biopsies, flexible cystoscopy and urodynamic studies. The Unit is staffed by Clinical Nurse Specialists, Staff Nurses and Health Care workers, in addition to visiting Radiographers and Radiologists. A review of urological service provision in Northern Ireland was conducted in 2008/09, resulting in a reconfiguration of responsibilities for services to be provided to changed geographical areas and by three separate teams of urologists. Team South, based at Southern Health and Social Care Trust (SHSCT), took on responsibility for the provision of services to the population of County Fermanagh, with effect from 1st January 2013. County Fermanagh has a population of 61,175. More recently, SHSCT has agreed to provide urological services to the population of and surrounding Cookstown, County Tyrone, bringing the entire catchment population to 427,000.	2017 Appraisal pages 244 – 245 AOB-23122 - AOB-23123
April 2015	Operational Policy Urology Cancer Service Southern Trust	Operational Policy Urology Cancer Service Southern Trust includes **6. MDT CORE NURSE MEMBER** The Department of Urology at Craigavon Area Hospital employs two Clinical Nurse Specialists (CNS). Mrs K O'Neill is a Band 7 Urology CNS employed by the Trust on a full time basis (5 days). Mrs J McMahon is a Band 7 Urology CNS employed by the Trust over 4 days (32.5 hours). Both have worked in Urological Nursing for many years, and are experienced in performing urodynamic studies, flexible cystoscopy and transrectal, ultrasound guided, prostatic biopsies. They have been further supported by the appointment of two Band 6 practitioners experienced in urodynamic studies and the provision of intravesical chemotherapy. Mrs. O'Neill has been nominated the Core Nurse Member of the Urology MDT and whose responsibility it is to oversee the responsibilities of all Nursing Practitioners / Key Workers involved in the ongoing assessment and management of cancer patients, as outpatients.	2017 Appraisal page 253 AOB-23131

		85. **MDT QUORUM** In earlier years, it had not been possible to have a clinical oncologist present at or video-linking with MDM. With the appointment of Dr. Fionnuala Houghton, it has been possible to have her, or her deputy, video-link with MDM on most occasions. There has been the additional benefit that Dr. Houghton and her deputies have been competent in advising on chemotherapeutic management options for patients. Since the appointment of Dr. Judith Carser as Consultant Medical Oncologist, MDM has had the benefit of her attendance, which has additionally enhanced recruitment of patients to clinical trials. Dr. Marc Williams is the Lead Consultant Urological Radiologist, who has been covered by or accompanied by Dr. Mark McClure, Consultant Radiologist, to facilitate the presence of an imaging specialist at most MDMs. Both are experienced urological radiologists, and particularly in the field of MRI scanning. The current unavailability of Dr. McClure presents a significant challenge to ensuring that the management of cancer and suspect cancer patients is completed within target times, in addition to MDT quoracy.	2017 Appraisal page 256 AOB-23134
April 2015	Urology MDT Annual Report for 2014/15	Urology MDT Annual Report for 2014/15 includes **Appointment of Consultant Urologists** Whilst the previous year of 2013/14 had begun with 5 Consultant Urologists in post, two subsequently left during that year, the resulting vacancies partially mitigated by the appointment of Mr. Suresh in late 2013. The resultant reduction in service capacity had impacted negatively on the ability of the MDT to meet demand and deliver cancer services within agreed target times. That negative impact has been eliminated by the appointments of Mr. Haynes and Mr. O'Donoghue during 2014, bringing the consultant compliment to six by August 2014. **Red Flag Referrals** There has been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past year, up from 2902 in 2013 to 4063 in 2014. The greatest increase has been to the Southern Trust, with an increase of 84% from 410 in 2013 to 753 in 2014.	2017 Appraisal page 272 AOB-23150

		This has occurred in the context of the Southern Trust having the greatest percentage increase in all urological referrals, with an 18% increase from 3987 in 2013 to 4695 in 2014. **Operative Capacity** The main limiting factor in providing a complete cancer service is operating theatre capacity and operator time. Though the MDT has provided for the increased demand on Red Flag pathways, it has been at the expense of patients having, or suspected of having, recurrent bladder tumours, and those awaiting prostatic resection to facilitate their progress to radical radiotherapy for prostatic carcinoma having to wait increasingly longer periods of time for surgery, in addition to all those with non-cancerous pathology. This is a common and concerning experience across Northern Ireland, and will remain an increasing challenge until operative capacity is increased. **Conduct of MDM** The quality of the conduct of MDM has been a singular achievement these past five years. The quality of participation has been enhanced by increasing the number of persons chairing, and by having time allocated for preview. It is intended to increase the core membership in the near future to include all consultant urologists. However, challenges and failures persist. The main inadequacies have remained the absence of a consultant urological radiologist at too many meetings. The MDT is cognisant of the current problems regarding the provision of experienced radiological cover and will encourage the Trust to address this issue. Whilst the presence of clinical and medical oncologists has improved significantly in recent years, it is still not complete. Both of these inadequacies have resulted in a MDM quoracy of 23% for 2014, as evidenced by the MDT Attendance Spreadsheet. Lastly, it has been a collective failure of MDT and the Trust to see developed the functions of Key Workers. This will certainly be a priority issue for the MDT during 2015/16.	2017 Appraisal pages 274 – 275 AOB-23152 - AOB-23153
01.04.2015	Email from Ms Corrigan to Consultants	RE Update on review backlog · Validation letters sent only to patients on routine Cons-Led urology OPWLs (Urgent, Uro-Oncology, Stone Treatment, ICATS/Nurse-Led not included) · Commenced with longest waiters first from 2011 onwards · Letters sent to all patients on Mr Akhtar's list (CMAR) 2012, 2103 & 2014 (202 patients) · We did not send letters to patients where the GP had sent in new letter recently RE: overdue review (i.e. from Dec 2014 onwards) · We also did not send letters to patients who were highlighted as being "suitable for telephone review" (from previous clinical validation?) · Patient letters included a "Patient Detail Form" – therefore addresses, GPs, telephone numbers have also been checked/updated on PAS through the process (which will assist if requiring to contact patients at short notice; or potential for telephone validation clinics) · Patient letter validation commenced 24 February 2015 – for 1st letter · 1st patient validation letter sent = 974 (this included several letters re-issued as originals were returned as patients had moved) · 2nd patient validation letter (reminder) sent = 320	TL5 page 1016 – 1022 AOB-73211 – AOB-73217

		· Reminder letters (2nd letter) issued w/c 23 March 2015 · RE: 2nd validation letters sent – patients have until latest Friday 3 April 2014 to respond (i.e. 1 week from date letter printed & posted). However, I am allowing a bit of extra time for patients to respond as I found there were a number of patients who said they only received 1st letters 2-3 weeks after they were posted (there seemed to be a problem specifically for letters sent out on 26/27 February from both the Rowans and Booking Centre –110 approx.. 200 letters printed and posted on those dates). We will also likely have to make allowances for Easter Bank holidays. · All letters were posted 2nd class, and the Freepost envelope for returning responses is also 2nd class. · To date, there have been only 80 responses to 2nd validation letters sent · Total responses to date = 81% of the total responders have requested a review appointment. · Of the 19% who have requested no further review, some of these are Under 18s which have not yet been processed on PAS (forms sent to Consultant/Secretary). · There are other Under 18 patients who are still on the review backlog where Under 18 discharge forms had been sent to Consultant/Secretary some time ago but still not processed on PAS (includes some patients from 2011 onwards) – indeed, we have re-issued some Under 18 forms as they were originally sent so long ago · With regards to patients who do not respond to validation letters x 2 – are we permitted to close these off PAS automatically (with exception of Under 18 patients), or do these need to be flagged to you or the consultants first? Approx. 1900 patients were data validated (PAS & Patient Centre) commencing in Dec 2014 – for 2011, 2012, 2013 and some of the lists for 2014.	
02.04.2015	Email from Ms Corrigan to Mr O'Brien	Notes that there will be no additionality for the foreseeable	TL5 page 1023 – 1024 AOB-73218-AOB-73219
10.04.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient wanted date for surgery, has been on waiting list since 2013	TL5 page 1092 AOB-73287
15.04.2015	Email From Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re surgery as been on waiting list since August 2014	TL5 page 1117 AOB-73312
15.04.2015	Email from Mr O'Brien to Ms Corrigan and Mr Young	Re Wednesday Operating Sessions Notes that he will not be undertaking operating beginning at 12 noon after 01 June 2015 due to the delays experienced (his theatre did not begin until 2.20 when it was due at 12).	TL5 page 1118 AOB-73313

17.04.2015	Minutes of Urology Department Governance Meeting		TL5 page 1135 – 1137 AOB-73330 – AOB-73332
21.04.2015	Email from Ms Corrigan to consultants	Enclosing presentation for SHSCT urology overview – shows capacity, waiting lists etc	TL5 page 1180 – 1191 AOB-73389 – AOB-73391
21.04.2015	Email from Mr O'Brien to Ms Corrigan	Mr O'Brien raises his concerns on how the data has been pulled for the urology presentation sheets	TL5 page 1194 – 1196 AOB-73389 - AOB-73391
21.04.2015	Email from Ms Reddick to Mr O'Brien	Enclosing list of referrals received for Urology 62 day and 31 day	TL5 page 1192 – 1193 AOB-73387 – AOB-73388
23.04.2015	Agenda for Regional Urology Meeting dated 30 April 2015	1. Welcome 2. Context 3. Current regional urology position (a) Workforce (b) Referral patterns (c) Demand (d) Capacity (e) Waiting times (f) Theatre capacity (g) Unscheduled 4. Current OP & IP/DC SBA models 5. Current modernisation/service improvement initiatives (a) One stop clinics (b) Electronic GP referrals (c) GP mentorship programmes (d) PSA tracking 6. Regional expertise in urology conditions 7. Alternative commissioning models for long waiting procedures 8. Current & potential future pathways for procedures currently referred through ECR process 9. Agree process for implementation	TL5 Page 1209 – 1211 AOB-73402 – AOB-73406
29.04.2015	Email from Mr Haynes to Ms Burns and Consultants	Re Regional urology meeting Notes that are meeting their demand but backlog remains an issue and requires a separate solution. They will need an additional member of consultant team by 2 years in order to meet demand.	TL5 page 1254 – 1257 AOB-73449 –

			AOB-73452
30.04.2015	Email from Mr Young to Consultants	Re June - August rotas	TL5 page 1270 – 1277 AOB-73465 – AOB-73472
08.05.2015	Email from Ms Glenny to Consultants	Re Uro Planned Patients – EDA may 2015 or less Approx 57 patients – AOB Approx 36 patients – MY Approx 17 patients – MH Approx 22 patients – KS Approx 4 patients – JOD Approx 21 patients – AJG	TL5 page 1393 – 1417 AOB-73588 – AOB-73612
14.05.2015	Minutes of Urology Departmental Meeting	Discussion points 1. Rolling topics heading for each week 2. Trial removal of catheter pathways 3. Flexible cystoscopy list activity re management of bladder tumours	TL5 page 1511 – 1512 AOB-73705 – AOB-73707
19.05.2015	Letter from Director of Commissioning	Re Urology Planning and Implementation TOR **Terms of Reference** To agree arrangements and identify resources for a system wide approach to the organisation and profile of urology services across Northern Ireland. The service reconfiguration will concentrate on the six principles that were agreed at the regional workshop: • Development of a regional multi-professional workforce plan that maximises skills and expertise on a regional basis and is based on the agreed future service profile. • Identify current and future needs for urology services at a regional level and development of robust service and budget agreements to reflect these needs. • Eliminate regional variation through consideration of physical and staff infrastructure and best clinically agreed pathways. • Review current access, consider and agree alternative pathways for patients currently waiting and agree future pathways which are evidence based and in line with best practice.	TL5 page 1505 – 1509 AOB-73700 – AOB-73704

		• Consider regional expertise in service configuration and explore cross Trust working. • Consider clinical and cost effective NI solutions for those procedures where patients are currently travelling outside NI for treatment.	
20.05.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient wondering when date for surgery – he was cancelled off list in March 2015 due to overrunning	TL5 page 1500 AOB-73695
27.05.2015	Email from Ms Glenny to Consultants	Re Urology Planned waiting list Observations are as follows: · There are currently 167 patients on the planned waiting list with EDA June 2015 or less, 62 of which have dates, but 105 do not have dates as yet for procedure. · Of the 105 without dates, the longest waiter in terms of EDA is January 2014, 17 months beyond the original planned return date. · The vast majority of the planned patients without dates are currently on Mr O'Brien's waiting list (57%). · There are 19 patients who are waiting greater than 6 months beyond the original planned return date – 14 on Mr O'Brien's waiting list and 5 on Mr Young's waiting list AJG 9 17 26 Mar-15 AOB 6 60 66 Jan-14 JOD 3 2 5	TL5 page 1537 – 1566 AOB-73732 – AOB-73761

<table>
<tr>
<td></td>
<td></td>
<td>Jun-15
KS
19
6
25

Apr-15
MDH
11
4
15

May-15
MY
14
16
30</td>
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<td>27.05.2015</td>
<td>Email from Ms Glenny to Consultants</td>
<td>Re Urology Total Urgent Waiting List
<table>
<tr><th></th><th>With Dates</th><th>Without Dates</th></tr>
<tr><td>AJG</td><td>15</td><td>28</td></tr>
<tr><td>AOB</td><td>2</td><td>128</td></tr>
<tr><td>JOD</td><td>25</td><td>43</td></tr>
<tr><td>KS</td><td>17</td><td>44</td></tr>
<tr><td>MDH</td><td>12</td><td>26</td></tr>
<tr><td>MY</td><td>25</td><td>110</td></tr>
<tr><td>TOTAL</td><td>96</td><td>379</td></tr>
</table></td>
<td>TL5 page 1567 – 1685

AOB-73762 – AOB-73880</td>
</tr>
<tr>
<td>16.06.2015</td>
<td>Email from Ms Glenny to Consultants</td>
<td>Re top 20 longest waiting patients

Longest waiting is 94 weeks (Mr JOB patient but used to be Mr AOB).

4 patients waiting between 80-90 weeks for procedure, with 13 urgent patients waiting 70-80 weeks.</td>
<td>TL5 page 2267 – 2274

AOB-74462 –</td>
</tr>
</table>

			AOB-74469
16.06.2015	Peer Review Visit Report	Peer Review Visit Report of 16 June 2015 comments as follows:- "The Urology configuration in Northern Ireland was reviewed and reorganised in 2009 to help address long waiting times and to move towards complying with the Improving Outcomes Guidance (IOG). Three urology cancer MDTs were agreed namely Southern, North West and the specialist MDT at Belfast. The County Fermanagh part of the Western Health and Social Care Trust (WHSCT) catchment area population was therefore included in the Southern UrologyMDT and so the MDT covers a combined population of 409,832. The transfer of this work has been achieved relatively seamlessly as there was already a single urology team based on a single site at Craigavon. Some outpatient and diagnostic services are provided at South Western Acute Hospital (SWAH) in Enniskillen" "Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisionsare being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment." **"Serious Concerns** 1. There is now a single handed radiologist supporting the Urology MDT with no cover arrangements in place. Attendance at the MDT during 2015 is not consistent due to clinical commitments in order to deliver timely waits for patients. This could adversely affect the treatment planning decisions for patients. Trust response: The Trust can confirm that the reduction of radiology provision to the urology MDT was entirelyunpredictable. The Trust has taken appropriate measures and has advertised a replacement radiologist with urology interest/expertise. 2. Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisionsare being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment. Trust response: The attendance from clinical oncology at MDT has significantly improved over the past year, however, this improvement must continue and to this end HSCB are working with the RegionalOncology Centre to ensure adequate oncology cover at all MDTs." 85. The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment. Patients who have a diagnosis of urological cancer following routine referral have a significant delay in diagnosis and this could impact on the treatment pathways and significantly affect outcomes for patients.	2015 Appraisal pages 85-86 AOB-22735 – AOB-22736 Pages 90-92 AOB-22740 – AOB-22742

Trust response:
All referrals to the Trust are triaged by consultants, affording the opportunity for routine referralsto be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients."

"Concerns

Lack of implemented keyworker policy.

Lack of HNA and documentation.

No agreed pathway for follow up of patients after referral to mainland services.

No joint or parallel clinic in place to discuss treatment options.

Lack of agreed clinical guidelines.

Lack of data provided on local identification of patients suitable for recruitment to clinical trials.

Lack of a specific information leaflet describing the MDT function and roles.

Timeliness in communicating to GPs as reliant on postal service.

Not all appropriate core members have attended Advanced Communication Skills Training."

Notification of Immediate Risks and Serious Concerns

Trust:	**Southern HSC Trust**
Date of Visit:	16th June 2015
Service:	Local Urology MDT
Immediate Risks:	None
Serious Concerns:	1. There is now a single handed radiologist supporting the Urology MDT with no cover arrangements in place. Attendance at the MDT during 2015 is not consistent due to clinical commitments in order to deliver timely waits for patients. This could adversely affect the treatment planning decisions for patients. Trust Response The Trust can confirm that the reduction of Radiology provision to the Urology MDT was entirely unpredictable. The Trust has taken appropriate measures and has advertised replacement radiologists with Urology interest/expertise.
	2. Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment. Trust Response The attendance from Clinical Oncology at MDT has significantly improved over the past year, however, this improvement must continue and to this end HSCB are working with the Regional Oncology Centre to ensure adequate Oncology cover at all MDTs
	3. The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment. Patients who have a diagnosis of urological cancer following routine referral have a significant delay in diagnosis and this could impact on the treatment pathways and significantly affect outcomes for patients.

Pages 95-96

<table>
<tr><td></td><td></td><td>
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<tr><td></td><td>All referrals to the Trust are triaged by consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients.
With specific regard to the waiting times, HSCB are about to undertake a review of outpatient services with view to reform where appropriate and relevant.</td></tr>
<tr><td></td><td>4. Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the NICaN agreed clinical guidelines.
Trust Response

The Guidelines remain to be agreed by NICaN and HSCB, and that it is the intent that they will be by January 2016.</td></tr>
</table>
</td><td></td></tr>
<tr><td>19.06.2015</td><td>Email from Ms Corrigan to Consultants</td><td>Haematuria referrals are on the increase</td><td>TL5 page 2320 – 2321

AOB-74515 – AOB-74516</td></tr>
<tr><td>23.06.2015</td><td>Email from Mr Young</td><td>Re August Rota</td><td>TL5 page 2336 – 2339</td></tr>
<tr><td>25.06.2015</td><td>Email from Ms Glenny to Consultants</td><td>Re Urology Longest waiting urgent – waiting time decreasing

<table>
<tr><th>Consultant</th><th>In-Patient</th><th>Day Case</th><th>Total</th><th>Longest Waiting Urgent Patient</th></tr>
<tr><td>AOB</td><td>10</td><td>0</td><td>10</td><td>82 weeks</td></tr>
<tr><td>MY</td><td>9</td><td>1</td><td>10</td><td>89 weeks</td></tr>
<tr><td>TOTAL</td><td>19</td><td>1</td><td>20</td><td></td></tr>
</table>
</td><td>TL5 page 2351 – 2352

AOB-74546 – AOB-74547</td></tr>
<tr><td>26.06.2015</td><td>Email from Ms Corrigan</td><td>Notes that she has advised MLA of long waiting times and focus on cancer patients in response to his query about a patient</td><td>TL5 page 2355 – 2356

AOB-74550 – AOB-74551</td></tr>
<tr><td>26.06.2015</td><td>Email from Ms Corrigan</td><td>Re Publication of the Northern Ireland Cancer Waiting Times Statistics Release</td><td>TL5 page 2359 – 2362

AOB-74554 – AOB-74557</td></tr>
<tr><td>26.06.2015</td><td>Regional Urology Meeting</td><td>I have listed below what was on the agenda and a brief update:

85. Excess Patients Waits</td><td>TL5 page 2364 – 2365</td></tr>
</table>

		· New Outpatients – agreed that this would be looked at regionally but in advance of this we all were tasked with going back to our Trusts and validating what was waiting to be seen – e.g. how many vasectomies, circumcisions etc and to ensure that the patients were not seen already e.g. validation to ensure they still needed their appointment. I will action this…… There was quite a bit of discussion around one-visit clinics and apart from the Western Trust all other Trusts were keen to move to our model and Dean has asked for their plans on what they need to do to move to this. · Review Outpatients – agreed that this could NOT be looked at regionally (we have the biggest volume with Belfast next and then the rest of the Trusts not having a problem). Dean has requested that all Trusts go back and look at 3 months + and advise the Board of what is required to reduce this and send in our plans of where we will be able to get to if we get funding. · IPDCs – again a lot of discussion around this point. The figures show that the tail-end of the other Trusts long-waiters are Circumcisions, Vasectomies and routine flexible cystoscopes, bit worrying there was also TURBT's included but on discussion around the table we all felt that it was more likely to be TURP's instead. Each Trust have been asked to look at their waiting lists and come back to the Board with what is waiting (again I will action this) as we don't have a problem with flexis, circumcisions nor vasectomies as being our long waiters. Discussion followed regarding Saturday's or if it was feasible to send a team of consultants, nurses etc… to the likes of SWAH or Causeway that have no issue with theatre space or beds and do a run of theatre lists there? Dean has asked David and Lynne to explore this option but for us to put a proposal through for in-house as well although all Trusts are saying the same in that we are limited to theatre space and beds!). there was an agreement from the other Trusts that the flexis, vasectomies and circumcisions could be sent to the independent sector whilst I expressed my concerns and the fact that the IS have not worked for us this is going to be explored. There was also discussion on whether the NHS in Northern Ireland should cease offering vasectomies as a procedure, again a lot of debate but we agreed that this is a Commissioners decision and couldn't be made by those sitting around the table. 85. Opportunities for Integrated Working small working group to be set up. Eastern Trust GP in the room who was very signed up to this and had suggested things like training for GP's to do reviews in their practices etc… follow-up PSA!, using the likes of the LUTs Pathway guidance and ensuring that all is done before patient is referred in……. Heather spoke with him at the end and he advised that we needed to speak with Frances O'Hagan who was the Southern Trust GP representative. I will discuss this further when the email comes out requesting nominees. I will also update Peter Beckett. · Primary care support · CCG Banner Page Guidance · Request for advice 85. Workforce Planning small short-life working group to be meet to discuss and update (e.g. we are showing as having 4 Staff Grades and 1 GPWSI working in our Trust!) 4. Urological Cover for Acute Sites this was mainly in relation to Antrim and debate between the Board and Chris on what they actually provided. Colin and I advised that there was no issues of cover in our areas, e.g. for Southern Trust – SWAH and DHH.	AOB-74559 – AOB-74560

		5. Procedure Based Service and Budget Agreements working group to be set up and Dean was very clear that SBA would not get in the way of the delivery of service and that it was up to them to sort and they would work with planners/local commissioning etc to take forward. I have asked that some clinicians and service managers be involved as well as we know what is deliverable and achievable!! 85. Boundary Arrangements for Urology Referrals it has been agreed to formalise the boundary arrangements that had been agreed at the beginning of the year with GP's which for us is BT80. As these have been redirected to me I have worked out we get about 3-5 per week and couldn't argue on Friday that this is not manageable. By formalising this it will mean that the referrals will be sent direct rather than sending to Causeway to be sent on to ourselves. All other Trusts were in agreement of this for their areas. 85. Regional Solutions · reconstruction – Brian spoke to this and explained about the monthly meeting that has been established and that this was working very well with representation from all Trusts. Dean agreed that this should continue but wanted to formalise this and has asked for Board and PHA involvement to take this forward. Clinicians were in agreement. Board to take forward. · prostatectomies – Chris spoke to this and advised that the Belfast Trust have a business case ready to send to the Board looking for funding and support for a Robot. Debbie spoke to Dean after the meeting and advised of our concerns regarding this so that he is aware that the rest of the region are not necessarily in agreement with this proposal.	
29.06.2015	Email from Ms Dignam	Re July Schedule	TL5 page 2368 – 2369 AOB-74563 – AOB-74564
01.07.2015	Letter from Mr McMahon	Letter of notification re Trusts Serious concerns following the peer review	TL5 page 2457 – 2461 AOB-74652 – AOB-74656
16.07.2015	Email From Ms Elliot to Mr O'Brien	Re Patient query Patient notes was supposed to have CT scans done every 6 months and 1 year has now passed without the scan being done	TL5 Page 2462 AOB-74657
17.07.2015	Email From Ms Reddick to Consultants	Re Peer review reports and requesting review for factual accuracy	TL5 page 2490 – 2498 AOB-74685 – AOB-74693

18.07.2015	Email from Mr O'Brien to Ms Reddick	Mr O'Brien provides his comments on the draft peer review report . Section: Structure and Function of Service Paragraph 2 '…….and so the MDT covers a population of 348,657.' It is my understanding that this figure is the population of the Southern Health and Social Care Board Area. The population of County Fermanagh is 61,175 (at last census) The combined, total population for which we had responsibility during the year under review, 2014, was 409, 832. 2. Section: Structure and Function of Service Paragraph 2 The acronym for South West Acute Hospital is SWAH (not SWAT) 3. Section: Coordination of Care/Patient Pathways Paragraph 3 Computerised Tomography (CT) scanning is not integrated into the Single Visit Clinic 4. Section: Coordination of Care/Patient Pathways Paragraph 6 'Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the NICaN agreed clinical guidelines.' This is factually incorrect as the NICaN Clinical Guidelines have not been agreed.	TL5 page 2499 – 2501 AOB-74694 – AOB-74696
18.07.2015	Email from Mr O'Brien to Ms Reddick and Ms Corriagn	Mr O'Brien provides his comments on the Trust CEO letter in relation to the Peer Review Visit Serious Concern 1: I have had the opportunity of discussing this problem of Dr. Stephen Hall who has advised that the Trust has advertised for two radiologists, with either GI or Urology interest/expertise. I believe that it can be truthfully reported that the problem with radiology cover was entirely unpredictable, and that the Trust has taken appropriate measures to address that problem by being prepared to appoint additional staff. Serious Concern 2: I believe that the attendance data by Clinical Oncology during 2015 to date will go a long way to confirm that Oncology attendance has been addressed. It would be useful to have that attendance data for Paula to include in her reply. Serious Concern 3: I believe that it has been a failure on my part not to have stated in the Peer Review Documentation that all referrals to the Trust are triaged by consultants, affording the opportunity for referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent or by some other means, thereby minimising the risk of inordinate delay in diagnosis. I have the impression that the Review Team were or are not appreciative of Consultant triage of all referrals. I believe that it should be reassuring for Paula to include that in her response. Serious Concern 4:	TL5 page 2502 – 2503 AOB-74697 – AOB-74698

		The NICaN Clinical Management Guidelines have not been agreed. It is incorrect to state that nephron sparing surgery should be undertaken by the specialist MDT as it has not been agreed by NICaN that it should be, nor agreed by the HSCB that it be so. In Paula's response, she should be aware that the issue of nephron sparing surgery was raised as a concern on the day of Peer Review when the Peer Review Team may not have been aware that the Clinical Management Guidelines were in draft form, and yet to be agreed. However, once a serious concern has been raised, it cannot be deleted. Since then I have had the opportunity of advising Clare Langslow of this, my comments being included in our draft Peer Review report, in addition to those of Altnagelvin and Belfast. Therefore, I believe that it will suffice for Paula to advise that the guidelines remain to be agreed by NICaN and HSCB, and that it is the intent that they will be by January 2016,	
20.07.2015	Notes from Peer Review Feedback Meeting		SUPOCT Page xx

UROLOGY		
Quorum	• Need to do a separate piece of work – oncology, pathology, radiology, CNS in particular • Look at demand, current capacity and investments – outstanding requirements	Worki develo
Routine waits	• Agree and progress through regional meetings no separate discussions required	Sara Beth M
Penile surgery / Nephron sparing Surgery	• Discussions to take place through the Regional Urology process / Beth Malloy	Sara Beth M
Length of the Regional MDT	• Develop an options appraisal for Specialist MDT	
CNS	• Regionally developing CNS plan	Trust priorit

21.07.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's mother querying for date of surgery as been on waiting list since July 2014	TL5 page 2509 AOB-74704
22.07.2015	Email From Ms Corrigan to Consultants	Ms Corrigan notes that things are slipping again re meeting targets and explains that this is for various reasons but is expected to get worse over the annual leave in summer	SUP OCT Page xx
23.07.2015	Agenda for Urology Departmental Meeting	1. Regional Review Paper for discussion along with nominations for sub-groups 2. RQIA Visit to 3 South 3. Infection Control Issues – 4th Floor 4. Peer review – serious concerns 5. New Clinics – stocktake 6. AOB	TL5 page 2522 AOB-74717

24.07.2015	Email from Ms Dignam	Re August rota	TL5 page 2548 – 2551 AOB-74743 – AOB-74746
30.07.2015	Email from Ms Dignam	Re rota September 2015	TL5 page 2595 – 2598 AOB-74790 – AOB-74793
30.07.2015	Email from Ms Dignam	Re Schedule September 2015	TL5 page 2599 – 2600 AOB-74794 – AOB-74795
18.08.2015	Email from Ms Corrigan to Consultants	Re funding for equipment that need/like.	TL5 page 2679 AOB-74874
18.08.2015	Email from Ms Elliot to Mr O'Brien	Request to overbook Mr O'Brien's clinic to fit a patient in	TL5 page 2683 AOB-74878
19.08.2015	Minutes from Urology Departmental Governance Meeting	1. HAND OVER – This is proving an on-going issue; it is still recorded that this should be in person and in writing. It is recognised that the clinical governance committee are awaiting to report on this however in the interim our Registrar's will attend the surgical hand over in the morning at 8:40am. This will be the interim measure until it is defined what exactly will be the on-going arrangement. It is also appreciated that there is a hand over in the evening. 2. LOCUM WORK – It's not exactly clear when Locum's are commencing their shift time. There is an appreciation that they are working in other Trusts prior to commencing work for us in the evening. A more realistic start time may be recommended. Outcome is for Martina Corrigan to audit start time. 3. Where a patient is an inpatient and a urology consult is requested we are recommending that as much as possible	SUPOCT Page

		from a urology investigative point of view should be performed as an inpatient rather than bringing the patient back as an outpatient. 4. The daytime Registrar cover of the urology unit was discussed with regards to the change noted in July where all day cover for a full week had been instigated; Dr Martin felt that there was good continuity of care. We are currently trialling the consistency of a single Registrar covering the morning sessions from Monday to Friday for two months. In October we will again trial the all day Monday to Friday approach. 5. There has been an adoption of one bleep only for the on-call urology Registrar i.e. the bleep is handed between Registrars' as opposed to switchboard etc. having to look at a rota for each session. 6. There are on-going training issues with regards to Immax (now called - Note). The M&M form data needs to be completed by the individual consultant and then at the audit meeting this will be completed by the audit members led by the chairman. 7. The Trust audit on fifty inpatients has had a poor uptake to date. It was hoped that 'google-doc' could be used but this has not been possible due to Trust computer blocking systems. Martina Corrigan will be addressing this with the IT Department but we have suggested that if this is not immediately correctable that a paper version would be undertaken. Plan to start 01st September 2015. 8. The stent register process is on-going. Mr Haynes has liaised with BAUS central office. Update for next meeting. 9. Audits for the incoming year: 1. Partial nephrectomy – All partial nephrectomies undertaken from 2010 onwards to be reviewed by Jenny Martin.	

		2. Outcome of invasive transitional cell carcinoma from 2000 – 2010. This is a pathology based audit to identify all outcomes of such patients. Mr Mukhtar to liaise with Mr O'Brien on this topic. 3. Audit of hand over quality – Mr Tyson. 4. On-line catheterisation teaching questionnaire for FY1's. These audits are in addition to the index control audit of TURBT and TURP. 10. Dr McAllister's comment on VTE prophylaxis was noted. The outcomes for each ward are recorded. Discussion on this topic did record that for 3 South the VTE risk assessment was only at 55%. Discussion also noted that our ward was a mix of ENT and urology. This led to a discussion around whether Clexane should be given to patients where bleeding is at risk, namely haematuria, TURBT and prostate surgery. It was concluded that all patients will be given the appropriate Clexane and TED stockings unless there is a specific default from same recommended by the consultant in charge. A focus at the daily ward round on the drug 128ardex is to be instigated. 11. <u>COMPLAINTS</u> – There is a general trend of complaints with regards to waiting times for outpatients and inpatients. No specific complaint with learning point has been recorded. 12. <u>CLINIC TIMES</u> – It is recorded that the afternoon clinics are overrunning often finishing well after 5:00pm and sometimes at 6:30pm. The afternoon clinics start at 1:30pm. The booking times towards the end of the clinic are to be readdressed by Martina Corrigan. It is recommended that last patient appointments should be at 4:00pm; this is to be trialled, actioned by Martina Corrigan. 13. No mortalities are recorded this month. 14. <u>MORBIDITY</u> – Case of bilateral flexible ureteroscopy with resultant acute renal failure from obstruction. The case	

		presented with bilateral diagnostic flexible ureteroscopy with passage of urine for 48 hours post-procedure which then progressed to acute onset of anuria. Renal function blood tests then defined increasing creatinine. An ultrasound scan did not show any hydronephrosis. Patient then developed pain. Nephrology input requested as unusual presentation of obstruction. Proceeded with bilateral stent insertion; this resolved the renal function. Outcome learning points: 1. Treat bilateral ureteroscopy with utmost respect with insertion of ureteric catheters or stenting. 2. A lack of hydronephrosis does not necessarily exclude obstruction – clinical judgement to take precedence. 15. <u>NEXT MEETING</u> – General hospital audit on 15th September 2015. (post- script = this date is same as Regional Audit in the Ulster Hospital)	
21.08.2015	Email from Mr Elliot to Mr O'Brien	Re patient query – notes that have not received date for surgery and patient is deteriorating. However, notes that Mr O'brien is a very busy man	TL5 page 2715 AOB-74910
21.08.2015	Email From Ms Corrigan to Consultants	Re Review backlog Clinic funding Allocated funding for 650 face to face appointments and 1200 validation patients. Notes that there is an indication by some to do these during working week and displace one SPA and only one of these can be done during the working hours of 9am – 5pm in any week. Another preference was to stay on in the evenings and do for example 5pm – 8pm and there is no limit to how many of these can be done in each week. There is also the option of Saturday's either an AM or an all -day session.	TL5 page 2717 AOB-74912
23.08.2015	Email correspondence between consultants	Re Regional Action plan Notes that they need to prioritise and would not be willing to do lower clinical priority until sort their own issues	TL5 page 2724 – 2725 AOB-74919 – AOB-74920

24.08.2015	Email from Ms Corrigan to Consultants	Re Urology Team Response to Regional Action Plan	TL5 page 2726 – 2739 AOB-74921 – AOB-74934
26.08.2015	Email from Mr Young to Consultants	Re October Rota	TL5 page 2750 – 2753 AOB-74945 – AOB-74948
01.09.2015	Email from Ms Elliot to Mr O'Brien	Re patient query Patient pregnant and cannot have a CT scan. Was due CT scan in August. In previous CT scan no signs of metastasis but no follow up appointment was ever given or any correspondence to go through report. Have not been seen by Mr O'Brien from February 2014 which was over 18 months. Notes that if no response will take this further.	TL5 page 2772 – 2773 AOB-74967 – AOB-74968
04.09.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Notes patient as due to surgery in March 2015 but was cancelled due to overrunning	TL5 page 2824 AOB-75019
07.09.2015	Email from Ms Dignam to Consultants	Re Schedule for September	TL5 page 2835 – 2836 AOB-75030 – AOB-75031
07.09.2015	Email from Ms Glenny to Consultants	Re Urology Total Elective Waiting List **885 Patients in Total on Waiting List** **8 Dates in the past - to be updated on PAS b** **113 Patients with dates for surgery** **764 Patients without dates for surgery** **369 Of which are Urgent - longest waiter 85 we** **395 Of which are Routine - longest waiter 107** **At the end of September - projected to have 170 patients waiting greater than one year for surgery**	TL5 page 2839 – 2920 AOB-75034 – AOB-75115
11.09.2015	Email from Ms Barr	Notes that due to inpatient demand, currently unable to offer outpatient CT appointments in Craigavon.	TL5 page 2959

			AOB-75154
11.09.2015	Email from Ms Glenny to Consultant	Re Urology Outpatient dashboard – shows position of urology dept	TL5 page 2960 – 3001 AOB-75155 – AOB-75196
17.09.2015	Email from Ms McElvanna to Consultants	Re No staff trained on administration of Mitomycin – of great concern	TL5 page 3049 AOB-75244
18.09.2015	Email from Ms Haughey to Mr O'Brien	Re radiology Crisis Here are the points. 1. Oncologists have more than doubled in numbers since 06 and we have had 2 new radiologists who have not been full time oncology (EN and RL) 2. 3 semi retirees in july means that over 40 cancer ct scans and numerous mp mri scans are reported per week as wli. For the first time since BPH, lists will be cancelled when a consultant is on leave. This will have a knock on effect re targets and patients being scanned in time for each chemo cycle / dxt fraction etc. We cannot develop any sort of service for the future. We cannot participate in research or adequately in clinical trials. 3. Oncology imaging is to be outsourced. As this involves a time line and comparisons on 3 pacs systems it is unlikely that appropriate reports will be generated. Also they will be reported by general radiologists who will not be contributing to the mdms. This will have a massive impact on us regarding having to do the comparisons that were not done and also at the mdm level to sort out all the reports advising discussion at these meetings. 4. A move to force BCH radiologists to become radiologist of the week at the RVH will further decimate the service. 5. Currently no-one will apply for a job in radiology in BCH/NICC as terms and conditions are so much better in the dgh's and units.	TL5 page 3050 – 3051 AOB-75245 – AOB-75246
25.09.2015	Email from Ms Farrell to Mr O'Brien	Re Patient query/complaint (Mr Personal Informati Patient's mother called to complain that patient is now deteriorating. Was supposed to have a simple procedure done 2 years ago. When first met with Mr O'Brien he advised that the procedure would be done in 2 weeks.	TL5 page 3099 – 3100 AOB-75294 – AOB-75295
28.09.2015	Email From Ms	Re Regional Capacity	TL5 page 3105 – 3109

	Corrigan to Consultants	Notes that there is a theatre staff problem in SWAH as not experienced enough to manage TURPs. However, if enough theatre staff in CAH who would be willing to travel to SWAH to do all day TURP this could be explored. Ms Corrigan queried whether any of the Consultants were interested in working additional weekends	AOB-75300 – AOB-75304
28.09.2015	Email from Ms Dignam to Consultants	Re October Schedule	TL5 page 3115 – 3116 AOB-75310 – AOB-75311
30.09.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient wondering when date for review appointment would be. Has been on waiting list and was due in September 2014.	TL5 page 3118 AOB-75313
30.09.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Have been on waiting list since September 2014	TL5 page 3119 AOB-75314
01.10.2015	Email from Mr Haynes	Response to Datix W[Personal information redacted by] Our single FY1 this week is split across two wards at present resulting in significant inefficiency and difficulty in working. There is no CST supporting them in this work. At the same time I understand that there have been times when there are strikingly different levels of FY1 / jnr dr staffing levels on other wards (eg 4N). Indeed I do not recall seeing fewer than 2 FY1s on 4N at any point. I believe on occasion this week there have been 3. Because they are ward based the FY1s are doing the jobs on their ward and not any other. Thus while our FY1 is struggling on their own, staying late every night and working across two locations, their colleagues are leaving on time. Added to this, it is my view based upon experience of working elsewhere that our FY1s are performing duties (eg first dose IV Abx) which are not considered the duties of a doctor in any other hospital / trust that I have worked in. The result of this is that our FY1 this week is becoming increasingly disillusioned with her job and career. Her pat on the back is an IR1 form (this may not be intended to be critical of the FY1 but I am sure that is how the FY1 will interpret it). Something has to give. Either the FY1 staffing levels across all surgical wards need to be reviewed daily so that the 3 on one ward and 1 on another (that is split to two places) situation does not arise or we need to agree what the FY1 should be prioritising (should it be the bloods, the imaging, the IV access, empting their bladder, the incomplete drug kardexs, the patient that needs reviewing, the consultant ward round, their lunch etc) and what can be left to the bottom of the priority list. If nothing can be left then we need to ensure that 'the shit flows uphill', our Registrars need to start helping out with FY1 duties and we start doing the Registrar duties, inevitably something wouldn't get done though. Long term I think the duties expected of an FY1 need to be looked at here (CAH / NI) and brought into line with the rest of the NHS (along with support nursing / auxiliary staff) as this is the only way we will have FY1s	TL5 page 3266 – 3270 AOB-75461 – AOB-75463

		being trained and not being disillusioned by their urology experience (how many of our FY1s are finishing thinking they've experienced urology in some way and are keen to explore it as a career?). The problem is across the FY1 grade in CAH, I hear the medical FY1s dare not allowed on the medical ward round and simply get given a list of jobs by the team	
05.10.2015	Email from Ms Glenny to Consultants	Re Urology Patient Dashboard	TL5 page 3293 – 3294 AOB-75488 – AOB-75489
06.10.2015	Email from Ms Corrigan	Re Urology Departmental meeting – Draft agenda **AGENDA** 1. Administration of Mitomycin 2. Infection control 3. FY1 duties on the wards 4. Saline TURP System (do we need Susan England at meeting) 5. Antibiotic Stewardship (do we need to invite Melanie Pathiraja – Consultant microbiologist to a future meeting?) 6. Paediatrics – Daisy Hill Hospital 7. Emergency Theatre utilisation 8. Urology oncall Registrar rota 9. Working Group updates (SBA/CCG referral for advice and banner guidance) 10. Triage 11. Greenlight laser – Rep Mark Devoy would like to attend a future meeting to provide information on this. 12. Hospital at night 13. TROC pathway (Kate and Jenny to attend) 14. FPSA or not FPSA?? (Derek McKillop attending the meeting on 22 October at 12:30)	TL5 page 3295 – 3296 AOB-75490 – AOB-75491
06.10.2015	Email from Ms Dignam to Mr O'brien	Mr O'Brien notes that patient should not wait so long for admission re stent change – Ms Dignam explained that patient was due in July but were not able to provide a date until now. Note – this is a patient of Mr Young's but Mr O'Brien performed stent change	TL5 page 3297 AOB-75492
08.10.2015	Email from Mr Wright	RE Doctors Behaviour Notes the extreme pressures that many staff are experiencing in delivering care at ward level. However, experiencing surge in C.Diff cases at CAH	TL5 page 3327 – 3328 AOB-75522 – AOB-75523
12.10.2015	Email from Ms Troughton to Mr O'brien	Re Patient query Patient has been on waiting list since December 2014 for surgery and having increased problems	TL5 page 3347 AOB-75542

22.10.2015	Minutes of Urology Department Governanc e Meeting	1. Minutes of last meeting 2. Update on registrar audits received 3. Mr Glackin Nephrectomy cases 4. M&M 5. Audit of UTI post Flexible Cystoscopy in the Thorndale Unit 6. Complaints & Compliment s 7. Learning from SAI 8. AOB	TL5 page 3416 – 3418 AOB-75611 – AOB-75613
26.10.2015	Email from Mr O'brien to Ms Elliot	Noted that a patient's procedure was cancelled due to lack of available bed. She has been rescheduled	TL5 page 3471 AOB-75666
29.10.2015	Email from Ms Dignam to Consultants	Re Dec & Nov rota	TL5 page 3494 – 3499 AOB-75689 – AOB-75694
31.10.2015	Email from Mr O'brien to Ms Elliot	Notes that patient did not have surgery performed on 28 October 2015 due to lack of bed post op. have rearranged	TL5 page 3522 AOB-75717
02.11.2015	Email from Ms Dignam	Re November Schedule	TL5 page 3523 AOB-75718
02.11.2015	Email from Ms Corirgan to Mr O'Brien	Mr O'Brien was requesting to carry out additional works	TL5 page 3524 – 3525 AOB-75719 – AOB-75720
03.11.2015	Email from Ms Elliot to Mr O'Brien	Re patient query Patient wanted date for surgery and has been on waiting list since March 2014	TL5 page 3531 AOB-75726
12.11.2015	Email From Ms Hunter to Ms Gishkori	Re concerns on 3 South While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters. Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions.	TL5 page 3566 – 3570 AOB-75761 – AOB-75765

		In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation. Main issues 1. Staff shortages 2. Staff Morale 3. Skills mix 4. Nursing care records 5. Cancellation of staff training 6. Staffing of ENT Clinical room during the day 7. Pharmacy cover on ward	
13.11.2015	Email from Mr Haynes to Ms Hunter	Re Response to 3 south concerns This is extremely concerning and in particular if patients incidents have occurred due to staffing issues already we need to act now and not wait for a more significant incident to occur. My experience of Bank / agency staffing is that while they may fill a vacant gap, they often do not perform the full role as we would see performed by a regular member of staff. The result is that the regular members of staff come under increased pressure during their shift. In addition to the Bank and agency staff you also highlighted to me that some members of our nursing team are very newly qualified and this has meant that at times the ward staffing (at staff nurse level) has been made up of bank / agency staff, a newly qualified nurse and one more experienced nurse, increasing the pressure on the regular members of staff significantly. I recently operated on the relative of a colleague and the informal feedback from this family regarding the ward was that the staff are excellent but under significant pressure and not able to attend to patients as would be expected. Where the ward is understaffed for the 31 beds continuing with 36 beds open and relying on Bank / agency staff is not safe as you highlight. In prioritising care, emergency admissions come first and so we should not be admitting elective patients while the current situation exists	TL5 page 3571 – 3572 AOB-75766 – AOB-75767
13.11.2015	Email correspodnences between consultants	Re response to concerns in 3 South Ward	TL5 page 3593 – 3598 AOB-75788 – AOB-75793
17.11.2015	Email from Ms Gishkori	Notes the continuance to provide a safe and effective service despite current challenges. Winter pressures started around a month earlier this year but opening up the winter beds should help with extreme bed pressures we are facing the moment	TL5 page 3602 – 3603 AOB-75797 – AOB-75798
18.11.2015	Email from Ms Dignam	Re December Schedule	TL5 page 3604 – 3605

			AOB-75799 – AOB-75800
24.11.2015	Email from Ms Corrigan to Consultants	Re 62 day active longest waiters breachers Longest wait is 136 weeks 18 patients over the 62 days	TL5 page 3624 – 3634 AOB-75819 – AOB-75829
24.11.2015	Email from Ms McMahon to Consultants	Re Urodynamics waiting list remains considerable	TL5 page 3635 – 3654 AOB-75830 – AOB-75849
24.11.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient is on waiting list for review which was due in Jan 2015	TL5 page 3655 AOB-75850
24.11.2015	Email from Mr O'Brien to Ms Corrigan and Consultants	Mr O'Brien raises his concerns for non-cancer patients due to waiting lists	TL5 page 3656 AOB-75851
25.11.2015	Email from Mr Young	Re Jan rota	TL5 page 3657 – 3661 AOB-75852 – AOB-75856
01.12.2015	Email from Ms Personal Information to Mr O'Brien	Re Patient query My father and I are very appreciative of the care and treatment he received during his stay in CAH and your telephone call to check on his progress and outline the arrangements for the removal of the catheter. This was to consist of a morning visit from the District Nurse followed by a scan at the Thorndale Unit on a date when you would be present to see my father. Not having been given a date for the procedure I contacted your secretary who told me that no scan had been arranged and the District Nursing team would be responsible for the removal of the catheter and the follow up check in the afternoon of Thursday 12 October. Unfortunately there seemed to be some confusion over this arrangement and the DN team contacted me to say that they had been given insufficient information and would not be removing the catheter on that day. Removal was rescheduled for Monday 16 November and catheter was removed around noon followed by a check at 3pm and then 4 pm when catheter was reinserted as my father hadn't been able to pass urine. This process was repeated on Thursday 19 November with the catheter being removed earlier in the day but with the same result. I was again contacted by the DN team who said my father would be referred back to you for further investigation.	TL5 page 3690 AOB-75885

		Your secretary advised me my father has been put on the list for a clinic in Armagh on Monday 7 December but as yet he has received no written confirmation of this. By then the catheter will have been in for almost 10 weeks. I am not sure what the purpose of this clinic visit is but am concerned that if the catheter is removed at this stage no scan or visit from DN will have been arranged for the afternoon and my father's health might be put at risk. I am sorry to contact you directly but my father is Personal and I don't want the visit to Armagh to be a wasted journey. He has built his hopes up on three occasions that the catheter would be removed permanently and I worry that another disappointment will cause him to become depressed. I would be extremely grateful if you could look into the arrangements for the appointment in Armagh and advise me accordingly.	
03.12.2015	Email from Ms Dignam	Re December schedule	TL5 page 3696 – 3697 AOB-75891 – AOB-75892
04.12.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list since June 2014 and was ringing re a date	TL5 page 3700 AOB-75895
07.12.2015	Email from Ms Neilly to Ms Elliot	Re Patient query Patient on urgent waiting list since September 2014	TL5 page 3723 AOB-75918
10.12.2015	Email from Ms Glenny to Consultants	Re Additional theatre session funding Funding for additional theatre sessions in Jan – March 2016. Ongoing bed pressure so agreed that could do Saturday morning lists with day case procedures only.	TL5 page 3728 AOB-75923
14.12.2015	Email from Ms Dignam to Mr O'Brien	Re patient query Patient was due stent removal in September 2015 and is very distressed	TL5 page 3753 AOB-75948
18.12.2015	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list since May 2014 and wondering for date	TL5 page 3761 AOB-75956
18.12.2015	Email from Ms Elliot to Mr O'Brien	Notes that urodynamics cannot accommodate 3 uro and 2 flexi on the same session as per which Mr O'Brien wanted booked	TL5 page 3779 AOB-75874
22.12.2015	Email from Ms Robinson to Mr O'brien	Re patient query Patient wondered when surgery would be – has been on waiting list since April 2015	TL5 page 3783 AOB-75978

<table>
<tr><td>29.12.2015</td><td>Email from Mr O'Brien to Ms Elliot</td><td>Mr O'Brien notes that he could not carry out patients surgery as no bed available for her in ICU or HDU</td><td>TL5 page 3797

AOB-75992</td></tr>
<tr><td>29.12.2015</td><td>Email from Mr Young</td><td>Re 2016 oncall rota and Feb rota</td><td>TL5 page 3798 – 3801

AOB-75993 – AOB-75996</td></tr>
<tr><td>30.12.2015</td><td>Email from Ms Smyth to Mr Glackin</td><td>Re Patient query

Patient referred in Dec2014 but notes he has not received a letter and is not on waiting list</td><td>TL5 page 3804

AOB-75999</td></tr>
<tr><td>30.12.2015</td><td>Email From Ms Glenny to Consultants</td><td>Re Urology Planned Waiting List – Expected date of admission Jan 2016 or less

There are a total of 189 patients – 71 with dates, 118 with no dates.

<table>
<tr><th>Consultant Code</th><th>Total Volumes</th><th>Longest Waiter</th><th>Volumes with Dates</th></tr>
<tr><td>AJG</td><td>29</td><td>Oct-15</td><td>21</td></tr>
<tr><td>AOB</td><td>52</td><td>May-14</td><td>1</td></tr>
<tr><td>JOD</td><td>11</td><td>Oct-15</td><td>8</td></tr>
<tr><td>KS</td><td>30</td><td>Mar-15</td><td>17</td></tr>
<tr><td>MDH</td><td>17</td><td>Dec-15</td><td>3</td></tr>
<tr><td>MY</td><td>50</td><td>Oct-14</td><td>21</td></tr>
<tr><td></td><td>189</td><td></td><td>71</td></tr>
</table>
</td><td>TL5 page 3806 – 3837

AOB-76001 – AOB-76032</td></tr>
<tr><td>31.12.2015</td><td>Email from Mr Williams to Consultants</td><td>Re no attendance at X-Ray meetings</td><td>TL5 page 3852

AOB-76047</td></tr>
<tr><td>31.12.2015</td><td>Email from Ms Glenny to Consultants</td><td>Re Total Urodynamics waiting list</td><td>TL5 page 3853 – 3871

AOB-76048 – AOB-76066</td></tr>
<tr><td>31.12.2015</td><td>Email from Ms Corrigan</td><td>Jan on call rota</td><td>TL5 page 3872 – 3873</td></tr>
</table>

			AOB-76067 – AOB-76068
2016	Elective Inpatient Operating 2016	AOB's analysis of Elective Inpatient Operating 2016 **Elective Inpatient Operating 2016** **Sessions** Wednesday 06 January Urologist of the Week Wednesday 13 January 9 am – 8 pm 2.75 Wednesday 20 January 12 noon – 8 pm 2.0 Wednesday 27 January 12 noon – 8 pm 2.0 Wednesday 03 February 12 noon – 8 pm 2.0 Wednesday 10 February 12 noon – 8 pm 2.0 Wednesday 17 February Urologist of the Week Wednesday 24 February 9 am – 8 pm 2.75 Friday 26 February 1.30 am – 5.30 pm 1.0 Saturday 27 February 9 am to 1 pm 1.0 Wednesday 02 March Professional Leave: expert witness Wednesday 09 March 12 noon – 8 pm 2.0 Saturday 12 March 9 am – 1 pm 1.0 Wednesday 16 March 9 am – 8 pm 2.75 Wednesday 23 March 12 noon – 8 pm 2.0 Wednesday 30 March Urologist of the Week Wednesday 06 April 12 noon – 8 pm 2.0 Wednesday 13 April 9 am – 8 pm 2.75 Wednesday 20 April Audit Wednesday 27 April 12 noon – 8 pm 2.0 Wednesday 04 May 12 noon – 8pm 2.0 Wednesday 11 May Urologist of the Week Wednesday 18 May 12 noon – 8 pm 2.0 Wednesday 25 May 12 noon – 8 pm 2.0 Wednesday 01 June 12 noon – 8 pm 2.0 Wednesday 08 June Urologist of the Week Wednesday 15 June 12 noon – 8 pm 2.0 Wednesday 22 June Professional Leave: expert witness Wednesday 29 June 9 am – 8 pm 2.75	2017 Appraisal page 347 & 348 AOB-23225 & AOB-23226

		Wednesday 06 July 9 am – 8 pm 2.75 Wednesday 13 July 9 am – 8 pm 2.75 Monday 18 July 1.30 pm – 5.30 pm 1.0 Wednesday 20 July 9 am – 1 pm 1.0 Wednesday 27 July 9 am – 8 pm 2.75 Wednesday 03 August Urologist of the Week Wednesday 10 August 9 am – 8 pm 2.75 Wednesday 17 August 12 noon – 8 pm 2.0 Wednesday 24 August 9 am – 8 pm 2.75 Friday 26 August 9 am – 5 pm 2.0 Saturday 27 August 9 am – 1 pm 1.0 Wednesday 31 August 9 am – 8 pm 2.75 Wednesday 07 September 12 noon – 8 pm 2.0 Wednesday 14 September Urologist of the Week Wednesday 21 September 9 am – 8 pm 2.75 Wednesday 28 September 9 am – 8 pm 2.75 Wednesday 05 October 12 noon – 8 pm 2.0 Wednesday 12 October 12 noon – 8 pm 2.0 Wednesday 19 October Audit Wednesday 26 October Urologist of the Week Wednesday 02 November 9 am – 8 pm 2.75 Wednesday 09 November 9 am – 8 pm 2.75 Total = 83.25 sessions Plus 1.5 hours of perioperative patient care for each date: 58.5 hours = 14.625 sessions Plus 1 hour of administration time per session: 83.25 hours = 20.8125 sessions **Total =118. 6875 sessions** **Number of elective inpatient sessions contracted at per Job Plan = 58**	
January 2016	Urology Presentation	Outlines the position of the Urology Department	TL6 page 143 – 154 AOB-76230 – AOB-76241
January 2016 to December 2016	CHKS Consultant Level Indicator Programme	CHKS Consultant Level Indicator Programme January 2016 to December 2016. Contained in 2016 Appraisal.	2016 Appraisal Pages 28 – 34 AOB-22858 - AOB-22864
January 2016 to December 2016	CLIP (Consultant Led Indicator Programme) Report	CLIP Report	2016 Appraisal page 36 AOB-22866

		What issues can I identify from the report? For several years, I have had doubts regarding the reliability and utility of the data contained within CLIP reports. On this occasion, I have had reason to have a detailed knowledge of all of the sessions of clinical activity conducted during the first ten months of 2016 [Personal Information redacted by the USI] I conducted 83.25 elective inpatient operating sessions during that time, in contrast to the 58 sessions in my job plan. However, that additional operative work had only a minimal, negative effect on outpatient clinic activity (1.5 sessions). Moreover, the CLIP report takes no account of sick leave or other circumstances impacting upon performance. The report has detailed that I performed 36 prostatic resections in 2016. I actually performed 46. I have written to CHKS seeking an explanation. I have not received a reply. What actions will I undertake? At best, none. I will be even more circumspect than before regarding the merit of CLIP reports, if there is any. Final outcome after discussion at appraisal: (Complete at appraisal)	
January 2016 to December 2016	Urology MDT Annual Report for January – December 2016	Urology MDT Annual Report for January – December 2016 **3.0 KEY CHALLENGES** **Oncology and Radiology** The greatest challenge for the MDT during the past year has been the inadequacy of the availability of a clinical oncologist and or a radiologist at all MDMs. The inadequacy in both cases has essentially been due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the post where they are required. The inadequacy has been addressed with the appointment authorities. **Red Flag Referrals** There had been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past few years, up from 2902 in 2013 to 4761 in 2015/16. The greatest increase was to the Southern Trust, with an increase of 84% from 410 in 2013 to 753 in 2014. The increase has continued throughout 2015/16 – there were 1878 red flag referrals in 2016. **Performance** Even though there has been an increase in Red Flag referrals over the past few years, the increased compliment of Consultant Urologists has enabled the MDT to absorb the increased demand and complete the assessment of patients and enact their definite management within the agreed time period of 62 days. This has been reflected in the Cancer Performance data. The monthly average waits for an appointment between September-December 2016 were as follows: Prostate: 22 day wait Haematuria: 23 day wait Others: 15 day wait 3	2017 Appraisal page 283 & 285 AOB-23161 & AOB-23163

		Operative Capacity The main limiting factor in providing a complete cancer service is operating theatre capacity and operator time. Though the MDT has provided for the increased demand on Red Flag pathways, it has been at the expense of patients having, or suspected of having, recurrent bladder tumours, and those awaiting prostatic resection to facilitate their progress to radical radiotherapy for prostatic carcinoma having to wait increasingly longer periods of time for surgery, in addition to all those with non-cancerous pathology. This is a common and concerning experience across Northern Ireland, and will remain an increasing challenge until operative capacity is increased.	
04.01.2016	Email from Ms Dignam to Consultants	Re Jan & FEB ROTA	TL6 page 12 – 20 AOB-76099-AOB-76107
05.01.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient would like date for surgery – has been on waiting list from May 2015	TL6 page 23 AOB-76110
11.01.2016	Email from Ms Corrigan to Consultants	Notes that a member of the Board had highlighted that a patient was complaining that has not had a date for surgery. Noted that board member (David McCormick), knows only too well the current situation but has asked to ask if there is any indication on when this patient will have his procedure.	TL6 page 77 – 78 AOB-76164 – AOB-76165
11.01.2016	Email from Ms Dignam to Ms Elliot & Mr O'Brien	Patient's surgery was cancelled due to lack of beds	TL6 page 80 AOB-76167
12.01.2016	Email from Ms Corrigan to Mr Personal Information redacted by the USI	Re Personal Information redacted by the USI complaint Ms Corrigan advised Mr Personal Information redacted by the USI that the team will keep him in mind if any cancellations but that the waiting list for non-cancer is out at 120 weeks and there is nothing more that can be done. It was also noted that this patient was a Belfast patient	TL6 page 81 – 82 AOB-76168 – AOB-76169
12.01.2016	Email from Ms Elliot to Mr O'Brien	Re patient query Notes that patient was seen in May 2015 as has bladder cancer. Was due review in 6 weeks but has not yet had an appointment. It was noted that the patient understands that urology is very under resourced at the moment	TL6 page 83 AOB-76170
12.01.2016	Email from Ms Corrigan to Consultants	Re Urology Backlog presentation	TL6 page 84 – 116 AOB-76171 – AOB-76203

15.01.2016	GP Access times	Outpatients (Urology) – 81 weeks In patients (urology) – 128 weeks Diagnostics (urology) – 69 weeks	SUPOCT Page
18.01.2016	Email from Ms Glenny to Consultants	Re Total TURBt Waiting list X9 patients of Mr O'Brien X3 patients for Mr Young X4 patients for Mr Haynes X6 patients for Mr Glackin	TL6 page 122 – 123 AOB-76209 – 76210
18.01.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient is on urgent waiting list from July 2014 and nurse noted that this was quite a long time	TL6 page 124 AOB-76211
18.01.2016	Email from Ms Neilly to Mr O'Brien	Re patient query Patient is DARO'd CT scan in Jan 2015 but has not heard anything from this	TL6 page 125 AOB-76212
25.01.2016	Email from Ms Neilly to Ms Elliot	Re Patient query Patient wanted to know when surgery would be. Has been on waiting list from February 2014 and has heard nothing	TL6 page 191 AOB-76278
25.01.2016	Email from Ms Corrigan to Mr O'Brien	Re – Mr Personal Information redacted by the Mr O'Brien volunteered to carry out this man's surgery (patient has complained). However, Ms Corrigan noted that due to the current situation with the beds, she cannot guarantee that he would be cancelled on the day	TL6 page 216 – 218 AOB-76303 – AOB-76305
27.01.2016	Email from Ms Robinson to Mr O'Brien	Re Patient query Patient's GP rang. He is on waiting list for review which was due in March 2014 but he has yet to be seen and he has known prostate cancer	TL6 page 221 AOB-76308
28.01.2016	Email from Ms Dignam to Consultants	Re March Schedule	TL6 page 222 – 224 AOB-76309 – AOB-76311
28.01.2016	Email from Ms Dignam to Mr O'Brien	Re Patient query Patient has been on waiting list since October 2015 and is red flag. This is a 3 month wait for red flag	TL6 page 225 – 226 AOB-76312 – AOB-76313
03.02.2016	Email from Ms Haughey to Consultants	Re Peer Review Feedback for discussion at Business meeting **Serious concerns** 1. Single handed radiologist with no cover in place 2. 25% quoracy due to low clinical oncology and radiology attendance 3. Long waits for routine referrals (up to 52 weeks)	TL6 page 260 – 271 AOB-76347 – AOB-76358

		4. Nephron sparing surgery undertaken locally **<u>Concerns</u>** 1. Lack of implemented key worker policy 2. Lack of HNA and documentation 3. Copy of consultation letter to patient does not routinely happen 4. No agreed pathway for follow up of patients after referral to mainland services 5. No joint/parallel clinic to discuss treatment options 6. Lack of agreed clinical guidelines 7. Lack of data on local identification of patients suitable for clinical trials 8. Lack of MDT information leaflet 9. Timeliness of GP communication 10. Attendance at advanced communication skills training	
04.02.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list for review April 2015 and advised of patient's symptoms	TL6 page 280 AOB-76367
09.02.2016	Email from Ms Hanvey to Mr O'Brien	Re Patient query Patient was last reviewed in July 2015 and was due a review in September 2015. Patient is still taking ciprofloxacin.	TL6 page
09.02.2016	Email from Dr Wright to Mr O'Brien	Re Legal report *"Thank you very much for completing the recent legal report. This was clearly very much appreciated by the legal team. You raised a number of issues regarding pressures of work in your email which I can fully understand and empathise with. I would appreciate the opportunity to discuss this matter further with you some time in the near future. As one of our most senior consultants I would greatly value your thoughts on this issue."*	TL6 page 438 AOB-76525
10.02.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list since April 2015 and was wondering when this could be done	TL6 page 439 AOB-76526
10.02.2016	Email from Ms Glenny to Consultants	Re Urology TURBT Procedures on Waiting List X10 AOB X 4 AJG X1 JOB X2 KS X7 MDH X6 MY	TL6 Page 440 – 442 AOB-76527 – AOB-76529
10.02.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient has been on waiting list since March 2014 and would like to be considered before June if possible	TL6 page 443 AOB-76530

11.02.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list since March 2014	TL6 page 445 AOB-76532
11.02.2016	Email From Ms Elliot to Mr O'Brien	Re Patient query Patient last attended CAOBUO clinic in August 2012 and was due for review in June 2015	TL6 page 447 AOB-76534
12.02.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient was last seen in February 2011 and was due a review in January 2014. Was ringing re date for review	TL6 page 452 AOB-76539
15.02.2016	Email from Ms Glenny to Consultants	Re Urology elective and planned waiting lists Total urology waiting list – approx. 981 in total **AOB –** Approx 280 **MY –** Approx 332 **AJG –** Approx 89 **JOD** – Approx 58 **KS –** Approx 88 **MH** – Approx 133 Total Planned waiting list – approx. 206 in total **AOB –** Approx 52 **MY** – Approx 61 **AJG** – Approx 29 **JOD** – Approx 15 **KS** – Approx 31 **MH** – Approx 23	TL6 page 472 – 495 AOB-76559 – AOB=76582
17.02.2016	Email from Ms OReilly to Mr O'Brien	Re Patient query Patient was reviewed in July 2013 for prostatic carcinoma and was told that he would undergo an MRI back in August 2015 but this has not yet happened and the patient is anxious	TL6 Page 499 AOB-76586
18.02.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient has been on waiting list for cystoscopy and intramural injection of botulinum toxin since September 2013 and notes that her symptoms have gotten worse	TL6 page 504 AOB-76591
23.02.2016	Email from Ms Glenny to Consultants	Re Urodynamics total waiting list – longest waiting patient is 67 weeks	TL6 page 530 – 537 AOB-76617 – AOB-76624
23.02.2016	Email from Mr O'Brien to Ms Glenny	Mr O'Brien noted that he had tried to contact the longest waiter but to no avail	TL6 page 546 AOB-76633
24.02.2016	Email from Mr Young	Re April rota	TL6 page 555 – 558 AOB-76642 –

			AOB-76645
26.02.2016	Email from Ms Dignam to Consultants	Re March Schedule	TL6 page 559 – 560 AOB-76646 – AOB-76647
26.02.2016	Email from Mr Haynes to Consultants	Notes that FY1s are experiencing difficulties with workloads and conscientiously staying behind their shift times to complete work. Sadly this is starting to effect the wellbeing of our current FY1. This problem is not unique to our current FY1s and my understanding is that the previous FY1 hours monitoring came out as non compliant with new deal requirements. Our FY1s are supposed to finish at 5pm on day shift and it is frequent they stay beyond 7-8pm. It is clear that seer bulk of workload is an issues there are patterns of senior medical practice that can add to this burden. An additional component is a lack of formalised handover process for the FY1s. Practices which worsen workload 1. Late start to ward rounds 2. Ward rounds starting as SPR with consultant joining later and re-reviewing the patients 3. Multiple days ward rounds performed by SPR alone 4. Full evening ward rounds continuing beyond 5pm	TL6 page 600 – 601 AOB-76687 – AOB-76688
29.02.2016	Email from Ms Corrigan to Consultants	Re request to refrain from listing cancer patients for surgery over Easter period due to capacity limitations	TL6 page 602 – 603 AOB-76689 – AOB-76690
01.03.2016	Email from Mr O'Brien to Ms Corrigan	Re Paediatrics on Saturdays Mr O'Brien provides an update on his paediatric waiting list and provides a resolution to getting the waiting list by doing paediatric theatres on Saturday mornings. Query of whether funding can continue for this	TL6 page 605 AOB-76692
03.03.2016	Email from Ms Troughton to Mr o'Brien	Re Patient query Patient wanted results of MRI which was taken in October and a follow up plan. Patient has also been on antibiotics for 18 months	TL6 page 608 AOB-76695
03.03.2016	Email from Ms Smyth to Mr O'Brien	Notes that patient's TURBT was cancelled due to bed pressures	TL6 page 609 - 610 AOB-76696 – AOB-76697
04.03.2016	Email from Ms Glenny to Consultants	Re Urology TURBT Procedures waiting list Approx 17 patients in total **AOB –** 4 Patients **AJG –** 4 Patients **KS** – 2 Patients **MDH –** 3 patients **MY –** 3 patients	TL6 page 636 – 638 AOB-76723 – AOB-76758

04.03.2016	Email from Ms Corrigan to Consultants	RE Actions from AMD and Urology Consultant Meeting Actions 1. Mr Young to meet with Mr Personal Information this week/early next week and explain what process are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him 2. Mr Mackle to meet with Mr Personal Information on Wednesday 16th March in AMD office 3. Mr Mackle and Mr young to advise him that he should be seeking appropriate course that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate 4. A Multi Disciplinary feedback questionnaire should be completed and collated within the Team – This will be used as constructive feedback for Mr Personal Information 5. Formalise evening cover and the purpose of this will be explained to Mr Personal Information. 6. Formalise the ward rounds with one of the consultant Team accompanying Mr Personal Information each day 7. The consultants involved in the "second on call" and ward rounds will be remunerated by ½ PA	TL6 page 639 – 640 AOB-76726 – AOB-76757
07.03.2016	Email from Ms Corrigan to Consultants	Re Discussion Prompts for meeting	TL6 page 641 – 646 AOB-76728 – AOB-76733
09.03.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re follow up appointment. Last attended CAOBUO clinic in February 2015 and was due to be reviewed in September 2015. PSA has increased	TL6 page 660 AOB-76747
14.03.2016	Email from Ms Neilly to Mr O'Brien	Patient has had catheter in from February 2014 – GP queried when was going to be seen as this is long time for patient to have catheter	TL6 page 685 AOB-76772
16.03.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient has been on waiting list as urgent since Feb 2014 and is now experiencing pain on both kidneys	TL6 page 686 AOB-76773
23.03.2016	Email from Ms Dignam	Re April Schedule	TL6 page 929 – 930 AOB-77016 – AOB-77017
30.03.2016	Email from Mr Young	Re May rota	TL6 page 942 – 945 AOB-77029 – AOB-77032
30.03.2016	Email from Ms Glenny	Re Urology TURBT Procedures	TL6 page 946-947

	to Consultants	Total of 10 patients – none of which are AOB	AOB-7703 – AOB-77034
31.03.2016	Email from Ms Coleman to Mr O'brien	Patient awaiting review from March 2014 but due to backlog a date has not been selected	TL6 page 964 AOB-77051
April 2016	List of Staff	List of staff from 01 April 2016 aligned to Organisational Units under Head of Urology and ENT X 41 staff members	TRU-02651
02.04.2016	Email from Ms Corrigan to Mr Suresh	Re Actions from AMD and Mr Suresh Meeting To formalise, please see the notes/actions arising from your meeting with Eamon and I on 23 Marc Present: Mr Mackle, Mr [redacted] Mrs Corrigan. Venue: Associate Medical Directors Office, Admin Floor, Craigavon Area Hospital Mr Mackle advised that the purpose of the meeting was to follow up from the meetings that Mr Yo O'Brien had with Mr [redacted] Actions agreed: 1. Mr Mackle asked Mr [redacted] to source appropriate courses that will assist him in building u decision making skills and that Mr Mackle will approve if these are appropriate. Mr [redacted] to Source and provide details of courses to Mr Mackle/Mrs Corrigan by Friday 2 that arrangements can be made to approve/attend if deemed appropriate. 2. A Multi-disciplinary feedback questionnaire should be completed and collated within the T to the 360 feedback) – Mrs Corrigan to organise and will collate responses. This will be use feedback for Mr [redacted] and will be strictly confidential. 3. Formalise evening cover for all oncall weeks for Mr [redacted] Mr Young has agreed to formalise after discussions with the rest of the Team and that this with all the Team, Mr Mackle and Mrs Corrigan. Formalise the Ward rounds with one of the Consultant Team accompanying Mr [redacted] eac Thursday) Weekends to be agreed on what cover needs to be provided and the team are g up and share with Mr Mackle and Mr [redacted] and Mrs Corrigan. 4. Mr [redacted] to arrange to attend theatres with the other consultants in order to train in his s details of when and what cases he is involved in should be logged and shared with Mr Mac – this should be provided on a monthly basis. A further meeting in 3 months to be organised in order to update on progress – Mrs Corrigan to co	TL6 page 1367 AOB-77453
04.04.2016	Email from Ms Neilly to Mr O'Brien	Notes that patient is on urgent waiting list from July 2014 but no word yet of procedure.	TL6 page 1005 AOB-77092
09.04.2016	Email correspondence between Ms Corrigan and Consultants	Re: Urology Action Plan AMD & Suresh meeting Mr Young notes that following a meeting with Mr Mackle, the rota needs to be defined to cover Mr Suresh. Thursday 17th (holiday day) Mr Young coming off call so will be handing over – Mr Young to do rest of day and night Friday 18th – (Mr Young on Annual leave) – Needs defined Sat/Sun – Needs defined (John covered last weekend) Mon 21 – Thought Mark could cover ? Tues 22 – MY to do Wed 23 – Thought AOB could do?	TL6 Page 1364 – 1366 AOB-77450 – AOB-77452

		Day time am round Friday - ? John if free Mon – Mark Tues – MY Weds - AOB	
12.04.2016	Email from Ms Corrigan to Ms Elliot	Ms Corrigan confirms that new urgents are spiralling out of control and routine are at 73 weeks.	TL6 page 1035 – 1036 AOB-77122 – AOB-77123
19.04.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list from September 2014	TL6 page 1068 AOB-77155
19.04.2016	Email from Ms Corrigan to Consultants	Re Red Flag Urology Referrals for Escalation Notes that there are quite a few which could not be given appointments by day 10-14. Ms Corrigan would like to book them all into the next available clinic	TL6 page 1069 – 1071 AOB-77156 – AOB-77158
19.04.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Patient has been on waiting list since November 2014 and advised that his urinary symptoms have worsened	TL6 page 1072 AOB-77159
26.04.2016	Email from Ms Elliot	Notes that patient has been due review since June 2015	TL6 page
26.04.2016	Email from Ms Elliot to Mr O'Brien	Re Patient Query Patient ringing re date for surgery. Has been on waiting list for TURP since 11 June 2014 and notes his symptoms have gotten worse	TL6 page 1114 AOB-77201
26.04.2016	Email from Ms Clayton to Consultants	Re Red Flag appointments now stretching out as far as day 26	TL6 page 1115 – 1116 AOB-77202 – AOB-77203
27.04.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re follow up appointment. Been on waiting list since January 2014 and is having to rise 3-4 times each night	TL6 page 1120 AOB-77207
27.04.2016	Email from Mr Young to Consultants	Re June rota	TL6 page 1122 – 1127 AOB-77209 –

			AOB-77213
28.04.2016	Email from Ms Dignam to Consultants	Re May Schedule	TL6 page 1132 – 1133 AOB-77218 – AOB-77129
06.05.2016	Email from Ms Corrigan to Consultants	Re Patient compliant Patient has been waiting 2 years for enlarged prostate operation and has not yet been given a date. He is patient of Mr Youngs. Ms Corrigan responded to highlight that Urology team were concentrating on cancer patients. Routine urology surgery has increased to 124 weeks for routine surgery so will be at least another 10 months before patient will have surgery	TL6 page 1172 – 1173 AOB-77258 – AOB-77259
09.05.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st OP appointment longest wait Urology (prostate) 26 Urology (Haematuria) 25 Urology (Other) 22	TL6 page 1193 AOB-77279
10.05.2016	Email from Ms Corrigan to Consultants	Notes a 52% increase in referrals in one year period	TL6 page 1214 – 1217 AOB-77300 – AOB-77303
18.05.2016	Email from Ms Elliot to Mr O'brien	Re patient query Patient has been on waiting list for circumcision since October 2014 and is becoming distressed with his symptoms	TL6 page 1253 AOB-77339
20.05.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's GP ringing re patient's surgery. Has been on Waiting list since April 2015 and is now presenting with rectal bleeding	TL6 page 1272 AOB-77358
20.05.2016	Email from Ms Corrigan to Consultants	Cancer Performance April 2016	TL6 page 1273 – 1284 AOB-77359 – AOB-77370
23.05.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st OP Appointment longest wait Urology (Prostate) – 22 Urology (Haematuria) – 22 Urology (Other) – 22	TL6 page 1285 AOB-77371
25.05.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Is on waiting list since July 2015	TL6 page 1290 AOB-77376

25.05.2016	Email from Mr Young to Consultants	Re July rota	TL6 page 1292 – 1295 AOB-77378 – AOB-77381
26.05.2016	Email from Ms Dignam to Consultants	Re June Schedule	TL6 page 1300 – 1301 AOB-77386 – AOB-77387
27.05.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st OP Appointment longest wait Urology (prostate) – 21 Urology (Haematuria) – 21 Urology (Other) – 21	TL6 page 1302 AOB-77388
31.05.2016	Email from Ms Cunningham to Consultants	Re Backlogs Discharges to be typed –AJG 7 (May 16), MY 10 (May 16) Clinic typing – JOD 16 (May 16), AOB 7 (May 16), AJG 25 (May 16) Clinics awaiting dictation – 0 Discharges to be dictated – AOB 13 (Oct 15), AJG 2 (May 16), MY 16 (Feb 16) Results to be typed – MH 30 (May 16), JOD 8 (May 16), KS 20 (May 16), AJG 4 (May 16) Results to be dictated – KS 50 (May 16), AOB 4 (March 16), AJG 96 (May 16), MY 30 (April 16)	TL6 page 1325 – 1327 AOB-77411 – AOB-77413
02.06.2016	Email from Ms Elliot to Mr O'Brien	Re patient query Patient is on waiting list for change of stent since July 2014	TL6 page 1333 AOB-77419
07.06.2016	Email from Ms Corrigan to Mr Young	Re rota to fit around Mr Personal Information plan – relates to further supervision on Mr Personal Information	TL6 page 1360 – 1367 AOB-77446 – AOB-77453
08.06.2016	Email from Ms Corrigan to Consultants	Re July Rota	TL6 page 1368 – 1371 AOB-77454 – AOB-77457

08.06.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient was reviewed at CAOBUO Clinic in July 2015 and was due to be reviewed again in December 2015 – his family would appreciate if he could be reviewed as soon as possible	TL6 page 1375 AOB-77461
12.06.2016	Email from Mr O'Brien to Ms Corrigan	Re: Mr Personal Information *"In Michael's absence, I am unaware of any support having been offered. In any case, I have provided* Personal Informati *with support since Thursday morning when he came on call. I have over the management of each inpatient with him, as I have done again today. I take this opportunity to share my opinion that* Personal Informati *has made every effort to improve his management of inpatients while on call and that he has succeeded.* *In fact, I have been impressed this weekend with his diligence, picking up one or two omissions of mine last week. I think that he is now up to speed and as good as the rest of us.* Personal Informati*'s ability to undertake major open surgical intervention, particularly in a very acute setting, is distinct from his general clinical management of inpatients.* *I believe that we had better get used to the fact that only a proportion of urologists completing their training these days would be able to do so, and would not be expected to do so.* *So, I do believe that* Personal Informati *has been made progress and is keen to improve his open surgical competence. I also believe that he deserves and has earned our ongoing support."*	TL6 page 1401 – 1404 AOB-77487 – AOB-77492
17.06.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's GP ringing re review appointment. Last attended clinic in Jan 2014 and is on waiting list as outpatient for review since July 2014. District Nurse is concerned re catheter problems	TL6 page 1442 AOB-77528
17.06.2016	Email from Ms Corrigan to Mr O'Brien	Have funding for weekend theatres for paediatrics	TL6 page 1443 AOB-77529
21.06.2016	Email from Ms Corrigan to Consultants	RE Bed pressures Notes that experiencing significant bed pressures which are impacting on the running of elective lists. Notes that only red flag patients should be operated on.	TL6 page 1459 AOB-77545
27.06.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st OP appointment Urology (prostate) – 29 Urology (Haematuria) – 29 Urology (Other) – 28	TL6 Page 1464 – 1465 AOB-77550 – AOB-77551
27.06.2016	Email from Ms Corrigan	Re Cancer Performance Dashboard Urology Inter Trust transfer breaches – 22 Urology Internal breaches – 12 Urology Day 31 Breaches – 0 Also notes reasons for breaches. Gives outline of amount of referrals which are coming through to each speciality.	TL6 page 1466 – 1477 AOB-77552 – AOB-77563

27.06.2016	Email from Ms Corrigan to Consultants	Ms Corrigan asks that all non-red flag patients are cancelled due to bed pressures	TL6 page 1478 – 1479 AOB-77564 – AOB-77565
27.06.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st Appointment Longest wait Urology (Prostate) – 29 Urology (Haematuria) – 29 Urology (Other) – 28	TL6 page 1480 – 1481 AOB-77566 – AOB-77567
28.06.2016	Email from Mr O'Brien to Ms Corrigan	RE Cancellation of non – red flag patients Mr O'Brien notes that it is unacceptable. Spent all of Thursday reviewing all 275 patients on inpatient waiting list and allocating to five categories of urgency. Equated red flags, those cancer pateints who have no red flag status, those with indwelling stents for up to two years, those with indwelling catheters for over two years whilst trying to accommodate in some equitable fashion those who have been pleading through various channels. Mr O'Brien highlights patients who are not red flag status but who are clinically important. Mr O'Brien notes that the Trust cannot continue like this and advised that he will not	TL6 page 1482 – 1484 AOB-77568 – AOB-77570
29.06.2016	Letter from Dr Wright	Dr Wright noted staffing issues and requested for anyone to do additional sessions to be able to provide adequate services	TL6 page 1486 – 1488 AOB-77572 – AOB-77574
29.06.2016	Email from Mr O'Brien to Ms Corrigan	Notes that 5 patients were cancelled due to no beds available	TL6 page 1489 AOB-77575
30.06.2016	Email from Ms Corrigan to Consultants	RE 40 DAY PTLs & 31 day PTLS 46 Patients on 40 day PTL waiting list 13 Patients on 31 day PTL waiting list	TL6 page 1490 – 1496 AOB-77576 – AOB-77582
30.06.2016	Email from Mr Young to Consultants	Re August rota and On call	TL6 page 1502 - 1507 AOB-77588 – AOB-77593
02.07.2016	Email from Ms Hunter	Provides reasoning for leaving 1. Patient safety and quality of care.	TL6 page 1508

		2. Vacancies on the ward and posts not being filled and being expected to keep beds open to maximum 3. Feel management do not want to know	AOB-77594
04.07.2016	Email from Ms Dignam to Consultants	Re July schedule	TL6 page 1511 – 1515 AOB-77597 – AOB-77601
06.07.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient last attended clinic and was due to be reviewed in August 2014. Wife was ringing to advise that patient is dribbling and has to wear pads. Would appreciate review as soon as possible	TL6 page 1517 AOB-77603
06.07.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient GP ringing re date for surgery. Patient has been on waiting list for TURP since 08 July 2014	TL6 page 1518 AOB-77604
12.07.2016	Email from Mr O'Brien to Ms Cunninghma	Re Clinic templates Mr O'Brien raises his concerns over the increase in patients appointed to his clinics. Notes that there are at times so many patients that he does not get time to have a break, something to eat or even a cup of coffee	TL6 page 1545 – 1548 AOB-77631 – AOB-77634
26.07.2016	Email from MS Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery . Has been on routine waiting list since Jan 2015 but worried for health	TL6 page 1596 AOB-77682
27.07.2016	Email from Mr Young to Consultants	Re Sept Rota	TL6 page 1597 – 1608 AOB-77683 – AOB-77693
01.08.2016	Email From Ms Dignam to Consultants	Re August Schedule	TL6 page 1620 – 1624 AOB-77705 – AOB-77709
01.08.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st OP Appointment longest wait Urology (prostate) – 23 Urology (Haematuria) – 16 Urology (Other) – 10	TL6 page 1625 – 1626 AOB-77710 – AOB-77711

03.08.2016	Email from Ms Cunningham to Ms Corrigan and Consultants	Re Admin Backlog Discharges to be typed – AJG 1 (July 2016) Clinic typing – KS 16 (Aug 2016), AJG 29 (July 2016) , MY 20 (July 2016) Clinics awaiting dictation – MH 35 (July 2016), AOB 32 (?Nov 15) Discharges to be dictated – MY 10 (July 2016) Results to be typed – AJG 113 Results to be dictated matched – MH 30 (Mid July 2016), KS 60 (July 2016), AOB 16, AJG 25 (July 2016), MY 10 (July 2016) Results to be dictated unmatched – AJG 24	TL6 page 1666 – 1667 AOB-77751 – AOB-77752
05.08.2016	Notes of FSS HOS Joint HR/Finance & Governance/Performance Meeting	Notes that the backlogs are increasing	TRU-22190 – TRU-22192
09.09.2016	Email from Ms Corrigan to Consultants	Re Day 62 Active Longest Waiters breachers Longest wait – 85 (in august) No over 62 days – 2 (in august)	TL6 page 1720 – 1734 AOB-77805 – AOB-77819
14.08.2016	Email from Ms Corrigan to Consultants	Re Red Flag 1st Appointment longest wait Urology (prostate) – 18 Urology (Haematuria) – 14 Urology (Other) – 10	TL6 page 1741 – 1743 AOB-77825 – AOB-77828
15.08.2016	Email from Ms Corrigan to Consultants	Re 62 day Active Longest Waiters breachers Longest wait – 64 No over 62 days – 1	TL6 page 1745 – 1756 AOB-77830 – AOB-77841
17.08.2016	Email from Ms Corrigan to Consultants	Re Departmental meeting Notes meeting will take place to discussed the oncall week. [no minutes or record of this meeting]	TRU-01517
18.08.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list for cystoscopy since March 2014.	TL6 page 1769 AOB-77854

<table>
<tr><td>21.08.2016</td><td>Email from Mr Young to Consultants</td><td>Re October Rota</td><td>TL6 page 1773 – 1777

AOB-77858 – AOB-77862</td></tr>
<tr><td>25.08.2016</td><td>Email From Ms Dignam to Consultants</td><td>Re September schedule</td><td>TL6 page 1781 – 1785

AOB-77866 – AOB-77870</td></tr>
<tr><td>30.08.2016</td><td>Email from Ms Clayton to Ms McMahon and others</td><td>RE Urodynamics PTL list

Approx 153 patients on waiting list with patients waiting from 2014</td><td>TL6 page 1802 – 1818

AOB-77887 – AOB-77903</td></tr>
<tr><td>07.09.2016</td><td>Email from Ms Cunningham to Consultants</td><td>Re Backlog in admin

<table><tr><th>Urology</th><th>MH</th><th>JOD</th><th>KS</th><th>AOB</th><th>AJG</th><th></th></tr><tr><td>Discharges to be typed</td><td>0</td><td>0</td><td>0</td><td>9 (02.09.16)</td><td>12 (02.09.16)</td><td></td></tr><tr><td>Clinic typing</td><td>4 (02.09.16)</td><td>17 (31.08.16)</td><td>4 (05.09.16)</td><td>21 (23.08.16)</td><td>2 (02.09.16)</td><td>1</td></tr><tr><td>Clinics awaiting dictation</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td></tr><tr><td>Discharges to be dictated</td><td>0</td><td>0</td><td>0</td><td>12</td><td>1 (Aug 16)</td><td>24 (ap</td></tr><tr><td>Results to be typed</td><td>0</td><td>9 (02.09.16)</td><td>25 (05.09.16)</td><td>0</td><td>10 (01.09.16)</td><td></td></tr><tr><td>Results to be dictated matched</td><td>25 (end Aug 16)</td><td>0</td><td>10</td><td>2</td><td>54 (Aug 16)</td><td>16 (</td></tr><tr><td>Results to be dictated unmatched</td><td>5</td><td>0</td><td>0</td><td>0</td><td>10 (Sept 16)</td><td></td></tr></table></td><td>TL6 page 1892 – 1894

AOB-77977 – AOB-77979</td></tr>
<tr><td>13.09.2016</td><td>Email from Ms Elliot to Mr O’Brien</td><td>Re patient query

Patient ringing re date for surgery. Has been on waiting list for injection since August 2014 and advises that is now incontinent both day and night</td><td>TL6 page 2012

AOB-78097</td></tr>
<tr><td>14.09.2016</td><td>Email from Ms McMahon to Ms Elliot</td><td>Re urodynamics PTL

128pts no dates; 4pts over 52 weeks
Longest wait routine = 90 weeks
Longest wait urgent = 86 weeks</td><td>TL6 page 2016 – 2040

AOB-78101 – AOB-78125</td></tr>
<tr><td>15.09.2016</td><td>Email correspondence between Ms Corrigan and Mr Weir</td><td>Email correspondence between Mr Gibson, Mr Wright, Ms Toal and Ms Gishkori

Re cancellation of meeting

Email from Ms Gishkori: “Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr OB performance was of course part of that. … I would like to try out their strategy first. I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr Ob.

I appreciate you highlighting the fact that this long running issue has not been resolved. However given the trust and respect that Mr O’B has won over the years… I would like to give my new team the chance to resolve this in context and for good.</td><td>Doc File 2 pages 160 – 161

AOB-01053 - AOB-01054</td></tr>
</table>

		Email response from Mr Wright: *"As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay.. I would need to see what plans are in place with the issues and understand how progress would be monitored over the three month period…"* Email from Ms Gishkori to Mr Weir, Mr McAllister and Mr Carroll: "*FYI below… and my response will be?"*	
23.09.2016	Email fro Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re surgery. Has been on waiting list since Jan 2015	TL6 page 2077 AOB-78162
27.09.2016	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery as been on waiting list since December 2015	TL6 page 2102 AOB-78187
28.09.2016	Email from Mr Young to Consultants	Re November rota	TL6 page 2108 – 2114 AOB-78193 – AOB-78199
29.09.2016	Email from Ms Elliot to Mr O'Brien	Re Patient Query Patient ringing re date for surgery. Has been on waiting list for TURP since August 2014	TL6 page 2115 – 2116 AOB-78200 – AOB-78201
29.09.2016	Email from Ms Dignam to Consultants	Re October Schedule	TL6 page 2118 – 2119 AOB-78203 – AOB-78204
October/November 2016	Urology External Assessment	*"Core membership complete but there is no listed cover for the radiologist or the clinical oncologist so therefore attendance and quoracy remain an issue. Only 42 MDT meeting were held in 2015 with a four week gap in December. 43% meetings had no radiologist present and 19% no oncologist. Overall quoracy was only 48%"* *"Attendance at advanced communication skills training remains challenging"* *"Four serious concerns were raised at the peer review visit in 2015* 1. *There is a single handed radiologist supporting the Urology MDT with no cover arrangements in place – this is not resolved* 2. *Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate – not resolved but quoracy up to 48%*	SUP 353 – 356 AOB-03849 - AOB-03852

<table>
<tr><td></td><td></td><td><ol start="3">
The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment – partially addressed as referrals to the Trust are triaged by consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients
Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the draft NICaN clinical guidelines – not resolved across the region.</td><td></td></tr>
<tr><td>08.10.2016</td><td>Email from Ms Corrigan to Consultants</td><td>Notes that Urology Specialty Doctor will commence post in January 2017</td><td>TL6 page 2179 – 2181

AOB-78264 – AOB-78266</td></tr>
<tr><td>13.10.2016</td><td>Urology Performance</td><td><u>Urology PERFORMANCE – 13 October 2016</u>

New Outpatient waiting lists
Total on waiting list – 2902 longest wait = 83 weeks
Total URGENT waiting a date is 983 (longest = 65 weeks)

<u>Urology REFERRALS RECEIVED</u>
<table>
<tr><th>Year</th><th>GP only</th><th>**Total</th><th>Red Flags</th></tr>
<tr><td>2013-2014</td><td>2980</td><td>5471</td><td>929</td></tr>
<tr><td>2014-2015</td><td>2955</td><td>5120</td><td>1227</td></tr>
<tr><td>2015-2016</td><td>2857</td><td>5147</td><td>1357</td></tr>
<tr><td>Apr 16- Sept 16</td><td>1433</td><td>2241</td><td>835</td></tr>
</table>
**Total includes ED, Consultant, etc
Review outpatient backlog – should have been seen by 31 October 2016
<table>
<tr><th>Consultant</th><th>TOTAL October</th><th>Should have been seen by</th></tr>
<tr><td>Mr Young (stones)</td><td>616</td><td>April 2014</td></tr>
<tr><td>Mr Young (general)</td><td>158</td><td>April 2013</td></tr>
<tr><td>Mr O'Brien</td><td>746</td><td>July 2013</td></tr>
<tr><td>Mr Glackin</td><td>68</td><td>December 2015</td></tr>
<tr><td>Mr Haynes</td><td>43</td><td>May 2014</td></tr>
<tr><td>Mr O'Donoghue</td><td>408</td><td>March 2015</td></tr>
<tr><td>Mr Suresh up to Aug 17</td><td>408 (289 by Oct)</td><td>July 2013</td></tr>
<tr><td>Overall total</td><td>2447</td><td></td></tr>
</table>
<table>
<tr><th>Consultant</th><th>Inpatients Urgent</th><th>Waiting time (weeks)</th><th>Inpatients Routine</th><th>Waiting time (weeks)</th></tr>
<tr><td>Mr Young</td><td>56</td><td>111 weeks</td><td>60</td><td>146 weeks</td></tr>
<tr><td>Mr O'Brien</td><td>136</td><td>131 weeks</td><td>96</td><td>137 weeks</td></tr>
<tr><td>Mr Glackin</td><td>18</td><td>48 weeks</td><td>11</td><td>38 weeks</td></tr>
<tr><td>Mr Haynes</td><td>44</td><td>53 weeks</td><td>33</td><td>120 weeks</td></tr>
<tr><td>Mr O'Donoghue</td><td>38</td><td>36 weeks</td><td>21</td><td>110 weeks</td></tr>
<tr><td>Mr Suresh</td><td>31</td><td>41 weeks</td><td>10</td><td>70 weeks</td></tr>
<tr><td>Total</td><td>323</td><td>131 (AOB)</td><td>231</td><td>146 (MY)</td></tr>
</table>
146 232 29 77 59 41
<table>
<tr><th>Consultant</th><th>Daycases Urgent</th><th>Waiting time (weeks)</th><th>Daycases Routine</th><th>Waiting time (weeks)</th></tr>
<tr><td>Mr Young</td><td>48</td><td>115 weeks</td><td>119</td><td>138 weeks</td></tr>
<tr><td>Mr O'Brien</td><td>10</td><td>87 weeks</td><td>19</td><td>128 weeks</td></tr>
<tr><td>Mr Glackin</td><td>24</td><td>45 weeks</td><td>24</td><td>41 weeks</td></tr>
<tr><td>Mr Haynes</td><td>20</td><td>38 weeks</td><td>55</td><td>106 weeks</td></tr>
<tr><td>Mr O'Donoghue</td><td>13</td><td>45 weeks</td><td>17</td><td>78 weeks</td></tr>
<tr><td>Mr Suresh</td><td>23</td><td>25 weeks</td><td>39</td><td>67 weeks</td></tr>
<tr><td>Total</td><td>138</td><td>115 (MY)</td><td>291</td><td>138 (MY)</td></tr>
</table></td><td>Doc File 2 page 188

AOB-01081</td></tr>
<tr><td>13.10.2016</td><td>Email from Ms Elliot to Mr O'Brien</td><td>Re Patient query

Patient on waiting list since June 2014 and ringing re surgery date as soon as possible</td><td>TL6 page 2206

AOB-78291</td></tr>
</table>

21.11.2016	Email from Ms Corrigan to Consultants	Day 62 longest waiters Longest wait – 103 No over 62 days – 2	TL6 page 2280 – 2287 AOB-78365 – AOB-78372
22.11.2016	Email from Mr Young to Consultants	Re Jan rota & on call	TL6 page 2298 – 2302 AOB-78378 – AOB-78379
25.11.2016	Email from Ms Dignam to Consultants	Re Jan Schedule	TL6 page 2309 – 2312 AOB-78394 – AOB-78397
25.11.2016	Email from Mr O'Brien to Ms Elliot	Mr O'Brien noted that he had left 10 patients for his colleagues to try to admit whilst he was on Personal Information leave but this was not done	TL6 page 2327 – 2328 AOB-78412 – AOB-78413
27.11.2016	Email from Ms Corrigan to Consultants	Re additionality over weekend as Board willing to give funding	TL6 page 2336 - 2337 AOB-78421 – AOB-78422
28.11.2016	Email from Ms Dignam to Consultants	Re December Schedule	TL6 page 2338 – 2339 AOB-78423 – AOB-78424
30.11.2016	Email from Ms Corrigan to Consultanst	Re additionality for New Urgent Outpatient clinics	TL6 page 2342 AOB-78427
30.11.2016	Email from Ms Trouton	Notes that due to January pressues expected, should only schedule red flag patients	TL6 page 2343 – 2347 AOB-78428 –

			AOB-78432
08.12.2016	Email from Ms Elliot to Mr O'Brien	Request to over book SWAH clinic to fit all patients in	TL6 page 2381 AOB-78466
09.12.2016	Email frm Ms Elliot to Mr O'Brien	Patient attended CAOBUO in April 2014 and was due a review in October 2014 but never happened. Patient getting worried that symptoms relate to prostate	TL6 Page 2403 AOB-78488
16.12.2016	Personal Developme nt Plan structured reflective template)	2015 Appraisal Personal Development Plan structured reflective template Requirement: annual Name of doctor: Aidan O'Brien Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: Having completed a four year tenure as Lead Clinician and Chair of the NICaN Clinical Reference Group in Urology, during which time I believe I made a significant contribution to rendering NICaN Urology fit for Peer Review, in addition to ensuring that the Southern Trust was prepared for Peer Review, I considered it reasonable to step down from the role earlier in 2016. I also did so as the role required a significant work load, requiring much time, without any facilitation of any kind by the Southern Trust. Date of reflection: 16 December 2016	2015 Appraisal page 29 AOB-22679
20.12.2016	Email from Ms McVeigh to Consultants	Re PET CT Few complaints and issues with patients being told incorrect information regarding waiting times for PET scans. Due to technical issues some patients are waiting up to 4 weeks for their scan, however they are being triaged and booked based on clinical priority. Trying to get approval to send patients to Dublin to improve overall waiting times.	TL6 page 2436 – 2437 AOB-78521 – AOB-78522
23.12.2016	Email from Ms Dignam to Consultants	Re Jan Schedule	TL6 page 2487 – 2488 AOB-78572 – AOB-78573
30.12.2016	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 5 (Section D – H) – Page 6 (Section A – D) "Mr O'Brien: I don't know what is your view about that because the – I mean, some the context of this though is the enormous pressure to operate. The complaints and the enquiries that I deal with every day are, when am I having my operation done? People's clinical outcomes are being compromised all of the time, day in day out, because of not only the	Transcript FILE 1 AOB-56005 - AOB-56006

		lack of capacity as a whole but, in addition, the inequity within departments. For example, in performance data – I think it's ironic that it's called performance data because it is not the performance, it is not what you do, it is what has to be done. In October I had 288 people on my waiting list for in-patient admission and one of my colleagues 29. And I have implored that situation would be addressed. What was driving me back was, you know, the demands for operating. In fact, when I went off I circulated a list of the ten most urgent people to be done and the two who are waiting the shortest period of time have been done by one colleague and none of the rest. I – just to give you, Richard, a context. It is very, very important to appreciate, you know, the totality of the work that we do. I have when we had a meeting to deal with triage, I triaged the red flag referrals, that you don't have the time to triage. This thing of triaging non-red flag referrals it is a historical hangover from a time when we as a department, and particularly if I may in the view of Michael Young, there wasn't enough to do when you are call so we need to have something to fill in the time in order justify the new system. And if you are person who tries to operate on the acute admissions as they come in – like the last week I was on call I did 21 additional operations that week, whereas others, and particularly the person who recently left you know, and I always followed him on the week on call and then this past year more – Mrs O'Brien: You supervised him. Mr O'Brien: I have been supervising him and backing him up. As Martina Corrigan used to say, now you are starting your week on call after having the other week in call. Dr Wright: Yes. Mr O'Brien: And then you picked up, you know, everything that had been long-fingered and deferred, and when you are operating and you have already worked 12, you don't have the time to sit down and triage. Dr Wright: One of the things that I said in this, in my experience (inaudible) whilst sometimes (inaudible) criticisms of individuals, there is almost inevitably a detailed look back at the Trust systems. (inaudible) and they are often a contributor, so I don't doubt that that will be an issue that will be looked at"	
30.12.2016	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 6 (section F-H) – Page 7 (Section A – D) "Mr O'Brien: It takes me session and then I have been doing extended operating days. I know there's a context (inaudible) but I just actually – I have done 19 additional theatre sessions in the ten months of this year, my being off the last six weeks, 15 extra oncology clinics, 14 extra urodynamic sessions and all under pressure to do so and expectation to do so. And you wrote to us all about the highly recompensed consultant in the earlier part of the year, do you remember, additional sessions and all of that, I am not here to discuss money, but all of that completely un— Dr Wright: I do realise that (inaudible). I am well aware of the amount of work that you put in on our behalf. So all the more reason that (inaudible) structure around that is right and that we are not actually – and the Trust is not asking you to do too much or so this will all give you the opportunity to explain all of that (inaudible).	Transcript FILE 1 AOB-56006 - AOB-56007

		…. Mr O'Brien: I have been (inaudible) a meeting to discuss this two years ago, it must be two years ago, that I didn't have the capacity to do it and I wouldn't be doing it and I agreed that red flags certainly yes, particularly if you are doing advanced triage. I mean, and there are various ways of doing triage. But if you are going to sit down, you ring the patient, you get the CT scan done, and all of that rather than just ticking a box."	
30.12.2016	Meeting with Dr Wright, Mr O'Brien, Mrs O'Brien	Page 13 (Section D – H) – Page 14 (Section A – Section F) "Mr O'Brien: The contextual problem in all of this is, do you know whilst on leave, Richard, I spent four good days there in mid-December doing my appraisal documents because I had spent all of my SPA time either operating or reviewing cancer patients. And, you know, I do know that there are people who to the letter of the law will not do that and there are people who can – I work with people who never regard the suffering of patients as their (inaudible). It is a Trust issues. That's a trust problem. Like, I have been pleading for this past two or three years that I shouldn't even see any more new patients and adding people to my waiting lists all the time. The immorality or not being able to undertake what you have pledged to do and then you spend every additional operating session that's vacated, when other people go on holiday, to operate on them. And as a consequence other things get neglected. Mrs O'Brien: Where is the fairness to a patient who – it's like a lottery. If they draw the straw that they are a new patient going to Mr O'Brien, they are immediately going to wait three years longer than someone else. Dr Wright: That may well be one of the things (inaudible). I don't know. (Inaudible) it that may be well something that has to change as a result of this. (Inaudible investigation. It is a difficult issues. It has come (inaudible) conversation. The evidence is going to be presented to us. We have to investigate. That's what it is, an investigation. (inaudible). Mr O'Brien: But there is – by definition there is fault because of you – there's just not enough hours in the day to be faultless and I tried it. I tried it without sleeping. I tried it without food. And that's the reality. You try to hopefully allocate the fault or the inadequacy to that area that's least likely to have consequences for patients. I am devastated Richard, Absolutely devastated. Dr Wright: It's probably a lot (inaudible) consolation but there would be at any one time quite a few of these investigations going on in the Trust, which to be fair (inaudible) majority of (inaudible) for yourself but it is not unusual. (Inaudible). The process it's one that (inaudible) so we have to follow (inaudible). But what I will undertake is to make sure that the timetable is ramped up as quickly as possible. (Inaudible). It may well be that it turns out that the work we are asking you to do is far too much. Your job plan is unrealistic Mrs O'Brien: No, Aidan's job plan is realistic. It is just the job plan – he can't stay to his job plan because things are allocated to SPA, or whatever they are – Dr Wright: Then may be the job plan is not realistic. It is on (Inaudible) what is on written down on paper and what actually happens in practice) Mr O'Brien: Mr job plan – Dr Wright: The job plan doesn't (inaudible)	Transcript FILE 1 AOB-56013 - AOB-56014

		Mrs O'Brien: No, (inaudible), because when he got his first, when they come on to the new consultant contract, Aidan's first job plan was for 15.5. Then now it is down to 12. But when he was doing the 15, when it was ascertained, it was really 18 but that was unrealistic. Dr Wright: But the real answer is to find other ways to get that work done. Get other people as opposed to (inaudible) Mr O'Brien: You can't. You can't Mr O'Brien: You would need ten consultants then. That's what it needs. Dr Wright: Then that is what we do."	
30.12.2016	Meeting with Dr Wright, Mr O'Brien and Mrs O'Brien	Page 14 (Section H) – Page 15 (Section A) "Dr Wright: It Seems what we are saying this is an investigation. It is not – we haven't got an outcome. I have no doubt the Trust is going to be criticised as a result (inaudible). Mrs O'Brien: I certainly hope that that is the conclusion. It is the Trust that will be criticised. Dr Wright: (Inaudible) but this – I suppose this report has been put in front of me (inaudible) and I have to investigate this. "	Transcript FILE 1 AOB-56014 - AOB-56015
January – December 2017		Comments in AOB's 2017 Appraisal I left that brief meeting wholly despondent, knowing that I would receive no support or assistance in addressing the concerns. I still remained Lead Clinician of Urology MDT, having responsibility for endeavouring to ensure that urological cancer diagnostic and therapeutic services were delivered to patients within the required timelines. In addition, I was daily conscious of the morbidity suffered by so many patients on our waiting lists, morbidity which was often acute and life threatening, requiring acute readmission to hospital with urosepsis as a consequence of the delay in elective admission for definitive surgical management. For that reason, I used every available operating session, undertaking 22 additional operating sessions during 2016 to endeavour to mitigate the risk to patients. I similarly conducted an additional 10 oncology review clinics for similar reasons. Personal information redacted by USI Personal information redacted by USI in order to provide continued support to one of my consultant colleagues while he was urologist of the week. When he advised me that he had taken up an appointment in England, commencing in November 2016, I a I had also received the agreement of Mrs. Corrigan, Head of Service, to use my time of recovery at home to process and have patients' charts returned from my home. I did so by contacting all patients by telephone to update their clinical status, dictating letters to GPs and to the patients themselves. In doing so, I had scheduled all inpatient and day case operating for January 2017, and had my secretary schedule review appointments for the more clinically significant patients at clinics in January and February 2017. In doing so, I had processed two thirds of all the remaining patients.	2017 Appraisal page 78 AOB-22956
03.01.2017	Email from Ms Elliot to Mr O'Brien	Re SWAH clinics cancelled and moving patients to February clinic	TL6 page 1

			AOB-78588
12.01.2017	Email from Ms Dignam	RE Jan Schedule	TL6 page 45 – 46 AOB-78632 – AOB-78633
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 3 (Section A – C) "Colin Weir: So we can go through it and maybe let you read it. You probably just want to read it rather than me talking for a second (Pause) Mr O'Brien: So the first is, you know, since March of this year at various stages, you know, I had just been doing my own validation of referrals that had not been triaged by me even though I had made it clear that I had found it impossible to do so and didn't have the time to do so and that there should be another mechanism for doing so. Colin Weir: Okay. Mr O'Brien: So that brings us up to June 15 and I have no idea – obviously that's the number – that had not been triaged thereafter. So four consultants will – my colleagues obviously are undertaking that at the moment? Colin Weir: Yes.	Transcript FILE 3 AOB-56035
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 8 (Section H) – Page 11 (Section A – D) "Mr O'Brien: The letter was just telling that others shared my concerns. And the biggest concern that I had then and had for years and had since then was the big elephant in the room, which is not on any of these things, and that is the sheer numbers of patients awaiting admission and re-admission for procedures and operations and suffering poor clinical outcomes as a consequence. Siobhan Hynds: Can I ask who you were raising that with at a point? Mr O'Brien: At a point. Siobhan Hynds: No, I mean at the various points, who was it you were raising that with? Mr O'Brien: I have raised that with everybody that I can think of over 20 years. This is – I have raised this with – the titles have changed it's that long. Clinical directors, Ivan Sterling, Liam McCathy, John Templeton, Michael Young. And they, sort of, cliched response that these are Trust issues. Except for the fact, regrettably, the Trust doesn't make than an issue. It is – I mean, I do have already prepared, I have gone through all of my operating over recent years, and in fact whilst I would like to have the opportunity at a subsequent time when meeting both to share these with you, but like, for example in 2013, as far as the job plan would go, I would have been expected to do 84 sessions. I did 113 elective sessions that year. Colin Weir: Is that operating? Mr O'Brien: Operating. I would have been expected to do 79 session in 2014 as the urologist of the week was introduced that year and I did 101. 2015, 70 sessions according to my job plan, I actually did 95.5 four hour sessions. You multiply that by four for every hour. In 2016, up until I left, I would have been pro rata expected to do 61 sessions. I did 83.25	Transcript FILE 3 AOB-56040 - AOB-56043

		And in the doing of that and the organisation of that – that's just operating I mean, I am not talking about other activities as well, like extra clinics and so forth, I have been directing in a sense in a lonely manner without any response to raising the concerns with regard to the inequity involved in such lists. Like in October of last year when performance data were published, which is a contradiction in itself because they didn't publish performance data they published the things that still needed to be performed you know, and when I had 233 I think patients on my in-patient waiting list at that time one of my colleagues had 29. Can you get that addressed? No. And just to – Ill do this all in detail in due course, but I do think actually two things about it. One is, when you have been raising it and talking about it and worrying about it and trying to get a response for 20 odd years, you know, you stop talking about it. And lastly, do you know, I was – I must say after these 25 years I was so disappointed. On 7 November I sent Martina and my colleagues a list of 10 patients whom I really wanted to have done next and come the end of December they weren't even addressed. I was coming back after having my prostate resected too early. Why? Because of the need to address this. … Colin Weir: So, Aidan, issues over these 20 years are just that; the workload and the capacity to do the workload. Is that what you – the gist of it? Mr O'Brien: Colin, if I were to put my case in one sentence, if I had not been overworked, if I hadn't agreed to be overworked, I wouldn't be in this position today and others are not in this position today. Colin Weir: Because they manage – Mr O'Brien: because they didn't overwork Colin Weir: Control Mr O'Brien: no, they wouldn't Colin Weir: Okay. … Colin Weir: Just to get the general tenor of what you are saying about workload and you tried to engage with the Trust's management over an extended period of time to help manage that in some way. Mr O'Brien: Yes. Colin Weir: but the work has just kept coming Mr O'Brien: and a failure of management to deal with it. Colin Weir: To deal with it. Right ok	
24.01.2017	Meeting With Mr Weir, Ms Hynds & Mr O'Brien	Page 18 (Section H) – Page 19 (Section A – B) "Colin Weir: … I am also conscious of the fact that I – and this is difficult because – the difficult bit of this and is why I didn't want to do it, is because I know what your – clinically, and do you know what I mean, I	Transcript FILE 3 AOB-56050 -

		know what you do in the things that you have just said, urologist of the week and your operating, those extended operating days that you do, remember we've done your job planning not that long ago, so I've been part of that process as well so … Mr O'Brien: I mean, this is all – up until I met with Colin, in October, all un-job planned, unremunerated work. I am not here to talk about money"	AOB-56051
24.01.2017	Meeting With Mr Weir, Ms Hynds & Mr O'Brien	Page 20 (section F – H) – Page 21 (Section A – F) "Mr O'Brien: Can I also ask the question? Will the Trust actually be considering as well by virtue of my practice and what I have done in recent years, whether harm was avoided and good was done? I am not meaning in a sort of altruistic manner. I mean, I could keep a committee going with SAIs. I have not never completed an SAI in my life. I mean, there are people suffering severely because of delays. I mean, in the data that I will submit to you, I haven't missed an operating session availability during 2016. Even if I took a couple of days off, I never took off on a Wednesday. I refused to even go to court on behalf of the Trust or be available as an expert witness in defence of cases if it interfered with operating on a Wednesday. I have used every available opportunity and I have actually prevented poor definite clinical outcomes in scores of patients. And even in spite of all of that overperformance, I still haven't succeeded because I know of poor clinical outcomes of patients that are—have occurred and one of which has occurred since I took off. I know about that. I mean, this is – this is the enormous elephant in the room that is not being addressed at all. And you are asking me, Colin and Siobhan, in a sense, who have you raised this with before and I am raising it now. It will never appear on this A4 sheet of paper. Michael O'Brien: You have your formal meetings (inaudible) your meetings on Thursday Mr O'Brien: Yes, we have departmental meetings. And occasionally what we have done is say, wonder if you take ten or 20 patients from Michael's list and my list and give to the others and then that's done for another six months Colin Weir: (inaudible) explore that. You have departmental meetings every Thursday (inaudible). So you have a degree of governance and oversight on the team. The team are kind of – you are discussing cases and you have conferences (inaudible). Mr O'Brien: We are discussing – well, I chair, and this is another issue that will be used in my defence or mitigation. I took over as lead clinician and chair of MDM in April 2012. I chaired every MDM that occurred each week until I had the idea of having a rotation for chairing in September/October – September 2014. So you know, I would do my operating. I would finish at 8 o'clock in the evening operating. Sometimes 7.30. Sometimes I would over run. I would always do my administration. I was very particular about that with regard to outcomes of patients following surgery and I'd do it by email to my secretary, or whatever. And then I would leave the hospital at 9 o'clock and I'd go home and get something to eat. And then I would sit down for three to four hours, you know, until 2/3 o'clock in the morning previewing 35, 40, 45 cases. Its like doing an enormous cancer clinic. Most of the patients you don't know. Reviewing all the digitalised images and so forth	Transcript FILE 3 AOB-56052 - AOB-56053

		and getting if you are lucky, two or three hours of sleep and coming in the following day. I did all that. “	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O’Brien	Page 23 (Section E – H) – Page 24 (Section A) “Mr O’Brien: I can see, in terms of in-patient management as a urology of the week, I mean, there has never been a concern, do you know. I am meticulous in that regard. Colin Weir: Okay. Mr O’Brien: To the extent that I find it not possible to triage non-red flag referrals, as I said a couple of years ago. And, secondly – Siobhan Hynds: When you say, I am sorry, can I put you back over that, when you say you have said that a couple years ago, in what context was that? Mr O’Brien: That was at a meeting that we had with personnel from appointments. I cant recall or don’t have a record of the date of that meeting Siobhan Hynds: Was that agreed then at that stage that you wouldn’t triage referrals? Mr O’Brien: No, you see – you know, it’s like we’ve been discussing this at home in recent times. Do you know when you have a meeting convened by A and B they’re not always interested in hearing what C and D have to say. In fact actually, you know, I have had the terrible experience of having a situation where as lead clinician of MDT the regulation is that clinicians have to provide a clinical summary for their patient to be discussed. There is no expectation for a cancer tracker to be taken excerpts or cannibalising a copy of a letter. They’re not to do that. Well, I tried for three, four years to get my colleagues to do that and sometimes even the majority will just walk out, fail to do it or in fact just say you know, I refuse to do that. Michael O’Brien: It will be important to try and get the minutes of that meeting (inaudible) personnel and it was said that you couldn’t do non-red flags. Siobhan Hynds: Those are the sort of things (inaudible) Mr O’Brien: So I said that, you know, I had found it impossible to do. I can explain to you – do you want me to explain to you now actually my view on the whole thing or the relationship between it and urologist of the week or leave it for another day? Colin Weir: No, tell me quickly because it would be pertinent to – Mr O’Brien: I’ll tell you, Colin. First of all actually, and I don’t know how you recognise this. There is a difference between being surgeon of the week and being the surgeon on call. Practically and conceptually they can be two very different things. Urologist of the week was to be, in my view, hands-on in-patient management as a consultant with your junior staff, as have seen you doing when you are surgeon of the week. It is also about responding to calls for assessment and management from other wards in our hospital, from the emergency department, and in our case, in urology, we also have to respond similarly to such calls from Daisy Hill Hospital and South West Acute hospital. We have – I have raised and we have discussed, all of us, our concerns that some of those calls from elsewhere are not being attended to. …”	Transcript FILE 3 AOB-56055 - AOB-56056

24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 26 (Section E – H) – Page 27 (Section A- D) "Mr O'Brien: And that's distinction. I didn't even consider it as a reply. I didn't know what I had to reply. My response was to continue. I did extra clinics. I continued to do additional operating. I haven't missed one Wednesday this year from annual leave as I have said before. And in fact actually – Siobhan Hynds: (Inaudible_ Mr O'Brien: -- even though I had stated previously that I had found it impossible to do all of these no-red flag referrals, triaging in the manner than we are talking about – we call iit advanced triage – whilst being urologist of the week – following 23 March I thought, you know, well at least what I could do, if I have any spare time at all, I'll take these chronologically. I'll go through 2014 and so forth. I did get up to June 2015 when I had other greater priorities to attend to, not least the charts and the undictated outcome patients, which was even greater for me. Anyhow, getting back to exclusion. Siobhan Hynds: Can I just finish that? In terms of – so you said you didn't reply but you responded in terms of trying to clear some of that (inaudible). Mr O'Birne: My response was run faster still Siobhan Hynds: Okay. Did anybody know that? Michael O'Brien: (inaudible) – some clinics Mr O'Brien: yes, I mean – Michael O'Brien: (Inaudible) additional clinics, wouldn't you/ Mr O'Brien: Yes. Colin Weir: so there is a record of additionality Mr O'Brien: Yes, I have it. I have a record of additionality Siobhan Hynds: Yes. But I suppose, I mean, I'm getting it in very simple terms in my head, is you receive a letter from someone in management to say this is a concern. Mr O'Brien: Yes. Siobhan Hynds: How do you let them know you are addressing that or did you let them know you were addressing it? Mr O'Brien: but sure, they've always Colin Weir: I think you are saying that there is a letter of concern, get on with it	Transcript FILE 3 AOB-56058 - AOB-56059
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 28 (Section A – G) "Michael O'Brien: But one of the issues was the review back log and I think you will be able to show as well that the review back log has been cleared. One of the things that occurred to me, and you did the job plan recently, there is a very limited amount of time in that job plan associated with administration work. …. Mr O'Brien: I cant even recall actually.	Transcript FILE 3 AOB-56060

		Michael O'Brien: it might be three or four hours a week of admin. Now if you're – if you have three or four hours per week of admin, and lets just say in a crazy world there is an idea that the Trust would actually require their consultants to work to their job plan and no more than what they are actually contracted to do, and you have an administrative back log and the you undertake additional operating and additional review clinics, how can you clear (inaudible). Colin Weir: Somebody might say, okay, lets be an advocate from the other side. Well, you don't work as quickly as the other person. You don't see as many patients as most consultants. Your through-put isn't as much as another person. All I am saying is being from another – Michael O'Brien: It could be, yeah – Colin Weir: -- from another view, is it, or somebody might – you know, you're working in a factory and the person who is not making as many cars is going to be – say you're not making as many cars as the next person. There are lots of ways of looking at that and how you work. And this is nothing to do with job plan, but we did – it is a two way process and I thought you had a job plan that suited your extended operating dates and things that you wanted to do Michael O'Brien: Because it is just competing demands Colin Weir: So I think we have to, you know, so a long term process might look at (inaudible) practices and conditions and all of those things"	
24.01.2017	Meeting With Mr Weir, Ms Hynds & Mr O'Brien	Page 34 (Section D – H) – Page 35 (Section A – E) "Mr O'Brien: Nobody has been more concerned about the issues raised that I have been. I mean, I have worked night and day to try to cope with all. I am regretful that I didn't regard, as my colleagues do, all of those patients suffering as Trust issues. Because they do. In fact, it is even written on my appraisal of last month. Michael O'Brien: Do you think that you have (inaudible)? Colin Weir: Sorry, your appraisal has been, who signs off your – Mr O'Brien: It was Michael and – Colin Weir: and so that was satisfactory? Mr O'Brien: My professional development plan raised the issue of – … Mr O'Brien: because I used all my SPA time reviewing people and operating on people. … Colin Weir: That is very naughty actually. SPA, you've got to do SPA. Michael O'Brien: He is doing SPA. He is just doing other things. Colin Weir: You've got to do SPA.	Transcript FILE 3 AOB-56066 - AOB-56067

		Mr O'Brien: I told Richard I spent four whole dates of what was passing clots post TURP, yes, doing actually – getting my appraisal together Colin Weir: Yes, but you've got to build SPA in your (inaudible) week. … Mr O'Brien: Yes, I had three professional development plans, which almost sounds like a contradiction because they are nearly a professional – personal—what do you call it? Personal recreation plans. One was to address the long waiting list. Colin Weir: That was your PDP? Mr O'Brien: to reduce the gross inequity that there is for patients and to significantly reduce the number of new patients that I would see. You know, Michael's – Michael O'Brien: It is really startling the idea – two of the five consultants have been there a long time: dad the longest and Michael Young's been there, what 15 years now at this stage? Mr O'Brien: 98 Michael O'Brien: Sorry even longer then. The three newer consultants they come in because, obviously , it is decided that the service provision requires an expansion. But the legacy of 20 years of practice remains with the two consultants who are in place. SO they are seeing new patients and not sharing the workload of the massive legacy. I think (inaudible)"	
26.01.2017	Minutes of Case Conference	In attendance: Ms Toal, Dr Wright, Ms McVey, Dr Khan, Mr Gibson, Mr Weir and Ms Hynds Context : "*the purpose of the meeting, which was to consider the preliminary investigation into issues identified with Mr O'Brien and obtain agreement on next steps following his period of immediate exclusion, which concludes on 27th January."* 1. *Preliminary Investigation* 2. *Historical attempts to address issues of concern* 3. *Discussion* 4. *Decision* 5. *Formal Investigation* … *It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties – there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.* *It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.* …	TRU-00037 – TRU-00040

31.01.2017	Email from Ms Dignam to Consultants	Re February Schedule	TL6 Page 117 – 126 AOB-78704 – AOB-78714
31.01.2017	Email from Ms Coleman to Ms Elliot	Notes that Mr O'Brien's backlog is behind and RBC cannot bring patients forward. They are currently booking 2015 reviews. It was noted that the patient in question was needed to be seen urgently as it is life threatening	TL6 page 127 AOB-78714
06.02.2017	Memo from Dr Wright	Notes that the Trust are beginning to emerge from one of the most intense periods of sustained pressure on acute services in recent times.	TL6 page 180 – 181 AOB-78765 – AOB-78768
07.02.2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 31 (Section D – F) "Mr O'Brien: As I said to Dr Wright, there are only 24 hours in a day. I have tried to increase them but it doesn't work. I have done it without sleep. I have done it without food. To give you an idea, like when I would chair MDM, I would operate all day on a Wednesday, operating ending at -- starting at 9 ending at 8 o'clock in the evening. I would usually do my administrative work arising from that by email and so forth. See the last one or two patients in recovery. Usually be in the changing room at 9 o'clock. Drive home. Arrive there at quarter to 10. Have something to at eat and then sit down and preview 40 cancer cases to be discussed at the meeting that I would chair the following case, ending at 2/3 o'clock in the morning for years. Unallocated, unrecognised.	Transcript FILE 4 AOB-56103
09.02.2017	Letter from OH to Ms Corrigan	*"Mr O'Brien has indicated that prior to his exclusion, he felt under increasing pressure principally due to what he felt is an excessive workload coupled with what he indicated was an inequitable balance of waiting lists comparing himself with his peers."*	TRU 00160 - 00161
09.02.2017	Meeting with Dr Khan and Mr O'Brien	Page 35 (section A– H) MR O'BRIEN: That is a concern, It is also a concern of mine from the point of view of the patients because there is another reality here and that is that, you know, if I – if I am not – If I am quarantined from a whole load of patients and as a consequence they are not going to be reviewed by anybody else, because there's a limited capacity, you know, they're suffering. Like as I was saying, I had certainly booked up until the first three monthly clinics of 2017 in South West Acute Hospital. To my knowledge only two of those patients have been reviewed and there's a lot of people needing to be reviewed. I mean, I think a lot of these 668 patients with no outcomes formally dictated would have been cancer review patients that I would have done updates on CAPS, which my colleagues didn't do, instead of dictating letter, but these people all need to be reviewed.	Transcript FILE 5 AOB-56139
09.02.2017	Meeting with Dr Khan and Mr O'Brien	Page 37 (Section D – H) MR O'BRIEN: I will just give you a snippet. I quantified all of my additional elective in-patient operating. Right. My additional. Over what I was job planned or expected to do. From 2012 through to the end of 2016. And that has required 3.78 additional hours per week. DR KHAN: Nearly a PA.	Transcript File 5 AOB-56141

		MR O'BRIEN: A PA. probably my administration time. And that's only one activity. I can tell you MDM and what I was previewing, four hours. Another one. Gone. Non-existent in the scam job plan. But I can tell you something, If I hadn't done any of that we wouldn't be sitting having this meeting with me and I feel very angry when it comes to that. DR KHAN: Yes. MR O'BRIEN: And for a Trust that has been completely derelict in its obligations to patients by sorting out those disparities. Either they don't know or they just – this is a Trust that is dysfunctional in a vertical sense. You are talking about escalating up. I have escalated up before and I can tell you horror stories. ..	
20.02.2017	Email correspondence from Ms Corrigan and Ms Robinson and Mr Carroll	Re: TRUS Biopsy /MRI reports Ms Robinson notes *"We have been trying to secure additional capacity with the IS providers for a number of months for this particular examination. We had some initially success but this was short-lived and unfortunately we no longer have an IS option for MRI prostate. We have ongoing medical staffing shortages and there is just one consultant in the Trust who reports MRI prostate who is not currently undertaking additionality sessions and therefore we have no current outlet for this reporting other than what can be done during core reporting hours for Dr Williamson*	TL6 page 217 – 220 AOB-78804 – AOB-78807
20.02.2017	Email from Mr Young to Consultants	Re April rota	TL6 page 221 – 224 AOB-78808 – AOB-78811
24.02.2017	Email from Mr O'Brien to Ms Elliot	Notes the urgent cases which he had asked his colleagues to look after whilst he was on Personal Information leave (he sent an email to colleagues on 07 November 2016 listing who were urgent and why)	TL6 page 242 – 243 AOB-78829 – AOB-78830
24.02.2017	Meeting with Mr Weir and Mr O'Brien	Page 12 (section G -H) & Page 13 (Section A – B) MR O'BRIEN: No, just before we go onto triaging. There are a number of things – there are three things that I will not do in the future I am going to propose. The first is that I will not be doing long days and theatre from 9am to 8pm. COLIN WEIR: Okay. Good idea. MR O'BRIEN: My job plan is 12 o'clock to 8pm. COLIN WEIR: Yes MR O'BRIEN: Right. For years I have been doing, when it is available, 9o'clock until 8o'clock. COLIN WEIR: Look after yourself. Do the best for your patients	Transcript File 6 AOB-56158 - AOB-56159

		MR O'BRIEN: Unremunerated. Unacknowledged. COLIN WEIR: Don't do it. MR O'BRIEN: Had to organise it. Had to do all of that COLIN WEIR: So you were busting yourself MR O'BRIEN: One of the reasons why I am here in this situation	
24.02.2017	Meeting with Mr Weir and Mr O'Brien:	Page 13 (Section E – H) & Page 14 (Section A – H) MR O'BRIEN: Arising out of that, and this is what, you know, now that you are not the investigator, you know I feel so angry and aggrieved, You know, for – I took over as chair of MDM in April 2012. By end of 2012 the extended days had come in. And from 13 onwards I used every available morning session as well, going from 9 until 8. And you would finished a long day operating and you would get to the changing room by 9 o'clock after seeing your patients and done the admin and you go home and you get something to eat. And then I sat down and spent three/four hours previewing MDM for the following day. COLIN WEIR: That's stupid. That's crazy. MR O'BRIEN: Yes, that's the – so one thing I am not doing anymore is I am not going to preview and chair MDM. …. MR O'BRIEN: … This is the situation we are in, and I am not the only one affected. Yesterday we were scheduling. My first scheduling meeting now since October. And John O'Donoghue was telling me that the day before he was I think sitting triaging at 4 o'clock. He gets a call from gynaecology. There's an injured bladder during some gynaecological. He spends the evening doing that. And yesterday when we were scheduling he was trying to preview because he was charing in the afternoon. This thing of doing three things at the one time. So I am not going – COLIN WEIR: I think the team, I can't tell urologists how best to run their MDM or how it is done. You would need to maybe have that conversation with Michael. … MR O'BRIEN: Yes. So: "The oncall week commences on Thursday am for seven days. Therefore triage for all referrals must be completed by 4.00pm on the Friday after Mr O'Brien's consultant of the week ends". So I have consistently held for years that, you know, it wasn't possible to do it, what I am going to do is I am going not be at the MDM on the Thursday afternoon and I am going to use that time to complete any non-red flagged triaging that has to be done so that it is returned by 4.00pm at the latest on Friday. … MR O'BRIEN: Now that you are not the investigator, what I find remarkable is that I convened a meeting, I think it took place on 2 April 2015, as lead clinician of MDT, to address how we were going to do the	Transcript File 6 AOB-56159 - AOB-56161

		red flag referrals and particularly with regard to advanced triage. I couldn't get the agreement of my consultant colleagues to do advanced triaged of red flag referrals whilst on call. Why? And this is all approved minutes, because it was too time consuming and the other duties of being urologist of the week didn't allow time for it.	
24.02.2017	Meeting with Mr Weir and Mr O'Brien	Page 18 (section D – H) & Page 19 (Section A – C) MR O'BRIEN: Just the other thing from a job plan point of view, is that I do – urodynamics and oncology review on a Friday morning and I will not be doing Friday afternoon, which is my SPA time, which I have used consistently, leaving myself with no SPA time. COLIN WEIR: Remember when we did a job plan before I said you have got to. You have got to have some SPA. MR O'BRIEN: And we will leave all of this, as Michael Young says, Trust issues, except the Trust that we work for never makes them an issue. COLIN WEIR: We have got to protect your – you know, if it is seeing less patients or doing something to do SPA then that is the way it has got to be. MR O'BRIEN: Who is going to ever address the inequities? COLIN WEIR: Of, what? Inequities of? MR O'BRIEN: The fact that I could have 280 people on my in-patient waiting list and someone else has 29. COLIN WEIR: I think we need to – maybe there's – I don't know. Maybe there needs to be an action to deal with the back log, to start a with a clean sheet going forward, to reduce the number of people that you are seeing in some of the clinics a bit. MR O'BRIEN: I am not talking about the number of people I am going to be seeing in a clinic. Who is going to address the big issues because I am tired of it. I have done it for 25 years…. …. MR O'BRIEN: The health system in in an awful state anyway COLIN WEIR: It is. I think that's part of the problem. There's not enough money in the system to do what we want to do. There's not enough resources.	Transcript File 6 AOB-56164 - AOB-56165
09.03.2017	Meeting in relation to return to work with Mr O'Brien, Mr Weir and Ms Corrigan	Discussions between Mr O'Brien, Ms Corrigan and Mr Weir re his return to work. During that the following issues were addressed:- ***"3. New Outpatient Clinics*** *Mr O'Brien advised Mr Weir and Mrs Corrigan that he no longer felt it was fair that he would continue to see New Outpatients. Mrs Corrigan advised that this was not feasible as all Consultants needed to see New Outpatients. Mr O'Brien clarified that the reason he felt this was because he had the most patients waiting to be operated on with the longest waiting times and that it wasn't fair for him to continue to see new patients and adding to his waiting list as he couldn't deal with them.*	Doc File 2 pages 576 – 581 AOB-01469 - AOB-01474

		Mrs Corrigan clarified that Mr O'Brien didn't have the most nor the longest waiting times for In and Day patients: *Mr Young - 228 patients (162 weeks)* *Mr Suresh - 267 patients (93 weeks)* *Mr O'Brien - 257 patients (152 weeks)* *Mr Haynes - 191 patients (143 weeks)* *Mr Glackin - 146 patients (62 weeks)* *Mr O'Donoghue - 134 patients (101 weeks)* *Mrs Corrigan gave further detail on Mr O'Brien's total waiting with their longest waiting times:* *Daycases: 37 Urgent (longest waiting 110 weeks)* *25 Routine (longest waiting 137 weeks)* *Inpatients 124 Urgent (longest waiting 148 weeks)* *71 Routine (longest wailing 152 weeks)* *Mr O'Brien advised that he didn't agree with classifications of an Urgent or of a daycase and that whilst these were the numbers waiting they should be classified differently.* *Follow-up note - Mrs Corrigan to work with Mr O'Brien to get these validated and classified accordingly…..* *Mrs Corrigan shared Mr O'Brien's Review Urgent Outpatient backlogs:* *CAOBUO (oncology reviews) - 2014 = 89* *2015 = 77* *2016 = 46* *End of March 2017 = 32* *Total = 244* *EUROU = Enniskillen Urgent 2014 = 1* *2015 = 1* *2016 = 25* *End of March 2017 = 32* *Total = 63* ***6. MDT*** *Mr O'Brien raised about the Urology Oncology MDT and advised Mr Weir and Mrs Corrigan that he was no longer prepared to operate on a Wednesday until 8pm then go home and preview for the next day's MDT as he had done in the past. He advised Mr Weir and Mrs Corrigan that he hadn't quite made up his mind if he was going to continue with chairing this MDT group but if he did continue then he Wouldn't be coming into work on a Thursday morning but the time would be spent previewing for the MDT. Mr O'Brien advised that he spends considerable time preparing for the meeting if he is going to Chair and that he went through all patients in great detail including all their images. He also advised that in the past he had spent considerable time after the MDT correcting the outcomes i.e. grammar etc. He advised that he prided himself on having one of the best-prepared and well-run MDTs."*	
10.03.2017	Email from Ms Corrigan to Consultants	Re Urology escalations Noted that there are 58 patients in total that will not get sorted	TL6 page 302 – 304

			AOB-78887 – AOB-78888
15.03.2017	Email from Ms Corrigan to Consultants	Re Urology performance ahead of departmental meeting New Outpatients – Total 2606. Longest wait routine – 76 weeks. Longest wait Urgent – 58 weeks. Inpatients – Total – 620. Total Urgent – 411 Total Routine – 209 Daycases excluding Flexi – Total 689. Urgent – 155. Routine – 534 Flexible Cystoscopies – Unplanned Total 106. Urgent – 85. Routine – 21. Planned Total 129. Urgent in – 45. Urgent day – 30. Routine In – 9 Routine day - 45	TL6 page 332 – 337 AOB-78919 – AOB-78924
22.03.2017	Meeting with Mr Wilkinson and Mr O'Brien	Page 17 (Section F – H) MR O'BRIEN: The big elephant of why did I end up in this situation? Well, it was overwork on several fronts but the biggest reason for the overwork was all of the additional in-patient operating that I had done under pressure and expectations from patients and under concerns that I would have had for their clinical outcomes. I have shared that with you before. And, you know, Siobhan did ask me and she did record who would have raised these concerns with before? And I said above all, you know, I have raised – I have raised my concerns with everybody at every level over 20 years without change. But the important thing is, and I am telling you something now, I am raising it with the both of you right now. …	Transcript File 7 AOB-56189
24.03.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient was ringing re date for surgery and has been on waiting list for TURP since July 2015	TL6 page 385 AOB-78972
27.03.2017	Email from Ms Dignam to Consultants	Re May rota	TL6 page 404 – 408 AOB-78991 – AOB-78995
29.03.2017	Email from Ms Dignam to Consultants	Re April Schedule	TL6 page 414 – 422 AOB-79001 – AOB-79009
19.04.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list since March 2015 and is experiencing a lot of pain	TL6 page 509 AOB-79096
26.04.2017	Email from Ms Dignam to Consultants	Re June Rota	TL6 page 530 – 536

			AOB-79117 – AOB-79123
04.05.2017	Email from Ms Corrigan to Consultants	Notes that there was a 10% increase in urology red flag referrals in 2014/2015 and a further increase of 15% in 2016/2017. MRI prostate activity has increased 22% from 2015/2016 to 2016/2017.	TL6 page 559 – 561 AOB-79146 – AOB-79148
04.05.2017	Email from Mr Haynes to Ms Corrigan	Re increase in red flag urology referrals. Mr Haynes notes that these figures should have been provided after consultant input. He further notes that NICE guidance is 3 years outdated	TL6 page 562 – 564 AOB-79149 – AOB-79151
09.05.2017	Email from Ms Corrigan to Consultants	Ms Corrigan notes that they cannot fill locum slots and wonders if any of the consultants have availability to fill them	TL6 page 587 – 588 AOB-79174 – AOB-79175
09.05.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list since June 2014	TL6 page 589 AOB-79176
11.05.2017	Email from Ms Corrigan to Consultants	Re May rota	TL6 page 593 – 594 AOB-79180 – AOB-79181
12.05.2017	Email from Ms Corrigan to Others	Re Red Flag Longest wait Urology (Prostate) – 29 Urology (Haematuria) – 30 Urology (Other) – 35	TL6 page 595 – 598 AOB-79182 – AOB-79185
22.05.2017	Email from Ms Mulligan to Mr O'Biren	Re Patient query Patient ringing about review appointment. Has been on waiting list since September 2016 and is suffering quite badly	TL6 page 629 AOB-79216
25.05.2017	Email from Ms Dignam to Consultants	Re July rota	TL6 page 632 – 635 AOB-79219 – AOB-79222
25.05.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient on waiting list since January 2015 and advised that she is very symptomatic recently with painful haematuria	TL6 page 636

			AOB-79223
25.05.2017	Meeting with Mr Weir, Ms Corrigan and Mr O'Brien	Page 2 (Section A – B) MARTINA CORRIGAN: I thought you were going to bring it with you? Aidan was up until quarter to 3 this morning operating COLIN WEIR: What?	Transcript File 8 AOB-56204
25.05.2017	Meeting with Mr Weir, Ms Corrigan and Mr O'Brien	Page 5 (Section E – H) – Page 6 (Section A – B) MARTINA CORRIGAN: Are you going to stay on for MDT? Are you not very tired? MR O'BRIEN: I am very tired and I have a lot of triaging to complete for tomorrow so it's non-stop. But I will see what – MARTINA CORRIGAN: (Inaudible) MR O'BRIEN: It's not a matter of, you know, operating late. It is a concern for the patients. I mean life threatening concern. We had really sick septic people. I did a laparotomy last night starting at 11 o'clock you know. COLIN WEIR: You need an AMD for anaesthetics and theatres and we need I think. MR OBRIEN: We need. COLIN WEIR: Full time MARTINA CORRIGAN: (inaudible) You may probably not agree with this. The guys are saying today that there is no decision being made in theatre. Theatres in the sense of – there seems to be no organisation in it or. COLIN WEIR: There is not enough emergency theatre capacity between 9 and 5 when everybody is about and you want to get the work down. You would be in the safe environment, maximum expertise. MR O'BRIEN: But yesterday is even worse than all of that because when you have two theatres blocked with ventilated patients, right, and you have to wait until – only that Altnagelvin was able to take one at 4 o'clock and a person died in intensive care. And you have sick people, I mean waiting, really sick people. Their lives – COLIN WEIR: This is a recurring problem. This happened on Monday. Theatre 1 big case. Then somebody sick. Theatre 2, was my list, had to stop. So you are losing – in all sorts of ways you are losing.	Transcript File 8 AOB-56207 - AOB-56208
30.05.2017	Email from Ms Evans to Consultants	Re Admin backlog Discharges awaiting dictation – Mr Glackin 10 (April/May 2017) Discharges to by typed – Mr Glackin 13 (April 2017) Clinics to be dictated – Mr Glackin 1 (April 2017) Clinics to be typed – Mr Glackin 35 (May 2017). Mr Haynes 4 (May 2017). Mr O'Brien 6 (May 2017). Mr O'Donoghue 62 (May 2017).	TL6 page 665 – 667 AOB-79252 – AOB-79254

		Results to be dictated – Mr Jakob 58 (May). Mr Glackin 21 (May 21). Mr Haynes 40 (May 17). Mr O'Brien 4 Results to be typed – Mr Jakob 2 (May 2017). Mr Glackin 19 (May 2017). Mr ODonoghue 8 (May 2017	
30.05.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list since May 2015	TL6 page 668 AOB-79255
30.05.2017	Memo from Chief Executive	Notes the Trust's budget limitations	TL6 page 669 AOB-79256
June 2017	Cancer Performanc e Report	Notes breaches and reasons for delays	TL6 page 938 - 943
01.06.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's wife ringing for date for surgery as been in waiting list for TURP since March 2016 and is having to rise 5 times per night	TL6 page 673 AOB-79260
06.06.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's father rang re date for surgery. Patient has been on waiting list for circumcision since August 2014	TL6 page 699 AOB-79286
12.06.2017	Email from Ms Corrigan to Consultants	Re Red Flag longest waiters Urology (Prostate) – 27 Urology (Haematuria – 27 Urology (Other) – 25	TL6 page 723 – 726 AOB-79310 – AOB-79313
14.06.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient has been on waiting list for TURP since 25 November 2014 and would like date for surgery as soon as possible	TL6 page 736 AOB-79323
23.06.2017	Email from Ms Corrigan to Consultants	Re Red Flag longest waiters Urology (Prostate) – 30 Urology (Haematuria) – 30 Urology (Other) – 36	TL6 page 787 – 790 AOB-79374 – AOB-79377
27.06.2017	Email from Ms Dignam to Consultants	Re July Schedule	TL6 page 794 – 799 AOB-79381 – AOB-793886
27.06.2017	Email from Mr Young	Re August schedule	TL6 page 800 – 803

	to Consultants		AOB-79387 – AOB-79390
28.06.2017	Email from Mr Young to Consultants	Re August rota	TL6 page 804 – 810 AOB-79391 – AOB-79397
28.06.2017	Email from Ms Elliot to Mr O'Brien	Re Patient Query Patient Ringing for date for surgery. He is on waiting list since August 2015 and notes that he is symptomatic	TL6 page 811 AOB-79398
28.06.2017	Email from Ms Elliot to Mr O'Brien	Re patient query Patient wanted date for surgery as on waiting list since August 2015 and his catheter is blocking every 6 weeks	TL6 page 812 AOB-79399
30.06.2017	Email from Ms Evans to Consultants	Re Admin backlog Discharges awaiting dictation – Mr Glackin 6 (May/June), Mr O'Brien 8 (May 17). Discharges to be typed – Mr Jakob 8 (June 17), Mr Glackin 6 (June 17), Mr Haynes 7 (June 17) Clinics to be dictated – Mr Glackin 2 (June 17) Clinic letters to be typed – Mr Jakob – 23 (June 17). Mr Glackin 18 (June 17) Mr O'Donoghue 59 (June 17) Results to be dictated – Mr Jakob – 20 (June). Mr Glackin 67 (May/June)/ Mr O'Brien 4 Results to be typed – Mr Jakob – 8 (June). Mr glackin 8 (June 17). Mr O'Donoghue 20 (June 17)	TL6 Page 836 – 838 AOB-79423 – AOB-79425
03.07.2017	Email from Ms Dignam to Consultants	Re July Schedule	TL6 page 840 – 841 AOB-79427
04.07.2017	Email from Ms Elliot to Mr O'Brien	Patient ringing re date for surgery as been on waiting list since January 2015 and has had several infections	TL6 page 842 AOB-79429
07.07.2017	Email from Ms Elliot to Mr O'Brien	Noting that no nursing staff available for clinic so will have to cancel patients. Mr O'Brien raises his issue with this with Ms Corrigan Ms Corrigan's response	TL6 page 882 – 884 AOB-79469 - 79471 TL6 page 886 – 887

			AOB-79473 – AOB-79474
07.07.2017	Email from Ms Corrigan to Consultants	Re Red Flag longest waiters Urology Prostate – 27 Urology Haematuria – 27 Urology Other – 19	TL6 page 888 – 891 AOB-79475 – AOB-79478
17.07.2017	Email from Ms Corrigan to Consultants	Re Red Flag long waiters Urology Prostate – 35 Urology Haematuria – 30 Urology Other – 32	TL6 page 918 – 922 AOB-79505 – AOB-79519
25.07.2017	Email from Ms Corrigan to Consultants	Re Red Flag Longest Wait Urology prostate 34 Urology haematuria 30 Urology other 30	SUPOCT Page
25.07.2017	Meeting with Martina Corrigan, Colin Weir, Ronan Carroll and Mr O'Brien	Page 10 (section G – H) Ronan Carroll: I don't think anybody is going to disagree. We all know that we don't have enough of anything. We don't have enough clinicians, we don't have enough nurses, we don't have operating time and --	Transcript File 9 AOB-56219
26.07.2017	Email from Mr Young to Consultants	Re Sept rota Mr Young also queries whether Mr O'Brien or Mr O'Donoghue would like to take on locum shifts	TL6 page 966 – 969 AOB-79553 = AOB-79556
01.08.2017	Email from Ms Evans to Consultants	Backlog Report	TL6 Page 1006 – 1008 AOB-79593 – AOB-79595
01.08.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient wanted a date for surgery. Has been on waiting list for TURP since March 2015 and notes that his symptoms have worsened	TL6 page 1009 AOB-79596
03.08.2017	Email from Mr Morgan to Mr O'Brien	Notes that a patient has not had confirmation about surgery and nothing has been recorded on PAS	TL6 page 1914 AOB-79601
03.08.2017	Information in relation to Additional	In the context of the MHPS investigation, AOB relates to additional work 2012 to 2016 in detail in document. He emphasises these are underestimates and take no account of holidays etc.	Doc File 3 page 132

	work Time between 2012 and 2016 provided by Mr O'Brien	The mean time allocated to NICaN per week during 2012 to 2015 – 1 hour. Time as mean time, additional time, allocated to MDT and MDM work from 2012 to 2016 – 3.9 hours per week. Additional time allocated to Clinics 2012 to 2016 – average 2.65 hours per week.	AOB-01700
08.08.2017	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re surgery. Is on waiting list for injection since April 2015 and noted that symptoms are worsening	TL6 page 1034 AOB-79621
09.08.2017	Email from Ms Dignam to Consultants	Re August Schedule	TL6 page 1035 – 1042 AOB-79622 – AOB-79629
15.08.2017	Email from Ms Browne to Mr O'Brien	Notes that patient is due review in September 2017 but due to backlogs she will not be seen in this timeframe. It was also noted that all Mr O'Brien's review clinics in September have been cancelled	TL6 page 1061 AOB-79638
16.08.2017	Cancer Performance Report for July 2017		TL6 page 1062 – 1067 AOB-79649 – AOB-79654
18.08.2017	Email from Ms Corrigan to Consultants	Re Red Flag longest waiters Urology prostate 32 Urology Haematuria 30 Urology Other 30	TL6 page 1073 – 1075 AOB-79660 – AOB-79662
29.08.2017	Email from Ms Corrigan to Consultants	Request for cover of locum shifts which were unfilled	TL6 page 1102 AOB-79689
30.08.2017	Email from Mr Young to Consultants	Re October rota	TL6 page 1104 – 1107 AOB-79691 – AOB-79694

31.08.2017	Email from Ms Reddick to Ms Corrigan	"Article" on Urological Suspect Cancers	TL6 page 1110 – 1121 AOB-79697 – AOB-79708
31.08.2017	Email from Ms Corrigan to Consultants	Re Sept on call rota	TL6 page 1122 – 1123 AOB-79709 – AOB-79710
01.09.2017	Email from Ms Dignam to Consultants	Re Sept Schedule	TL6 page 1135 – 1140 AOB-79722 – AOB-79727
01.09.2017	Urology MDT, Annual Report for January - December 2016	Parts to note from this report include the following:- ***"3.0 KEY CHALLENGES Oncology and Radiology*** *The greatest challenge for the MDT during the past year has been the inadequacy of the availability of a clinical oncologist and or a radiologist at all MDMs."* Noted there had been a 40% increase in the number of Red Flag referrals throughout Northern Ireland and in the Southern Trust an increase of 84% from 410 in 2013 to 753 in 2014. "*This increase has continued throughout 2015/16 – there were 1878 red flag referrals in 2016……"* *"the increased compliment of Consultant Urologists has enabled the MDT to absorb the increased demand….."* In relation to operating capacity (page 5) it notes "*The main limiting factor was operating theatre capacity and operator time. Though the MDT has provided for the increased demand on Ref Flag pathways, it has been at the expense of patients having, or suspected of having, recurrent bladder tumours, and those awaiting prostatic resection to facilitate their progress to radical radiotherapy …….. in addition to all those with non-cancerous pathology."* Noted this was "*a common and concerning experience across Northern Ireland, and will remain an increasing challenge until operative capacity is increased."* On page 7 it is noted that the MDT quorum for 2016 was 11% with Radiology and Clinical Oncology presence being the key issues. Noted Mr O'Brien had stepped down as Clinical Lead for Urology and Mr Haynes was appointed as the new Clinical Lead.	Doc File 3 pages 137 – 186 AOB-01705 - AOB-01754

04.09.2017	Email from Ms Evans to Consultants	Re Admin backlog Discharges awaiting dictation – Mr Glackin 2 (July 17), Mr O'Brien 10 (August 2017), Mr Young 38 (Nov 16). Discharges to be typed – Mr Glackin 3 (August 17), Mr O'Brien 1 (Sept 17) Clinics to be dictated – Mr Glackin 6 (April 17) Clinic letters to be typed – Mr Jakob 11 (August 2017) Results to be dictated – Mr Glackin 75. Mr Haynes 10 (August 17). Mr O'Brien 35. Mr Young 31 (July 2017) Results to be typed – Mr Jakob 2 (August 17), Mr Glackin 18 (August 17), Mr O'Donoghue 4 (August 17)	TL6 page 1141 – 1143 AOB-79728 – AOB-79730
07.09.2017	Email from Ms Corrigan to Consultants	Re 62 Day Cancer PTL Notes that the SHSCT are not doing too bad compared to Belfast	TL6 page 1148 - 1150 AOB-79733 – AOB-79737
07.09.2017	Email from Ms Corrigan to Consultants	Re 31 day Cancer PTL	TL6 page 1151 – 1152 AOB-79738 – AOB-79739
07.09.2017	Email from Ms McCourt to Consultants	Notes that due to staffing skill mix within Thorndale the urodynamics sessions will be cancelled	TL6 page 1153 AOB-79740
15.09.2017	Email from Ms Corrigan to Consultants	Notes that the lack of FY1s has meant limited resources and therefore the consultant/reg will have to complete the Kardex & VTE risk assessment with patient for all elective patients	TL6 page 1165 AOB-79752
19.09.2017	Email from MLA	Notes that the patient's procedure was cancelled due to bed pressures.	TL6 page 1184 – 1186 AOB-79771 – AOB-79773
21.09.2017	Email from Ms Corrigan to Consultants	Re Red Flag long waiters Urology Prostate 24 Urology Haematuria 20 Urology Other 20	TL6 page 1189 – 1193 AOB-79776 –

			AOB-79780
29.09.2017	Email from Ms Dignam to Consultants	Re October schedule	TL6 page 1373 – 1374 AOB-79960 – AOB-79961
29.09.2017	Email from Ms Corrigan to Consultants	Re October Rota	TL6 page 1375 – 1376 AOB-79962 – AOB-79963
03.10.2017	Email from Ms Evans to Consultants	Re Admin backlog Discharges awaiting dictation – Mr Glackin 1 (Sept 17), Mr O'Brien 13 (June 16), Mr Young 11 (Jan 17) Discharges to be typed – Mr Glackin 7 (Sept 17), Mr Young 17 Clinics to be dictated – Mr Glackin 2 (June 17) Clinic letters to be typed – Mr Jakob 17 (October 17), Mr Glackin 28 (Sept 17), Mr Young 2(Sept 17) Results to be dictated – Mr Jakob 35 (Sept 17), Mr Glackin 8 (Sept 17), Mr Haynes 7 (Sept 17), Mr Young 17 (July 17) Results to be typed – Mr Jakob 5 (Sept 17), Mr Glackin 7 (Sept 17) Mr ODonoghue 7 (Sept 17)	TL6 page 1377 – 1379 AOB-79964 – AOB-79965
03.10.2017	Email from Ms Corrigan to Consultants	Re Red Flag longest wait Urology prostate 24 Urology Haematuria 21 Urology Other 13	TL6 page 1380 – 1384 AOB-79967 – AOB-79971
10.10.2017	Email from Ms Nelson to Consultants	Notes that on the grounds of patient safety, all adult elective surgery will be cancelled. There are minus 64 beds with extra patients on the wards. Based upon the predictions it would not be appropriate to operate on elective patients knowing that could not safely accommodate and care for them	TL6 page 1403 AOB-7990
11.10.2017	Email from Mr Carroll to Mr O'Brien	Mr O'Brien raised his concerns and frustrations at the late notification of cancellation of beds. Mr Carroll sets out to Mr O'Brien why the decision was so late and highlighted that he understood the frustration & disappointment of consultants, surgeons and family of patients	TL6 page 1404 – 1417 AOB-79991 – AOB-80004
15.10.2017	Email from Mr O'Brien to Mr Haynes	Notes that Mr O'Brien has has 14 elective surgeries cancelled over the past 4 weeks	TL6 page 1432 – 1433

			AOB-80019 – AOB-80020
22.10.2017	Email from Mr O'Brien to Ms Browne	Notes that there were 20 patients appointed to his SWAH clinic when there is a quota of 16 patients	TL6 page 1472 AOB-80059
23.10.2017	Email from Ms Dignam to Consultants	Re December rota	TL6 page 1474 – 1477 AOB-80061 – AOB-80064
23.10.2017	Email from Ms Donnelly to Mr O'Brien	Notes that patients surgery were postponed due to bed pressures	TL6 page 1478 AOB-
28.10.2017	Email from Ms Corrigan to Consultants	Re November rota	TL6 page 1503 – 1504 AOB-80090 – AOB-80091
01.11.2017	Email from Ms Dignam to Consultants	Re November schedule	TL6 page 1505 – 1506 AOB-80092 – AOB-80093
03.11.2017	Email from Ms Evans to Consultant	Re Admin backlog Discharges awaiting dictation – Mr Glackin 4 (Oct 17), Mr O'Brien 13 (June 16), Mr Young 20 (Jan 17) Discharges to be typed – Mr Glackin 6 (Oct 17) Clinics to be dictated – Mr Glackin 2 (June 17) Clinic letters to be typed – Mr Jakob 6 (Oct 17), Mr Glackin 1 (Oct 17), Mr O'Donoghue 14 (Oct 17), Mr Young 2 (Nov 17) Results to be dictated – Mr Jakob 34 (Sept 17), Mr Glackin 81 (Oct 17), Mr Haynes 2 (Oct 17), Mr O'Brien 3 Mr Young 14, 11 reg (July 17) Results to be typed – Mr Jakob 5 (Oct 17), Mr Haynes 26 (Oct 17), Mr O'Donoghue 21 (Oct 17)	TL6 page 1509 – 1511 AOB-80096 – AOB-80098
14.11.2017	Email from Ms Corrigan to Consultants	Notes that elective surgery for specialities will be reduced by 30% between 4 December – 31 March due to bed pressures	TL6 page 1576 AOB-80163

22.11.17	Email from Mr young to Consultants	Re Dec rota	TL6 page 1581 – 1584
22.11.2017	Email from Mr O'Brien to Mr Young	Notes that he cannot respond to demands and clinical needs for surgery with only 5 operating sessions throughout the month of Dec 2017.	TL6 page 1585 AOB-80172
30.11.2017	Personal Development Plan	Comments by AOB in his 2016 Appraisal Name of doctor: Aidan O'Brien Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: During 2016, I focussed on the areas which I believed were most clinically pressing, performing 25 additional, inpatient operating sessions, and 20 additional oncology review sessions, in the ten months available to me. I have no doubt that doing so significantly reduced the poor clinical outcomes and suffering of significant numbers of patients. I also have no doubt that doing so contributed to the issues since subject to formal investigation. My appraiser recorded that these were Trust issues to be discussed and agreed in 2017. They have yet to be so! Date of reflection: 30 November 2017	2016 Appraisal page 40 AOB-22870
01.12.2017	Email from Ms Evans to Consultants	Re Admin Backlog Discharges waiting dictation – Mr Glackin 3 (Nov), Mr O'Brien 12 (June 16), Mr Young 3 (Feb 17). Discharges to be typed – Mr Glackin 3 (Nov 17), Mr Haynes 10 (Nov 17) Clinics to be dictated – Mr Glackin 3 (June 17) Clinic letters to be typed – Mr Jakob 3 (Nov 17), Mr Glackin 2 (Nov 17) Mr O'Donoghue 14 (Nov 17), Mr Young 36 (Nov 17) Results to be dictated – Mr Jakob 3 (Nov 17), Mr Glackin 80 (Oct), Mr Haynes 1 (Nov 17), Mr Young 15, 17 Reg (July 17) Results to be typed – Mr Jakob 35 (Nov 17), Mr Glackin 7 (Nov 17), Mr Haynes 23 (Nov 17), Mr O'Donoghue 11 (Nov 17)	TL6 page 1613 – 1615 AOB-80200 – AOB-80202
01.12.2017	Email from Ms Corrigan to Consultants	Re December rota	TL6 page 1616 – 1617 AOB-80203 – AOB-80204

21.12.2017	Email from Mr Haynes	2 new SHOs starting to deal with winter pressure	TL6 page 1672 – 1673 AOB-80250 – AOB-80260
28.12.2017	Email from Ms Dignam	Re Jan Schedule	TL6 page 1698 – 1706 AOB-80285 – AOB-80293
December 2017	Cancer Performance Report		TL6 page 93 - 98 AOB-80386 – AOB-80391
03.01.2018	Email from Mr O'Brien to Mr Cullen	Notes that the bed situation is so bad that you cannot confidently arrange an admission for the following week	TL6 page 10 AOB-80303
04.01.2018	Email from Ms Dignam to Consultants	Re Feb rota	TL6 page 11 – 13 AOB-80304 – AOB-80306
05.01.2018	Email from Ms Corrigan to Consultants	As you will be aware from the media coverage and from the bed situation this week in our Trust, the availability for beds for elective patients has been non-existent due to the high admissions of emergency patients. But from next Monday there has been an agreement to schedule red flag surgery only. If we happen to get more capacity then we will book urgents as well. All routine and urgent patients (this includes ALL orthopaedics) that had been scheduled until end of January have now been cancelled. So moving forward can you please book red flags to your lists only? I will monitor this and if we have a day that is 'light' on RF then I will be in touch with your secretaries to schedule the urgents. I know that this far from ideal but as it is regional/national directive we are not the only departments/Trusts in this position and is totally outside of our control. Paediatrics can be booked to lists but again we can't overload as they will be in the same position if they get a high rate of emergency admissions, but I will monitor to ensure there are not too many being booked between the lists. Can I take this opportunity to thank you all for your continued co-operation and patience during this very difficult pressurised period	TL6 Page 16 – 17 AOB-80309 – AOB-80310

<table>
<tr><td>09.01.2018</td><td>Email from Ms Corrigan to Consultants</td><td>Notes that x5 patients were cancelled</td><td>TL6 Page 19

AOB-80312</td></tr>
<tr><td>30.01.2018</td><td>Email from Ms Elliot to Consultants</td><td>Re Feb & March Scheduled</td><td>TL6 page 127 – 133

AOB-80420 – AOB-80426</td></tr>
<tr><td>Jan 2018</td><td>Cancer Performance Report</td><td></td><td>TL6 page 197 – 213

AOB-80490 – AOB-80506</td></tr>
<tr><td>14.02.2018</td><td>CHKS Consultant Level Indicator Programme</td><td>CHKS Consultant Level Indicator Programmer Report

Activity

The activity tables display a collection of activity based indicators split by inpatient and outpatient workload.

Admitted Workload

<table>
<tr><th>Indicator</th><th colspan="2">Consultant</th><th>Local</th><th>Peer</th></tr>
<tr><td>Total FCEs</td><td>928</td><td>-</td><td>719.43</td><td>409.30</td></tr>
<tr><td>% Elective FCEs</td><td>758</td><td>81.68%</td><td>84.11%</td><td>73.55%</td></tr>
<tr><td>% Elective FCEs - Inpatients</td><td>167</td><td>22.03%</td><td>14.94%</td><td>29.80%</td></tr>
<tr><td>% Elective FCEs - Day Cases</td><td>585</td><td>77.18%</td><td>75.78%</td><td>68.84%</td></tr>
<tr><td>% Regular Attenders</td><td>7</td><td>0.92%</td><td>9.30%</td><td>1.72%</td></tr>
<tr><td>% Emergency FCEs</td><td>129</td><td>13.90%</td><td>12.73%</td><td>24.28%</td></tr>
<tr><td>% Other FCEs</td><td>41</td><td>4.42%</td><td>3.16%</td><td>2.17%</td></tr>
</table>

Outpatient Workload

<table>
<tr><th>Indicator</th><th colspan="2">Consultant</th><th>Local</th><th>Peer</th></tr>
<tr><td>Total Attendances (OP)</td><td>939</td><td>-</td><td>1086.86</td><td>2491.37</td></tr>
<tr><td>Total New OP Attendances</td><td>430</td><td>-</td><td>458.43</td><td>877.50</td></tr>
<tr><td>Total Follow up OP Attendances</td><td>509</td><td>-</td><td>628.43</td><td>1613.76</td></tr>
</table>
</td><td>2017 Appraisal pages 25 - 39

AOB-22903 - AOB-22917</td></tr>
</table>

Outpatient Attendances with a Procedure	70	7.45%	3.43%	36.32%		
New Outpatient Attendance with a Procedure	67	15.58%	5.67%	43.42%		
Follow up Attendances with a Procedure	3	0.59%	1.80%	32.46%		
New Outpatient Attendance M referred by GP	273	63.49%	66.10%	53.79%		
Total DNA's	27		43	189.21		
% of DNA's New Attendances	16	59.26%	47.18%	31.13%		
% of DNA's Follow-up Attendances	11	40.74%	52.82%	68.87%		

Trend

This analysis displays a collection of performance and efficiency indicators for the target consultant comparing performance year on year data for the selected time period. Up to a maximum of five years can be displayed depending on the availability of data.

Data may be missing if your organisation has not submitted historical data to CHKS or if you became a consultant at the organisation within the last five years.

If a period of less than 12 months is selected then this is also the period that will be reported for the previous years. For example, if the selected period is January - June 2016 then the previous four years will be the January- June period in each year.

Indicator	Jan 13 – Dec 13	Jan 14 – Dec 14	Jan 15 – Dec 15	Jan 16 – Dec 16	Jan 17 – Dec 17
Total FCEs (Exclusions: Standard and Day-cases)	634	594	412	351	337
Average Length of Stay (FCE - zero trimmed}	4.31	4.88	4.83	4.67	4.55
Day Case Rate	47.40 %	53.17 %	64.98%	72.35%	78.28%

		Mortality Rate	0.40%	0.39%	0.37%	0.60%	0.33%	
		Readmissions within 7 days	1.30%	2.92%	2.20%	2.16%	0.99%	
		Readmissions within 14 days	2.10%	4.63 %	3.79%	3.24%	2.43%	
		Readmissions within 28 days	3.70%	6.14%	6.11%	4.68%	3.76%	
		Total New OP Attendances	499	285	462	347	430	
		Total Follow-up OP Attendances	966	614	647	573	509	
		Outpatient DNA Rate	5.36%	4.06 %	3.90%	5.25%	2.80%	
		Outpatient DNA Rate - Follow-up Attendances	6.30%	4.36%	2.41%	4.82%	2.12%	

14.02.2018	CLIP (Consultant Led Indicator Programme Report	Southern Health and Social Care Trust *Quality Care - for you, with you* CLIP (Consultant Led Indicator Programme) Report structured reflective template Requirement: One annually Name of doctor: Aidan O'Brien GMC No: 1394911 Date of report: 14 february 2018 What issues can I identify from the report? Average length of stay for patients is a meaningless indicator of clinical outcomes. My average length of stay is higher than the peer group. Perhaps the only indicator of related quality of clinical outcomes is that my complication rate and readmission rates are lower than the peer group, possibly as a consequence of a one day longer length of stay. Regarding outpatient clinics, my new:review ratio of 1:1.18 is lower than the peer group, as is my DNA rate. Total inpatient and day case admissions were negatively affected by my being not working during the first three months of 2017, as were outpatient attendances. Total outpatient attendances do not include virtual clinic episodes. In all, the CLIP report does not have any measure of quality of clinical outcomes. It is disappointing that it continues to use indicators of performance instead. What actions will I undertake? I will continue to offer the best management which I am capable of providing to those in most need of it. That apart, the total numbers will have increased during 2018 due to a full working year. Final outcome after discussion at appraisal: (Complete at appraisal)	2017 Appraisal Page 40 AOB-22918
21.02.2018	Email from Ms Dignam to Consultants	Re April rota	TL6 page 268 – 270 AOB-80561 – AOB-80563
23.02.2018	Email from Ms Gishkori to Mr Wright	Noting preferential treatment provided by Mr Wright for patients who "shout the loudest". Referring to patient's who complain and then get an appointment to avoid it going any further	TL6 page 275 – 276 AOB-80568 – AOB-80569
28.02.2018	Email from Ms Elliot to Mr O'Brien	Re Patient query Notes that patient has been on waiting list since September 2016 and was ringing re a date for surgery	TL6 page 297 AOB-80590
28.02.2018	Email from Ms Corrigan to Consultants	Re March Rota	TL6 page 298 – 299

<table>
<tr><td></td><td></td><td></td><td>AOB-80591 – AOB-80592</td></tr>
<tr><td>Undated (but joined the Trust in March 2018)</td><td>Witness Statement of Shane Devlin</td><td>Accepting the position I inherited I would consider that during this process of creating steadiness it is likely that identification and addressing of problems was not optimal</td><td>WIT-00027</td></tr>
<tr><td>01.03.2018</td><td>Email from Global Circular</td><td>Notes that all outpatient clinics will be cancelled</td><td>TL6 page 300

AOB-80593</td></tr>
<tr><td>05.03.2018</td><td>Email correspondence between Ms Corrigan and Ms Dignam</td><td>Ms Dignam raises that there are 9 RF patients on Mr Young’s waiting list going back to November 2017. Ms Corrigan notes her concern for this as none of these patients have been on her radar</td><td>TL6 page 324 – 327

AOB-80617 – AOB-80620</td></tr>
<tr><td>06.03.2018</td><td>Email from Ms Dignam to Consultants</td><td>Re March Schedule</td><td>TL6 page 329 – 330

AOB-80622 – AOB-80623</td></tr>
<tr><td>13.03.2018</td><td>Email from Ms Corrigan to Consultants</td><td>Notes that a decision has been made that the 30% reduction in elective surgery for a further 6 weeks from April 2018</td><td>TL6 page 336 – 337

AOB-80629 – AOB-80630</td></tr>
<tr><td>15.03.2018</td><td>Urology Performance 2018</td><td>New outpatient waiting lists – Total 2676 with longest routine wait 110

Total 426 urgent with longest wait 19 weeks

Review outpatient backlog

<table><tr><td>Consultant</td><td colspan="2"></td></tr><tr><td></td><td>total</td><td>Longest da</td></tr><tr><td>Mr Young (general)</td><td>186</td><td>October 201</td></tr><tr><td>Mr Young (stones)</td><td>552</td><td>February 20</td></tr><tr><td>Mr O’Brien</td><td>483</td><td>June 2016</td></tr><tr><td>Mr Glackin</td><td>110</td><td>September 20</td></tr><tr><td>Mr Haynes</td><td>0</td><td></td></tr><tr><td>Mr O’Donoghue</td><td>505</td><td>March 201</td></tr><tr><td>Mr Jacob</td><td>365</td><td>April 207</td></tr><tr><td>Enniskillen</td><td>185</td><td>Feb 2015</td></tr><tr><td>Total</td><td>2386</td><td></td></tr></table>
Inpatient and daycase waiting lists

Mr Young – Inpatients - Urgent 137, wait weeks, 181, routine 59, wait weeks 215</td><td>TL6 page 367 – 369

AOB-80660 - AOB-80662</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>Daycases – Urgent 94, wait weeks 159, routine 267, wait weeks 202

Mr O'Brien – Inpatients – Urgent 170, wait weeks 205, routine 66, wait weeks 188
Daycases – Urgent 44, wait weeks 162, routine 31, wait weeks 186

Mr Glackin – Inpatients – Urgent 30, wait weeks 73, routine, 25, wait weeks 70. Daycases – Urgent 31, wait weeks 66, routine 23, wait weeks 65

Mr Haynes – Inpatients – Urgent 78, wait weeks, 162, routine 38, wait weeks 176, Daycase – urgent 33, wait weeks 155, routine 51, wait weeks 167

Mr O'Donoghue – Inpatients – urgent 104, wait weeks 107, routine 26, wait weeks 148, Daycases – urgent 57, wait weeks 96, routine 26, wait weeks 153

Mr Jakob – Inpatients – Urgent 38, wait weeks 108, routine 17, wait weeks 112. Daycase – urgent 62, wait weeks 96, routine 191, wait weeks 118

Planned waiting lists – position at end of March 2018
<table>
<tr><th>Consultant</th><th colspan="2">Year</th></tr>
<tr><th></th><th>2016</th><th>2017</th></tr>
<tr><td>Mr Young</td><td>1</td><td>11</td></tr>
<tr><td>Mr O'Brien</td><td>3</td><td>14</td></tr>
<tr><td>Mr Glackin</td><td>0</td><td>2</td></tr>
<tr><td>Mr Haynes</td><td>0</td><td>4</td></tr>
<tr><td>Mr O'Donoghue</td><td>0</td><td>6</td></tr>
<tr><td>Mr Jacob</td><td>0</td><td>12</td></tr>
<tr><td>Total</td><td>4</td><td>49</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>21.03.2018</td>
<td>Email from Ms Mulligan to Mr O'Brien</td>
<td>Notes that waiting times for routine are 112 weeks</td>
<td>TL6 Page 366

AOB-80659</td>
</tr>
<tr>
<td>23.03.2018</td>
<td>Email from Ms Corrigan to Consultants</td>
<td>Re April rota</td>
<td>TL6 page 391 – 392

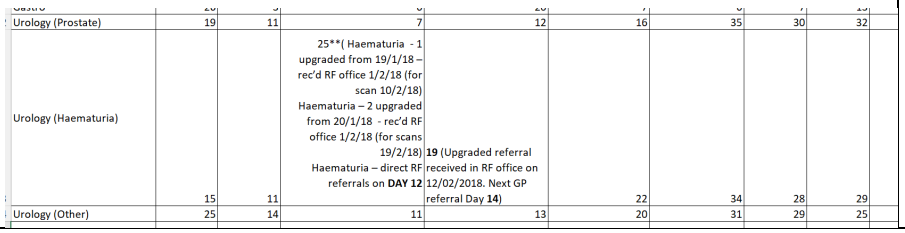
AOB-80684 – AOB-80685</td>
</tr>
<tr>
<td>26.03.2018</td>
<td>Email from Ms Corrigan to Mr O'Brien</td>
<td>Notes that a query came in from MLA on behalf of patient who was due to have surgery in September 2014 but it was cancelled due to low blood count. She has since had to wait to be recalled. Ms Corrigan has advised that Mr O'Brien's wait time is 207 weeks and he is focusing on red flag</td>
<td>TL6 page 394 – 395

AOB-80687 – AOB-80688</td>
</tr>
<tr>
<td>26.03.2018</td>
<td>Email from Ms Mulligan to Mr O'Brien</td>
<td>Notes that patient's GP was ringing re review appointment. Patient was due to be seen in March 2015</td>
<td>TL6 page 396

AOB-80689</td>
</tr>
</table>

29.03.2018	Email from Ms Corrigan to Consultants	Re review backlog additional clinics Notes that have received funding for 48 review backlog patients to be seen before end of June & request to do additional waiting list initiative clinics	TL6 page 413 AOB-80706
29.03.2018	Email correspondence between Ms Corrigan, Ms Robinson and Consultants	Notes that demand is outstripping supply	TL6 page 414 – 416 AOB-80707 – AOB-80709
04.04.2018	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list for TURP since September 2014	TL6 page 419 AOB-80712
04.04.2018	Email from Ms Dignam to Consultants	Re April Schedule	TL6 page 420 – 421 AOB-80713 – AOB-80714
04.04.2018	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery. Has been on waiting list since November 2014 and was advised he would have surgery in Feb 2017.	TL6 page 441 AOB-80734
10.04.2018	Email from Ms Elliot to Mr O'Brien	Notes that Mr O'Brien's clinics have been cancelled until 29 May 2018	TL6 page 456 AOB-80749
11.04.2018	Email from Ms Corrigan to Consultants	Re Red Flag 1st appointment longest wait 12/01/2018 – 19 23/01/2018 – 11 05/02/2018 – 7 14/02/2018 – 12 02/03/2018 – 16 30/03/2018 – 35 Urology (Prostate) Urology (Haematuria) 15 11 25**(Haematuria - 1 upgraded from 19/1/18 – rec'd RF office 1/2/18 (for scan 10/2/18) Haematuria – 2 upgraded from 20/1/18 - rec'd RF office 1/2/18 (for scans 19/2/18) Haematuria – direct RF referrals on **DAY 12** **19** (Upgraded referral received in RF office on 12/02/2018. Next GP referral Day **14**) 22 34 Urology (Other) 25 14 11 13 20 31	TL6 page 457 – 458 AOB-80749 – AOB-80751
17.04.2018	Email from Ms Corrigan to Consultants	Re Urology Escalations List of x21 patients who cannot be booked but are unable to be appointed by Day14. Ms Corrigan notes that she understands as no one has capacity	TL6 page 493 – 495 AOB-80786 – AOB-80788
18.04.2018	Email correspondence	Notes that patient needs to be seen sooner that Mr O'Brien's next clinic date and therefore Mr O'Brien is to overbook his clinic	TL6 page 496 – 499

	between RF appointment, Mr O'Brien and Ms Corrigan		AOB-80789 – AOB-80792
20.04.2018	Email correspondence between Ms Corrigan, Consultants and RF appointments	Notes X27 patients who cannot be appointed by Day14. Ms Corrigan sends to consultants highlighting that she was just sending on for their information but knows that they cannot provide availability as no one can accommodate anything sooner	TL6 page 514 – 516 AOB-80807 – AOB-80809
23.04.2018	Email from Ms Mulligan to Mr O'Brien	Re Patient query Patient rang re review appointment which was due to be reviewed in March 2018 and was advised by the booking centre that is likely to be 11 months before he is called.	TL6 page 535 AOB-80828
24.04.2018	Email from Mr Young to Consultants	Re June rota	TL6 page 536 – 540 AOB-80829 – AOB-80833
25.04.2018	Email from Mr Haynes to Consultants and Ms Corrigan	Raised his concerns over the difficulties that the lack of flexible cystocopes in outpatient department were causing to the treatment pathways of patients and efficiency of services. Potential breach is due to this ongoing issue. Mr Haynes wondered whether an IR1 should be raised regarding this issue as the ongoing lack of sufficient equipment is delaying cancer diagnosis and subsequent treatment	TL6 page 545 – 546 AOB-80838 – AOB-80839
26.04.2018	Email from Ms Corrigan to Consultants	Re June schedule	TL6 page 547 – 551 AOB-80840 – AOB-80844
27.04.2018	Email from Ms Dignam to Consultants	Re May Schedule	TL6 page 552 – 553 AOB-80845 – AOB-80846
09.05.2018	Email from Ms Elliot to Mr O'Brien	Noting that there is a problem regarding the extended theatre days due to shortages of nurses	TL6 page 601 AOB-80894
10.05.2018	Email from Mr Young to Consultants	Re Scopes & Cabinet in Thorndale Unit Loss of 2 more cabinets. Now 4 cabinets out of action in theatres and a reduced number of baths for the cleaning of scopes. Will be obtaining	TL6 page 609 – 611 AOB-80905 –

	and Ms Corrigan	scopes from DSU but will cause delays. This has potential to considerably affect scope activity	AOB-80907
11.05.2018	Email From Ms Graham to Consul tnats	Noting the increase in urology referrals over recent months	TL6 page 615 – 617 AOB-80908 – AOB-80910
12.05.2018	Email from Ms Corrigan to Consultants	Re Red Flag Longest Wait 	TL6 page 638 – 642 Aob-80931 – AOB-80935

Urology (Prostate)	19	11	7	12	16	35	30	32
Urology (Haematuria)	15	11	25**(Haematuria - 1 upgraded from 19/1/18 – rec'd RF office 1/2/18 (for scan 10/2/18) Haematuria – 2 upgraded from 20/1/18 - rec'd RF office 1/2/18 (for scans 19/2/18) Haematuria – direct RF referrals on **DAY 12**	**19** (Upgraded referral received in RF office on 12/02/2018. Next GP referral Day **14**)	22	34	28	29
Urology (Other)	25	14	11	13	20	31	29	25

22.05.2018	Email correspondence between Mr Haynes and Ms Gishkori	**O'Brien, Aidan** **From:** Haynes, Mark **Sent:** 22 May 2018 13:31 **To:** Gishkori, Esther **Cc:** Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed **Subject:** Urology Waiting Lists **Importance:** High Dear Esther I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients. As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running. The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow. Tragically, a Personal information redacted old male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure. Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur. 1	Doc File 3 pages 243 – 244 AOB-01811 - AOB-01812
22.05.2018	Email from Mr Haynes to Ms Gishkori	Dear Esther I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients.	TL6 page 666 – 667 AOB-80959 –

		As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running. The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow. Tragically, a Personal Information redacted by the old male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure. Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.	AOB-80960

		The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases). Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4 additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list. Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale. I am happy to meet to discuss timescales to implement the changes required.	
24.05.2018	Email from Mr Young to Consultants	Re July rota	TL6 page 675 – 678 AOB-80968 – AOB-80971
25.05.2018	Email from Ms Corrigan to Consultants	Re Red Flag 1st appointment longest wait 12/01/2018 / 23/01/2018 / 05/02/2018 / 14/02/2018 / 02/03/2018 / 30/03/2018 / 09/04/2018 / 16/04/2018 / 11/05/2018 Urology (Prostate): 19 / 11 / 7 / 12 / 16 / 35 / 30 / 32 / 35 Urology (Haematuria): 15 / 11 / 1 upgraded from 19/1/18 – rec'd RF office 1/2/18 (for scan 10/2/18) Haematuria – 2 upgraded from 20/1/18 - rec'd RF office 1/2/18 (for scans 19/2/18) Haematuria – direct RF referrals / **19** (Upgraded referral received in RF office on 12/02/2018. Next GP referral Day **14**) / 22 / 34 / 28 / 29 / 29 Urology (Other): 25 / 14 / 11 / 13 / 20 / 31 / 29 / 25 / 36	TL6 page 684 – 686 AOB-80877 – AOB-80979
31.05.2018	Email from Mr O'Brien	Re Attendance at Reconstruction of Urology Meeting	SUP 462

	to Mr Duggan	*I am so aware that I have not been attending. I do have a cancer review clinic Friday mornings and SPA in the afternoons. Because of review backlogs, I yield to temptation to run over into the afternoon…"*	AOB-03958
01.06.2018	Email from Ms Corrigan to Consultants	Re June rota	TL6 page 722 – 723 AOB-81015 – AOB-81016
06.06.2018	Email from Mr Young to Consultants	Re July Rota	TL6 page 758 – 762 AOB-81051 – AOB-81055
07.06.2018	Email from Ms Corrigan to Consultants	Re Red Flag 1st appointment longest wait **Longest Wait** Urology (Prostate): ######### 19; ######### 11; 05/02/2018 7; 14/02/2018 12; 02/03/2018 16; 30/03/2018 35; ######### 30; ######### 32; ######### 35; 25/05/2018 **35** (D40 Upgraded); Clinics S Urology (Haematuria): ######### 15; ######### 11; 05/02/2018 - 1 upgraded from 19/1/18 – rec'd RF office 1/2/18 (for scan 10/2/18) Haematuria – 2 upgraded from 20/1/18 - rec'd RF office 1/2/18 (for scans 19/2/18) Haematuria – direct RF referrals; 14/02/2018 **19** (Upgraded referral received in RF office on 12/02/2018. Next GP referral Day **14**); 02/03/2018 22; 30/03/2018 34; ######### 28; ######### 29; ######### 29; 25/05/2018 30 Urology (Other): ######### 25; ######### 14; 05/02/2018 11; 14/02/2018 13; 02/03/2018 20; 30/03/2018 31; ######### 29; ######### 25; ######### 36; 25/05/2018 24; Clinics S	TL6 page 763 – 765 AOB-81056 – AOB-81058
07.06.2018	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient was due to have surgery in October 2017 but was cancelled due to bed pressures. Patient was ringing for date for admission	TL6 page 766 AOB-81059

<table>
<tr>
<td>08.06.2018</td>
<td>Email correspondence between Mr Haynes and Ms Gishkori</td>
<td>
O'Brien, Aidan

From: Haynes, Mark
Sent: 08 June 2018 13:28
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M; Devlin, Shane
Subject: RE: Urology Waiting Lists

Dear Esther

Following on from below, a meeting took place. However, that meeting was to resolve the issues of the impact of the loss of extended day operating on the urology team such that the impact of this was spread across the surgical teams. The meeting did not result in Urology having its full number of weekly theatres (11 with backfill), nor was it intended to address any increase in urology operating to address the waiting list backlog.

In preparation for the meeting, waiting time information across different specialities were collated as below (as at 25/5/18):

<table>
<tr><th>Specialty</th><th>Urgent Inpatients</th><th>Weeks Waiting</th><th>Routine Inpatients</th><th>Weeks waiting</th><th>Urgent Daycases</th><th>Weeks waiting</th><th>Routine Daycases</th><th>Weeks waitin</th></tr>
<tr><td>Urology</td><td>596</td><td>208</td><td>237</td><td>225</td><td>378</td><td>173</td><td>541</td><td>212</td></tr>
<tr><td>ENT</td><td>29</td><td>1x38
19</td><td>142</td><td>64</td><td>64</td><td>23</td><td>923</td><td>80</td></tr>
<tr><td>General Surgery</td><td>113</td><td>147</td><td>75</td><td>139</td><td>437</td><td>131</td><td>901</td><td>121</td></tr>
<tr><td>Breast</td><td>16</td><td>1 x 41
27</td><td>15</td><td>82</td><td>10</td><td>1 x 19
4</td><td>9</td><td>38</td></tr>
<tr><td>Orthopaedics</td><td>200</td><td>1 x 160
85</td><td>1155</td><td>171</td><td>130</td><td>1 x 101
80</td><td>805</td><td>128</td></tr>
<tr><td>Gynae</td><td>28</td><td>11</td><td>168</td><td>50</td><td>26</td><td>1 x 26
6</td><td>106</td><td>44</td></tr>
</table>
As such, consideration needs to be given as to how the clinical risk associated with such significant waiting time disparities across specialities should be managed. As highlighted in my previous e-mail, amongst the urology cases are patients where there is well documented increased risk associated with longer waiting times. Unfortunately given the current constraints of available theatre time and inpatient beds along with nursing staffing pressures, I cannot see a solution that doesn't impact on the waiting times of patients from other specialities. However, I do not believe we can justify accepting the current situation.

Could we look to meet at some point next week to discuss this, perhaps we could use our 1:1 meeting next Tuesday with Ronan, Martina and Barry joining us?

From a urology team perspective, I think it would also be helpful to meet the full consultant team. We are all available on Thursday 14th June at 12:30 and would be happy to meet then if that suits?

Thanks

Mark

1
</td>
<td>Doc File 3 page 246

AOB-01814</td>
</tr>
<tr>
<td>10.06.2018</td>
<td>Email correspondence between Mr Haynes and Ms Mageean</td>
<td>Noting the lack of junior medical staff</td>
<td>TL6 page 791

AOB-81084</td>
</tr>
<tr>
<td>12.06.2018 – 13.06.2018</td>
<td>Email correspondence between Martina Corrigan to Consultant</td>
<td>Re Mark Haynes Cover

“Unfortunately Mark is going to have to go off now for at least a week… Mark is due to come oncall this Thursday, therefore, I will need cover this from Thursday for daytime/night time and the weekend please. This will be as locum…”

Mr Young Response:
“I can’t help till Monday … this backup concerns I have for July in principle”</td>
<td>SUP 472

AOB-03968</td>
</tr>
</table>

		Martina Corrigan: *"John covered last night oncall* *Derek is covering from Thursday 9am until Saturday 9am* *Tony is covering from Saturday 9am until Sunday 9am* *Aidan is covering from Sunday 9am until Monday 9am*	
18.06.2018	Email from Ms Dignam to Consultants	Re June Schedule	TL6 page 820 – 821 AOB-81113 – AOB-81114
21.06.2018	Email From Mr Haynes to Ms Muckian	Mr Haynes refers to an email chain which was chasing the urology consultants for a response to a coroner's investigation. Mr Haynes notes that the Urology Department have had a difficult few weeks from a staffing perspective due to Mr Haynes being off sick and his colleagues having to consequently backfill for him in addition to covering the unscheduled care activity from ongoing vacant posts. Another SPR has been off sick meaning that the colleagues are also backfilling this absence	TL6 page 829 AOB-8122
24.06.2018	Email from Ms Corrigan to Consultants	Re July rota	TL6 page 867 – 868 AOB-81160 – AOB-81161
28.06.2018	Article from DOH	NI Cancer Waiting times	TL6 page 874 – 890 AOB-81167 – AOB-81183
02.07.2018	Email from RF Appointment to Mr O'Brien	Notes that Mr O'Brien does not have availability for red flag appointments until September 2018	TL6 page 891 AOB-81184
03.07.2018	Email from Ms Elliot to Consultants	Re July Schedule	TL6 page 892 – 896 AOB-81185 – AOB-81189
03.07.2018	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient ringing re date for surgery as been on waiting list since May 2015	TL6 page 897 AOB-81190
04.07.2018	Email from Mr O'Brien to Dr Khan	Re MHPS Investigation deadline *"However, our department does have a significant problem at present, particularly as a consequence of Mark Haynes being unable to return to work, in additional to others being on annual leave…"*	SUP 484 AOB-03980
05.07.2018	Message from Chief Executive	References the challenges the Trust has faced	TL6 page 898

<table>
<tr><td></td><td>Shane Devlin</td><td></td><td>AOB-81191</td></tr>
<tr><td>06.07.2018</td><td>Email from RF Appointment to Mr O'Brien</td><td>Notes that a patient is to be booked at next clinic but next RF clinic in CAH is not until September 2018 and next available in SWAH August 2018</td><td>TL6 page 903

AOB-81196</td></tr>
<tr><td>30.07.2018</td><td>Email from Mr Young to Consultants</td><td>Re August & September rota</td><td>TL6 page 959 – 964

AOB-81252 – AOB-81257</td></tr>
<tr><td>10.08.2018</td><td>Email from Ms MCaul to Consultants</td><td>Re Admin backlog
<table><tr><th>Consultant</th><th>Discharges awaiting Dictation</th><th>Discharges to be typed</th><th>Clinic letters to be dictated</th><th>oldest date of clinic letters to be dictated</th><th>Clinic letters to be typed</th><th>oldest date</th><th>Results to be dictated</th><th>Results to be typed</th></tr><tr><td>Mr Jakob</td><td>7</td><td>7</td><td>0</td><td></td><td>2</td><td>06.08.18</td><td>60</td><td>60</td></tr><tr><td>Mr Glackin</td><td>10</td><td>13</td><td>9</td><td>july</td><td>0</td><td></td><td>44</td><td>3</td></tr><tr><td>Mr Haynes</td><td>0</td><td>0</td><td>0</td><td></td><td>23</td><td>02.08.18</td><td>8</td><td>70</td></tr><tr><td>Mr O'Brien</td><td>31</td><td></td><td>44</td><td>08.05.18</td><td>17</td><td>06.08.18</td><td>10</td><td>0</td></tr><tr><td>Mr O'Donoghue</td><td>0</td><td>0</td><td>0</td><td></td><td>3</td><td></td><td>0</td><td>47</td></tr><tr><td>Mr Young</td><td>0</td><td>0</td><td>0</td><td></td><td>12</td><td>01.08.18</td><td>0</td><td>4</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Sub Speciality Totals</td><td>48</td><td>20</td><td>53</td><td></td><td>57</td><td></td><td>122</td><td>184</td></tr></table></td><td>TL6 page 1016 – 1018

AOB-81309 – AOB-81311</td></tr>
<tr><td>28.08.2018</td><td>Email from Ms Dignam to Consultants</td><td>Re October rota</td><td>TL6 page 1072 – 1076

AOB-81365 – AOB-81369</td></tr>
<tr><td>28.08.2018</td><td>Email from Ms Scott to Consultant</td><td>Notes that all surgery in DHH would be cancelled as well as x3 surgeries in CAH due to bed pressures</td><td>TL6 Page 1077 – 1078

AOB-81370 – AOB-81371</td></tr>
<tr><td>04.09.2018</td><td>Email from Ms McCaul to Consultants</td><td>Re Admin backlogs
<table><tr><th>Consultant</th><th>Discharges awaiting Dictation</th><th>Discharges to be typed</th><th>Clinic letters to be dictated</th><th>oldest date of clinic letters to be dictated</th><th>Clinic letters to be typed</th><th>oldest date</th><th>Results to be dictated</th><th>Results to be typed</th></tr><tr><td>Mr Jakob</td><td>0</td><td>8</td><td>0</td><td></td><td>10</td><td>03.09.18</td><td>10</td><td>0</td></tr><tr><td>Mr Glackin</td><td>4</td><td>19</td><td>4</td><td>06.06.18</td><td>21</td><td>23.08.18</td><td>49</td><td>29</td></tr><tr><td>Mr Haynes</td><td>0</td><td>9</td><td>0</td><td></td><td>6</td><td>30.8.18</td><td>15</td><td>12</td></tr><tr><td>Mr O'Brien</td><td></td><td></td><td></td><td></td><td>81</td><td>01.06.18</td><td>5</td><td></td></tr><tr><td>Mr O'Donoghue</td><td></td><td></td><td></td><td></td><td>55</td><td>28.08.18</td><td>14</td><td>0</td></tr><tr><td>Mr Young</td><td>11</td><td>0</td><td>2</td><td>24.08.18</td><td>0</td><td></td><td>44</td><td>0</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Sub Speciality Totals</td><td>15</td><td>36</td><td>6</td><td></td><td>173</td><td></td><td>137</td><td>41</td></tr></table></td><td>TL6 page 1081 – 1083

AOB-81374 – AOB-81376</td></tr>
<tr><td>14.09.2018</td><td>Email correspondence between consultants</td><td>Noting that a meeting between consultants should still take place on 24 September 2018 as there are departmental issues which need to be discussed</td><td>TL6 page 1110 – 1111

AOB-81403-AOB-81404</td></tr>
<tr><td>21.09.2018</td><td>Meeting with Mr Weir and Mr O'Brien</td><td>Page 22 (Section C – E)

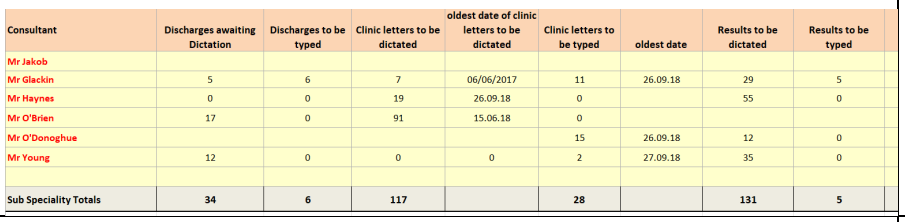
Mr O'Brien: I think it is a pretty overworked speciality</td><td>Transcript FILE 15</td></tr>
</table>

		MR WEIR: Yeah, yeah MR O'BRIEN: And the other big issue that needs to have a response from the Trust, which is appalling at present, is having 597 patients awaiting urgent in-patient admission. MR WEIR: Yes. MR O'BRIEN: With a waiting time of 210 weeks and gynaecology have 28 patients waiting 11 weeks.	AOB-56386
24.09.2018	Departmental Meeting with Consultants	Page 3 section C – Page 21 Section D Mr O'Brien: *"Can I kick off on that because that's my top concern and it's something I have written about here and I did it with some trepidation. So basically, as I said actually in that second paragraph, it is always has been my understanding that the whole raison d'etre for introducing urologist of the week was to have a consultant urologist providing the in-patient care in our ward.* *And, as I said here, from the outset in – I found the discussions regarding the introduction of the urologist of the week, that was in 2014, to be frustrating and incomprehensible. I simply couldn't understand how it could not be a good thing to have a system where all in-patient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff in training.* *I couldn't understand how it was considered that the Trust would not support and fund the urologist of the week without offering to undertake other duties when urologist of week as it would not take all one's time to look after in-patients. At one time we even considered doing an afternoon clinic when urologist of the week In my view, it is another issue.* *We did agree to include triage in the duties of urologist of the week but I came to realise that there's a range of perspectives I think, which we all need to listen to, as to what is the whole concept of urologist of the week, because for me it was where I would be literally providing the in-patient care to the best of my ability and to those of the team working with me from day to day, doing ward rounds, operating on people, and also taking on board all of those queries and calls for advice regarding patients who are acutely ill elsewhere, whether in our hospital in the emergency department, in the other two hospitals that we provide cover for. And which I think is done rather poorly and with inadequate input, if any at times, from ourselves, as largely a registrar provided service, and that always does concern me.* *So basically I had always understoon that that week would begin at 9 o'clock on a Thursday morning. It would start with a ward round as the handover ward room, where once consultant would hand over to me. There would be junior staff there. And that was probably the most important ward round of the entire week, where I would endeavour to learn as much as possible about the in-patients, their history, examine them, etc and that that was – that had primacy.* *It wasn't to be replaced by any other activity. It wasn't to be replaced by, as Mark has done a couple of weeks ago, like operating elsewhere. It wasn't to be replaced by a stone MDM or a stone clinic. I am guilty in that I have facilitated it, running alongside sometimes, and I have stopped it now, doing urodynamic studies because of the long waiting list. It is not to be replaced by a post MDM oncology review. It's not to be replaced by*	Transcript File 16 AOB-56389 - AOB-56407

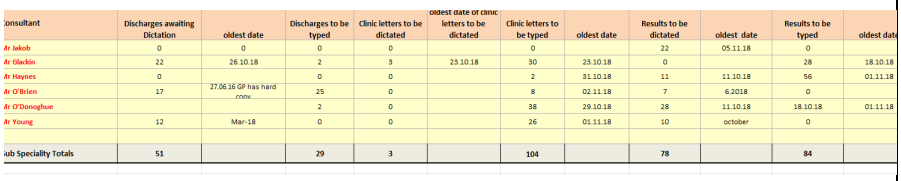
		getting your documentation ready for your appraisal. And, lastly, it's not be replaced by triage. *And that I would do the same again on Friday and Saturday and Sunday and Monday and Tues and Wednesday. And then I would hand over to the next consultant the following Thursday morning. And that handover, like the first one, would continue and it wouldn't be curtailed by a departmental meeting, with the exception possibly of scheduling. It could be interrupted because that's a very important one. And it was of prime importance. That was my understanding of it.* *And the only – in my experience the two activities that have conflicted with that is when you have a bad week and you have a lot of operating to do and you're the best one to be doing that operating rather than the registrar. So concurrently you have operating and you have ward rounds going on and you miss out on that and you try to do your best by doing a dry round or a lter round or a catch up. But there have been days when I have done six or secen cases in theatres all day, and that the worst I have ever done, and I have found myself regretting declining the offer of coming to theatre at 10 o'clock in the morning because you may not get in again until 10 o'clock that night.* *So when I'm urologist of the week that's what I have been doing. That has been my understanding of the whole concept. It wasn't to be on call. It wasn't to be available when the registrar identified a problem. It was to be – you're the person who is providing the care. The mains issues that I have had when I have been urologist of the week have been the conflict between operating and doing the ward round.* *And secondly, I have that grave concern about the quality of advice given by junior staff to other clinicians in other places without us being consulted about it, without us having input and ending up with kind of a default "oh just refer him into the department". So then two weeks later someone else is sitting. In fact actually, I don't know, I have had the experience of patients being briefly under my care somewhere and they have been referred and I am triaging them fro a trial removal of catheter. I don't understand for one moment why, when you're consulted about something, like trial removal or a small in a person with ureteric colic that's now pain free after they have had their analgesia, why the review isn't organised there and then, why it's referred in. I can't get my head round that. I mean, having patients being discharged from our department, not having had, we'll say, a flexible cystoscopy done, and then being referred in fro a red flag flexible cystoscopy.* *So I think actually that those are my concerns as urologist of the week. And I have no doubt – just one other concern I do have and I'll just be pointed about it. There is an element of, you know, let the registrars get on with it. A concern I would have is that not infrequently they're left to get on with it in theatre and on occasion, a few occasions, I have been convinced that the outcomes have not been as good as if that consultant had been in that theatre doing it himself or supervising, which, for the reasons I have already said, is not always possible because you have two important activities going on as the one time. But you know, ward rounds have not been done for entire weekends. Ward rounds have not been done at all for long back holiday weekends.* *…* *Mr O'Brien: Yes, we've had the report, I don't know whether it is true or not, that a whole week went by without a ward round being done at all by*	

		one person. And we have witnessed and observed, and we were just mentioning it you know, to see people actually triaging letters at 10 o'clock in the morning instead of doing a ward round is – to me that's not what I though it was all about. Now, what I would like to do is to listen to other people's perspectives and above all… what I want out of this process is not for us to come into a room like this, listen to everybody's perspective and leave with some woolly consensus or agreement that is not concrete. I think actually our Trust needs to be put on the spot on a whole range of issues and I know you're an assistant medical director but it's not just medical directorship. This is – the executive needs to actually – I want to know at the end of the day in writing what is expected of me as an individual. I would have thought that we was a department would want to know what the trust expects of us collectively. *Mr Haynes: I think my own view, certainly as medical director, and that is that the department is – as a department we are the ones who advise what we feel is required. So that's where our role is. So we should be saying, this is how we think care should be delivered. Many of the things we say will be – outlined by Simon Harrison in that GIRFT urology document. So it's on us to say what is required and the Trust to either support that or say no, we don't want you to do that.* *Mr O'Brien: Or most likely of all Mark?* *Mr Haynes: Say nothing.* *….* *Mr Young: I'm generally happy with urologist of the week, yes.* *Mr Glackin: Okay, Mark?* *Mr Haynes: Tony, the two aspects that Aidan has brought up about the ward rounds and I think we can all have different ways in which we run the ward rounds but my personal view.. so the weekends look to me, I don't disagree with the principle of seven-day working, but that's to be in a job plan as a seven say working, not provided for free.* *Mr O'Brien: I think one of the things that concern me about some weekends is the last weekend that I was on, because you organised junior support for me. I had a different person every day. And if I weren't there as the continuity factor, you know, they go off early and they can't be contacted. It's very, very fragmented.* *…* *Mr Haynes: … I think I might have a different view to everyone. I think it should come to us. I think too much palming off happens at registrar level and I think, particularly during 9 to 5 hours when we are in the hospital, rather than it coming to juniors where – if that patient was in our hospital we would be involved in that patient's care. Just because they're in Enniskillen with their urosepsis we should be involved directly in that decision making. And I think it is even – I think the hardest group of patients to manage are the patients who are not in front of you and I think it should be a consultant who is directly contacted in that situation. And I think our barrier – our level for transfer of the patient would suddenly plumb down because we would say no, bring them over.*	

		Mr O'Brien: That concerns me a great deal, that whole issue. The only thing that I would say is that when I am operating I don't like taking phone calls and having phones held to my ear. *…* *Mr Haynes: … So all of those – there are different ways of skinning a cat – each of us are going to have different perspectives on the same condition…"* *Page 18 Section F –* *Mr Glackin: First things first, the ward round. I completely agree there should be a consultant provided ward round. It should start on time and the registrar should be there on time. I agree with Mark the level to which the consultant participates in the review of each patient depends on the experience of the registrars. We've had the experience of having people who are towards the ends of their training and they can clearly be given a lot more leeway that the speciality doctors or the junior trainees. But my personal view is we should be there. We should also have a senior nurse leading the ward round. And on occasions I have been offered a management student, which I've objected to and said that's not appropriate. It should be the ward sister if they are available and if they're not available it should be an experienced staff nurse because there's an awful lot of discussion and handover between ourselves and them as to the care of each patient. I do find it somewhat frustrating on occasions when, particularly on the Wednesday and Thursday ward rounds that there has been a large volume of collective work done the day before and you are reading people's notes and it is as you, it's somewhat difficult to decipher what the next steps of care are going to be for some of these patients/ And that the person who's operated on the patients hasn't been up to see them to give the pateints or you a steer as to where we are going. I think that could be done between.* *…* *Mr Glackin: … If it is something that the registrar can do, I would prefer to be standing over their shoulder. There's very few of them I would let downstairs to do anything on their own. Similarly, in the evening times, I will come in and supervise them because for most of them I'm not happy with them exploring a scrotum never mind doing anything more complicated.* *Mr O'Brien: Just before you go leave that because I think that remains a – I can see an emerging consensus about the big principles but how can we more robustly formalise that? It still seems to be nebulous to me.* *Mr Glackin: I've got some thoughts on that. One that is we that we would have a communication sheet and that for every phone call a summary is written on the communication sheet. That's one way of doing it… And you know, so I think we need to have a .. robust system.* *…* *Mr Glackin: .. The discharge plans, yes I share a lot of your frustrations about who owns the patient at discharge…. The other things that we have spoken about… handover… I find it grossly unacceptable that the receiving consultant isn't present and not so much as a phone call on*	

		occasions to say that they won't be there…. It just shows that other things are being prioritised over the in-patient care.	
25.09.2018	Email from Ms Corrigan to Consultants	Noting that they have received funding to appoint CNS Urology Band 7 and Support worker	TL6 page 1164 – 1170 AOB-81457 – AOB-81463
25.09.2018	Email from Mr Young to Consultants	Re November Rota	TL6 page 1171 – 1173 AOB-81464 – AOB-81466
28.09.2018	Email from Ms Dignam to Consultants	Re October Schedule	TL6 page 1183 – 1184 AOB-81476 – AOB-81477
October 2018	Life after prostate study		TL6 page 1360 – 1410 AOB-81650 – AOB-81703
01.10.2018	Email from Ms McCaul to Consultants	Re Admin Backlog 	TL6 page 1187 – 1188 AOB-81480 – AOB-81481
25.10.2018	Phone call between Mr O'Brien and NCAS	Page 8 section A – D Mr O'Brien: *.. I am really concerned Grainne, and I am concerned about all of this. I have no difficulty. The Trust is sitting doing nothing at all about patients that we have written to them about whom we are gravely concerned about the potential for harm. One patient died in May as a consequence of urosepsis due to a stent being left in for too long and it will not matter. If had been a cancer patient it might have mattered, but he was just a stone patient. He dies because of that. But we are really concerned. I have dedicated my entire life. I have – it's been a vocation for me. It's not a job with a job plan. I can hold my hand on my heart and I have worked 80/90 hours per week now for 40 years in the interests of patients. I understand all that. But I am talking about not only actual harm, using a definition I have never ever come across before, but to at least five patients. At least. At least. Where does this tone come from?*	Transcript File 18 AOB-56458

Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed
Mr Jakob								
Mr Glackin	5	6	7	06/06/2017	11	26.09.18	29	5
Mr Haynes	0	0	19	26.09.18	0		55	0
Mr O'Brien	17	0	91	15.06.18	0			
Mr O'Donoghue					15	26.09.18	12	0
Mr Young	12	0	0	0	2	27.09.18	35	0
Sub Speciality Totals	34	6	117		28		131	5

07.11.2018	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's GP contacted re date for surgery. Patient has been on waiting list since April 2016 and symptoms have deteriorated dramatically	TL6 page 1333 AOB-81626
08.11.2018	Email from Ms McCaul to Consultants	Re Admin Backlog 	TL6 page 1334 – 1335 AOB-81627 – AOB-81628
09.11.2018	Urology Performance dated 09 November 2018	CONFIDENTIAL: PERSONAL Resolution Practitioner Performance Advice (formerly NCAS) 2nd Floor, 151 Buckingham Palace Road London SW1W 9SZ Advice line: 020 7811 2600 Fax: 020 7931 7571 www.resolution.nhs.uk CST-B@resolution.nhs.uk 9 November 2018 PRIVATE AND CONFIDENTIAL Dr Aidan O'Brien Consultant Urologist Southern Health and Social Care Trust Ref: 18665 (Please quote in all correspondence) Dear Dr O'Brien, Thank you for your letter dated 1 November 2018 setting out some clarifications to my letter following our discussion on 30 October 2018. Practitioner Performance Advice (formerly NCAS) does not usually reissue letters (unless it would change the advice which has been given) but the letter has been added to the file so that the clarifications are on record. Following our conversation of 30 October 2018, I contacted the Trust to explore issues further with them and to offer to meet. On the 31 October 2018, I had a telephone conference call with Dr Ahmed, Mr Gibson and Ms Hynds, and we discussed the case. The Trust are of the view that a full and detailed response was provided to you by letter on 30 March 2017 setting out the reasons for the decision to manage the concerns through a formal investigation process. It is also considered that, notwithstanding some of the acknowledged management issues, the evidence in the report warrants putting the matter forward to a hearing. I note that it is also likely, as per earlier correspondence with the Trust, that they will want to support you moving forward. These decisions made by the Trust are ultimately matters for them as your employer, and Practitioner Performance Advice cannot arbitrate on these decisions or take on the role of your advocate. In these circumstances therefore, it was considered that a meeting with Practitioner Performance Advice was unlikely to be of any benefit. I would suggest you seek support from your representative about the options available to you. Yours sincerely, Personal information redacted by USI Dr Grainne Lynn Adviser Practitioner Performance Advice	Doc File 3 pages 440 – 441 AOB-02008 - AOB-02009
12.11.2018	Email correspondence	Re Urology lists and Transient increase in urology operating capacity	SUP 510

	between Martina Corrigan and Consultants	Michael Young – *"I welcome the belated acknowledgement that the allocation of theatre sessions to our speciality has been disproportionately inadequate.* *I hope that this reversal of fortunes may also be an indication of an acceptance of the suffering and risk of mortality endured by hundreds of our patients awaiting admission for surgery. I wish to take this opportunity to acknowledge Mark's contribution to this recent increased allocation of theatre sessions.* *..* 1. *It has always been my view and it remains so, that the only cohort of patients at proportionately greater risk than those awaiting admission, is that group of patients who have been admitted whether acutely or electively, and who remain as inpatients. Therefore it is my view that the handover, consultant led, ward round on Thursday mornings should not be sacrificed or compromised by the availability of a theatre session on Thursday mornings.* 2. *I would also be concerned that the utilisation of the available theatre session on Thursday afternoons will erode attendance at MDM. ..*	AOB-04006
15.11.2018	Cancer Performance Report	Re October 2018	TL6 page 1411 – 1427 AOB-81704 – AOB-81720
19.11.2018	Email from Ms Dignam to Consultants	Re December rota	TL6 page 1449 – 1450 AOB-81742 – AOB-81743
20.11.2018	Email from Ms Corrigan to Consultants	Highlighting that due to winter pressures, only urgent and red flags should be booked to reduce elective activity by 30%. This will start on 01 December 2018	TL6 page 1451 – 1453 AOB-81744 – AOB-81746
21.11.2018	Email from Ms Elliot to Mr O'Brien	Noting that a red flag patient has not yet been offered an appointment as all clinics are booked with earliest being 3 December 2018 but all clinics are suspended. There was a query of whether the clinics should be overbooked	TL6 page 1454 AOB-81747
27.11.2018	Email from Ms Dignam to Consultants	Re Jan rota	TL6 page 1485 – 1486 AOB-81778 – AOB-81779

27.11.2018	Minutes of away day	**1.1 Urologist of the week working model.** This topic was discussed extensively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved. Where possible definitive care should be delivered during the current inpatient stay. **1.2 Triage of new referrals.** The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the curent long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week. **1.3 Annual leave.** The team is define the number of consultants and other members of middle grade staff who can be away at any one time. Discussion of Christmas and Summer holidays should be well in advance of holiday time to permit good planning. A process for agreeing leave should be developed and adhered to. **Other business:** Mr O'Brien tabled a written document setting out his issues of concern for discussion at the meeting. Similarly Mr Young provided an email listing topics for discussion. It was suggested that those items not discussed should be given time at the weekly departmental meetings. ▪ First Out Patient Consultation Waiting Times ▪ Development of care pathways (bladder cancer, LUTS/BOO) ▪ Outreach clinics ▪ Specialty Doctor Clinics ▪ Consultant Job Planning ▪ Care of Benign Urology Patient ▪ Cancer MDT ▪ Theatre allocation and usage ▪ Waiting List Management ▪ Winter pressure planning ▪ Technology & Equipment	TL6 page 1503 – 1505 AOB-81796 – AOB-81798

		2.1 Ward issues: 1. Outlying of urology patients to facilitate medical inpatients. 2. Staff retention and vacancies. 3. Staff education program for Urology inpatient care. 4. Lack of medical support for medical inpatients on ward 3 South due to locum staff and lack of continuity. 5. Interruptions to ward rounds. **2.2 Thorndale issues:** 1. Too few cystoscopes. 2. Clinics overrunning. 3. Requests for inpatient flexible cystoscopy. 4. Introduction of endoscopy check list. 5. New patient clinic running problems due to time keeping and case mix. 6. Provision of intravesical chemotherapy service. Sr Leanne McCourt tabled a prostate cancer option grid to be piloted within th Department. Sr Jenny McMahon tabled the Southern Health and Social Care Trust endoscopy safet checklist.	
November 2018	Cancer Pathway Escalation policy		TL6 page 1519 – 1526 AOB-81812 – AOB-81819
04.12.2018	Email from Ms McCaul to Consultants	Re Admin Backlog | Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	oldes
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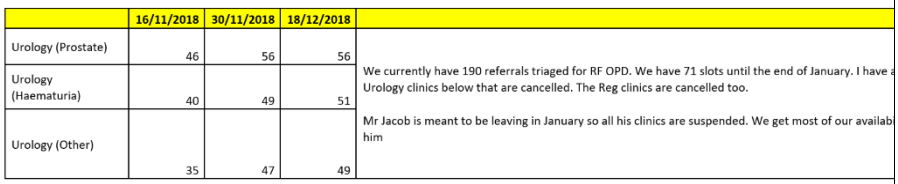
Mr Jakob	0		5	0		0		5	03.12.18	34	19.1
Mr Glackin	8	oct/nov	0	3	19.09.18	3	28.11.18	25	05.11.18	10	28.1
Mr Haynes	0		20	0		12	26.11.18	6	19.11.18	14	02.1
Mr O'Brien	13	27.06.16 gp has the hard copy	5	10	30.11.18	10	27.11.18	13		10	
Mr O'Donoghue	0	0	0	0	0	0	0	0	0	0	
Mr Young	12		9	0		26		40		55	
Sub Speciality Totals	33		39	13		51		89		123			TL6 page 1514 – 1515 AOB-81807 – AOB-81808
07.12.2018	Email from Mr Haynes to Ms Corrigan	Re Cancer Pathway Escalation Policy Mr Haynes notes that: I not sure what the intended clinician response to escalation is, can this be clarified?. Failure to adhere to the 31/62 pathway included in the document within urology is a pure capacity issue. No consultant, their secretary, or you can affect this in the urology service. From receipt of referral, I assume every RF referral is escalated to the chief exec at the point of receipt as we cannot meet step 1 of the pathway (1st appointment day 10, trigger 1 is day 10, trigger 2 day 21, I believe our patients are seen on approximately day 40).	TL6 page 1544 – 1545 AOB-81837 – AOB-81838
11.12.2018	Email from Mr O'Brien to Ms Corrigan	RE Cancer Pathway Escalation Policy I note the comments of Mark and Tony.	TL6 page 1576 – 1579

		I would like to make a few comments; • When I was Lead Clinician from 2012 – 16, a system evolved initiated by Vicki Graham, then cancer tracker, bringing to my attention the identities of patients who had either breached or were about to do so. We then looked to see when it was next possible for the patient to progress to the next step, whether it be an outpatient appointment or an operation. If the nominated consultant could not undertake the next step in a timely manner, then I delegated another to do so, including myself. After a short while, this simple process prevented anyone breaching. Vicki would then advise me on a weekly basis the identities of two – four patients furthest out on their timeline. We would work in a similar manner on these. With time, not only did we not have a single patient breach in 2015 by the time of Peer Review, but the mechanism slowly resulted in patients being progressed after incrementally shorter periods, and in less danger of breaching. • Such a mechanism could easily be dismissed at present on the grounds that the referrals are greater in number now. I believe that would be mistaken, as it is so easy to overlook the 'Red Flag' status of someone on an inpatient waiting list. You recently escalated a patient placed on a waiting list in mid-October, with no evidence since of any plan or intent to have the patient admitted. I believe that such a process could be tried again, the cancer tracker presenting to the Chair of MDM each week the identities of those patients furthest along their timelines. Waiting for a breach to occur before escalating is too late! • It will probably be the case that the above measure will not completely succeed due to the numbers of referrals. • I also do think that we should audit 'Red Flag' referrals. With a cancer diagnostic rate of ~ 9%, I believe that we could look at ways of removing patients from the process in a safe and effective manner: for example, applying PSA densities rather than age-related PSA densities, downgrading biochemical haematuria, but doing both with imaging arranged etc. • The Escalation Policy has been finalised without consultation with clinicians, who are those who will review and operate on patients. Indeed, one would nearly get the impression that the purpose of the Escalation Policy is to ensure that patients will not breach. If it only takes an Escalation Policy to succeed in doing so, there should have been no breaches in the first instance. • Mr. Glackin is not the Chair MDT. He is the Lead Clinician of Urology MDT. He is also one of four Chairs of Urology MDM.	AOB-81869 – AOB-81872

		• Was this Escalation Policy finalised without input from the Lead Clinician?	
13.12.2018	Email from Ms Dignam to Consultants	Re December Schedule	TL6 page 1580 – 1581 AOB-81873 – AOB-81874
17.12.2018	Email from Ms Corrigan to Consultants	Notes that theatre capacity will decreased from 11 to 10.5	TL6 page 1596 AOB-81889
17.12.2018	Email from Martina Corrigan to consultants	Reversal of decision to increase theatre capacity	SUP 755 AOB-04251
19.12.2018	Letter from Directorate of Commissioning	Re Redirection of urology referrals I am writing to request that the Western Trust takes back the urology referrals from the BT80 catchment area. <u>Background</u> The Regional Urology Planning and Implementation Group continues to work with Trusts to agree a system wide approach to the organisation a design of urology services across Northern Ireland. This work includes monitoring current demand and available capacity to help reduce variat in waiting times across the region. As you are aware, the Board previously agreed that interim referral arrangements would be put in place to address the Northern Trust's urc capacity constraints and increasing waiting times. These arrangements which were effective from February 2015, included the temporary redirection of urology patients from BT80 to the Southern Trust. <u>Current Position</u> Given that the critical consultant workforce issues that existed in Team North-West have now been resolved, coupled with the current challeng facing the urology team in the Southern Trust, the Board asks that the Western Trust, with immediate effect, revert to accepting referrals from catchment covered by BT80.	TL6 page 1597 – 1600 AOB-81890 – AOB-81893
21.12.2018	Email From Ms Corrigan to Consultants	Re RF 1st Appointment longest wait  16/11/2018 30/11/2018 18/12/2018 Urology (Prostate) 46 56 56 Urology (Haematuria) 40 49 51 Urology (Other) 35 47 49 We currently have 190 referrals triaged for RF OPD. We have 71 slots until the end of January. I have a Urology clinics below that are cancelled. The Reg clinics are cancelled too. Mr Jacob is meant to be leaving in January so all his clinics are suspended. We get most of our availab him	TL6 page 1623 – 1624 AOB-81916 – AOB-81917
28.12.2018	Email from Ms Corrigan to Consultants	Re Jan rota	TL6 page 1664 – 1665

			AOB-81957 – AOB-81958
2019	Witness Statement of Shane Devlin	In 2019 I commissioned two reviews to provide assurances around clinical governance processes. Having worked in other Trusts I was concerned that the assurance processes were not as robust as I had been used to. In particular the importance of a completely integrated governance system was not as explicit and in my experience felt under resourced.	WIT-00036
2019	Witness Statement of Shane Devlin	As reference above, in 2019, I commissioned the HSC Leadership Centre to review the complete governance system within the Trust. I was concerned that the system was disjointed and that from my experience the system was not operating as I had experienced in other HSC organisations. I had a number of concerns based on my experiences; 1. The level of expenditure on the governance functions felt light. I was used to appropriately funded teams for areas such as SAI management, complaints, standards and guidelines.	WIT-00037
Undated	Witness Statement of Shane Devlin	Limited Resources – Lessons that relate to staffing or physical infrastructure can be challenging to implement given the significant constraints in this regard.	WIT-00070
Undated	Witness Statement of Shane Devlin	Limited Resources – lessons that relate to staffing or physical infrastructure can be challenging to implement given the significant constraints in this regard.	WIT-00071
Undated	Witness Statement of Shane Devlin	It has not been my experience that departments seek additional budget based on risk. Each directorate has its own dedicated accountant and financial team and, in partnership with the operational team, budget allocation is regularly reviewed to ensure that we can meet our objectives, which include patient safety.	WIT-00074
Jan 2019	Cancer Performance – Dashboard Report	Sets out breaches in departments and any risk factors	TL4 page 411 – 443 AOB-07688 – AOB-07720
04.01.2019	CURWL WAITING LIST	Approx 281 patients on waiting list	TL4 page 416 – 27 AOB-07293 – AOB-07304
07.01.2019	Email from Mr Haffey	Re outstanding urology cases	TL4 page 40 – 41 AOB-07317 – AOB-07318
09.01.2019	Email from Ms Coleman to Ms Elliot	Re: Patient Query Patient called into office querying his review with Mr O'Brien. On CAOBUOR for review in March 2016. Has been having problems of late	TL4 page 48 AOB-07325

10.01.2019	Email from Ms Elliot to Mr O'Brien	Re: Scheduling Mr Young offered Mr O'Brien a number of slots for extra clinics & theatre	TL4 page 50 AOB-07327
15.01.2019	Email from Ms Corrigan to Consultants	Re: Red Flag waiting times Only for information as have nothing sooner. 17 Patients on list waiting 40 – 56 for first appointment	TL4 page 79 – 81 AOB-07356
17.01.2019	Email from Ms Dignam to Consultants	Re: Feb Rota	TL4 Page 88 – 90 AOB-07365 – AOB-07367
17.01.2019	Email from Ms Elliot to Mr O'Brien	Re: Patient and query to overbook the clinic to fit specific patient in	TL4 page 96 AOB-07373
22.01.2019	Email from Ms Corrigan to Consultants	Re: RF 1st appointment longest wait Breast – 11 Gynae – 5 E-Gynae -6 ENT – 10 Surgical (GPC) – 11 Surgical (OC) – 10 E-Gastro – 10 Urology Prostate – 67 Urology Haematuria – 60 Urology other – 31 Lung – 10 Skin – 6 Oral Surgery – 20	TL4 Page 174 – 175 AOB-07451 – AOB-07452
22.01.2019	Email from Ms Corrigan to Consultants	Re Escalations re referrals unable to appoint by day 14 with longest waiter on day 98.	TL4 page 176 – 178 AOB-07453 – AOB-07455
23.01.2019	CURE Company Accounts	Remains the case that CURE activity continues to be governed by the imposed realities of on-going clinical, financial and personnel constraints within public healthcare provision.	TL4 Page 183 – 194
February 2019	Cancer Performance February	Inter-Trust Transfer Urology Breaches – 61 Internal Urology Breaches – 63 Day 31 Urology Breaches – 1	TL4 page 709 – 760 AOB-07986 – AOB-08037
05.02.2019	Email from Ms Corrigan to Mr O'Brien	Re: Urology Escalation	TL4 page 266 – 267

		Query whether Mr O'Brien has a date planned for patient who is day 58 of waiting and is likely to breach. Ms Corrigan notes that she can ask another on the team if Mr O'Brien has no capacity	AOB-07543 – AOB-07544
05.02.2019	Email from Ms Dignam to Consultants	Re: Feb Rota	TL4 page 271 – 273 AOB-07548 – AOB-07550
06.02.2019	Email correspondence between Mr O'Brien and Ms Corrigan and Ors	Notes times for waiting for first appointment are now sitting at Urology (Prostate) 67 days, Urology (Haematuria) 61 days and other Urology 26 days. Martina Corrigan noted that there were still 87 haematuria patients, 50 prostate patients and 1 other to be booked. Requests thoughts on how it could be addressed "*as it is really escalating and is very concerning."* AOB replies essentially with a detailed email referring to triage, nursing assistance and expansion of the service.	Doc File 3 pages 560 – 561 AOB-02128 - AOB-02129
13.02.2019	Email from Ms Dignam to Consultants	**Re: March Rota**	TL4 page 384 – 388 AOB-07661 – AOB-07665
19.02.2019	Email from Mr O'Brien to Ms Elliot	**Re: CT requests** Mr O'Brien alerts secretary to the fact that patient admissions may need to be cancelled due to results of scans not being available in time	TL4 page 406 AOB-07683
20.02.2019	Email from Ms Corrigan to Ms Graham	**Re: Urology Escalations** List of patients who are breaching targets. Ms Corrigan confirmed that there was no capacity for anything sooner	TL4 page 444 – 446 AOB-07721 – AOB-07723
21.02.2019	Consultant Level Indicator Programme	**Scorecard**	2017 Appraisal page 397 – 399 AOB-23275 - AOB-23277

The scorecard below is a collection of performance and efficiency indicators at consultant level. For each indicator consultant, local peer and selected peer values are displayed along with a peer range based on a RAG spectrum. See overview for explanation of values.

Indicator	Consultant		Local	Peer	Peer Range
Average Length of Stay (FCE - zero trimmed)	1524	4.03	4.20	3.30	
Elective Average Length of Stay (FCE - zero trimmed)	416	2.87	3.04	2.41	
Non-elective Average Length of Stay (FCE - zero trimmed)	1108	4.76	4.98	4.02	
Elective Average Pre-Op Length of Stay (Spell - zero trimmed)	5	0.05	0.07	0.09	
Day Case Rate	568	78.34%	82.99%	72.40%	
Day Case Overstays	19	3.24%	5.32%	8.08%	
Elective IP - procedure not carried out	0	0%	0.93%	0.63%	
Elective IP - procedure not carried out - patient reason	0	0%	0%	0.02%	
Elective IP - procedure not carried out - other than patient reason	0	0%	0.93%	0.61%	
Elective IP - no procedure	1	1.01%	0.94%	0.83%	
Mortality Rate	4	0.41%	0.25%	0.26%	
Mortality Rate - Elective	0	0%	0%	0.02%	
Mortality Rate - Non-elective	4	0.41%	0.25%	0.23%	
Readmissions within 28 days	55	5.73%	4.62%	7.45%	
Complication rate - attributed	11	1.13%	0.52%	1.41%	
Misadventure rate	0	0%	0.06%	0.19%	
Outpatient New to follow-up ratio	680	1 : 2.07	1 : 1.13	1 : 1.72	
Outpatient DNA Rate	39	3.72%	3.70%	6.98%	
Outpatient DNA Rate - New Attendances	16	4.64%	4.70%	6.45%	
Outpatient DNA Rate - Follow-up Attendances	23	3.27%	2.80%	7.29%	

Activity

The activity tables display a collection of activity based indicators split by inpatient and outpatient workload.

Admitted Workload

Indicator	Consultant		Local	Peer
Total FCEs	1016	-	1071.80	451.32
% Elective FCEs	763	75.10%	82.38%	71.34%
% Elective FCEs - Inpatients	172	22.54%	15.83%	27.85%
% Elective FCEs - Day Cases	578	75.75%	72.80%	70.53%
% Regular Attenders	15	1.97%	11.51%	1.97%
% Emergency FCEs	193	19%	14.07%	26.62%
% Other FCEs	60	5.91%	3.55%	2.04%

Outpatient Workload

Indicator	Consultant		Local	Peer
Total Attendances (OP)	1009	-	1388.80	2757.07
Total New OP Attendances	329	-	652.20	1012.03
Total Follow-up OP Attendances	680	-	736.60	1743.41
Outpatient Attendances with a Procedure	81	8.03%	3.01%	38.12%
New Outpatient Attendance with a Procedure	78	23.71%	5.52%	46.34%
Follow-up Attendances with a Procedure	3	0.44%	0.79%	33.38%
New Outpatient Attendance - referred by GP	144	43.77%	63.23%	49.93%
Total DNA's	39	-	53.40	206.91
% of DNA's New Attendances	16	41.03%	60.30%	33.73%
% of DNA's Follow-up Attendances	23	58.97%	39.70%	66.27%

March 2019	Trust Governance Committee Meeting – Quarterly Report	Re: Litigation Claims Notes that in previous governance reports, it has been shown that a failure to diagnose/delay in diagnosis are the top reasons recorded as to why Clinical and Social Care Negligence claims have been taken against the Trust. A high level review of this has been undertaken to determine if the claims are linked to lengthy waiting lists. A review of the information contained on the Claims Management Database suggests that the majority of claims have been taken due to a diagnosis not being made earlier and are linked to allegations such as: 1. Not being examined properly to enable a diagnosis to be made 2. A failure to properly investigate the cause of an illness 3. Misinterpretation of x-rays or 4. A misdiagnosis of illness The very high level review undertaken identified the below two examples which specifically refer to waiting list issues: [First example relates to hip replacement] 2. A claim has been lodged related to a delay in Urology Services. The patient alleges that he was referred by his GP for a camera test however that there was a significant delay with same. The patient has since been diagnosed with inoperable prostate cancer. Investigations into this claim are ongoing. Further in-depth work is required, in conjunction Governance colleagues to determine risks associated with increasing patient waiting times on Trust waiting lists….	TRU-20828
01.03.2019	DOH Newspaper	*"Waiting list for surgery jumps by 43 in one year – the number of people waiting longer than a year for an operation in a Northern Ireland Hospital has rocketed by 43% in just 12 months. The Department of Health has released its quarterly waiting list bulletin which has revealed the shocking scale of the crisis facing the NHS in Northern Ireland".* *"Pressures – There has been a warning from a leading doctors as it emerges that waiting lists times have risen again that services are at breaking point in the Health Service"*	TL4 page 507 – 509 AOB-07784 – AOB-07786
06.03.2019	Email from Ms Corrigan to Consultants	Re: March rota	TL4 page 568 – 569

			AOB-07845 – AOB-07846
06.03.2019	Email from Ms McCaul to Urology	Re: Backlogs – April 2018 **Mr Jakob:** Discharges awaiting dictations – 0. Discharges to be types – 10 (13.04.18). Clinic letters to be dictated – 0. Clinic letters to be typed – 15 (12.04.18). Results to be dictated – 0. Results to be typed – 40 (09.04.18). Filing – 2 lever arch files. **Mr Suresh N/A** **Mr Glackin:** Discharges awaiting dictations – 3. Discharges to be typed – 10. Clinic letters to be dictated – 15 (28.03.18). Clinic letters to be typed – 1. Results to be dictated – 98 (02.04.18). Results to be typed – 3. **Mr Haynes:** Discharges awaiting dictations – 0. Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be typed – 0. Results to be dictated – 10 (05.04.18). Results to be typed – 15 (15.04.18). Filing- 70 Sheets. **Mr O'Brien:** Discharges awaiting dictation – 30 (06.04.18). Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be typed - 57 (27.93.18). Results to be dictated – 10. Reuslts to be typed – 0. Filing 6 lever arch files. **Mr O'Donoghue:** Discharges awaiting dictation – 0. Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be dictated – 57 (10.04.18). Results to be dictated - 0. Results to be typed – 10 (12.04.18). Filing – 1 Lever arch file **Mr Young:** Discharges awaiting dictation – 9. Discharges to be typed – 0. Clinic letters to be dictated - 1. Clinic letters to be typed – 0. Results to be dictated – 39 (March/April). Results to be typed – 0. Filing – 2 boxes	TL4 page 570 – 572 AOB-07847 – AOB-07849
08.03.2019	Email from Ms Corrigan to Consultants	Re: RF 1st Appointment longest wait (March 2019) Breast – 8 Gynae – 9 E-Gynae – 9 ENT – 8 Surgical (GPC) – 19 Surgical (OC) – 19 E-Gastro – 15 Gastro – 27 Urology (Prostate) – 39 Urology (Haematuria) – 57 Urology (other) – 38 Lung – 10 Skin – 12 Oral Surgery – 24	TL4 page 640 – 657 AOB-07917 – AOB-07834
20.03.2019	Email from Ms Corrigan to Consultants	RE: Urology Escalations List of patients on waiting list for their first appointments – does not detail which consultant the patients belong to.	TL4 page 699 – 701 AOB-07976 – AOB-07978

21.03.2019	Email from Ms Corrigan to Consultants	RE: MRI Prostates Delay with MRI scanning as patients have to have scanning performed during day.. Will have a further impact on performance if patients are to have scanning performed in the first instance	TL4 page 761 – 762 AOB-08038 – AOB-08039
21.03.2019	Email from Ms Elliot to Mr O'Brien	Can only facilitate Mr O'Brien's urology clinic on 2nd Monday of each month commencing May 2019	TL4 page 763 AOB-08040
21.03.2019	Email from Ms Corrigan to Consultants	Re: Urology Escalations Haematuria – 74 Prostate – 50 Other – 3	TL4 page 774 – 775 AOB-08051 – AOB-08052
26.03.2019	Email from Ms Elliot to Consultants	Re: May rota	TL4 page 811 – 817 AOB-08088 – AOB-08094
29.03.2019	Email from Ms Corrigan to Consultants	RE: April rota	TL4 page 832 – 833 AOB-08109 – AOB-08110
29.03.2019	Email from Appointments to Mr O'Brien	Asking if they can overbook Mr O'Brien's clinic as clinic is full and next clinic will not be until June 2019	TL4 page 853 AOB-08130
31.03.0219	Email from Ms Corrigan to Mr O'Brien	RE: Uro Oncology Review Backlog until end of March 2019 Approx 173 patients on Mr O'Brien's list	TL4 page 858 – 862 AOB-08135 – AOB-08139
01.04.2019	Email correspondence between Mr O'Brien and Ms Corrigan	Discussed Mr Derek Hennessey reviewing Mr O'Brien's longest waiters. Ms Corrigan also notes that patients were cancelled due to a fault on her part and Mr Obrien explained his process with his secretary in terms of booking patients to lists	TL4 page 863 – 864 AOB-08146 – AOB-08148
04.04.2019	Other roles structured reflective template	AOB's reflection comments	2017 Appraisal page 104 AOB-22982

<table>
<tr>
<td></td>
<td></td>
<td>
Other roles structured reflective template

<table>
<tr><td>Name of doctor: Aidan O'Brien GMC No: 1394911</td></tr>
<tr><td>Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role:
I was Lead Clinician and Chair of the NICaN Clinical Reference Group in Urology from January 2013 until January 2016. During that time, I prepared all of the work for and chaired all of the Group's meetings. In preparation for the first National Peer Review of Northern Ireland's Urological Cancer Services, I constructed all of the referral pathways for patients suspected of having a cancer. I commissioned, supervised, revised and gained multidisciplinary agreement for the Northern Ireland's first Urological Cancer Clinical Guidelines. I brought the five Trusts towards Peer Review in June 2015 with robust Guidelines and Operational Policies. As a trained Peer reviewer, I assisted Team North West in meeting Peer Review.

In addition, I was the Southern Trust's Lead Clinician of its Urology MDT and Chair of its MDM from April 2012 until December 2016. I developed its Operational Policy through repeated business meetings, in preparation for Peer Review. In the Annual Reports of 2014 – 2016, there was a progressive increase in Red Flag referrals, of cancer diagnoses and of MDM case discussions. By the time of Peer Review in June 2015, I had succeeded in having the Southern Trust not having one case in breach of a cancer timeline. I had done so by ensuring that all patients were processed within those timelines, either by their named consultants, or by myself, when colleagues took holidays etc.</td></tr>
<tr><td>They also brought the following drawbacks to my main clinical role:

I did all of the above without any assistance from my employing Trust: no time allocation, remunerated or otherwise. The significant time spent in executing the above roles had a significantly negative impact in fulfilling all aspects of my clinical responsibilities.</td></tr>
<tr><td>I could consider the following actions, to maximise the benefits and minimise the drawbacks:

Too late, except never do the same again, as it is at least thankless, if not punishable!
Date of reflection: 04 April 2019</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>05.04.2019</td>
<td>Email from Ms Evan to Consultants</td>
<td>Re: Backlog Report

Mr Tyson: Discharges awaiting dictation – 0. Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be typed – 6 (25.03.19). Results to be dictated – 14. Results to be typed – 6. Filing – 2 lever arch files.

Mr Glackin: Discharges waiting dictation – 1. Discharges to be typed – 4. Clinic letters to be dictated – 0. Clinic letters to be typed – 27. Results to be dictated – 28. Results to be typed – 15. Filing – 2 lever arch files

Mr Haynes: Discharges awaiting dictation – 0. Discharges to be typed – 5. Clinic letters to be dictated – 0. Clinic letters to be typed – 22. Results to be dictated – 37. Results to be typed – 23. Filing – 1 lever arch file.

Mr O'Brien: Discharges awaiting dictation – 18. Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be typed – 39. Results to be dictated – 15. Results to be typed – 0. Filing – 6 Lever arch files.

Mr O'Donoghue: Discharges awaiting dictation – 0. Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be typed – 20.</td>
<td>TL4 Page 897 – 931

AOB-08174 – AOB-08208</td>
</tr>
</table>

		Results to be dictated – 68. Results to be typed – 9. Filing- 3 lever arch files **Mr Young:** Discharges awaiting dictation – 3. Discharges to be typed – 0. Clinic letters to be dictated – 0. Clinic letters to be typed – 14. Results to be dictated – 37. Results to be typed – 9.	
11.04.2019	Email from Mr Tyson to Mr William and Consultants	Re: CT scans *"It is a problem of a long wait for ESWL and not enough sessions of ESWL to cope with the numbers. People wait so long due to the demand/lack of sessions that imaging can become out of date. We are hoping to have more session agreed to cope with backlog and present and future need for the service."*	TL4 page 950 AOB-08227
17.04.2019	Email from Mr Young to Consultants	Re: Theatres in May Theatre allocation for May has been changed with implication for urology. Request to put hold booking patients for May	SUPOCT Page
17.04.2019	Email from Ms Elliot to Mr O'Brien	RE: Patient query Patient's daughter ringing re date for surgery. Been on waiting list for TURP since 10 March 2015.	SUPOCT Page
18.04.2019	Email from Ms Dignam to Consultants	Re :May rota	TL4 page 956 – 961 AOB-08233 – AOB-08238
19.04.2019	Email from Mr O'Brien to Mr Young	RE: Mr O'Brien's scheduling for June	TL4 page 995 AOB-08272
01.05.2019	Email from Ms Corrigan to Consultants	Re: May 2019	TL4 page 1027 – 1028 AOB-08304 – AOB-08305
02.05.2019	Email from Ms Corrigan	Re: Red Flag appointment Team pressures Undergone a period of rapid change in the red flag appointments team with significant movement in staff for various reasons. Vat majority of team are new and inexperienced. This has impacted the prompt turnaround of red flag appointment upon triage and the team are faced with constantly backfilling RF appointment slots at very short notice. Have had to release some red flag appointment slots to the booking centre to ensure capacity at clinics was not lost.	TL4 page 1031 – 1032 AOB-08308 – AOB-08309
07.05.2019	Email From Ms Dignam to Consultants	Re May schedule	TL4 page 1049 – 1055 AOB-08326 –

			AOB-08332
07.05.2019	Email from Ms Dignam to Consultants	RE: June Schedule	TL4 page 1056 – 1062 AOB-08333 – AOB-08339
07.05.2019	Email from Mr O'Brien to appointments	Mr O'Brien notes that he writes to admit two additional patients as the clinic is full already. Suggesting Mr O'Brien is overbooking his clinic	TL4 Page 1064 AOB-08341
13.05.2019	Email from Mr Connolly to Ms Shannon	Mr Connolly noted that his longest waiter for PCNL is October 2016	TL4 page 1080 – 1085 AOB-08357 – AOB-08362
13.05.2019	Email from Appointments to Mr O'Brien	Re: RF triage Mr O'Brien had triaged patient to be seen at SWAH on 13 May 2019 but due to pressure in the Red Flag office this referral was only printed today and next clinic is not until 25 June 2019.	TL4 page 1088 – 1094 AOB-08365 – AOB-08371
22.05.2019	Email from Ms Elliot to Mr O'Brien	Re: Overbook Mr O'Brien's secretary queries whether to over book Mr O'Brien's clinic	TL4 page 1137 AOB-08414
23.05.2019	Email from Ms Elliot to Mr O'Brien	Re: Overbooked clinic s Mr O'Brien's secretary had to overbook the SWAH clinic and added 2 slots early morning to try to fit everyone in.	TL4 page 1138 – 1140 AOB-08415 – AOB-08417
26.05.2019	Email from Mr O'Brien to Mr Young	Re: Mr O'Brien's schedule for July 2019	TL4 page 1156 AOB-08433
30.05.2019	Email from Ms Corrigan to Consultants	Re: June rota	TL4 page 1159 – 1160 AOB-08436 – AOB-08437
30.05.2019	Email from Ms Dignam	Re: July rota	TL4 page 1161 – 1167

	to Consultants		AOB-08438 – AOB-08444
31.05.2019	Email from Mr O'Brien to Ms Corrigan	Re: SWAH Clinic Template Mr O'Brien sets out how there is a struggle to review all of the patients he would like to review at any clinic which tends to be more acute with the SWAH clinic. Mr O'Brien has found 20 patients appointed to his clinics to be too much and means he is working without a break. The SWAH clinic template is for 16 but Mr O'Brien is happy to see 18. The template is for 4 red flags, 2 new urgent, 2 new routine and 8 protected review. Mr O'Brien would like review increased to 10.	TL4 page 1171 AOB-08448
04.06.2019	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient's GP wondered when patient would have review – his review slot was for December and it is now 6 months past and patient has renal cell carcinoma.	TL4 page 1185 AOB-08462
05.06.2019	Email from Ms Dignam to Consultants	Re: July schedule	TL4 page 1188 – 1194 AOB-08465 – AOB-08471
06.06.2019	Email from Ms Evans to Consultants	Re: Urology Backlog report **Mr Tyson:** Clinic letters to be typed – 10. Results to be dictated – 10. Results to be typed – 42. Filing – 3 files **Mr Glackin:** Discharges awaiting dictation – 6. Discharges to be typed – 9. Clinic letters to be dictated – 5. Clinic letters to be typed – 28. Results to be dictated – 17. Results to be typed – 21. Filing 2 files **Mr Haynes:** Clinic letters to be typed – 31. Results to be dictated – 36. Results to be typed – 13. Filing – 2 lever arch **Mr O'Brien:** Discharges awaiting dictation – 18. Clinic letters to be typed – 38. Results to be typed – 6. Filing – 6 files. **Mr O'Donoghue:** Clinic letters to be typed – 25. Results to be typed – 2. Filing – 3 files **Mr Young:** Discharges awaiting dictation: 6. Clinic letters to be typed – 15. Results to be dictated – 25. Filing – 4.5 files	TL4 Page 1195 – 1255 AOB-08472 – AOB-08532
24.06.2019	Email from Appointment to Mr O'Brien	Re: Red Flag triage but no capacity on Mr O'Brien's clinics until 22 July 2019 SWAH or 20 August 2019 CAH	TL4 page 1307 – 1308 AOB-08584 – AOB-08585
28.06.2019	Urology Backlog	**Mr Tyson:** Clinic letters to be typed – 2 . Results to be dictated – 40. Results to be typed – 54. Filing – 3 files **Mr Glackin:** Discharges awaiting dictation – 7. Clinic letters to be	TL4 page 1383 – 1462

		dictated – 1. Results to be dictated – 31. Filing – 2 files **Mr Haynes:** Results to be dictated – 19. Results to be typed – 20. Filing – 1.5 files **Mr O'Brien:** Discharges awaiting dictation – 18. Clinic letters to be dictated – 43. Results to be dictated – 10. FILING – 6 files **Mr O'Donoghue:** Clinic letters to be typed – 12. Results to be dictated – 11. Results to be typed – 12. Filing – 3 files **Mr Young:** Discharges awaiting dictation – 6. Results to be dictated – 17. Filing – 2.5 files	AOB-08660 – AOB-08739
05.07.2019	Email from Ms Dignam to Consultants	Re: Urology Schedule – August and updated July	TL4 page 1524 – 1533 AOB-08801 – AOB-08810
05.07.2019	Email from Ms Corrigan to Consultants	Re: Urology rota July 2019 to include new Locum Mr Gyorgy Solt	TL4 page 1534 – 1535 AOB-08811 – AOB-08812
08.07.2019	Email from Ms Neilly to Mr O'Brien	RE: Patient query/Complaint *"Patient was seen by AOB 24/6/19 in SWAH. CT scan and bone scan to be done and review in August in SWAH Thursday he complained of new pain in his back.* Personal Information redacted by USI *contacted GP on Friday. GP came out on Friday and upped dose of MST from 5mg to 10mg. He said that he could contact radiologist on Saturday which he did and contacted* Personal Information redacted by USI *to say the Radiologist said it would have to be a clinical call so the GP advised taking him to A&E. Took to A&E on Sunday – No morphine on Sunday.* *Doctor there said they don't have the equipment or staff to do the examination and couldn't understand why GP sent them to A&E. Told not to give morphine but to give Co-Codamol but co-codamol does nothing for pain. The Doctor in A&E last night said he had been referred to Omagh for CT but Omagh has said that CT scan as near to his review appointment in August so the secretary suggested that* Personal Information redacted by USI *phone secretary in CAH to see if review appointment can be brought forward so CT scan can be done sooner"*	TL4 page 1551 AOB-08828
08.07.2019	Email from Ms McMahon to Mr O'Brien	No red flag appointments available until August so considering overbooking	TL4 page 1552 AOB-08829
09.07.2019	Email from Mr O'Brien to Mr Cullen & Mr Bennett	Re: Patient admission Mr O'Brien notes that patient has been waiting for operation since 2014 and he does not want to cancel due to risk of her waiting a long time for a date	TL4 page 1554 – 1555 AOB-08831 – AOB-08832

18.07.2019	Minutes of Cancer Performanc e Meeting		TL4 page 2058 – 2067 AOB-09333 – AOB-09343
24.07.2019	Email from Ms Corrigan to Consultants	Re: Urology escalations 13 patients who are on day 43 – 73 for 1st appointment.	TL4 page 1644 – 1645 AOB-08921 – AOB-08922
29.07.2019	Email from Ms Corrigan to Consultants	Re: Access times report June for July 2019 position Re waiting times that goes to GPs – New OP is 183 weeks IP is 286 weeks DC is 273 weeks	TL4 page 1669 – 1670 AOB-08946 – AOB-08947
31.07.2019	Email from Ms Dignam to Consultants	Re: Sept rota	TL4 page 1705 – 1708 AOB-08981 – AOB-08984
31.07.2019	Email from Ms Elliot to Mr O'Brien	Re: Patient query GP was in contact wondering is patient's review appointment could be expediated. Is on Mr O'Brien's waiting list from 20 December 2018	TL4 page 1710 – 1711 AOB-08986 – AOB-08987
02.08.2019	Email from Ms Dignam	Re: Urology scheduling August	TL4 page 1715 – 1716 AOB-08991 – AOB-08992
05.08.2019	Email from Ms Corrigan to Mr O'Brien	Re: Review backlog Another patient was added for SWAH so leaves 8 patients on Mr O'Brien's backlog	TL4 page 1730 – 1737 AOB-09006 – AOB-09013
06.08.2019	Email from Ms Corrigan to Consultants	Re: Urology rota	TL4 page 1748 – 1751

			AOB-09024 – AOB-09027
06.08.2019	Email from Ms Evans to Consultants	Re: Backlog report July 2019 **Mr Tyson/Solt:** Discharges to be typed: 3. Clinic letters to be typed: 9. Results to be dictated: 20. Results to be typed: 4. Filing – 3 lever arch files **Mr Glackin:** Discharges to be typed – 8. Discharges to be typed: 12. Clinic letters to dictated: 2. Clinic letters to be typed: 29. Results to be dictated: 21. Results to be typed: 61. Filing – 2 lever arch files **Mr Haynes:** Discharges to be typed: 3. Clinic letters to be typed: 37. Results to be dictated: 15. Results to be typed: 90. Filing: 1.5 lever arch files **Mr O'Brien:** Discharges awaiting – 34. Clinci letters to be dictated – 60. Results to be dictated – 7. Filing – 6 lever arch files **Mr O'Donoghue:** Clinic letters to be typed – 47. Results to be dictated – 65. Results to be typed – 2. Filing - 3 lever arch files **Mr Young:** Discharges awaiting dictation – 6. Clinic letters to be typed: 15. Results to be dictated – 11. Filing – 2.5 box files	TL4 page 1752 – 1756 AOB-09028 – AOB-09032
22.08.2019	Email from Ms Elliot to Mr O'Brien	Re Patient query Patient's daughter ringing re date for surgery. Has been on waiting list for TURP since July 2017	TL4 page 1816 AOB-09092
27.08.2019	Email from Mr Solt to Mr O'Brien	Mr O'Brien asked Mr Solt to carry out surgery but Mr Solt refuses as feels he is too inexperienced and inpatient	TL4 page 1832 AOB-09108
28.08.2019	Email from Ms Corrigan to Consultants	Re: Urology Rota Sept	TL4 page 1850 – 1854 AOB-09126 – AOB-09130
28.08.2019	Email from Ms Elliot to Consultants	Re October Rota	TL4 page 1855 - 1856 AOB-09131 – AOB-09132
August 2019	Cancer Performance	Provides summary of breaches and why there was a delay. **InterTrust transfer breaches – 62 days –** Urology total 56 (2 in August 2019)	TL4 page 2040 – 2067

	Dashboard Report	**Internal breaches – 62 days –** Urology total 68 (4 in August 2019) **Day 31 breaches –** Urology 1 (0 in August 2019) **62 day Referrals –** Testicular cancer August 2019: 4. Upper Gastrointestinal Cancer August 2019: 156. Urological Cancer: 151 **31 day referrals –** Testicular cancers August 2019: 0. Upper Gastrointestinal: 74. Urological Cancer: 57.	AOB-09316 – AOB-09343
01.09.2019	Email from Ms Corrigan to Consultants	Re: Urology RF waiting list to be booked. All prostate slots have been filled for September Prostate – 70 patients (referrals from 25/06/19 – 12/08/19) Haematuria – 31 patients (referrals from 05/07/19 – 11/08/19) Testicular – 3 patients (referrals from 22/07/19 – 12/08/19) Other – 14 patients (referrals from 08/07/19 – 12/08/19)	TL4 page 1859 – 1874 AOB-09135 – AOB-09150
03.09.2019	Email from Ms Dignam to Consultants	Re: Urology Schedule September	TL4 page 1891 – 1892 AOB-09167 – AOB-09168
05.09.2019	Email from Ms Evans to Consultants	Re: Urology Backlog **Mr Tyson:** Results to be dictated – 25. Results to be typed – 23. Filing – 3 lever arch **Mr Glackin:** Discharges awaiting dictation – 11. Discharges to be typed – 7. Clinic letters to be dictated – 28. Results to be dictated – 6. Results to be typed – 64. Filing – 2 lever arch files **Mr Haynes:** Clinic letters to be typed – 2. Results to be dictated – 24. Results to be typed – 19. Filing – 2.5 lever arch files **Mr O'Brien:** Discharges awaiting dictation – 25. Clinic letters to be dictated – 49. Results to be dictated – 11. Results to be typed – 7. Filing – 6 files **Mr O'Donoghue:** Clinic letters to be dictated – 1. Clinic letters to be typed – 36. Results to be dictated – 61. Results to be typed – 26. Filing – 3 lever arch files **Mr Young:** Discharges awaiting dictation – 9. Clinic letters to be typed – 25. Results to be dictated – 21. Filing – 3 file boxes	TL4 page 1912 – 1916 AOB-09188 – AOB-09192
06.09.2019	Email from Martina Corrigan to all consultants	*"Its not looking promising that we are going to get anyone to replace Gyorgy. So I need to let theatres know if we can use the theatres below. Mark has picked up a few in October and there are some listed below which are still available so can you let me know by Monday at the latest so that I can either put your name against it or give it over to one of the*	SUPOCT Page

		other specialties…..”	
18.09.2019	Email from Ms Dignam to Consultants	*Re: October rota*	TL4 page 1994 – 2002 AOB-09270 – AOB-09278
20.09.2019	Letter of complaint	Re: Patient 8 Has been waiting almost 5 years for urology procedure. Aware that Trust does not have enough capacity to see all patients on the waiting list and the cancer patients take precedence. However, patient has been waiting 5 years	TL4 Page 2242 AOB-09519
23.09.2019	Email from Ms Corrigan to Consultants	Re: October rota	TL4 page 2075 – 2076 AOB-09351 – AOB-09352
23.09.2019	Email from Ms Dignam to Consultants	Re: November 2019 rota	TL4 page 2111 – 2115 AOB-09386 – AOB-09389
26.09.2019	Email from Ms Elliot to Mr O’Brien	RE: Patient query Patient calling re date for surgery. Has been on waiting list for TURP since 23 November 2015.	TL4 page 2228 AOB-09501
28.09.2019	Email from Ms Corrigan to Consultants	*RE: October rota*	TL4 page 2238 – 2239 AOB-09511 – AOB-09512
28.09.2019	Email from Ms Corrigan to Client Liaison	*Re:* Patient 8 *complaint* Patient added to Mr O’Brien’s waiting list for surgery in October 2014. He is currently waiting 256 weeks and the waiting time for a routine patient is 268 weeks. We would like to apologise for the long wait as we currently do not have enough capacity to meet the demand and we are concentrating on treating our cancer patients for which we have a high volume	TL4 page 2240 – 2249 AOB-09513 – AOB-09522
October 2019	Achieving the best possible outcomes for men with	*“This report also provides advice on how to tackle the increasing burden on healthcare services from this growing prostate cancer population”.* *“… we believe require particular attention for adequate staffing levels in the future.”*	TL2 page 342 – 350 AOB-04799 -

	prostate cancer in Northern Ireland		AOB-04807
01.10.2019	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient awaiting surgery for TURP since 23/09/14. Rang this morning to advise happy to go ahead with surgery	TL4 page 2304 AOB-09577
06.10.2019	Email from Mr O'Brien to Ms McIlvenna	Mr O'Brien notes that he has been behind on dictation as his secretary has been behind in typing dictation. As a consequence, patient not placed on waiting list.	TL4 page 2317 AOB-09590
07.10.2019	Email from Ms Dignam to Consultants	Re: Team Schedule October	TL4 page 2321 – 2322 AOB-09594 – AOB-09595
08.10.2019	Email from Ms Dignam to Consultants	Re: Amended November rota	TL4 page 2323 – 2326 AOB-09596 – AOB-09599
08.10.2019	Email from Ms Robinson to Mr O'Brien	RE: Patient query Patient's family called as worried re patient. Patient had stents in and is now 22 weeks from initial stent and the recommendation is 12 weeks. Wondered if they could get a date	TL4 page 2330 AOB-09603
10.10.2019	Email from Ms Muldrew to Consultants	Requesting for overbooking clinic to fit patient in who has been red flag appointment from September and is now inpatient in Daisy Hill	TL4 page 2351 – 2352 AOB-09624 – AOB-09625
10.10.2019	Email from Ms Evans to Consultants	Re: Backlog review **Mr Tyson:** Results to be dictated – 45. Results to be typed – 45. Filing – 4 lever arch files **Mr Glackin:** Clinic letter to be typed – 47. Results to be dictated – 25. Results to be typed – 19. Filing – 2.5 lever arch files **Mr Haynes:** Discharges to be typed – 23. Clinic letters to be typed – 19. Results to be dictated – 10. Results to be typed – 41. Filing – 3 lever arch files **Mr O'Brien:** Discharges awaiting dictation – 30. Clinic letters to be dictated – 22. Clinic letters to be typed – 54. Results to be dictated – 11. Results to be typed – 6 Filing – 6 lever arch files	TL4 page 2353 – 2357 AOB-09626 – AOB-09630

		Mr O'Donoghue: Clinic letters to be typed – 61. Results to be dictated – 26. Results to be typed 15. Filing – 4 lever arch files **Mr Young:** Discharges awaiting dictation – 10. Clinic letters to be typed – 10. Results to be dictated – 28. Results to be typed – 7. Filing – 3.5 folscap boxes	
11.10.2019	Email from Mr Haynes to Consultants	Re: Emergency admission of patients on waiting lists As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies… these admissions would likely have been avoided if the patient had received timely elective surgery. Mr Haynes requests that an IR1 form is completed for any reasonable delay. It is hoped that in doing this will heighten the recognition of patients needs and suffering due to lack of capacity. It will also protect the consultants to some degree, aware that a specialty (not urology) in an NI trust has come under criticism because it did not flag/document delays in cancer treatments	TL4 page 2358 AOB-09632 – AOB-09633
11.10.2019	Email from Mr Carroll to Consultants	Enclosing SAI which shows the impact of the delays in relation to Mr Haynes emails above	TL4 page 2361 – 2373 AOB-09634 – AOB-09646
17.10.2019	Email from Ms Corrigan to Consultants	Re: Red Flag 1st Appointment backlog 21/01/2019 06/02/2019 08/03/2019 19/03/2019 03/04/2019 11/06/2019 09/07/2019 31/07/2019 19/08/2019 19/09/2019 15/10/2019 Breast 11 8 8 7 11 11 12 12 5 7 Gynae 5 8 9 21 7 E-Gynae 6 8 9 7 12 17 18 26 21 21 27 ENT 10 6 8 10 12 26 45 37 38 21 35 Surgical (GPC) 11 15 19 37 32 Surgical (OC) 10 15 19 34 32 40 70 72 58 48 51 E-Gastro 10 6 15 19 27 Gastro 7 11 27 33 26 36 41 50 68 50 35 Urology (Prostate) **67** **67** 39 50 42 47 70 81 83 84 87 Urology (Haematuria) **60** **61** 57 50 53 31 45 62 41 46 51 Urology (Other) 31 26 38 31 27 38 35 51 47 40 40 Lung 10 13 10 21 4 14 14 17 17 27 17 Skin 6 10 12 7 0 13 14 19 22 23 33 Haematology 49* 86* 107* 58* 53* Oral Surgery 20 24 24 22 10 35 36 11 10 30 21 *this is an approx value as referrals are triaged on a daily basis due to clinical need so this will extend out	TL4 page 2374 – 2375 AOB-09647 – AOB-09648
18.10.2019	Email From Ms Johnston to Mr O'Brien	Mr O'Brien had to cancel procedure as patient had not been adequately prepared. The patient was a red flag patient.	TL4 page 2391-2392 AOB-09664 – AOB-09665
25.10.2019	Email from Ms Corrigan to Consultants	Re: Urology RF Escalations Longest waiter for prostate referrals waiting 109 days for 1st appointment (42 patients)	TL4 page 2452 – 2455 AOB-09725 – AOB-09728
28.10.2019	Email from Ms Corrigan to Consultants	RE: Urology Backlogs for Mr Tyson and Mr Jacob Approx 367 patients on review backlog. Approx 52 patients on Mr Tyson's/Mr Jacob's Ins and days waiting list to	TL4 page 2456 – 2505

		be seen before end of 2020 Approx 210 patients on Mr Tyson's/Mr Jacob's in and days as of 25 Oct 2019	AOB-09729 – AOB-09776
31.10.2019	Email from Ms Elliot to Mr O'Brien	RE: Patient query Patient wants date for surgery. Has been on Waiting list for TURP since 26/7/16.	TL4 page 2512 AOB-09783
01.11.2019	Email from Ms Corrigan to Consultants	Re: Urology November rota	TL4 page 2517 – 2520 AOB-09788 – AOB-09791
04.11.2019	Email from Ms Evans to Consultants	Re: Backlog report October 2019 **Mr Tyson/Solt:** N/A **Mr Glackin:** Discharges awaiting dictation – 1. Discharges to be typed – 16. Clinic letters to be dictated – 1. Clinic letters to be typed – 3. Results to be dictated – 13. Results to be typed – 21. Filing – 2.5 lever arch **Mr Haynes:** Clinic letters to be dictated – 17. Results to be dictated – 11. Results to be typed – 15. Filing – 4 lever arch files **Mr O'Brien:** Discharges to be dictated – 35. Clinic letters to be dictated – 45. Clinic letters to be typed – 11. Results to be dictated – 21. **Mr O'Donoghue:** Clinic letetrs to dictated – 43. Results to be dictated – 19. Results to be typed – 78. Filing – 4 lever arch files **Mr Young:** Discharges awaiting dictation – 8. Clinic letters to be typed – 29. Results to be dictated – 32. Filing – 3 boxes	TL4 page 2544 – 2548 AOB-09815 – AOB-09819
06.11.2019	Email from Ms Dignam to Consultants	Re: December rota	TL4 page 2562 – 2565 AOB-09833 – AOB-09836
11.11.2019	Email from Ms Corrigan to consultants	Re RF 1st appointment longest wait **Breast: 11** **Gynae: 8** **E-Gynae: 8** **ENT: 10** **Surgical (GPC): 38** **Surgical (OC): 45** **E-Gstro : 38** **Gastro :38** **Urology Prostate : 103** **Urology Haematuria : 43** **Urology Other :45** **Lung :14** **Skin:24** **Haematology :40**	TL4 Page 2600 – 2602 AOB-09871 – AOB-09872

		Oral Surgery: 13	
12.11.2019	Email correspondence between Ms Donnelly and Dr O'Kane	In response to GMC the question on measures put in place to support Mr O'Brien to address current deficiencies the Trust Medical Director responded as follows:- "*The Trust has offered a meeting with Mr O'Brien on 12th December for further discussions on his job plan, which will include measures to support him in his working practices. As this meeting has not yet taken place, we have not yet had the opportunity to discuss the issues raised in his letter to clarify expectations, agree an action plan and consequence of continued non-compliance. Once an action plan hasbeen agreed, it will be monitored and non-compliance will lead to the implementation of appropriate Trust disciplinary processes."*	Doc File 4 pages 108 - 112 Page 111 AOB-02269 - AOB-02273
21.11.2019	Email from	RF 1st Appointment backlog **Breast: 10** **Gynae & E-Gynae: 12** **ENT: 3** **Surgical (GPC) & (OC): 46** **Gastro & E-Gastro: 26** **Urology Prostate: 60** **Urology Haematuria: 37** **Urology Other: 42** **Lung: 14** **Skin: 22** **Haematology: 43** **Oral Surgery: 14**	TL4 page 2668 – 2670 AOB-09938 – AOB-09940
27.11.2019	Email from Ms Dignam to Consultants	Re Jan rota	TL4 page 2698 – 2701 AOB-09968 – AOB-09971
28.11.2019	Email from Ms Corrigan to Consultants	Re Urology December rota	TL4 page 2704 – 2705 AOB-09974 – AOB-09975
29.11.2019	Email from Mr Young to Consultants	Re: Departmental meeting Expressing concern re lack of departmental meeting and having not met properly in a year. This is having a deleterious effect on running of the unit and retrograde steps in general	TL4 page 2706 AOB-09976
03.12.2019	Urology CRG meeting	… 5 Urology Overview: *Mr Haynes opened the meeting to enable colleagues to flag any concerns across their individual Trust Urology Service. The following were highlighted:* *BHSCT – Performance remains poor with red flag referrals now sitting at approximately 260 per months… Theatre access remains problematic. Difficult to implement due to ongoing nursing issues*	SUPOCT Page

		SET – Similar position as other Trusts. Red flag referrals have increased by 11% and waiting time for initial red flag appointment is currently seven weeks. Nursing shortages.	
05.12.2019	Email from Ms Evans to Consultants	Re Backlog report **Mr Tyson/Solt:** **Mr Glackin:** Discharges awaiting dictation – 6. Discharges awaiting to be typed- 1. Clinic letters to be typed – 5. Results to be dictated – 46. Results to be typed – 12. Filing – 1.5 lever arch **Mr Haynes:** Clinic letters to be typed – 23. Results to be dictated – 58. Results to be tuped – 2. Filing – 3.5 lever arch **Mr O'Brien:** Discharges awaiting dictation – 20. Clinic letters to be dictated – 42. Clinic letters to be typed – 6. Results to be dictated – 10. Results to be typed – 2. Filing – 6 lever arch **Mr O'Donoghue:** Results to be dictated – 22. Results to be typed – 17. Filing – 6 lever arch **Mr Young:** Discharges awaiting dictation – 7. Results to be dictated – 35. Filing – 4.5 lever arch	TL4 Page 2778 – 2782 AOB-70048 – AOB-70052
06.12.2019	Email from Brian Duggan to consultants	Re Waiting times in Urology "Dear all The issue of waiting times is affecting surgical practice in NI. The issue of urology waiting times in Northern Ireland was raised at BAUS Council last week and the President of BAUS is going to draft a letter to the Permanent Secretary. Mark Haynes as chair of NICAN has written to the HSCB about the same issue. In addition, the English College of Surgeons would like all of us to fille in a survey about how waiting times/lack of beds and cancellations are affecting day to day practice. You don't have to be a member of the English College to take part. Mark Taylor chairs a local group of surgeons from all specialities and Mark will use this survey data in discussion with the NI Department of Health. It's pretty short, only 15 questions and given that urology waiting times are among the worst in our region, it would be goo if we took part."	SUP 2 page 57 AOB-04310 – AOB-04311
20.12.2019	Email from Ms Corrigan to Consultants	Re: Urology escalations Noting a number of escalations that need actioned. Highlighted that prostate referrals are on the increase and encouraging the use of additionality	TL4 page 2876 – 2878 AOB-70146 – AOB-70148
30.12.2019	Email from Mr O'Brien to Ms Corrigan	Mr O'Brien queries whether his elective admission list will get cancelled due to the cancellations of lack of beds in Trust	TL4 page 2886 – 2887 AOB-70156 – AOB-70157
06.01.2020	Email from Ms	Re: Query re stent change delay	TL2 Page 25

	Corrigan to Consultants	*"This lady is on Matthew's waiting list awaiting change of stent which was due to be done in November. She has phoned today querying a date as she is in extreme pain."*	AOB-04482
06.01.2020	Email from Mr Young to Consultants	Re: Feb Rota	TL2 page 27 – 30 AOB-04484 – AOB-04487
07.01.2020	Email from Ms Poland to Management & Consultants	Re: Urology Backlog **Discharges awaiting Dictation** Mr Tyson: 0 Mr Glackin: 7 (Oldest Date Nov 2019) Mr Haynes: 0 Mr O'Brien: 16 (Oldest date Sep 2019) Mr O'Donoghue: 0 Mr Young: 8 (Oldest date March 2019) **Discharges to be typed** Mr Tyson: 0 Mr Glackin: 13 (oldest dated Jan 2020) Mr Haynes: 6 (oldest date Jan 2020) Mr O'Brien: 0 Mr O'Donoghue: 0 Mr Young: 0 **Clinic letters to be dictated** Mr Tyson: 0 Mr Glackin: 1 (oldest date Jan 2020) Mr Haynes: 0 Mr O'Brien: 78 (Oldest date Dec 2019) Mr O'Donoghue: 0 Mr Young: 0 **Clinic Letters to be typed** Mr Tyson: 0 Mr Glackin: 48 (oldest date Jan 2020) Mr Haynes: 4 (oldest date Jan 2020) Mr O'Brien: 0 Mr O'Donoghue: 35 (Oldest date Jan 2020 Mr Young: 30 (Oldest date Jan 2020) **Oncall letters to be typed** Mr Tyson: 0 Mr Glackin: 0 Mr Haynes: 40 (Oldest date Jan 2020) Mr O'Brien: 0 Mr O'Donoghue: 0 Mr Young: 0 **Results to be dictated** Mr Tyson: 3 (Oldest date Jan 2020) Mr Glackin: 30 (Oldest date Dec 2019) Mr Haynes: 68 (Oldest date Jan 2020) Mr O'Brien: 18 (Oldest date Oct 2018) Mr O'Donoghue: 55 (Oldest date Jan 2020)	TL2 Page 31 – 35 AOB-04488 – AOB-04492

		Mr Young: 27 (Oldest date Nov 2019) **Results to be typed** Mr Tyson: 2 (oldest date Jan 2020) Mr Glackin: 33 (oldest date Jan 2020) Mr Haynes: 28 (oldest date Jan 2020) Mr O'Brien: 0 Mr O'Donoghue: 0 Mr Young: 0 **Filing** Mr Tyson: 4 lever arch files Mr Glackin: 2 level arch files Mr Haynes: 4.5 lever arch files Mr O'Brien: 6 lever arch files Mr O'Donoghue: 6 level arch files Mr Young: 5 folscap boxe3s	
07.01.2020	Email from Mr Haynes to Consultants	Re: Cover *"I need help" I am urologist of the week on 24/25/26 January. Unfortunately I am supposed to be in Glasgow on these dates… Would anyone be able to cover the Friday afternoon/evening, Saturday and Sunday for me…*	TL2 page 36 AOB-04493
07.01.2020	Email from Mr Haffey	Re: Minutes from Combined Surgery Anaesthetics M&M/Patient Safety Meeting in Dec 2019 1. When scanner is non-operational in DHH then this places additional pressure on the CAH site. 2. Medication incidents (wrong frequency, lack of monitoring, wrong dose, wrong medicine, delay/failure to monitor) 3. Audit to improve efficiency of emergency theatres (delays caused by, ward not ready, patient not consented ventilated child in theatre, medical staff unavailable, surgical staff unavailable, anaesthetic staff unavailable, ERPC patient arrived late, further time to discuss)	TL2 page 38 – 53 AOB-04495 – AOB-04510
10.01.2020	Email from Ms Fox to Mr Young and Mr O'Brien	Re: SWAH cover Mr Glackin does not do SWAH clinics so Mr Young and Mr O'Brien were to fit this patient, who was triaged by Mr Glackin, into one of their SWAH clinics	TL2 page 67 – 68 AOB-04524 – AOB-04525
10.01.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query GP ringing re MRI scan which was supposed to be requested in December 2019. His PSA has increased and patient is anxious. Patient wants to have scan ordered as soon as possible	TL2 page 90 – 91 AOB-04547 – AOB-04548
10.01.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient query on date for surgery which was due to be performed in December 2019.	TL2 page 89 AOB-04546
10.01.2020	Email from Ms Elliot to Ms O'Brien	Re: Patient Query Patient calling for date for surgery – on waiting list since August 2019 for a Red flag TURP	TL2 page 87 – 88 AOB-04544 –

			AOB-04545
14.01.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient Query Patient on red flag waiting list for TURP and querying date.	TL2 Page 94 AOB-04551
20.01.2020	Email from Ms Corrigan to Mr O'Brien	Re: Outstanding triage There are 12 red flags, 6 urgent and 8 routine still sitting on ETriage from your week on call.	TL2 page 109 AOB-04566
21.01.2020	Email from Ms Corrigan to Urology Dept	Re: First Appointment Waiting Times January 2020 1. Breast – 6 2. Gynae – 6 3. E-Gynae – 6 4. ENT – 6 5. Surgical – 40 6. Surgical (OC) – 41 7. E- Gastro – 0 8. Gastro – 33 9. Urology (prostate) – 101 10. Urology (Haematuria) – 51 11. Urology (Other) – 51 12. Lung – 20 13. Skin – 14 14. Haematology – 45 15. Oral Surgery – 45 */35	TL2 page 113 – 114 AOB-04570 – AOB-04571
21.01.2020	Email from Ms Corrigan to Urology	Re: Urology Escalations List of referrals unable to appoint by day 14 – total number of **40**	TL2 page 115 – 117 AOB-04572 – AOB-04574
22.01.2020	Email from Medical Directors Office	Re: Waiting lists and enclosing Belfast Telegraph News article *"Almost 5,000 people died while on a health service waiting list in Northern Ireland in the last year"* *"The number of deaths is increasing year on year, rising by almost 50% since 2014".* *"Some people have died whilst being on a waiting list for up to five years"* *"Alarmingly, they have also revealed that some patients who have an urgent referral for a painful and debilitating condition can expect to wait between two and three years for their first hospital appointment."* *"The wait for an urgent urology appointment increased by 39% from 38 to 53 weeks"* *"Patients referred for a routine urology appointment in the Southern Trust faced a wait of 141 weeks in September 2018, but this had increased to 196 weeks by last November. The Trust has apologised for the waiting times and said it prioritises patients by urgency and in line with guidance"*	TL2 page 128 – 134 AOB-04585 – AOB-04591
23.01.2020	Email from Ms	Re: Urology Theatre rota for Feb 2020	TL2 Page 142 – 144

	Corrigan to Urology		AOB-04599 – AOB-04601
23.01.2020	Email from Ms Dignam to Urology	Re: Enclosing Urology Team schedule Feb 2020	TL2 page 145 – 151 AOB-04602 – AOB-04608
23.01.2020	Urology Cancer Business Meeting	Note: Mr O'Brien is not in attendance but no apologies made for him. a. *Urology red flag waiting times as of 14/01/2020* i. *Urology (Prostate) 101* ii. *Urology (Haematuria) 51* iii. *Urology (other) 51* iv. *The current demand is in excess of capacity. Other services have had significant investment to address waiting times (Breast). Urology is in a much worse position than any other speciality.*	TL2 page 163 – 167 AOB-04620 – AOB-04624
24.01.2020	Email from Ms Loughran to Ms Elliot	Re: Priority lists – Mr Young, Mr O'Brien and Mr Glackin are to cover Mr Tyson's priority list for stented patients. Request for Mr O'Brien to do repeat ureteroscopy on a patient of Mr Tysons.	TL2 page 154 – 155 AOB-04611 – AOB-04612
27.01.2020	Email from Ms Neilly to Ms Elliot	Re: Patient query Requesting Mr O'Brien to contact patient's daughter in relation to a date from Mr O'Brien. Patient is on red flag and have not received a date yet/	TL2 page 170 AOB-04627
28.01.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient Query Patient on waiting list for circumcision and flexible cystoscopy (August 2019). Ringing requesting a date as anxious that has not been followed up after bladder CA	TL2 page 188 AOB-04645
28.01.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query Requesting date for surgery. On waiting list for TURP. Would appreciate date as soon as possible	TL2 page 189 AOB-04646
29.01.2020	Email from Ms Elliot to Mr O'Brien	Re: patient query Requesting date for surgery. Been on waiting list for TURP since 30 September 2016. Wondering if can be considered for suprapubic catheter	TL2 page 191 AOB-04648
31.01.2020	Urology Rota	Urology Rota for March 2020	TL2 page 195 – 198 AOB-04652 – AOB-04655

31.01.2020	Email from RF Appointment to Mr O'Brien and Mr Young	Re: APT query Requesting for cover to see patient in SWAH as soon as possible. There are no RF slots until March but Mr O'Donoghue has requested that this patient is seen sooner and he was triaged to SWAH.	TL2 page 199 – 200 AOB-04656 – AOB-04657
31.01.2020	Email from Ms Corrigan to Consultants	Re: Urology Escalations Patients who have been unable to be appointed by day 14 – total of 41 (Longest wait 105 days) Further email sent later in the day re same issues except with a total of 9 (Longest wait 62 days)	TL2 page 201 – 206 AOB-04658 – AOB-04663
February 2020	Urology Rota	Urology Rota for Feb 01 – Feb 29	SUP 2 pg 66 - 68 AOB-04319 – AOB-04321
04.02.2020	Email from Ms Haffey to Consultants	Re: Urology Outstanding cases (for the Urology Speciality specific M&M) at 31 Jan 2020 **9** PATIENTS OUTSTANDING. 2 of which are Mr Glackin's 3 of which are Mr O'Donoghe's 1 of which is Mr Yousaf's 4 of which is Mr O'Brien's	TL2 page 229 – 230 AOB-04686 – AOB-04687
04.02.2020	Email from Ms Corrigan	Re: Patient Query **Complaint -** Patient was due to have prostate surgery this morning under the care of Mr O'Brien but it was cancelled at the last moment. This is the second cancellation.. **Ms Corrigan email: "**I do appreciate this patient's frustration and I am happy to respond and apologise on our behalf but I was wondering if you have any idea of when you will be able to get him fitted in , with me not underestimating the number of other patients also need a date."	TL2 page 231 – 232 AOB-04688 – AOB-04689
06.02.2020	Email from Ms McAuley to Ms Elliot	Re: Patient query Patient has been on TURP waiting list since 2016 and has ran into difficulty with failed TROC in June 2019… I appreciate the challenge in getting people listed and operated on, I said I would bring his case to your attention…	TL2 page 233 AOB-04690
10.02.2020	Email from Ms Holloway to Mr O'Brien	Re: Patient query Patient called to say had completed 6 week course of BCG therapy on December 2019. Informed me that has not been called for his check cystoscopy.	TL2 page 238 AOB-04695
10.02.2020	Email from Ms Neilly to Ms Elliot	Re: Patient query Patient's wife called. Advised that patient was to be reviewed in Jan 2020 with scans and PSA. But had one scan in Daisy Hill and nothing since. Would be grateful if something could be arranged. Requesting Mr O'Brien to contact patient	TL2 page 239 AOB-04696
11.02.2020	Email correspond	Re: Backlog reports	TL2 page 243 – 247

	ence between Ms Evans and Urology	*"With regards to the results awaiting dictation for Mr O'Brien's section, I have spoken to the secretary this morning who advises me these results have been generated from additional clinics which Derek Hennessy carried out. Noleen has been requesting the Reg's to come to her office to dictate some time now to no aval. We have inly become aware of the 2018 date as of today.."*	AOB-04700 – AOB-04704
11.02.2020	Email correspondence between Ms Corrigan and Urology	Re: Urology Theatre rota	TL2 page 268 – 270 AOB-04725 – AOB-04727
18.02.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient ringing querying date for surgery. Was on CURWL waiting list since 18 Jan 2019. Reported symptoms have worsened. Would appreciate a date for surgery as soon as possible	TL2 Page 280 AOB-04737
19.02.2020	Email from Ms Elliot to Mr O'Brien	RE: Patient query Patient on waiting list for TURBT since 6 Dec 2019. Daughter ringing for date for surgery. Patient not doing well	TL2 page 299 - 300 AOB-04756 – AOB-04757
24.02.2020	Email from Ms Corrigan to Urology	Re: 1st Appointment Longest Wait 20.02.2020 1. Breast: 14 2. Gynae: 21 3. ENT: 10 (62*) 4. Surgical (GPC): 40 5. Gastro: 33 6. Urology (Prostate); 116 7. Urology (Haematuria): 53 8. Urology (other): 52 9. Lung: 19 10. Skin: 10 11. Haematology: 59 12. Oral Surgery: 37	TL2 page 325 – 328 AOB-04782 – AOB-04785
24.02.2020	Email from RF Appointments	Re: Urology escalations in relation to first appointment Patients who were not appointed by day 10 -14 – 26 PATIENTS (Longest wait 114 days)	SUPOCT Page
24.02.2020	Email correspondence between Ms Corrigan and Ms Dignam	Re: Cancellation of EUROMY/EUROAOB clinics **Ms Dignam –** *"Per Mr Young can all bookings to the above clinics be put on hold for both March & April 2020 and until further notice? Mr Young has advised that any bookings to me made are to be review appointments only, no new patients. Mr Young will advise again in due course but until then please suspend all clinics"*>	TL2 page 329 AOB-04786

		Ms Corrigan – *"I had spoken with Mr Young about this earlier today but there has been no definite confirmation of this until a meeting happens next week with the Western Trust. The clinics should not be suspended and need to go ahead as normal and I will speak to Mr Young and Mr O'Brien about this as once we have the meeting I will need further conversations with quite a number of other departments inside and outside the Trust before anything will be happening."*	
25.02.2020	Email correspondence from Ms Corrigan to Urology	RE: Urology Oncall Rota for March 2020	TL2 Page 330 – 331 AOB-04787 – AOB-04788
25.02.2020	Email from Ms Corrigan to Mr Young and Mr O'Brien	Re: IPDC Backlog *"I do know that you are both under pressure with long-waiters"* *"I did explain the pressures and they are aware of these but I did say I would ask"*	TL2 page 332 – 333 AOB-04789 – AOB-04790
27.02.2020	Email From Ms Corrigan to Mr O'Brien	Re: Urology Outstanding Triage *There are a number of outstanding referrals on NIECR from Mr O'Brien's still to be triaged from 24/02/20 > 26/02/20. We also have not received back any of the paper referrals sent to TDU for grading from 20/02/20 >26/02/20 from Mr O'Brien*	TL2 page 337 – 338 AOB-04794 – AOB-04795
02.03.2020	Email correspondence from Brian Duggan to Consultants	Re: Reconstructive Surgery "We were discussing the challenges for reconstruction surgery currently in our service. I'm finding that it's almost impossible to do any reconstructive surgery as cancer cases and urgent stones are using up the small amount of theatre activity in urology. I'm hardly doing any urethroplasty cases because bladder tymours and stones are taking priority. I'm offering day case dilations or referral to London as alternatives to sitting on a waiting list. "	SUP 2 pg 72 AOB-04325
03.03.2020	Email from Ms Haffey to Consultants	Re: Outstanding M&M Cases Mr Haynes – 2 Mr O'Brien – 1 Mr Yousaf – 1	TL2 page 388 – 389 AOB-04845 – AOB-04846
04.03.2020	Email from Mr Carroll to Urology	RE: Critical Care Pandemic Plan *First attachment outlines when we are proposing to stop surgery & OPDS. Initially with routine, urgent in/dc lists box1 and all OPDs. Theatre & OPD staff "freed" up will be redeployed within theatre & to wards.* *Then stopping all elective surgery & procedures Box 2.* *..* <u>Enclosures:</u> 1. <u>Admission Plan for Covid-19 at Craigavon Area Hospital</u> 2. <u>Planned Screening Covid-19 process</u> 3. <u>Unplanned screening</u> 4. <u>Review of Trust Self-Assessment checklist</u>	TL2 page 397 – 448 AOB-04854 – AOB-04905

		5. ST Acute Services Critical Care surge capacity and extension of critical care service capabilities during pandemics 6. Regional Escalation Plan for Adult Critical Care (2017)	
05.03.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient on waiting list for a TURP since March 2016. Had PSA on 24 Jan 2020. Had checked it on 13 Feb 2020 and had decreased. Was ringing for a date for his surgery. I note there has been a red flag referral referred and is awaiting appointment for this	TL2 page 394 AOB-04851
06.03.2020	Email from Mr Carroll to Urology	Re: Covid Admission Plans *"we were* 1. *Mindful that in drafting this plan we needed to be specific as to what the trigger points/numbers would be. No ambiguity* 2. *Mindful that we would have an additional cohort of pts over and above what we have now, who required to be nursed – staff needed to be found* 3. *Mindful that it was best to stop services early rather than wait and be overcome* 4. *Mindful that in cancelling surgery the consequence of this would be more emergency admissions* 5. *Mindful that 20% of all staff would also not be available.* 6. *Mindful that the ICU/Critical care plan (NICANNI) required staff from recovery and theatres to enable pts to be ventilated in theatres* *…"*	TL2 page 449 – 451 AOB-04906 – AOB-04908
06.03.2020	Email from Mr O'Brien to Ms Elliot	Re: Oncology patients Mr O'Brien advises that he is skipping the patient safety meeting on Friday 13 March 2020 in order to facilitate reviewing oncology patients all day. Mr O'Brien requested to schedule 11 patients in	TL2 page 454 – 455 AOB-04911 – AOB-04912
10.03.2020	Email from Mr O'Brien to Ms O'Neil	Re: Pateint Query Mr O'Brien had intended to review patient in Feb last year (2019). Requesting that Mr O'Brien keeps him in mind for review. Mr O'Brien confirmed that he had reviewed the patient by telephone and defered further review to October 2020	TL2 page 478 AOB-04935
11.03.2020	Email from Day Clinical Centre to Mr O'Brien	Re: Patient No beds to facilitate admission of patient. Had to cancel admission.	TL2 page 479 – 480 AOB-04936 – AOB-04937
11.03.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient's wife ringing for date for surgery. Has been on waiting list for TURP since August 2018. Would appreaicte a date as soon as possible	TL2 Page 481 AOB-04938
11.03.2020	Email from Ms Corrigan to Urology	Re: Patients Medically Fit for Discharge Sets out that due to capacity issues, any patients medically fit are to be discharged	TL2 page 482 – 484 AOB-04939 –

			AOB-04941
13.03.2020	Email from Mr Carroll to Urology	Re: Covid *… A communication will be going out to the public to advise that next week the Trust is cancelling ALL acute outpatinet clinics on ALL sites. There is an appreciation that there may be some instances where a conusltant feels a pateint booked to a clinic next week really needs to be seen..*	TL2 page 489 – 492 AOB-04950 – AOB-04952
16.03.2020	Email from Mr Carroll to Urology	Re: Covid *Our challenge is having the capacity to allow theatre nuses to undertake stimulation, education and training to cope with critical care surge.* *…* *In preparation to meet increased patient demand with the downturn..*	TL2 page 500 – 503 AOB-04957 – AOB-04960
17.03.2020	Email from Mr O'Brien to Ms Elliot	Re: Covid cancellations 1. *CAOBUOR clini this morning to proceed as arranged* 2. *Operating session this afternoon, Wednesday 18 March, has been cancelled* 3. *Operating on Friday will proceed, though not surpised if some patient will be cancelled.* 4. *The DSU session on Tuesday 24 Marhc 2020 has been canclled* 5. *All admissions to DSU will not take place until further notice* 6. *There will be no CAOBTDUR clinic on Tuesday 24 March 2020. Requested to attempt to conduct clinics virtually.* 7. *Would defer arranging inpatient admissions of next week until after Departmental meeting* ..	TL2 page 510 AOB-04967
20.03.2020	Email from Mr Glackin to Consultants	Re: Urology theatre cases to be cancelled	TL2 page 556 – 559 AOB-05013 – AOB-05016
31.03.2020	Email from Ms Haffey to Consultants	RE: Outstanding urologly M&M cases 2 – Mr Haynes 1 – Mr O'Brien 1 – Mr Yousaf	TL2 page 610 – 611 AOB-05067 – AOB-05068
08.04.2020	Email from Mr Glackin to Mr O'Brien	Re: Mr O'Brien taking on theatre list for Mr Glackin.	TL2 page 643 – 644 AOB-05100 – AOB-05101
08.04.2020	Email from Ms Corrigan to Urology	Urology Theatres rota – April 2020	TL2 Page 457 – 460 AOB-04914 – AOB-04917

08.04.2020	Waiting List Management Reports dated 08 April 2020	This contains 11 pages of patients and the description of the procedure they were awaiting on. They are all down to AOB for surgery. There are approximately 11 pages with up to 30 names per page. The procedures go back to 2014. This is a helpful document in showing the extreme pressure AOB's backlogged waiting list for surgery was. *The allegations relate to :* • *Failure to triage patient referrals dating back to December 2014 (including patients who have since received a confirmed cancer diagnosis)* • *Failure to appropriately review patients on the Urology waiting list, and also patients on an oncology waiting list* • *Failure to make adequate documentation regarding Patient Centre letters, or consultation records/discharge notes relating to clinic outcomes* • *Keeping confidential patient records at home* • *Failure to adequately document over 60 undictated clinics with no outcome sheets* • *Adding private patients to the waiting list ahead of NHS patients without any apparent justification for them being given priority* • *Possible deviation from the agreed local action plan in September 2019*	Doc File 4 pages 215 – 225 AOB-02376 - AOB-02386
09.04.2020	Email from Mr Young to Urology	Re: Rota for week of 13 April 2020 *CNS only on CAH site each day so whoever the CNS is covering the day will liaise with the Registrar in the morning. If any issue in DHH contact CAH team*	TL2 page 647 AOB-05104
10.04.2020	Email from Ms Corrigan to Mr O'Brien	Re: Review Backlog *We are getting all the surgeons to work through their review backlogs whilst there is a downturn in surgery and clinics.* Review backlog of 716 number of patients 1 from 2016 Approx 133 from 2017 Approx 235 from 2018 Approx 263 from 2019 Approx 110 from 2020	TL2 page 648 – 780 AOB-05105 – AOB-05237
14.04.2020	Email from Mr O'Brien to Ms Corrigan	Enclosing memo re Utilisation of Independent Hospital facilities for Elective Surgery Activity during the Covid-19 pandemic	TL2 Page 781 – 784 AOB-05238 – AOB-05241
15.04.2020	Email from Mr Young to Urology	Re: Urology rota 20th April 2020	TL2 page 787 AOB-05244
21.04.2020	Email from Mr Young to Urology	Re: Urology rota 27th April 2020 *Changes made to rota on 24 April 2020*	TL2 page 805 AOB-05262

29.04.2020	Email from Ms Corrigan to Mr O'Brien	Re: Enclosing waiting list. Ms Corrigan advises that all consultants should start prioritisng the waiting list. **Ins and day waiting list as of 29 April 2020** Approx 266 patients with longest waiting from 2014. **Planned patients** Approx 67 patients with longest waiting from 2017	TL2 Page 813 – 869 AOB-05270 – AOB-05326
29.04.2020	Email from Mr O'Brien to Ms Corrigan	Re: Ins and day list waiting list *"I have always kept my waiting lists update in terms of clinical priority. I have done so, altering clinical priorities in response to representations and queries from patients, GP, etc. That exercise has been more scrutinous since the emergence of the pandemic. At present, I have patients being rescanned (two next Monday), awaiting the results of other investigations , awaiting optimisation of diabetic control etc.* *As a consequence, the next 6 patients whom I would choose today may be very different form the 6 whom I would choose next week.* *Concerns re:* 1. *Risk of being infected as a consequence of admission* 2. *Would it be betetr to ensure that the most recent meaures have been effective in minimising that risk, before loweing the threshold of clinical priority for elective admission* 3. *Should staff be tested whether or not symptomatic to additional ensure that admission wards are as covid free as will ever be humanely possible* 4. *Can the threshold be lower for one specility before others* *I am happy to be selecting patients for admission, but the above are my thought snad concerns in relation to doing so.*	TL2 page 870 – 871 AOB-05327 – AOB-05328
30.04.2020	Email from Ms Dignam to Mr O'Brien	Re: Patient query Patient requested results of scan she had done in November/December 2019. She remains on Mr O'Brien OPC waiting list and was due a review in Jan 2020 however due to backlog of appointmnets and now the current pandemix that this appointment hasn't yet been facilitated. Message left with Mr O'Brien re same.	TL2 page 884 AOB-05341
01.05.2020	Email from Mr Young to Urology	RE: Rota for 4th May 2020	TL2 Page 887 AOB-05344
05.05.2020	Email from Ms Haffey to Consultants	Re: enclosing M&M Backlog Mr Haynes – 2 Mr O'Brien – 2	TL2 page 889 – 890 AOB-05346 – AOB-05347
10.05.2020	Email from Mr Young to Mr O'Brien	Re: Rota for 18 – 24 May	TL2 page 895 – 897 AOB-05352 – AOB-05354

10.05.2020	Email from Mr Young to Mr O'Brien	Re: Rota for 11 – 17 May	TL2 page 898 – 900 AOB-05355 – AOB-05357
15.05.2020	Email from Ms Boyle to Mr O'Brien	Re: Ultrasound Mr O'Brien requested an US and was advised that no US procedures were being done in CAH presently.	TL2 page 928 AOB-05385
18.05.2020	Email from Mr Young to Consultants	RE: Rota for May 18 – 31	TL2 page 939 – 943 AOB-05396 – AOB-05400
22.05.2020	Email from Mr Glackin to Consultants	Requests for staff to cover lists from Monday 1st and Wednesday 3rd at Daisy Hill Hospital	TL2 page 960 AOB-05417
29.05.2020	Covid-19 Cancer Planning meeting	Re: Minutes 1. Notes of last meeting 2. Review of current red flag position by Tumour site *"Mr Haynes cannot anticipate any further increase in capacity for surgery at the minute due top demand, but has concerns regarding space and staffing moving forward.* 3. Update on CAPPs Enhancements 4. Update on Surgery Pathway (in-house & independent sector) 5. Planning for Surgical Surge 6. AOB **62 day referrals** 1. Breast (May 2020 – 234) 2. Brain/central tumour (May 2020 – 3) 3. Children's cancer (May 2020 – 0) 4. Gynae cancers (May 2020 – 90) 5. Haematological cancers (May 2020 – 16) 6. Head/Neck Cancer (May 2020 – 54) 7. Lung cancer (May 2020 – 17) 8. Lower Gastrointestinal Cancer (May 2020 – 178) 9. Acute Leukaemia (May 2020 – 0) 10. Other suspected cancer (May 2020 – 15) 11. Sarcomas (May 2020 – 1) 12. Skin cancers (May 2020 – 198) 13. Testicular cancers (May 2020 – 6) 14. Upper gastro cancer (May 2020 - 95) 15. Urological cancer (May 2020 – 87) **31 Day referrals** 1. Breast (May 2020 – 22) 2. Brain/Central tumour (May 2020 – 0) 3. Childrens Cancer (May 2020 – 0) 4. Gynae Cancers (May 2020 – 12) 5. Haematological Cancers (May 2020 – 5) 6. Head/Neck cancers (May 2020 – 8) 7. Lung Cancer (May 2020 – 15)	TL2 page 987 – 996 AOB-05444 – AOB - 05453

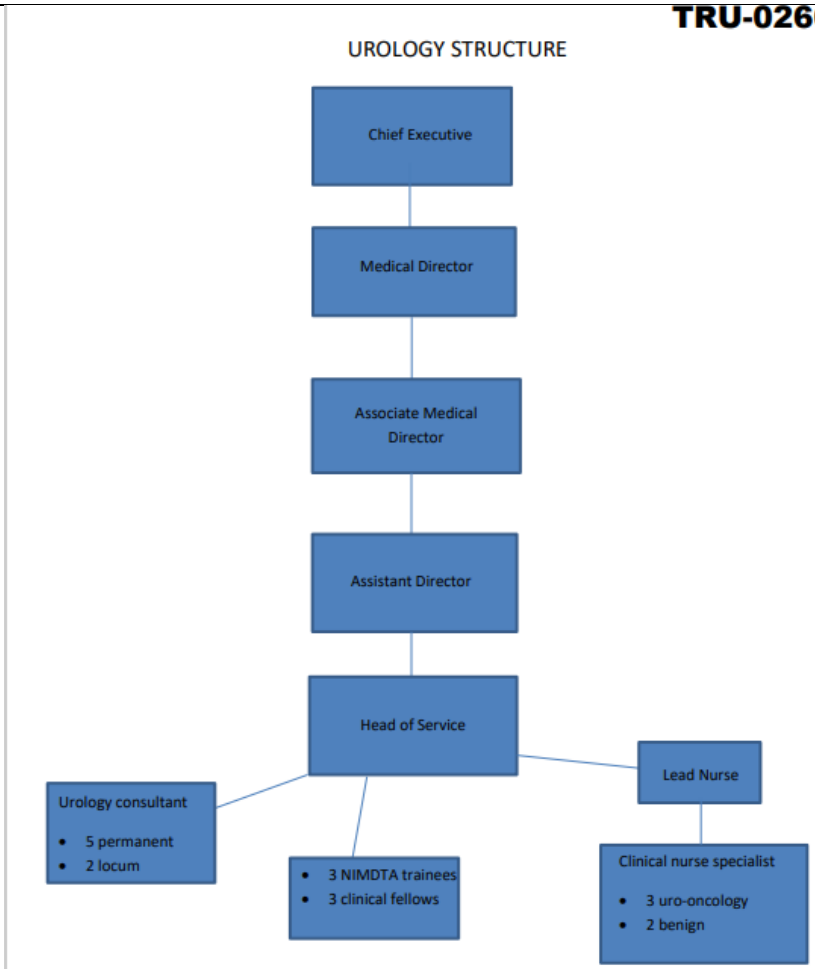
		8. Lower gast (May 2020 – 31) 9. Acute Leukaemia (May 2020 – 0) 10. Other suspected cancer (May 2020 – 1) 11. Sarcomas (May 2020 – 0) 12. Skin cancers (May 2020 – 0) 13. Testicular cancers (May 2020 – 1) 14. Upper gastro (May 2020 – 3) 15. Urological Cancer (May 2020 – 25) **PTL Report** 1. Breast – Awaiting triage: 6, Awaiting Appointment: 12 2. Dermatology – Awaiting Triage: 10, Awaiting appointment: 75 3. ENT – Awaiting triage: 9, Awaiting appointment: 4 4. Gynae – Awaiting triage: 20, Awaiting appointment: 10 5. Haematology- Awaiting triage: 9, Awaiting appointment: 21 6. Lung – Awaiting triage: 6, Awaiting appointment: 20 7. General surgery Lower GI – Awaiting triage: 36, Awaiting appointment: 33 8. General surgery Upper GI – Awaiting triage: 11, Awaiting appointment: 13 9. General surgery other – awaiting triage: 2, awaiting appointment: 5 10. Gastro lower – Awaiting triage: 4, Awaiting triage: 8 11. Gatro upper – Awaiting triage: 5, Awaiting appointment: 13 12. Gastro other – awaiting triage: 0 awaiting appointment: 0 13. Urology prostate – Awiating triage: 0, Awaiting appointment: 87 14. Urology haematuria – awaiting triage: 0, awaiting appointment: 149 15. Urology Testicular – awaiting triage: 0 awaiting appointment: 12 16. Urology other – awaiting triage:22 awaiting appointment: 14	
02.06.2020	Email from Mr Young to Consultants	Re: Rota 08 – 14 June	TL2 page 964 – 970 AOB-05421 – AOB-05427
03.06.2020	Email from Ms Elliot to Mr O'Brien	Re: Patient query Patient rang to query date for procedure. She has been on waiting list for Transposition for Urostomy since 30/4/17… would appreciate a date as soon as possible	TL2 page 971 AOB-05428
11.06.2020	Email from Ms Haffey to Consultants	Re: Outstanding Urolgy M&M cases Mr Haynes – 2 Mr O'Brien – 2	TL2 page 1030 – 1031 AOB-05487 – AOB-05488
17.06.2020	Email to Ms Boyd from Mr O'Brien	Re: cancelled surgery *"Richard apparently will be off that day and has deferred her admission to Thursday 02 July 2020."*	TL2 page 1048 – 1050 AOB-05505 – AOB-05507

Undated	Witness Statement of Shane Devlin	In addition to the Mr O'Brien challenge I was also aware of waiting list challenges in urology services. Given the consistent under-resourcing of elective care, Urology was one of many elective services with growing waiting lists. The key challenge for Urology was not necessarily a financial challenge but rather there were not the consultant staff available to meet the demand.	WIT-00097
30.06.2020	Email chain between Mr O'Brien and Ms Harrison	Re: Dowds SAR *" I know you are all up to your eyes.."* *"The governance people are growling"*	TL2 page 1082 – 1084 AOB-05539 – AOB-05541
01.07.2020	Email chain between Mr O'Brien and Ms Poland	Re: Secretarial support *"I appreciate this is not ideal but we are restricted in having to sort many different thinsg"*	TL2 page 1088 – 1089 AOB-05545 – AOB-05546
07.07.2020	Email from Ms Elliot to Mr O'Brien	RE: Flexible Cystoscopy waiting list as of 07 July 2020 Approx **83** Patients.	TL2 page 1092 – 1097 AOB-05549 – AOB-05554
08.07.2020	Email from Ms Elliot to Mr O'Brien	Re: Urology Total Waiting List Approx **242** patients (Longest waiting from August 2014)	TL2 page 1110 – 1134 AOB-05567 – AOB-05591
09.07.2020	Email from Ms Haffey to Consultants	Re : Urology M&M outstanding cases Mr Haynes – 3 Mr O'Brien – 3 Mr Young – 1	TL2 page 1135 – 1136 AOB-05592 – AOB-05593

17.07.2020	Letter to Mr O'Brien from Dr Lynn	You think that our organisation is being manipulated with misleading information, and that you have been victimised whenever you have raised concerns. You cited the extremely long waiting lists you had earlier highlighted (patients waiting 113 days for red flag referrals, urgent cases waiting 85 weeks and routine cases three and a half years). The greatest risk to patients you believe is due to these waiting lists, but Personal Information redacted by and you were very worried that you would suffer reputational damage even if you were subsequently to be vindicated. Both you and Personal Information redacted wanted to know why Advice did not discuss the matter with practitioners before writing back to Trusts. I explained that our advice is based on the information given to us – and that frequently practitioners and organisations have very different viewpoints. This is why we encourage openness and sharing of our letters and offer to speak in confidence to practitioners. We are not however able to arbitrate on disputed facts, and I advised that you take these matters forward with your representatives and legal advisers – I note you have access to comprehensive advice. They will also wish to raise your concerns about the timeliness of processes and take forward your allegations that you are suffering a detriment for being a whistle blower. I note you no longer have any confidence in Trust policies but I advised you to scrutinise the whistle blowing policy and take advice from your defence organisation/lawyers about what other options may be available to you.	Doc File 4 pages 394 – 395 AOB-02555 - AOB-02556
07.08.2020	Email from Ms Haffey to Consultants	Re: Urology Outstanding cases M&M Mr Haynes – 3 Mr O'Brien – 3 Mr Young – 2	TL2 page 1185 – 1186 AOB-05642 – AOB-05643
07.08.2020	Meeting with Mr O'Brien and Ms Shirley Young	Transcript File 25 Page 8 (Section B – Section C) *Michael O'Brien: That was just referencing 2016. In 2013 it was 70 sessions planned, 113 done. Similar in 2014, 1010 against 70 planned. And then 2015, 95.5 undertaken against 70 planned. That was a continual factor which does mean increased work if you are eating into tother time because there is a massive back log which is a significant patient safety concern..*	Transcript File 25 AOB-56564
07.08.2020	Meeting with Mr O'Brien and Ms Shirley Young	Transcript File 25 Page 8 (Section C – G) *Michael O'Brien: .. There is one other document that I am going to give to you if you want to consider it. That is these problems persisted for years and they persisted up to date and there was a collection of emails – dad didn't send these but they were provided to Mr Haynes to management in May 2018. It detailed the very serious—* *"I write to you to express serious patient safety concerns of the urology department regarding the current status of our in-patient theatre waiting list and the significant risk that has posed to patients"* *It is a long email but details the severity of waiting lists and how out of sync that is with other specialities and indeed references and individual case where there was a negative outcome as a consequence of that.*	Transcript File 25 AOB-56564
07.08.2020	Meeting with Mr O'Brien and	Trasncript File 25 Page 8 (Section H) – Page 9 (Section A) *Mr O'Brien: Yes. We had 596 pateints awaiting elective admission for urgent surgery, the longest waiting 208 weeks, exactly four years at that*	Transcript File 25

	Ms Shirley Young	*time. And down at the bottom you have 28 women awaiting admission for urgent gynaecological surgery, the longest waiting 11 weeks. Those figures could have been repeated any time since I came here in 1992.*	AOB-56564 - AOB-56565
17.08.2020	Letter to Mr Brammall (GMC) from Dr O'Kane	**Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management** The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress. The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.	Doc File 5 pages 67 – 70 AOB-02639 - AOB-02642
September 2020	CSCG Report to Governance	Notes: *" The Trust has a greater number of high severity problems which appears to suggest that complaints are mots often being made when something has gone very wrong for the complainant. Within the current COVID-19 pandemic the Trust finds itself balancing the stress and strain on staff, against the increasing demand and pressure for services to be "stood up" and delivered in an effective manner. This stress and strain may be evidenced through the current staff survey currently being undertaking by the Trust, which will assist with the identification of improvements and learning, as well as supports. Through this investment, it would be hoped to see a decreased in complaints made regarding communication towards service users. Additional staffing levels, which were already under pressure have been further affected by the current pandemic, which has required large numbers of staff to be redeployed or/ and self-isolate, having a further impact on service delivery"*	TRU-21627
14.09.2020	Email from Ms Haffey to Consultants	Re: Outstanding M&M Urology cases Mr Haynes – 2 Mr Young – 2 Mr O'Brien – 1	TL2 page 1199 – 1200 AOB-05656 – AOB-05657
15.09.2020	Email from Brian Duggan to Urology Department	Re Royal College Meeting … I've made both BAUS Council and the RCS Eng Council aware of the very long waiting times for Urology surgery in N.Ireland. There is a lot of sympathy for our plight but the college is limited in how it can affect resources in the NHS. It's main approach is to lobby the Department of Health. BAUS has written to Mr Pengelly (Stormont DOH permanent secretary) and a group of local College reps including myself had a meeting with Minister Swan. We raised the issue of long waiting times in urology and inadequate theatre capacity to deal with rising demand. We	SUP2 Page 141 AOB-04394

		got a sympathetic hearing but no promises of major change. There may be some progress in terms of elective day case facilities."	
15.09.2020	Email response to Brian Duggan from David Connolly	Re Royal College Meeting " I am not sure what we can change on the ground which will make much of a difference. The Trust are aware of the issues which urology in Belfast are having. Certainly in Belfast, a lot of things are till being held on pause given the potential for a second surge. BCH Tower remains on standby as the Nightingale hospital. In hindsight, it was not a good decision to place the Nightingale in the major cancer/elective surgery centre in Belfast which has many regional services. BCH is still running well below previous capacity. The BCH urology ward and our day care unit remain closed. All our emergencies are now being done in RVH where we do not have access to laser hence no primary ureteroscopy service. There is no ESWL. We are trying to keeping our Day case sessions going in DPU but these are at decreased capacity. There are no longer any DPU nurses as they have been redeployed so we are using our Daycare staff to run flexi lists/TP biopsy lists (at the expense of daycare work including BCG/urodynamics) Our biggest issue is access to operating lists. Prior to COVID, we had 22 operating lists per week (including our DPU/Daycase lists in Mater/Antrim). Most weeks now, we have 10 in-pt operating lists in BCH tower and 1 or 2 in UIC. Between Mar – June, we were doing 6 lists per week in UIC which was keeping on top of urgent stones/small TCCS. These patients now have to be done in inpt BCH tower lists….	SUP2 Pg 143 – 144 AOB-04396 - AOB-04397
16.09.2020	Email response to Brian Duggan from Siobhan Woolsley	Re Royal College Meeting Another issue that could be raised is the increasing number of MLA/DOH and even the health minister enquiries re why certain patients have not had their surgery performed…. I find it frustrating when we are only allowed to do priority cases and even at that there aren't enough lists to do the urgent cases. We weren't exactly in a good situation with waiting times in Urology prior to covid so it is hardly surprising that our waiting times are even longer.	SUP2 Page 146 AOB-04399
16.09.2020	Response from Brian Duggan to issues	Re Royal College Meeting I agree that urology was in a poor situation before covid and has now deteriorated.	SUP2 150 AOB-04403
07.10.2020	Email from Brian Duggan to Urology	Re Ministerial Meeting I made clear to the minister the excessive waiting times for inpatient urology surgery precovid and highlighted patients with catheters in situ waiting 6 years for TURP. We emphasised the need to expand theatre capacity for urology. Constraints such as shortage of theatre nurses were highlighted. Suggested 1. Ring fencing of beds 2. Theatre expansion on some or all of our current 4 inpatient sites 3. Covid free/light elective inpatient centres	SUP2 Pag 162 – 163 AOB-04415 - AOB-04416

		4. Reprofiling an existing acute site and making it a covid light inpatient elective care centre	
24.11.2020	Oral Statement to the Assembly by Health Minister	Some statistics in the Ministerial Statement of 24 November 2020 which may be relevant to resourcing issues. These include:- 1. Between 1 January 2019 and 30 June 2020 there was a total of 2,327 patients under AOB's care. 2. Operated on 352 elective patients. 3. 271 patients under the Consultant's care whose cases were discussed at MDT.	Doc File 5 pages 401 – 407 AOB-02973 - AOB-02979
01.12.2020	Urology Structure	TRU-02664  	TRU-02664
February 2021	CSCG Report to Governance Committee	Notes *"A high number of complaints with multiple problems indicates that the complaints reported are more complex and systemic issues are prevalent. In October – December 2020 data 81.1.% of problems were systemic which given current waiting times and access to services being limited is to be expected in the current circumstances…"*	TRU-21677
May 2021	Policy	Re: Protocol for CT Downtime SHSCT	TRU-14499 –

<table>
<tr><td></td><td></td><td></td><td>TRU-14505</td></tr>
<tr><td>14.10.2021</td><td>Letter from Shane Devlin to other Trusts</td><td>“I appreciate that demand for urology services in NI is already greater than the capacity we have but I am eager that we look at the resource on a regional basis to ensure that new patients can be seen in a timely manner whilst continuing to identify potential harm through the look back exercise.”</td><td>WIT-04202</td></tr>
<tr><td>19.10.2021</td><td>Overview of Cancer Services – Regional and Local to Southern Trust</td><td>“The SHSCT was established on 1 April 2007 under the Review of Public Administration and is one of 5 Health and Social Care Trusts across the region. It is an integrated Truts, providing acute and community hospital services together with a range of community health and social services to a population of approximately 360,000 people.”

The table below demonstrates the volume of confirmed cancers by diagnosis year on the 62 day pathway.

<table><tr><th>Calendar Year</th><th>Total Number of Confirmed Cancers by Diagnosis year</th></tr><tr><td>2015</td><td>785</td></tr><tr><td>2016</td><td>892</td></tr><tr><td>2017</td><td>999</td></tr><tr><td>2018</td><td>947</td></tr><tr><td>2019</td><td>1140</td></tr><tr><td>2020</td><td>975</td></tr><tr><td></td><td></td></tr></table></td><td>TRU-02655 – TRU-02660</td></tr>
<tr><td>28.10.2021</td><td>Email from Medical Directors</td><td>RE: Expression of interest for Interim Divisional Medical Director within Surgery and Elective care.</td><td>TL2 page 1218

AOB-05675</td></tr>
<tr><td>02.11.2021</td><td>Email from Medical Directors</td><td>Re: Expression of interest for Divisional Medical Director within cancer and clinical services</td><td>TL2 page 1220 – 1221

AOB-05677 - AOB-05678</td></tr>
<tr><td>Undated</td><td>Witness Statement of Shane Devlin</td><td>Demand grew at a faster rate than resources. It is clear that the required activity volumes could not be achieved with the resources that were available to the team. This was a composite of two factors. First, the overall amount of money available from the commissioner was not enough for elective care to meet the demands. This factor has been recognised throughout the HSC and major investment is required. The second factor is that there are not enough Urologists in Northern Ireland to meet the demand, even if money was made available.</td><td>WIT-00100</td></tr>
</table>

CHRONOLOGY
APPRAISAL - CV

MR AIDAN O'BRIEN
3911.100
MPS REF: AP1/LEA/646528/N

Date	Document Name	Comments	Document No.
May 1992	Mr O'Brien's CV		SUPAUG
01.02.2006	Email from Sharon Maxwell to Consultants	Re Appraisal Email requiring consultants to contact to arrange a suitable date for their appraisal with Mr Stirling.	TL1 Page 169 AOB-82210
16.08.2006	Statement of Main Terms and Conditions of Employment, Consultant Appointment	This contract imposes obligation to conduct appraisal in accordance with circulars HSS(TC8) 8/01 and HSS (TC8) 11/01.	Doc File 1 Pages 48 – 58 AOB-00048 – AOB-00058
2010	Form 1 – Background Details	CV information including QB Belfast December 1978. First registered on 27 February 1980. Consultant at Craigavon since 6 July 1992. Fellowships include:- Fellow of Royal College of Surgeons in Ireland – awarded 1983. Fellow of Ulster Medical Society – 1984 Fellow of Royal Academy of Medicine in Ireland – 1986 Fellow of Irish Society of Urology – 1992 Member of Bristol Urological Institute – 1992 Director of CURE – 1995	2010 appraisal pages 8 – 11 AOB-22010 – AOB-22014
23.11.2012	Letter from Dr Simpson to Mr O'Brien	Re: Appraisal Dr Simpson has not received Mr O'Brien's 2011 appraisal.	TL3 page 577 – 578 AOB-

			06255 – AOB-06256
2012/13	2012/13 Appraisal	In 2012/13 Appraisal AOB expands additional information in relation to his CV as follows:- "*….during 2012 and 2013, I have been* • *External Adviser to Royal College of Surgeons in Ireland in Specialist Registrar appointments in Republic of Ireland during 2012 and 2013* • *Chair of Urological Cancer MDT of Southern Health and Social Care Trust since 01 April 2012* • *Lead Clinician and Chair of Northern Ireland Cancer Network (NICaN) Urology Site Specific Group since 01January 2013*	2012/13 Appraisal Page 2 AOB-22321
2012/13	2012/13 Appraisal	2012/13 Appraisal confirms by this stage AOB was on a 1 in 4 on-call rotation.	2012/13 Appraisal Page 3 AOB-22322
01.07.2013	Memo from Mr Simpson to Clinicians	Re: stressing importance of attendance at M&M meetings	SUPAUG page
2014	2014 Appraisal	2014 Appraisal *"In addition to continuing to maintain my knowledge and skill base, and maintaining performance in qualitative and quantitative terms, the main focus of my efforts during 2015 will be to lead the Urological Cancer MDT of the Southern Health and Social Care Trust successfully through Peer Review scheduled for June 2015."*	2014 Appraisal page 17 AOB-22560
09.01.2014	Email from Ms Somerville to Mr O'Brien	Re: R & S training Mr O'Brien has not updated this training since 2007 and no record of completed e-refresher	SUPAUG Page
13.01.2014	Email from Medical Revalidation	Noting that Mr O'Brien's last appraisal was 2011 year.	TL5 (2014) page 14 – 17 AOB-70176 – AOB-70177
15.04.2014	Email from Mr Young to Mr O'Brien	Enclosing Patient Feedback form	TL5 page 516 – 528 AOB-70678 – AOB-70690
21.01.2014	Email from Mr O'Brien to Medical	Mr O'Brien requests to attend Appraisal Awareness session	TL5 page 102

	Revalidation		AOB-70264
January 2015 to December 2015	HSCNI Career Grade Medical Staff Appraisal Documentation	2015 Appraisal ***"Discussion*** *In addition to the above, I commissioned the Draft Clinical Management Guidelines for Urological Cancer in Northern Ireland, first submitted in March 2015 (enclosed), proposed and had agreed amendments to the Guidelines (enclosed). I commissioned and amended 'Urological Nursing in the Management of Urological Cancer' for inclusion in the Draft Guidelines for Peer Review in Northern Ireland (enclosed). I revised and had agreed the Urology Care Pathways for Northern Ireland, and designed the Hormone Treatment Only Pathway for Prostate Cancer Patients in Northern Ireland (enclosed), and amended the Regional Hormone Therapy Guideline to accommodate its inclusion (enclosed)."*	2015 Appraisal page 65 AOB-22716
30.11.2015	Email from Dr Wright to Mr O'Brien	"Dear Mr O'Brien, despite constant reminders as per the emails below, you have still not submitted appraisal documentation for the period January to December 2014 nor have you advised the Revalidation Team when you are planning to hold your appraisal meeting. As you are aware, the requirement to undertake an annual appraisal is a contractual one and it is also your professional responsibility to participate in the Trust Medical Appraisal Scheme.	SUPAUG
07.02.2017	Meeting with Mr Wilkinson & Mr O'Brien	Page 28 (Section C – H) – Page 29 (Section A – H) " Michael O'Brien: This will be something that we will put in the presentation if we have to go down that road eventually. When there was a job planning done in 2011, which is when the job planning was reduced from 15 sessions to 12, isn't that right. Dad had completed an issues – a commentary on the new job plan and raised a number of concerns, focusing entirely on the amount of time devoted to administrative work, saying I don't have enough time to o all of my administration. We can give you that at any tine. He was saying I have to triaging. I have to do this and I have to do that and I don't have enough time. That's 2011. There are a number of comments along the road where people have been unable to complete triaging. There was a meeting we found in March 2015 . Mr O'Brien: I convened a meeting actually because I was lead clinician of the cancer services. We just wanted to clarify exactly what kind of triaging we would do of the red flag referrals and – some of us were doing ticking a box. You know, yes, it stays red flag. Others were doing what is called advanced triage, including myself, which means you look at it and you say to yourself, now, this person needs a CT scan and then a flexible cystoscopy, or whatever. So I will ring the person up, some other would write to the person, and say – and organise a CT scan and then feed back to the office of cancer services. You know, this person will have a CT scan done next week, arrange an appointment he following week. … It's quite thorough. It's called advanced triaged, which other	Transcript FILE 4 AOB-56101 – AOB-56102

		specialities don't do. But I have the minutes of that meeting here, where I couldn't get the agreement of my colleagues to do that because (a) it was too time consuming and there simply was not enough time to do when you are urologist of the week. … However, you get about four times the number of non-red flag referrals and all of a sudden the reason why Personal Informati and the patient in the SAI waited 64 weeks to be seen for a routine referral, which I would have kept routine, is because I didn't do advanced triage and look into it and discover at that time that the radiologist had messed up the reporting. .. Michael O'Brien: And, for example, in his most recent appraisal it included that "*I only triage the red flag referrals".* Its there.	
09.03.2019	Email from Mr Scullion to Mr O'Brien	RE: Colleague Feedback Questionnaire Someone scored Mr O'Brien as "completely disagree" for patient confidentiality, trustworthiness, and ill health. Mr Scullion advise that all other comments were very supportive and commendable and that this is a case of misinterpretation and should be ignored	TL4 page 660 AOB-07937
11.11.2019	Email correspondence between The Medical Revalidation, Mr O'Brien, Dr O'Kane and Ms Shields	Email from Medical Revalidation to AOB indicating that the RO had decided to make a deferment recommendation to the GMC on the basis that there was incomplete information on which to base a recommendation to revalidate and ongoing local governance process, which is material to the Doctor's fitness to practise.	Doc File 4 Pages 105-107 AOB-02266 – AOB-02268

CHRONOLOGY
CONTRACT/JOB DESCRIPTION/JOB PLAN

MR AIDAN O'BRIEN
3911.100
MPS REF: AP1/LEA/646528/N

Date	Document Name	Comments	Document No.
Jan 1992	Southern Health and Social Services Board, Job Description, Consultant Urologist dated January 1992	This demonstrates the post as being made to establish a urology service at Craigavon Area Hospital. Aim was to "*Develop full range of urological service.* *To interface with BCH.* *Population to be served 286,000 patients in the Trust.* *Postholder to have access to 20 beds plus 3 operating sessions.* *To develop job plan consistent with establishing the service."*	Doc File 1 Pages 1 – 6 AOB-00001 - AOB-00006
29.06.1992	Letter of Appointment of Consultant	Points to note include:- Allows limited amount of private patient work including facilities being used at the service.	Doc File 1 Pages 7 – 10 AOB-00007

<table>
<tr><td></td><td></td><td></td><td>- AOB-00010</td></tr>
<tr><td>07.03.1996</td><td>Letter to Ms Helen Walker, Human Resources, Craigavon Area Hospital from Mr O'Brien</td><td>Page 4 states at that time Mr O'Brien notes that he had:-

1. Six operating sessions
2. Two OPD sessions
3. One/two cystoscopy sessions
4. Two urodynamic sessions

All without taking into account administration time and developing academic urology but not remunerated for that.</td><td>Doc File 1 Pages 18 – 22

AOB-00018 - AOB-00022</td></tr>
<tr><td>1997</td><td>Michael Young: Consultant Urologist Job Description</td><td>Notes:

Staffing in Urology: 2 consultants
1 specialist Registrar
1 Research/Clinical Fellow
1 Senior House Officer
1 Junior House Officer

Duties:
1. Clinical responsibilities: The appointee will share with his/her colleague the urological management of all patients within the Craigavon Area Hospital Group Trust. He/She will be expected to participate in a 1:2 on call rota.
2. Administration and Audit duties
3. Teaching input: The appointee will share in the training of junior medical and nursing staff, and in the teaching of medical and nursing students
4. Research Activities: The appointee will share in and promote urological research
5. Weekly Job Programme:

<table><tr><th></th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr><tr><td>A.M.</td><td></td><td>Theatre</td><td></td><td></td><td></td></tr><tr><td>P.M.</td><td>ESWL</td><td>Theatre</td><td>Admin.</td><td>Outreach Clinic</td><td>Outpatients</td></tr></table></td><td>TRU-101601 – TRU-101607</td></tr>
<tr><td>13.08.2004</td><td>Consultant on call of the week</td><td>1. There will be a Consultant on call, on a weekly basis who will provide emergency cover from 9am to 5pm on a daily basis. The rota fo the consultant on call of the week, will run from Friday to Friday with a changeover on a Friday 9am,
2. When a changeover occurs on a Friday, all "emergency" patients under the previous consultant of the week will be passed to the new consultant of the week (Exception – patients admitted to or transferred to another consultant with a Special Interest)
3. Night-time cover will be provided on an on-call basis from 5pm to 9am by the other remaining consultant surgeons on the rota. Any consultant surgeon undertaking emergency surgical care of a patient between 5pm and 9am will automatically pass that patient to the Consultant on call of the week, the following day (exception – patients admitted to or transferred to another consultant with a special interest)
4. Patients who are discharged and require outpatient follow up will be seen at the clinic of the consultant who "discharges" them and not the consultant under wgise care they were admitted.
5. The consultant on call of the week will undertake no other clinical duties (elective theatre lists and outpatient clinics) during this time.</td><td>TL1 Page 65 – 68

AOB-82106 - AOB-82109</td></tr>
<tr><td>10.07.2006</td><td>Letter to Mr O'Brien from Dr Orr</td><td>Given 5.5 PAs in recognition of additional workload "over and above the 10 Programmed Activities that constitute your standard contractual duties." Ex gratia payment of Personal made in recognition of extra contribution in the period of 1998 until new contract.</td><td>Doc File 1 Pages 39 – 40</td></tr>
</table>

			AOB-00039 - AOB-00040
10.08.2006	Letter to Mr O'Brien from Ms Richardson with enclosure	At that stage the Job Plan 10.5 PAs in recognition of additions. On-call 1 in 2	Doc File 1 Pages 45 – 46 AOB-00045 - AOB-00046
16.08.2006	Statement of Main Terms and Conditions of Employment, Consultant Appointment	Paragraph 6 refers to Job Plan Paragraph 7.3 notes Job Plan typically includes 7½ PAs for Direct Clinical Care and 2½ for Supporting Professional Activities. Where additional SPA activity is greater or lower than 2½ PAs "*local agreement to the appropriate balance between activities."* Paragraph 7.4 refers to provision in relation to external duties and the need to agree that with the Clinical Manager in advance. Paragraph 7.6 notes that additional PAs can be agreed "*up to the maximum permitted under the Working Time Regulations"*	Doc File 1 Pages 48 – 58 AOB-00048 - AOB-00058
23.10.2006	Letter to "Colleague" from Mr Stirling	Enclosing Job Plan. Refers to the following:- 8 PAs Direct Clinical Care 1.25 SPA 0.25 Annualised SPA On-call 1.57	Doc File 1 Pages 59 - 62 AOB-00059 - AOB-00062
Oct 2006 – Dec 2006	Mr O'Brien's Diary Entries in relation to "a day at work" dated 30 – 31 October 2006 Mr O'Brien's Diary Entries in relation to "a day at work" dated November 2006 Mr O'Brien's Diary Entries in relation to "a day at work" dated December 2006	Various diary entries by Mr O'Brien	Doc File 1 Pages 63 – 82 AOB-00063 - AOB-00082
01.04.2007 – 31.03.2008	Mr O'Brien's Consultant Job Plan Review Template dated 01 April 2007 to 31 March 2008	Provides for 11.5 PAs. Direct Clinical Care 8.38 SPAs 1.38 Annualised SPA 0.25 Total PAs 11.5 Job Plan does not appear to be signed or approved.	Doc File 1 Pages 83 – 87 AOB-00083 - AOB-00087
2007/2008	Clinical Excellence Award Application	Details Mr O'Brien's CV and extra curricular activities.	SUP 7 – 9 AOB-03504

Sept 2007	2010 Appraisal - Job Plan Schedule for 2007	**JOB PLAN SCHEDULE** **AIDAN O'BRIEN** **September 2007** **MONDAY** 9.00 am: Ward Rounds Appointments with patients' relatives Administration 11.30 am: Multidisciplinary ward meeting 2.00 pm: Histopathology meeting 3.00 pm: Histology reviews Administration 6.00 pm onwards: Administration of urodynamic studies Organisation of inpatient admissions (FIRST, SECOND AND FIFTH MONDAYS) 9.00 am: Urodynamic study 10.30 am: Urodynamic study 12.00 md: Mictiometry, scanning, other procedure 1.00 pm: Urodynamic study 3.00 pm: Urodynamic study 4.00 pm: Change of catheter, other procedure **TUESDAY** 9.00 am: Operating session, Day Surgical Unit 2.00 pm: Outpatient clinic, Craigavon Area Hospital 6.00 pm onwards: Dictation and administration of clinic Organisation of Day Surgical Admissions **WEDNESDAY** 9.00 am – 5.30 pm: Inpatient operating, Craigavon Area Hospital 5.30 pm: Postoperative round 6.30 pm onwards: Organisation of admissions for flexible cystoscopies Other administration **THURSDAY** 8.30 am: Radiology meeting 10.00 am: Grand ward round 12.30 pm: Implementation group meeting 2.00 pm: Outreach Clinics (First, Second and Fifth Thursdays) Review of Newly Diagnosed Prostate Cancer Patients after Staging (Third and Fourth Thursdays) 6.00 pm: Administration TRIAGE OF REFERRAL LETTERS **FRIDAY** 9.00 am: Ward Rounds Postgraduate Teaching Rita Assessments Research Review Or Public patient consultations / review 1.00 pm: Appointment with Medical Representative 2.00 pm: Private patient consultation 3.00 pm: Private patient consultation 4.00 pm: Private patient consultation **SATURDAY** 11.00 am onwards: Inpatient management Administration **SUNDAY** Emergencies only	2010 Appraisal Pages 15-17 AOB-22016 – AOB-22018
Oct 2007	Letter to Mr O'Brien from Mr Mackle (undated), received on 15 October 2007	Job Plan not agreed – for facilitation.	Doc File 1 Pages 88 – 91 AOB-00088

			- AOB-00091
04.12.2007	Letter to Mr O'Brien from Dr Hall	Trust offer of 11.5 PAs.	Doc File 1 Page 99 AOB-00099
12.12.2007	Letter to Dr Hall from Mr O'Brien	Mr O'Brien explains in detail his position in relation to the Trust's Job Plan. Notes how it is *"minimalist and incomplete. It is neither a complete or true portrayal of my work load".* Requests facilitation noting that did not occur in 2006.	Doc File 1 Pages 100 - 101 AOB-00100 - AOB-00101
16.04.2008	Letter to Mr O'Brien from Dr Loughran	Letter to Mr O'Brien advising of a reduction in his PAs, backdated, following Mr Akhtar's appointment and reduction in AOB's on-call commitments.	Doc File 1 Pages 117 – 118 AOB-00117 - AOB-00118
March 2009	Review of Adult Urology Services in Northern Ireland: A Modernization and Investment Plan	Page 39 *"SAC have confirmed that they are content, at this time, with the Consultant to population ratio proposals within this review i.e. 1:80,000"* *"A Consultant working alone should see between 1176 and 1680 (outpatients) per annum"* *"It is accepted to allow approximately 20 minutes for a new patient consultation and 10 minutes for a follow up consultation. Therefore a consultant working on his own should see 7 new patients and 7 follow up patients"* Page 42 *"The average consultant and his teal should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum"*	TL1 Page 358 AOB-82397
12.04.2009	Letter to Mr O'Brien from Dr Loughran	AOB awarded Local Clinical Excellence Award.	Doc File 1 Page 121 AOB-00121
2010	2010 Appraisal	In appraisal of 2010 Mr O'Brien notes how he was on 1 in 3 rota. Also notes that he was carrying out outreach clinics in Banbridge and Armagh on first, second and fifth Mondays of each month.	2010 Appraisal page 13 AOB – 22014

2010	2010 Appraisal - Current Job Plan/ Work Programme	**Current Job Plan / Work Programme** **Monday** **Am:** Outreach general urology clinic in Banbridge / Armagh (twice monthly) Ward rounds and administration (twice monthly) **Pm:** Ward attenders / Ward rounds / administration Management meeting at 5 pm **Tuesday** **Am:** Day Surgery (twice monthly) **Pm:** General urology outpatient clinic **Wednesday** **Am:** Inpatient operating **Pm:** Inpatient operating **Thursday** **Am:** Uroradiology meeting at 8.30 am Grand ward round at 10.00 am Departmental meeting at 12.00 noon. **Pm:** MDM Urological oncology **Friday** **Am:** Urodynamic studies all day **Pm:** Oncology outpatient reviews all day	2010 Appraisal page 18 AOB-22019
24.05.2010	Action note from project meeting	Re: Implementation Plan Beth Malloy has sent draft guidance for the implementation plan to Sandra Waddell for comment. It includes a section for each of the Regional Review's recommendations and requests a significant level of detail including: 1. Daily triage of "red flag" referrals 2. Current levels of pre-op assessment, admission on the day of surgery, day surgery rates by consultant and cancelled operations , along with actions to improve these 3. Existing job plans for all clinical staff and the new consultant team job plans	TL1 Page 420 – 422 AOB-82459 - AOB-82461
25.05.2010	Email from Heather Trouton to Consultants	Re Job Template for Clinicians Request for clinicians to fill out form as part of an implementation plan for the Urology Service Review. Mr Akhtar responded to point out that "*my job plan is not on am pm sessions it is new hourly count like Friday I am in DC from 8am to 6pm it does not count the 4 hour session.*"	TL1 Page 415 – 417 AOB-82454 - AOB-82456
29.09.2010	Email from Ms O'Reilly to Ms Sloan and Consultants	Response To Theatre Start Times This issue as you say has been raised before. Surely, we need to clarify the start and finish times of each consultant's session that appears on their job plan before we can decide what the actual surgical start time and finish time should be. .. It also has to be accepted that the start of a surgeon's session as defined by	TL1 Page 520 AOB-82559

		the job plan will not be the same the actual start time or the surgery. .. Without knowing and understanding these factors any auditing of theatre utilization seems to be rather meaningless.	
30.09.2010	Email from Mr Lewis in response to Ms Sloan email re Theatre start times	RE: Theatre start times An all day theatre session in CAH is 8 hours. Are the trust proposing addressing job plans to permit such a full day surgical list. Pre and post op visits typically add an hour to the day. Also, the surgeon needs to in theatre before anaesthesia commences. 8 hours of operating is therefore significantly more than two sessions of work.	TL1 Page 523 AOB-82562
07.10.2010	Email from Mr Lewis to Ms Sloan and Consultants	Re: Theatre Start Times Firstly can I say I would be delighted to enjoy the luxury of 8 (or even 9) hours operating time on my CAH all day list and 3.5 hours in day surgery…. However, if the intention of this exercise is achieve this then it will impact on job plans. … The issue of the surgeons presence during anaesthetic time has also largely been ignored.	TL1 Page 541 – 542 AOB-82580 - AOB-82581
22.10.2010	Email from Martina Corrigan to Consultants	Re Draft Job plans 3 consultant model job plans provided as well as 5 consultant model job plans provided Refers to meeting to discuss this on 25 October 2010	TL1 page 551 – 554 AOB-82590 - AOB-82593
22.10.2010	Email from Mr Akhtar to Martina Corrigan	Re: Draft Job Plans I think a proper meeting with time set aside with no other business to discuss this document. We cannot tell the issues on the email – serious issues for me are 1. Monday OPD 2. SPA 3. MDT 4. Friday OT times	TL1 Page 555 AOB-82594
30.11.2010	Email from Martina Corrigan to Mr O'Brien	Re Infrastructure Template for assessing capacity Objectives: 1. To create a clinical profile for each specialty within each Trust which will define current demand, the case mix by HRG, projected changes 2. To define achievable performance based on an agreed peer group and referenced UK best practice including optimum models of care 3. To evaluate the current clinical & service infrastructure and to model the capacity which can be delivered at upper quartile performance levels based on UK best practice 4. Using robust benchmarking & comparative analysis demonstrate any specialties/services which have capacity excesses/shortfalls … Can You please look at each of your clinical areas and see if you agree with the Pas that I have put in – I have deducted travel time as per discussions because we have to show true clinical time to that when the exercise is completed we are showing a true reflection of clinical time. **Weekly Outpatient Pas – 1.0625** **Weekly PA/Session for Day cases – 0.78125** **Weekly In patient Theatre PA – 2** **PA for On-call – 1.5**	TL1 page 587 – 593 AOB-82626 - AOB-82632

		Other PA – 0.5	
2011	2011 Appraisal	Commitments in 2011 are in line with the description outlined above in relation to 2010 in terms of number of consultants, outlying clinics, 1 in 3 rota etc. In this appraisal it is included under Details of any other clinical work "*Triage of letters of referral. Addressing concerns and queries regarding patients."*	2011 Appraisal page 6 AOB-22227
2011	Proposed Urology Job plan – 5 Consultant Model		TL3 page 27 AOB-05705
07.03.2011	Email from Mr Mackle to Consultants	Re: Urology Job plans Almost 5 months since attached proposed job plan to facilitate the new 5 man model. Requesting any changes to proposed job plans. A decision will not be made regarding sign off on the new posts if they are not agreed in which case we are expected to proceed with the 3 man job plan model.	TL3 page 26 AOB-05704
01.04.2011	Mr O'Brien's Job Plan	Total Pas: 12.544 Total Hours: 50.10 **Direct Clinical Care** 11.094 44:22 Admin other (please specify) 2.077 8:19 Day surgery 0.509 2:02 Grand Round 0.250 1:00 Other ward rounds 0.375 1:30 Outpatients 2.800 11:12 Planned in-patient operating sessions 2.000 8:00 Post-op ward round 0.250 1:00 Pre-op ward round 0.125 0:30 Predictable Emergency Work 0.000 0:00 Surgery MDT 0.688 2:45 Travelling time between hospitals 0.200 0:48 Unpredictable Emergency Work 1.570 6:16 Uroradiology meeting 0.250 1:00 **Supporting Professional Activities** 1.450 5:48 Other (please specify) 1.450 5:48 **Additional NHS Responsibilities** 0.000 0:00	TRU-102227 – TRU-102234
01.07.2011	Memorandum between Mr O'Brien and Ms Trouton	Refers to meeting on 9 June. First they need to complete Job Plan. Noted that AOB was to submit current breakdown of activities to Mr Mackle for Job Plan update. Noted that was submitted on 16 June 2011 and draft Job Plan was to be constructed for discussion.	Doc File 1 Pages 255 – 256 AOB-00255 - AOB-00256
01.07.2011 – 01.07.2012	Mr O'Brien's Consultant Job Plan Review Template dated 01 July 2011 to 01 July 2012	Direct Patient Care 8.18 PAs Supporting Professional Activities 1.5 PAs On-Call Allocation 1.57 PAs Total PAs 11.25 Rota on-call 1 in 3	Doc File 1 Pages 257 – 261 AOB-00257 - AOB-00261
01.07.2011	Mr O'Brien's comments relating to the Draft Job Plan Proposals of 01 July 2011 [undated]	Mr O'Brien's comments relating to draft Job Plan proposals. AOB contends 8.18 PAs for direct patient care inappropriate, inadequate and unsafe. AOB requests under the new Consultant Contract allocation of 2.5 PAs for SPAs which he has looked "*for years"* to enable audit and audit generated research. Notes issues until the "*Five Consultant Model has been established"*.	Doc File 1 Pages 262 – 265 AOB-00262 - AOB-00265

		Notes almost complete lack of time allocated for in-patient management from Thursday to the next Grand Board Round. Notes 2.5 hours per week "*for all the administration involved in effective execution of my job is wholly inadequate and reflects how detached Job Plans have in realities of our jobs."* Particular comments given on a day-by-day basis.	
14.07.2011	Email correspondence between Mr O'Brien, Mr Mackle and others	Mr O'Brien: "Dear Martina, I only became aware of the Draft Job Plan Proposal of 01/07/2011 late on Sunday 03/07/2011 when Mehmood contacted me by telephone to advise that he was ill, and was unable to return to work on Monday 04/07/2011. You may be aware that Michael has responded on our behalves to advise that we simply did not have the time or opportunity to consider or discuss the proposals, due to Mehmood's absence, having to cover for him and with only one registrar. In my case, this was further compounded by the acute admission to hospital of my mother-in-law. All of this made submission of comments by 08/07/2011 impossible. We three have planned to meet to discuss the proposals on 11/07/2011. I will be on annual leave next week, and will have time to submit comments by Friday 15/07/2011 at latest" Mr Mackle: ".. The job plans are individual and not team based so a response doesn't require a joint reply. I am happy to meet you Friday before your holidays" ..	SUP 53 – 56 AOB-03550 - AOB-03553
22.07.2011	Email correspondence between Mr Mackle, Ms Corrigan and Mr O'Brien	General discussion in relation to Job Plan. Reference to one more "*substantive issue, which is the totality of Administrative time, which currently stands at 4.25 hours."* Indicates there is *"no doubt that such an allocation is inadequate."* AOB puts forward that two PAs are required to be allocated to administration rather than one. Even with that he considers that he would be doing unremunerated work.	Doc File 1 Pages 273 – 276 AOB-00273 - AOB-00276
22.07.2011	Email correspondence between Mr O'Brien and Mr Mackle	Few issues to be clarified or resolved: 1. Going to Banbridge on fifth Monday of month. Confused as to how one calculates recognition of that, both with regard to travelling time and clinic time. Not been allocated any travelling or clinic time in the proposal. Is it difficult to do so for fifth "anything" in the month? Would it be better or easier not to do clinic on Fifth Monday? 2. Thorndale on Tuesdays between day surgery and outpatient clinic. Impractical to do Ward Round between 1pm and 1.30pm. It would be good to have that half hour bult into every Tuesday and to have instead of half hour for ward round from 5.30 to 6.00, which enables to visit and consent patients 3. To have inpatient theatre session extended to 5.30 on Wednesday followed by allocation of one hour for ward round 4. Three have accepted the split between DCC and SPA on Thursday mornings, but strongly believe that "grand" should be restored to "ward round". 5. Prefer to have admin and ward round on Friday switched around so admin done from 1 – 2. 6. The totality of admin time which stands at 4.25 hours. No doubt that such an allocation is inadequate. Impossible to do proposed work with one PA allocated to admin.	SUP 73 – 74 AOB-03570 - AOB-03571
24.08.2011	Email correspondence between Mr O'Brien and Mr Mackle	Eamon, I do not accept the revised Job Plan proposal of 10 August 2011 for following reasons: • I find it unacceptable the proposal to travel to Banbridge on the morning of the fifth Monday of the month, to conduct a clinic, lasting four hours, without credit in a Job Plan. If it cannot be	SUP 80 – 84 AOB-03577 - AOB-03581

		accredited, I would prefer that it would not be included in a Job Plan. • I believe that it was both important and reasonable to have time allocated to addressing patient management issues arising in Thorndale Unit. Last Friday, I spent one hour doing so. That included contacting the GP of a patient whose serum PSA had increased from 8 ng/ml to 803 ng/ml in less that one year. I had proposed the inclusion of a nominal time allocation of 30 minutes per week (on Tuesdays 1.00 to 1.30 pm). I believe that Urology ICATS cannot function safely without consultant urologists providing advisory input, and I believe time allocated to that function should be included in Job Plans. • I believe that it remains a necessity to allocate time to conduct a ward round on Tuesday evening. Irrespective of practices in other specialties, I would anticipate that we will continue to have some patients undergoing surgery, and who will not have been admitted electively on the day of surgery. In any case, all patients admitted electively will have given prior consent. Even if that prior consent is in written form, I believe that it would be better practice to review the patient following admission, and that it would be inappropriate to defer that review to the morning of surgery. Moreover, this round is not solely for the purpose of obtaining written consent from patients undergoing surgery the following day, but for all inpatients. • The time allocated to administration remains inadequate. I note a recent expectation that the results of all investigations (presumably of outpatients) be read by consultants as soon as the results are available. How much administrative time will this consume? How much time will be allocated in Job Plan? • Lastly, I would propose to increase SPA time by one PA per month to conduct audit in urological oncology. I have included this in Professional Development in appraisal for coming year, and as stated previously, I believe that audit must begin in order to satisfy MDT peer review. It will not begin with current SPA allocation	
26.08.2011	Email correspondence between Mr Mackle and Mr O'Brien	Mr Mackle refers to AOB's Job Plan and notes that he has "*reduced your allocation to 4.25 hours per week (re administration time) which is now similar to your colleagues."* Indicates he is content to request facilitation if not agreed.	Doc File 1 Pages 285 – 287 AOB-00285 - AOB-00287
01.09.2011 to 01.09.2012	Mr O'Brien's Consultant Job Plan Review Template dated 01 September 2011 to 01 September 2012	Direct Patient Care 8.87 PAs Supporting Professional Activities 1.50 PAs On-Call Allocation 1.57 PAs Total PAs – 12 PAs	Doc File 1 Pages 288 – 293 AOB-00288 - AOB-00293
01.09.2011 to 01.03.2012	Mr O'Brien's Consultant Job Plan Review template dated 01 September to March 2012	Direct Patient Care excluding on-call 9.56 PAs Supporting Professional Activities 1.50 Pas On-Call Allocation 1.57 Pas Total PAs 12.63 PAS	TL3 page 201 – 206 AOB-05879 – AOB-05884

01.09.2011 to 01.09.2012	Mr O'Brien's Consultant Job Plan Review Template dated 01 September 2011 to 01 September 2012	Direct Patient Care 9.12 Pas Supporting Professional Activities 1.50 PA On call Allocation 1.57 Pas Total PAS – 12.25 Pas	SUP 95 – 100 AOB-03592 - AOB-03597
01.09.2011	Email correspondence between Mr Mackle, Ms Corrigan, Mr Clegg and Mr O'Brien	Mr O'Brien requests facilitation.	Doc File 1 Pages 294 – 298 AOB-00294 - AOB-00298
01.09.2011	Email correspondence between Mr O'Brien and Mr Mackle	Mr O'Brien confirmed that unable to agree revised Job Plan proposal of 26 August 2011 as it is even less workable than previous proposal	SUP 91 AOB-03588
05.09.2011	Email from Mr Clegg to Mr O'Brien	Re: Facilitation *I received a request from your clinical manager (Mr Mackle) to commence the job plan facilitation process as I understand you have been unable to agree a proposed job plan for 2011/12. The referral was forwarded to Dr Simpson as Medical Director on FRIDAY 2ND September 2011.* *…* *It is essential that all areas of non-agreement within the job plan offer are identified at facilitation, as only the areas discussed during facilitation can be raised through the appeal mechanism.* *…"*	TL3 page 136 – 138 AOB-05814 – AOB-05816
19.09.2011	Mr O'Brien's comments and concerns regarding proposed Job Plan	AOB provides detailed comments regarding proposing Job Plan. There are a substantial number of comments relating to inadequate time for administration which he describes as "*grossly inadequate"*. Sets out a detailed schedule of administration required. See document for details.	Doc File 1 Pages 308 – 313 AOB-00308 - AOB-00313
19.09.2011	Email correspondence between Mr O'Brien and Mr Clegg	Re Facilitation Meeting Facilitation meeting was due to take place on this date but Mr O'Brien was not available as he would like to further work on his paper to submit to the facilitation meeting. He requested to meet on Monday 26 September to Thursday 29 September	SUP 101 AOB-03598
20.09.2011	Email correspondence between Mr O'Brien and Mr Clegg	Mr O'Brien's comments and concerns regarding proposed Job Plan.	SUP 103 AOB-03600
28.09.2011	Facilitation Meeting	Minute of meeting 1. Substantive issue for Mr O'Brien 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. 2. Lunch breaks, Mr O'Brien was adamant he did not require lunch breaks. 3. Specialist clinics. Specialist clinic on Friday morning which Mr O'Brien was happy to undertake but noted that it came with time pressures 4. On-Call Availability. Should not be on-call for emergencies. They are currently short on the ground with only one registrar.	SUP 106 – 108 AOB-03605 - AOB-03607
05.10.2011	Email from Mr Young to Ms	RE WLI	TL3 page 180

	Corrigan	*"Ahead of scheduling tomorrow – can you advise on the changes in the WLI statement sent out recently.* *It records that only SPA time x1 can be used for WLI. If clinical activity to include admin time is used to do these events then the Trust will not fund.* *Can you confirm this and define if there are exception?* *Does evening and weekend work have similar restrictions? Do the forms still need filled in to the same extent? Since there has been payment issues in the past we need clarity.* *It looks very like that our extremely efficient use of theatre for our dept is being curtailed and will have a big impact.* *Can you define this issue and who has defined the answer to these points"*	AOB-05858
12.10.2011	Letter from Mr Murphy to Mr O'Brien	Letter from Mr Murphy to Mr O'Brien following facilitation meeting in relation to Job Plan with Mr Mackle on 7 October 2011. Notes Job Plan has been compared with colleagues and that he is "*content that the time you have been allowed for administration seems appropriate. One of your colleagues has been allowed slightly more time; however he has agreed to undertake an additional clinic which will generate more administration.* *I do accept however, that you have historically worked significant amounts ofadministrative time and as a result I feel it is appropriate for me to agree a transitional period to allow you time to adjust your working practices. I am therefore recommending that you should be offered an additional 0.75 PA perweek for administration until 28 February 2012. This will result in a total of 2.75 PAs over and above 10 programmed activities. From 1 March 2012 however, you will reduce to 12 PAs per week.* *This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this."*	2012/13 Appraisal Page 11 AOB-22331
17.10.2011	Letter To Mr Murphy from Mr O'Brien	Letter to Mr Murphy in relation to Facilitation Meeting Your letter gives the impression, perhaps mistakenly, that the only issue addressed has been the time allocated to administration in the proposed Job Plan. Perhaps most pointedly, I may not have adequately emphasized that the job plan is physically impossible as it proposes that I carry out a specialist clinic, consisting of urodynamic studies and oncology reviews, in the exactly same rooms, and using the same equipment and staff as Mr Young will be doing at the same time as proposed in his job plan, which he has already accepted and implemented… Has this issue been addressed? Has the issue of lunch breaks been addressed and what is the outcome? …. Has the issue of availability for emergencies been addressed and what is the outcome? This is an issue arising with increased frequency, and no later than today. In particular, if one consultant is on leave, I believe that the other two cannot be off site, with one of them on-call for emergencies.	SUP 123 – 124 AOB-03620 - AOB-03621
21.10.2011	Email from Mr Murphy to Mr O'Brien	Re: Facilitation *"Dear Aidan* *… I was left with was that the main substantive issue related to administration time and this was the main point that I raised with Mr Mackle. I aplogise if this was a misinterpretation. I have gone back to Mr Mackle with the three additional points that you raise.* *In terms of specialist clinic he assures me that he has been told by Martina Corrigan that there is space to do both clinics at the same time. He suggests that if this is not the case that you should speak to him or Martina.*	TL3 page 189 AOB-05867

		Mr Mackle is happy with the lunch breaks and they will be accommodated in a revised job plan. *I discussed in detail the issue of covering for emergencies when consultants are at off site clinics particularly in the circumstance when a colleague is on leave. He recommends that you audit this over the next few months and if the audit shows this to be a significant problem he is happy to discuss at the next job plan review….."*	
31.10.2011	Email from Mr Clegg to Mr O'Brien	Re: Amended Job Plan enclosing Job Plan dated 1st Sept 2011 – 1st March 2012 *"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."*	TL3 page 200 AOB-05878
31.10.2011	Email correspondence between Mr O'Brien and Mr Clegg	Re Facilitation Meeting Outcome Job Plan Mr Clegg: 1. Dr Murphy felt to offer Mr O'Brien an extra 0.75 PA per week for administration until February 2012 which would reduce to 12 PA in March 2012 2. New 12.75 PA job plan which includes lunch break and specialist clinic moved from Friday morning to Friday afternoon Mr O'Brien: Issue that job plan attracts 12.63 PA as opposed to 12.75 and also issue that job plan from 01 September when it had not yet been agreed	SUP 127 AOB-03622
Oct 2011 – Sept 2012	CHKS Consultant Level Indicator Programme	In 2012/13 Appraisal CHKS Consultant Level Indicator Programme completed. Reflective document indicates the following:- *"Whilst the overall performance in terms of FCEs is consistently satisfactory at 1224 relative to previous years, and whilst the percentage of day cases is higher at 61% relative to the year 2012/13, it is still less than peer mean of 74.9%. The limited capacity of the Trust for day case surgery, and the methodof recording day case surgery, may be contributing factors.* *…… Outpatient performance is satisfactorily comparable to peer means, and new:review ratio of 1:2.0 is comparable to peer mean of 1:1.9."*	2012/13 Appraisal Pages 62 – 68 AOB-22382 - AOB-22388
03.11.2011	Email correspondence between Mr O'Brien and Mr Clegg	It allows an additional 0.7 PA per week for administration until 28 February 2012, however from 1 March 2012 the Job Plan would reduce to 12 PAs per week.	Doc File 1 Pages 319 -320 AOB-00319 - AOB-00320
09.11.2011	Email from Ms Corrigan to Ms Trouton	Re: Draft Job plans Notes that Mr O'Brien's "*may be slightly different as Malcolm was to revise this as per the facilitation (you can tell Eamon that the changes him and I discussed are in this version) and I am nots ure if Aidan has signed the amended one."*	TRU-01552
10.11.2011	Email correspondence between Mr O'Brien and Mr Clegg	Mr O'Brien notes that he feels compelled to accept the Job Plan although he neither finds it agreeable or acceptable : *"I will spend only that time allocated, whilst believing it will be inadequate"*	Doc File `1 pages 323 – 325 AOB-00323 – AOB-00325
10.11.2	Email	Re Job Plan	SUP 129 –

011	correspondence between Mr O'Brien and Mr Clegg	Mr Clegg clarified that job plan would be 12.75 PA and will be effective from 01 October 2011. Mr O'Brien: "*,,, I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Although I have 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, has 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"*	132 AOB-03624 - AOB-03627
24.11.2011	Email from Ms Stinson to Urology Consultants	Re: Job Plans *"Could you advise me if you would be available to meet with Dr Rankin, Mr Mackle and Heather re job plans on Monday 5th December 2011 at 4.30pm in the meeting room on the admin floor"*	TL3 page 213 AOB-05891
05.12.2011	Email correspondence between Mr Mackle, Mr O'Brien and Ms McCorry	""*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 the need for Trust support then you obviously do not need to contact me to organise a meeting."*	Doc File 1 Page 337 AOB-00337
30.01.2012	Letter to Dr Rankin from Mr O'Brien dated 30 January 2012	AOB lodges a grievance in relation to deductions made in relation to extra contractual payments due to him.	Doc File 1 Pages 342 – 343 AOB-00342 - AOB-00343
March 2012	Mr Anthony Glackin: Consultant Urologist Job Description	Notes current staffing:	TRU-101608 – TRU-101620

Consultants

Mr M Young
Mr A O'Brien
Mr M Akhtar (due to leave April 2012)
2 new posts

2 Specialist Registrars

Supported by:

1 Lecturer Nurse Practitioners
2 Nurse Practitioners
1 GP with Specialist Interest in Urology

Consultant Job Plan (Interest in Oncology)

(POST 3) - INTEREST IN ONCOLOGY (Replacement Post)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS DCC	SPA	APA	EPA	Total	Prem
Mon	09.00 – 13.00	Admin	CAH	4.0				7.5	
	13.00 – 17.00	Emergency Urologist **(Weeks 2 & 4)** OPD teaching/service development **(weeks 1, 3& 5)**	CAH	2.0					
	14.00 – 17.00		CAH	1.0	0.5				
Tues	08.30 – 09.00	Travel to STH **(weeks 2 & 4)**	STH	0.25				4.0	
	09.00 – 13.00	Day Surgery Unit – **(weeks 2 & 4)**		2.0					
	14.00 – 17.00	OPD - STH **(weeks 2 & 4)**	STH	1.5					
	17.00 – 17.30	Travel from STH **(weeks 2 & 4)**		0.25					
Wed		SPA **(weeks 1, 3 & 5)**							
	09.00 – 13.00	OPD teaching/service development **(weeks 2 & 4)**	CAH		2.0			7.5	
	09.00 – 13.00				2.0				
	13.00 – 17.00	Emergency Urologist **(weeks 2 & 4)**	CAH	2.0					
	14.00 – 17.00	Prostate Biopsy **(weeks 1, 3 & 5)** (Teaching)			1.5				
Thurs	09.00 – 13.00	SPA	CAH		4.0			7.0	
	14.00 – 17.00	MDT – weekly	CAH	3.0					
Fri	09.00 – 13.00	Theatres	CAH	4.0				8.0	
	13.30 – 17.30	Theatres	CAH	4.0					
TOTAL HOURS				24	10			34	
TOTAL PROGRAMMED ACTIVITIES				6	2.5			8.5	

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

EMERGENCY WORKLOAD

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

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

SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	7.00 (includes 1 PA for Ward rounds)	
Supporting Professional Activities:	2.50	Specific Role:
On-Call Allocation:	*Total including Predictable & Unpredictable* 1.00	
Any Additional HCS Responsibilities:		Reason:
Any External Duties:		Reason:
Any Annualised Activity & Reason		Reason:
TOTAL PA's:	10.5	

- **Job plan will be reviewed within 3 months of appointment**

Consultant Job Plan (Interest in Uro-oncology, Andrology or Female Urology)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS DCC	HOURS SPA	HOURS APA	HOURS EPA	Total	Per ort
Mon	09.00 – 13.00	SPA **(weeks 1, 3, & 5)**	CAH		2.00			7.56	
	09.00 – 13.00 07.45 – 09.00 09.00 – 13.00	OPD **(week 2)** Travel from CAH to Erne **(week 4)** Day surgery unit **(week 4)**	CAH CAH EKN	1.00 0.31 1.00					
	14.00 – 17.00 14.00 – 17.00 17.00 – 18.15	Admin **(weeks 1, 2, 3 & 5)** OPD – Erne **(week 4)** Travel EKN to CAH **(week 4)**	CAH EKN	2.25 0.75 0.25					
Tues	08.00 – 12.00	Theatre – **(weeks 2 & 4)**	CAH	2.00				7.5	
	12.00 – 19.00	Theatre – **(weeks 1,3 & 5)**	CAH	3.50					
	13.00 – 17.00	Emergency Urologist - **(weeks 2 & 4)**		2.00					
Wed	09.00 – 13.00	SPA	CAH		4.00			7.5	
	13.00 – 17.00 14.00 – 17.00	Emergency Urologist **(weeks 1,3 & 5)** Prostate Biopsy **(weeks 2 & 4)**	CAH	2.00 1.50					
Thurs	09.00 – 13.00	OPD teaching/service development **(weeks 1, 3 & 5)**	CAH		2.00			5.0	
	14.00 – 17.00	MDT weekly	CAH	3.00					
Fri	09.00 – 13.00 09.00 – 13.00	Admin **(weeks 1, 3 & 5)** Theatres – **(weeks 2 & 4)**	CAH DHH	2.00 2.00				6.83	
	14.00 – 17.00 17.00 – 17.40	OPD – teaching/service development **(weeks 2 & 4)** Return travel from DHH **(weeks 2 &4)**	DHH		1.50 0.67				
TOTAL HOURS				23.56	10.17			33.73	
TOTAL PROGRAMMED ACTIVITIES				5.9	2.5			8.43	

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

EMERGENCY WORKLOAD

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

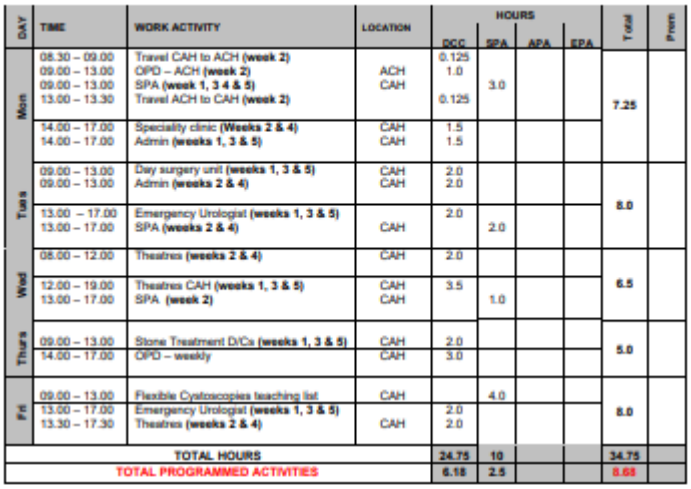
Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	On-Call Period	CAH	**1.00**
TOTAL PA's for ON-CALL:		**1.00**	

SUMMARY OF PROGRAMME ACTIVITIES

	Programmed Activities	
Direct Patient Care excluding on-call:	**6.9 (includes 1 PA for Ward rounds)**	
Supporting Professional Activities:	**2.5**	**Specific Role:**
On-Call Allocation:	***Total including Predictable & Unpredictable***	
	1.0	
Any Additional HCS Responsibilities:		**Reason:**
Any External Duties:		**Reason:**
Any Annualised Activity & Reason		**Reason:**
TOTAL PA's:	**10.5**	

- **Job plan will be reviewed within 3 months of appointment**

Consultant Job Plan (Interst in Stone Management)

		 **Please note that 1 PA per week has been allocated for Ward rounds – to be worked flexibly** **EMERGENCY WORKLOAD** **On-call availability Supplement** On-call Category: A Agreed on-call Rota Frequency: 1 in 5 (Medium Frequency) On-Call Availability Supplement: 5% **Type / Day/Time / Location / Allocated PAs** Predictable Emergency on-call Work* / / / Unpredictable Emergency on-call Work* / On-Call Period / CAH / 1.00 **TOTAL PA's for ON-CALL:** 1.00 **SUMMARY OF PROGRAMME ACTIVITIES** Direct Patient Care excluding on-call: 7.18 (includes 1 PA for Ward rounds) Supporting Professional Activities: 2.50 Specific Role: On-Call Allocation: *Total including Predictable & Unpredictable* 1.00 Any Additional HCS Responsibilities: Reason: Any External Duties: Reason: Any Annualised Activity & Reason Reason: **TOTAL PA's:** 10.75 • Job plan will be reviewed within 3 months of appointment	
01.04.2012	Mr O'Brien's Job Plan starting on 01 April 2012	Job Plan status in discussion stage. PA breakdown Direct Clinical Care 9.8 Supporting Professional Activities 1.48 Total 11.28	Doc File 1 Pages 361 – 371 AOB-00361 - AOB-00371 TRU-102235 – TRU-102243
10.04.2012	Letter from Dr Rory Convery to Mr O'Brien	Letter from Dr Rory Convery to Mr O'Brien	2016 Appraisal page 44 AOB-22874

		Southern Health and Social Care Trust 10 April 2012. Dear Mr. O'Brien, Re: Clinical Lead for the Urology Multidisciplinary Team I understand that the Urology Cancer Multidisciplinary Team have nominated you as the Lead Clinician for the service. I would like to confirm your position as Clinical Lead for the Urology Cancer Service from the 1st April 2012. This term of office will be for an initial 3 years, after which time it will be reviewed. The role and responsibilities for the Lead Clinician are detailed in the Operational Policy for the service. I would like to welcome you to the wider Cancer team and thank you for your agreement to act as the Clinical Lead. Yours sincerely, Personal information redacted by USI Dr. Rory Convery, Clinical Director of Cancer Services, Southern Health and Social Care Trust.	
01.05.2012	Job Description	Head of Cancer Services **Job Summary** • To be responsible for the operational / performance management and strategic development of Cancer services to include Chemotherapy Services. • To be responsible for the cancer tracking of patients through the cancer pathways • To be responsible for leadership, service provision and service development of Cancer services and ensuring high quality patient centred services. • To be responsible for the operational Line Management of the Clinical Nurse Specialists and Palliative Care Nurses working within Acute Services • To be responsible for achieving service objectives through the implementation of national, regional and local strategies and guidelines • To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a cancer service strategy, which support the Trust's and Division's overall strategic cancer direction and ensures the provision of a high quality responsive service to patients within resources. As a Head of Service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives. Notes *"make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.* *Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriatley managed"*	TRU-02587 – TRU-02595
October 2012 to September 2013	CHKS Consultant Level Indicator Programme	In 2012/13 Appraisal Reflective comments "*I have been satisfied to learn that my performances are very comparable to the mean of peer activity in all domains but two: my percentage day case rate was 49.9% (peer mean 75.7%) and my new:review outpatient ratio was*	2012/13 Appraisal Pages 69-79 AOB-22389 - AOB-22399

		1:2.5 (peer mean 1:1.8). *I believe that the explanation for the former is that the definition of a day case is determined by whether the intent at the time of commitment to admission is as a day case or otherwise, rather than whether the patient actually is admitted and discharged on the same day. I believe that that latter comprises a greater proportion of the total than is reflected in the CLIP report.* *I believe that my new:review outpatient ratio is a reflection of urological oncology being a significant portion of my practice. Indeed, if I did have the capacity to review all those patients who should have been reviewed when intended, the ratio would be 'worse'."*	
2012/13	2012/13 Appraisal	2012/13 Appraisal confirms by this stage AOB was on a 1 in 4 on-call rotation.	2012/13 Appraisal Page 3 AOB-22323
2012/13	2012/13 Appraisal	2012/13 Appraisal states as follows:- **CURRENT JOB PLAN** *"I have attached the proposed Job Plan which was to come into effect on 01 July 2011, and for a period of one year. This Job Plan provided for a total of 11.25 Programmed Activity sessions. Following facilitation in September 2011, the total number of Programmed Activity sessions was increased to 12.75 until 28 February 2012, reducing to 12 thereafter (letter attached). The current Job Plan (attached) was proposed to come into effect on 01 April 2013, providing for a total of 11.275 Programmed Activity sessions. However, that Job Plan was predicated on 5 Consultant Urologists in post, and which has only variously been the case since 01 April 2013. As a consequence, the initial job plan of 2011/12 remains in effect. However, that job plan has not been reviewed or amended to take account of changes in work patterns which have since developed, such as all day clinic sessions at South West Acute Hospital (rather than a half day) once monthly, extended inpatient operating sessions once weekly, and the additional work required in chairing Urology Multidisciplinary Team meetings."*	2012/13 Appraisal Page 5 AOB-22325
06.02.2013	Zircadian to Mr O'Brien	Re: Job Plan change DCC has increased by 0.79 (3:12 hours)	TL3 page 750 AOB-06428
08.02.2013	Zircadian to Mr O'Brien	Re: Job Plan Change DCC has increased by 0.06 (6 minutes)	TL3 page 759 AOB-06437
13.02.2013	Zicardian to Mr O'Brien	Re: Job Plan changes 1. DCC increased by 0.64 (2:36 hours) 2. SPA decreased by 0.45 (1.48 hours)	TL3 page 782 AOB-06460
19.02.2013	Zicardian to Mr O'Brien	Re: Job Plan changes 1. DCC decreased by 0.72 (2.54 hours) 2. SPA increased by 0.32 (1.18 hours)	TL3 page 829 AOB-06507
21.02.2013	Email from Mr Young to Mr O'Brien, Mr Glackin and Mr Pahuja	Re: Job plans *"Please have a look at proposed job plan.* *It is based on our discussions over the past few months.* *All posts have a similar theme with individual trends (as you will see). As you are aware I've had meetings with Dr Rankin and Robin. They are keen on a 11*	TL3 page 838 AOB-06516

		PA job. *Specific issue not previously defined was 8-30 start in theatre and if on the late shift it would be an 8pm finish. We were short of 4hrs operating time. 3x half hr (tues, weds, fir am lists) brought back 1.5hrs and 2x the extra hr tues and weds brings this nearly up to the limit required. I have discussed this with Robin and he feels we should get this signed off as acceptable in general principle, with further discussions pending. To get this signed off to allow us to go to press we all have to agree in principle on doing the number of outpatient sessions (as the figures fit the SBA). There is still some fine tuning required but this is the best I can do in the time allocated…"*	
05.03.2013	Email from Ms Corrigan to Urologists	Re: Urology Team Job Plans Assumptions on what needs to be included in clinics in order to deliver the agreed activity 1. Stone Treatment clinics will be setup to see 6 new and 11 review – there will be 1.5 clinics per week 2. Outreach will be set up to see 5 new and 7 review – there will be 2 outreach clinics per week 3. General at CAH will be set up to see 6 new and 8 review which will mean PM clinic starting at 1.30pm – there will be 3 general clinic per week 4. Oncology will be set up to see 3 red flag and 4 protective review and 4 uro-oncology review – there will be 3.75 of these per week. 5. D4 clinics will be set up to see 4 pateints – there will be 1 of these per week 6. Prostate D1 will be set up to see 8 red flags and 2 news and there will be 1 of these per week 7. In patients – assumed there will be 3 on a four hour session 8. Daycases – we have 10 flexible cystoscopies on a list and 5 patients on a daycase list 9.	SUP OCT Page
01.04.2013 – Mar 18	Mr O'Brien's Job Plan dated 01 April 2013 until March 2018	Noted to be in "*discussion stage"* at 20 March 2013. Noted to be "*locked down*" on 16 April 2015. Direct Clinical Care 9.8. Supporting Professional Activities 1.475 Total 11.275 On-Call Summary 1 PA	Doc File 1 Pages 431 – 436 AOB-00431 - AOB-00436 TRU-102244 – TRU-102252
01.04.2013	Mr Young's Job Plan dated 01 April 2013	Total PA: 11.2 Total hours: 47.36	TRU-102261 – TRU-102270

		Direct Clinical Care 9.775 38:48 Day surgery 0.663 2:39 Emergency operating sessions 0.975 3:54 ESWL Stone Treatment 0.400 1:36 Grand Round 0.400 1:36 New patient Clinic 1.762 7:03 Patient related admin (reports, results etc) 1.075 4:18 Planned in-patient operating sessions 1.800 7:00 Post-op ward round 0.250 0:54 Pre-op ward round 0.075 0:18 Predictable Emergency Work 0.000 0:00 Stone treatment clinic 0.825 3:18 Surgery MDT 0.200 0:48 Unpredictable Emergency Work 1.000 4:00 Urodynamics 0.100 0:24 Uroradiology meeting 0.250 1:00 **Supporting Professional Activities** 1.425 5:42 Continuous professional development. 1.425 5:42 **Additional NHS Responsibilities** 0.000 0:00 **External Duties** 0.000 0:00 **Fee Paying Services** 0.000 0:00 **Private Professional Services** 0.000 3:06	
October 2013 to December 2014	CHKS Consultant Level Indicator Programme	In 2012/13 Appraisal There was no reflective comments in this report.	2012/13 Appraisal pages 80 – 85 AOB-22400 - AOB-22405
December 2013	Mr Mark Haynes: Consultant Urologist Job Plan (With specialist interest)	Notes staffing of urology: Mr M Young Mr A O'Brien Mr R Suresh Mr A Glackin Vacant post 2 Specialist Registrars 1 Specialty Doctor (currently vacant) 1 Temporary Specialty Doctor (currently vacant) Supported by: 1 Lecturer Nurse Practitioners 2 Nurse Practitioners 1 GP with Specialist Interest in Urology Includes timetables for Consultant Urologists. Includes activities for Consultant Urologists. PA Breakdown: PA Breakdown Main Employer PAs / Total PAs / Total hours Direct Clinical Care (DCC) 8.68 8.68 31:18 Supporting Professional Activities (SPA) 1.93 1.93 7:42 Total 10.60 10.60 39:00	TRU-101623 – TRU-101636
December 2013	Mr O'Donoghue: Consultant Urologist (with	Notes staffing for urology:	TRU-101639 – TRU-

	specialist interest) Job plan	**Consultants** Mr M Young Mr A O'Brien Mr R Suresh Mr A Glackin Vacant post 2 Specialist Registrars 1 Specialty Doctor (currently vacant) 1 Temporary Specialty Doctor (currently vacant) Supported by: 1 Lecturer Nurse Practitioners 2 Nurse Practitioners 1 GP with Specialist Interest in Urology Includes timetable for Consultant Urologist Includes activities breakdown for Consultant Urologist PA Breakdown PA Breakdown | | Main Employer PAs | Total PAs | Total hours | | Direct Clinical Care (DCC) | 8.68 | 8.68 | 31:18 | | Supporting Professional Activities (SPA) | 1.93 | 1.93 | 7:42 | | Total | 10.60 | 10.60 | 39:00 |	101652
2013-2014	Actual Job Schedule	Monday 1. Outpatient Clinic Banbridge Polyclinic 9.00 – 13.00 first Monday each month 2. Outpatient clinic Armagh Community Hospital 9.00 – 13.00 second Monday each month 3. Outpatient Clinic South West Acute Hospital 10.00 – 17.00 fourth Monday each month 4. Outpatient Clinic Banbridge Polyclinic 9.00 – 13.00 fifth Monday of month Tuesday 1. Day surgical operating 9.00 – 13.00 two Tuesdays per month 2. Outpatient Clinical Craigavon Area Hospital 13.30 – 17.30 every Tuesday Wednesday 1. Inpatient Operating 9.00 – 19.00 every Wednesday 2. MDM Preview 21.00 – 23.00 every Wednesday Thursday 1. Radiology Conference 8.30 – 9.30 every Thursday 2. Grand Ward Round 10.00 – 12.30 every Thursday 3. Departmental Meeting 12.30 – 14.00 every Thursday 4. Urology MDM 14.15 – 17.00 every Thursday 5. MDM sign off 19.00 – 19.30 every Thursday Friday 1. Oncology Review Clinic and Urodynamic Studies 9.00 – 17.00 every Friday Out of Hours 1. Daily inpatient care 2. Addressing telephone queries from patients, relatives, family doctors 3. Dictation 4. Arranging elective inpatient and day surgical admissions and operating schedules 5. Previewing MDM cases 6. Signing off MDM outcome plans to family doctors 7. Selecting patients to attend for oncology review	SUP 294 – 297 AOB-03790 - AOB-03793

		8. Selecting and arranging patients to attend for urodynamic studies 9. Triage of letters of referrals	
22.02.2014	Email correspondence between Mr Clegg and Mr O'Brien	Re: Job Plan "*Dear Mr O'Brien* *Zoe has asked me to take a look at this for you. I have to admit I have absolutely no idea how there has come to be an 11.25 PA job plan on the Zircadian system. I can only suggest your CD or AMD may have been working on this.* *We really need all job plans in Zircadian system to match what consultant are being paid, so with your agreement, I am happy to amend the 11.25 PA job plan to reflect what you are currently being paid i.e 12PA. We will have a paper copy of this job plan on file. You will then be able to check this for accuracy on Zircadian"*	SUP 305 AOB-03801
12.05.2014	Mr Haynes Job Plan	Total PA: 12.712 Total Hours: 49.28 | Category	Total PAs	Total Hrs
---	---	---
Direct Clinical Care	11.172	43:19
Day surgery	0.476	1:54
Grand Round	0.397	1:35
New patient Clinic	0.794	3:10
Other ward rounds	0.099	0:24
Patient related admin (reports, results etc)	1.044	4:12
Planned in-patient operating sessions	1.641	6:19
Post-op ward round	0.168	0:33
Pre-op ward round	0.171	0:41
Predictable Emergency Work	2.000	8:00
Review Outpatients clinic	0.794	3:10
Sub Specialty clinic	0.794	3:10
Surgery MDT	0.998	4:00
Unpredictable Emergency Work	1.500	5:00
Uroradiology meeting	0.298	1:11
Supporting Professional Activities	1.540	6:09 | Received from SHSCT on 04/11/21. Annotated by the Urology Services Inquiry. Page 7 of **TRU-10231** |		
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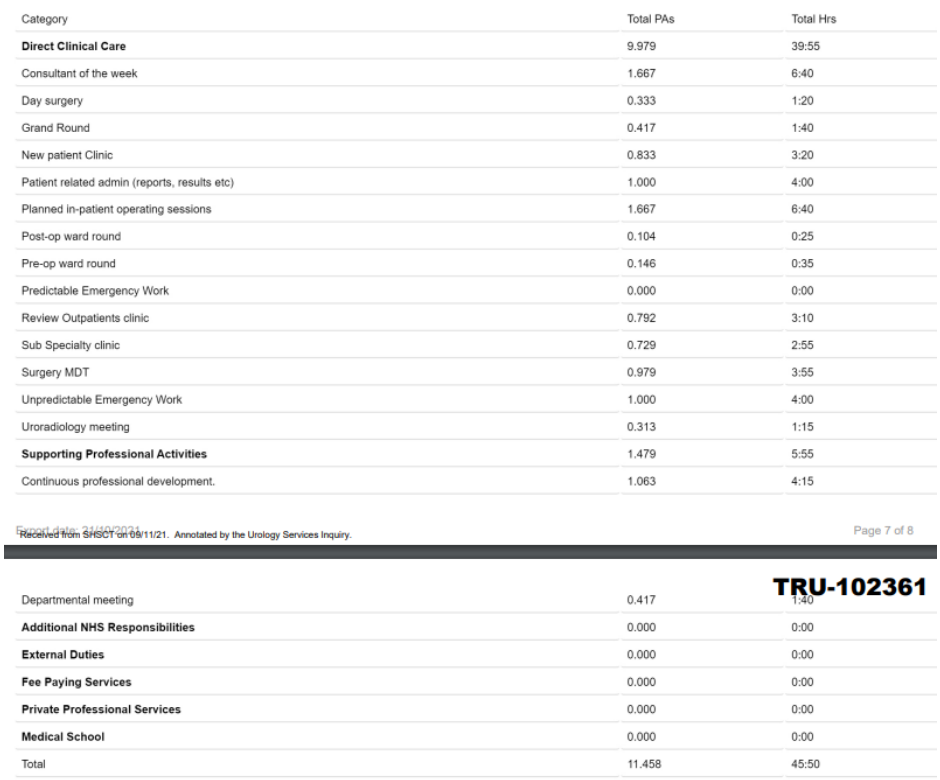
Continuous professional development.	1.143	4:34
Departmental meeting	0.397	1:35
Additional NHS Responsibilities	0.000	0:00
External Duties	0.000	0:00
Fee Paying Services	0.000	0:00
Private Professional Services	0.000	0:00
Medical School	0.000	0:00
Total	12.712	49:28		TRU-102304 – TRU-102311
19.05.2014	Letter to Mr O'Brien from Mr Clegg	Note adjusting on-call allowance as the 12 May is the "*date Mr Haynes comes into his post"*.	Doc File 1 Page 685 AOB-00685
23.05.2014	Email correspondence between Ms Carroll, Ms Corrigan and Ms Browne	Email from Anita Carroll to Martina Corrigan re missing triage attaching email outlining 35 patients on triage. Text in email "*Help"*.	Doc File 1 Pages 689 – 690 AOB-00689 - AOB-00690
26.05.2014	Email correspondence between Mr O'Brien and Mark Fordham	Re Report of Stock take of regional review of adult urological services in northern Ireland "*Inadequacy of time within job plans for administration generally and for leadership roles in particular. Results will not be achieved with goodwill and a shoe string alone"*	SUP 312 – 314 AOB-03808 - AOB-03810

01.01.2015	Mr Glackin Job Plan	Total PA: 11.458 Total Hours: 45.50 	TRU-102354 – TRU-102361
01.01.2015	Mr O'Brien's job plan starting on 1 January 2015	Job Plan for 1 January 2015.	Doc File 1 Pages 795 – 799 TL5 2015 page 3755 – 3760 AOB-00795 - AOB-00799 AOB-75949 – AOB-75955

Category	Total PAs	Total Hrs
Direct Clinical Care	9.979	39:55
Consultant of the week	1.667	6:40
Day surgery	0.333	1:20
Grand Round	0.417	1:40
New patient Clinic	0.833	3:20
Patient related admin (reports, results etc)	1.000	4:00
Planned in-patient operating sessions	1.667	6:40
Post-op ward round	0.104	0:25
Pre-op ward round	0.146	0:35
Predictable Emergency Work	0.000	0:00
Review Outpatients clinic	0.792	3:10
Sub Specialty clinic	0.729	2:55
Surgery MDT	0.979	3:55
Unpredictable Emergency Work	1.000	4:00
Uroradiology meeting	0.313	1:15
Supporting Professional Activities	1.479	5:55
Continuous professional development.	1.063	4:15

Departmental meeting	0.417	1:40
Additional NHS Responsibilities	0.000	0:00
External Duties	0.000	0:00
Fee Paying Services	0.000	0:00
Private Professional Services	0.000	0:00
Medical School	0.000	0:00
Total	11.458	45:50

<table>
<tr>
<td>January 2015 to December 2015</td>
<td>Medical Appraisal Documents & Checklist</td>
<td>
<table>
<tr><td>2.1 Please give a short description of your work, including the different types of activity you undertake</td><td>My work includes the clinical and operative management of acute urological admissions and referrals, in addition to the ongoing clinical management of all elective admissions, when urologist of the week, which pertains for one week in every six weeks. Otherwise, it includes the administrative, clinical and operative management of elective inpatient and day case surgery, flexible cystoscopy lists and urodynamic studies, new patient clinics, general and oncology review clinics.</td></tr>
<tr><td>2.2 List your main sub-specialist skills and commitments / special interests</td><td>Urological oncology.
Lead Clinician of the Urology MDT.
Chair of Urology MDM.
Acute Urology.
Lower urinary tract dysfunction.
Paediatric Urology</td></tr>
<tr><td>2.3 Please give details of any emergency, on-call and out of hours responsibilities</td><td>Since the introduction of 'Urologist of the Week' in September 2014, one consultant is responsible for all acute urological management for the Southern Health and Social Care Trust population, and for that of County Fermanagh, in addition to all referrals from Daisy Hill and South West Acute Hospitals. As one of six consultants, I participate in this rota. In addition to acute urology, it also includes the ongoing clinical management of patients electively admitted. During 2016, I also continued to provide support to Mr. Suresh when he was 'urologist of the week' until he left our department in October 2016..</td></tr>
<tr><td>2.4 Please give details of out-patient work if applicable</td><td>On Mondays, I conduct review clinics, rotating through Armagh Community , South West Acute and Craigavon Area Hospitals. On Tuesdays, I conduct a New Patient clinic at Craigavon Area Hospital. On Fridays, I conduct an Oncology Review Clinic concurrent with Urodynamic Studies.</td></tr>
<tr><td>2.5 Details of any other clinical work</td><td>I triaged Red Flag referrals while 'urologist of the week'.
I arranged inpatient and day case surgical admissions.
I arranged flexible cystoscopy and urodynamic lists.
I arranged oncology review clinics.
I reviewed, and amended if necessary, all outcomes of the weekly urological MDM, ensuring all reviews of all consultants were conducted within required timeframes.</td></tr>
</table>
</td>
<td>2016 Appraisal Page 6

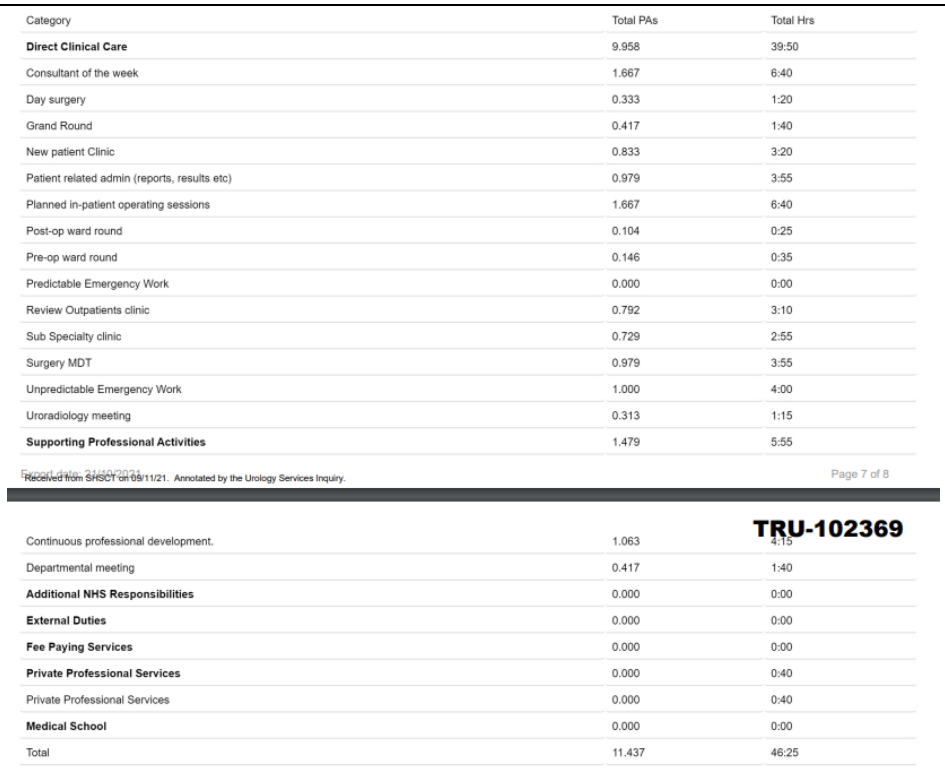
AOB-22836</td>
</tr>
<tr>
<td>January to December 2015</td>
<td>Medical Appraisal Documents & Checklist</td>
<td>2016 Appraisal comments by Mr Young

Discussion
Mr O'Brien has continued to deliver an excellent service in urology. He was lead Clinician in urology until December 2015 and helped oversee improvements in integrated Cancer service. His CPD has faltered due to issues beyond your control. His weekly training is up to date. His job plan is very heavy.

Actions Agreed
① Forward CPD to keep up to date.
② Reflect on job plan with line manager and during appraisal.</td>
<td>2016 Appraisal Page 8

AOB-22838</td>
</tr>
<tr>
<td>April 2015</td>
<td>Operational Policy Urology Cancer Service</td>
<td>In MDT Review AOB's responsibilities as Lead Clinician are described in the following terms::-</td>
<td>2017 Appraisal page 248</td>
</tr>
</table>

	Southern Trust	**3.1 Responsibilities of MDT Lead Clinician** • Consolidation of the MDT and its activities within the wider urological service. • Development of the concept and responsibilities of the MDT in its delivery of cancer services. • Oversight of systems to ensure that all cases of cancer or suspected cancer referred to the service are referred in an informative and timely manner to the MDT for their discussion at MDM. • Chairing or delegating the chairing of MDM. • Arrangement and oversight of systems to ensure that patients are reviewed following MDM in a timely manner. • Organising and chairing Business Meetings to advance the development of MDT and its activities. • Development of an Operational Policy for MDT. • Compiling Annual Reports and Work Plans. • Chairing an Annual General Meeting to agree Reports and Plans • Attending the Urology NSSG meetings (as the Lead Clinician is considered an integral member of the NSSG). • Ensuring a high quality integrated service, which meets local, regional and national standards. • Participation in the regular review of the regional guidelines. • Ensuring collection of appropriate cancer minimum dataset, working with the cancer management team. • Developing an audit programme and review of outcomes. • Ensuring governance arrangements are in place.	AOB-23126
16.04.2015	Email from Zicardian	Changes to job plan • DCC has increased by 10.458 (41:26 hours) • SPA has increased by 1.583 (6:20 hours)	TL5 page 1133 AOB-73328
22.04.2015	Email from Zicardian	• DCC has increased by 0.417 (1:40 hours) • SPA has decreased by 0.229 (0:55 minutes) Mr Clegg, Malcolm did not add a comment.	TL5 page 1197 AOB-73392
16.11.2015	Mr Glackin Job Plan	Total PA – 11.437 Total Hours: 46.25	TRU-102362 – TRU-102369

			
16.12.2015	Email from Mr Clegg to Mr O'Brien	Re Job Plan Direct clinical care – 10.875 PA Supporting Professional Activities (SPA) – 1.354 PA Total – 12.229 PA	TL5 page 3754 – 3760 AOB-75949 – AOB-75955
01.10.2016	Mr O'Brien's Job Plan	Direct Clinical Care – 10.635 Supporting Professional Activities – 1.508 Total 12.143 Job Plan Status "*In discussion stage"*	Doc File 2 Page 179 AOB-01072
01.10.2016	Job Plan 1 October 2016	Additional copy of a Job Plan for 1 October 2016	Doc File 2 Pages 179 – 183 AOB-01072 - AOB-01076

<table>
<tr>
<td></td>
<td></td>
<td>
<h2>Southern Health and Social Care Trust.</h2>
This job plan started 01 October 2016.
Job plan for Mr O'Brien, Aidan in Urology
<h3>Basic Information</h3>
<table>
<tr><td>Job plan status</td><td>In 'Discussion' stage</td></tr>
<tr><td>Appointment</td><td>Full Time</td></tr>
<tr><td>Cycle</td><td>Rolling cycle - 6 weeks</td></tr>
<tr><td>Start Week</td><td>1</td></tr>
<tr><td>Report date</td><td>12 Dec 2016</td></tr>
<tr><td>Expected number of weeks in attendance</td><td>42 weeks</td></tr>
<tr><td>Usual place of work</td><td>Craigavon Area Hospital</td></tr>
<tr><td>Alternate employer</td><td>None Specified</td></tr>
<tr><td>Contract</td><td>New</td></tr>
<tr><td>Private practice</td><td>Yes</td></tr>
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<h3>Job plan stages</h3>
<table>
<tr><th>Job plan stages</th><th>Comment</th><th>Date stage achieved</th><th>Who by</th></tr>
<tr><td>In 'Discussion' stage</td><td></td><td>16 Apr 2015</td><td>Mr Malcolm Clegg</td></tr>
<tr><td>In 'Discussion' stage - awaiting doctor agreement</td><td></td><td>10 Oct 2016</td><td>Mr Colin Weir</td></tr>
<tr><td>In 'Discussion' stage - request cancelled</td><td></td><td>10 Oct 2016</td><td>Mr Colin Weir</td></tr>
<tr><td>In 'Discussion' stage - awaiting doctor agreement</td><td></td><td>7 Nov 2016</td><td>Mr Colin Weir</td></tr>
</table>
<h3>PA Breakdown</h3>
<table>
<tr><th></th><th>Main Employer PAs</th><th>Total PAs</th><th>Total hours</th></tr>
<tr><td>Direct Clinical Care (DCC)</td><td>10.635</td><td>10.635</td><td>42:16</td></tr>
<tr><td>Supporting Professional Activities (SPA)</td><td>1.508</td><td>1.508</td><td>6:01</td></tr>
<tr><td>Total</td><td>12.143</td><td>12.143</td><td>48:17</td></tr>
</table>
<h3>On-call summary</h3>
<table>
<tr><th>Rota Name</th><th>Location</th><th>Weekday Freq</th><th>Weekend Freq</th><th>Category</th><th>Supplement</th><th>PAs</th></tr>
<tr><td>On-call Rota</td><td>Craigavon Area Hospital</td><td>6</td><td>6</td><td>A</td><td>5%</td><td>1.000</td></tr>
</table>
<table>
<tr><th>Type</th><th>Normal</th><th>Premium</th><th>Cat.</th><th>PA</th></tr>
<tr><td></td><td></td><td></td><td>Total:</td><td>1.000</td></tr>
<tr><td>Predictable</td><td>n/a</td><td>n/a</td><td>DCC</td><td>0.000</td></tr>
<tr><td>Unpredictable</td><td>n/a</td><td>n/a</td><td>DCC</td><td>1.000</td></tr>
</table>
The total PAs arising from your on-call work is: 1.000
Your availability supplement is: 5% (based on the highest supplement from all your rotas)
<h3>On-call rota details</h3>
On-call Rota (PA entry)
General information
</td>
<td></td>
</tr>
<tr>
<td>01.08.2016</td>
<td>Mr Suresh Job Plan</td>
<td>Total PAS: 11.229
Total Hours: 44.55
<table>
<tr><th></th><th>Main Employer PAs</th><th>Total PAs</th></tr>
<tr><td>Direct Clinical Care (DCC)</td><td>9.771</td><td>9.771</td></tr>
<tr><td>Supporting Professional Activities (SPA)</td><td>1.458</td><td>1.458</td></tr>
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</td>
<td>TRU-102509 – TRU-102514</td>
</tr>
<tr>
<td>01.08.2016</td>
<td>Mr O’Donoghue Job Plan</td>
<td>Total PAS: 11.545
Total Hours: 47.51</td>
<td>TRU-102404 – TRU-102411</td>
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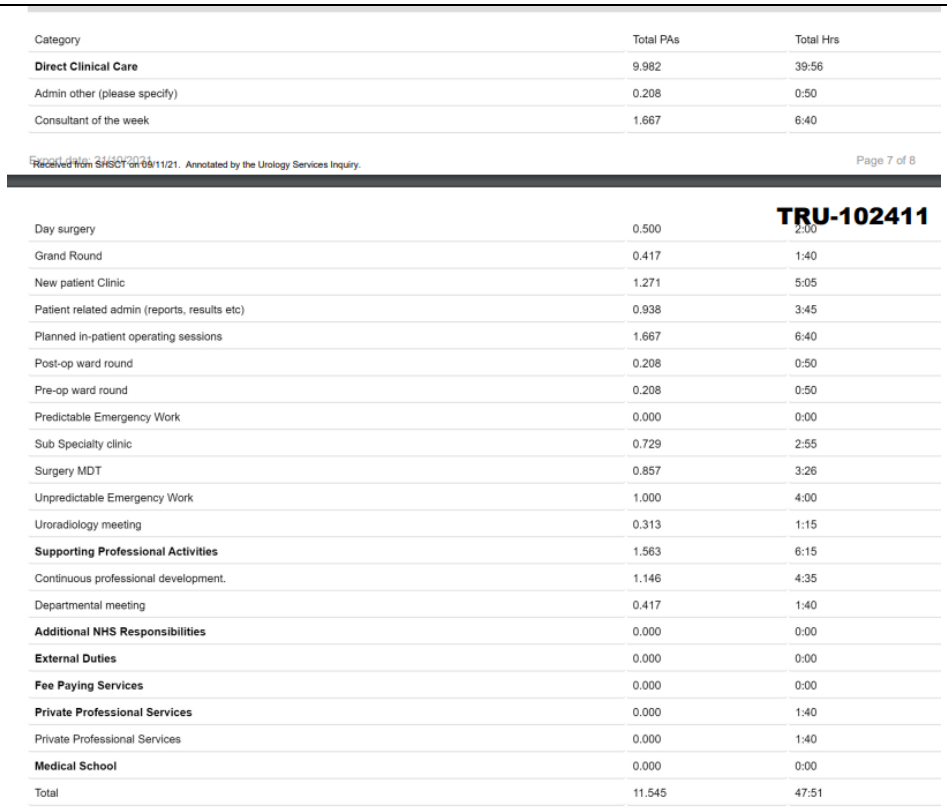
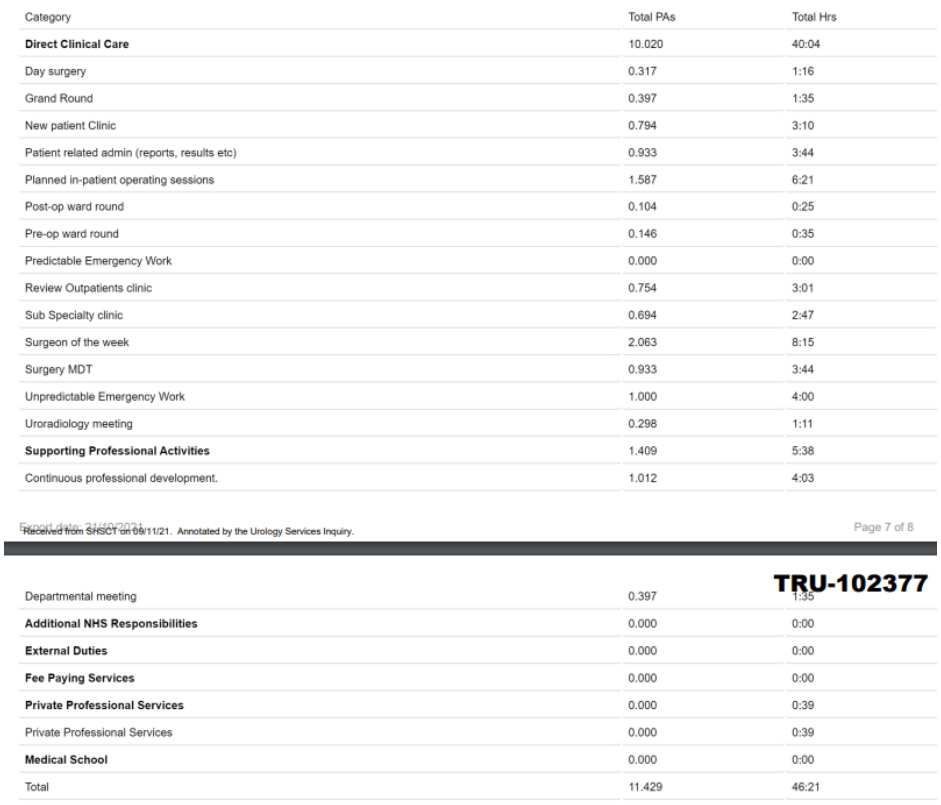
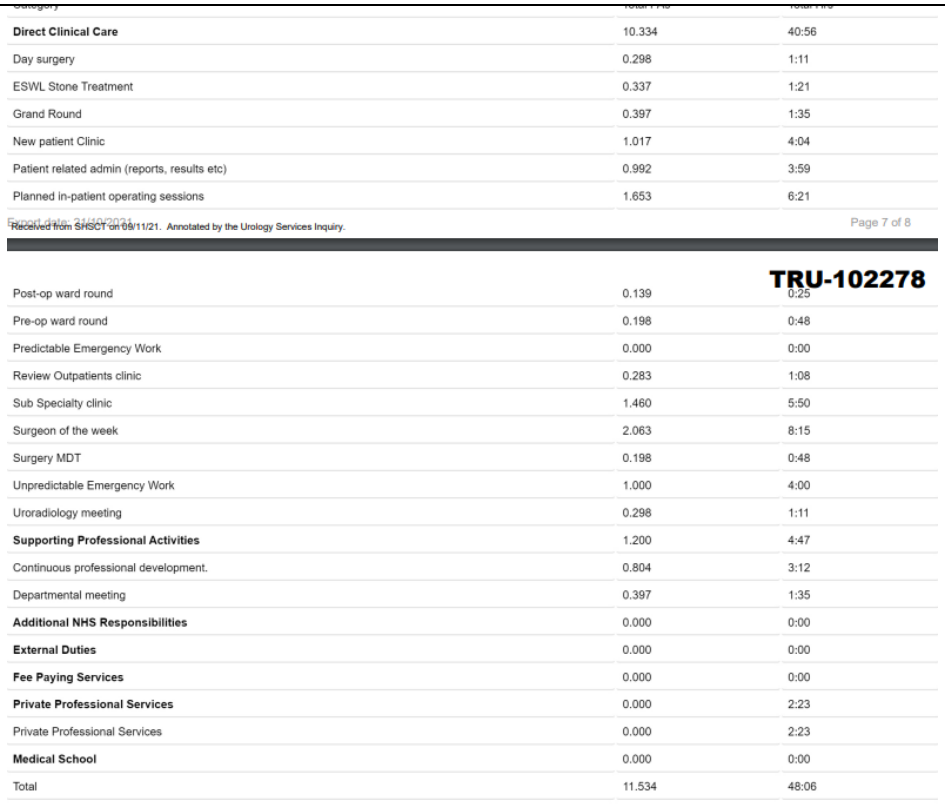
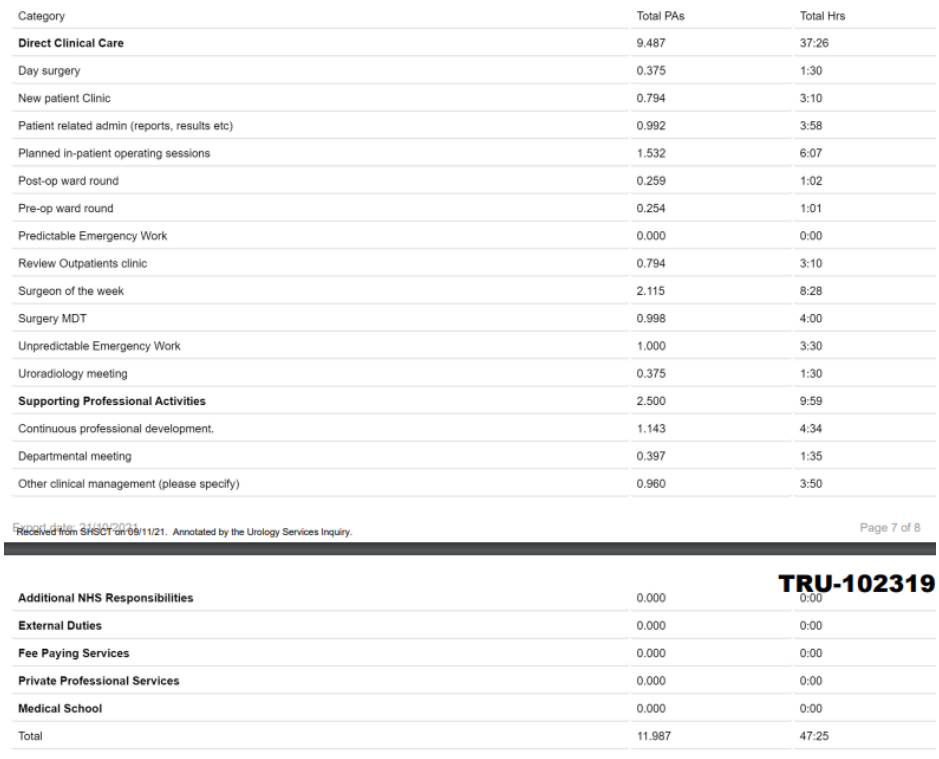
			
01.08.2016	Mr Glackin job plan	Total PA: 11.429 Total Hours: 46.21 	TRU-102370 – TRU-102377
01.10.2016	Mr Young's Job Plan 01 October 2016	Total Pas: 11.993 Total Hours: 49.56	TRU-102271 – TRU-102287

			
01.10.2016	Mr Haynes Job Plan	Total PA: 11.987 Total Hours: 47.25 	TRU-102312 – TRU-102319
2016	Clinics in 2016 (excluding SWAH clinics)	Note in AOB's 2016 Appraisal as follows:	2016 Appraisal page 35 AOB-22865

		Clinics in 2016 (excluding SWAH clinics) 2016 was a 30.5 week year (until commencement of sick leave on 16 Nov 2016) **Armagh:** Job Plan: One clinic per calendar month, 7 clinics Actual: 4 clinics **Craigavon New Clinic:** Job Plan: One clinic per week, 30.5 clinics Actual: 21 clinics **Craigavon Review Clinic:** Job Plan: One clinic per week (when not in Armagh or SWAH), 20.5 clinics Actual: 12 clinics **Specialty Clinics:** Job Plan: One clinic per week, 30.5 clinics Actual: Oncology: 8 clinics; Urodynamics 9 clinics; Urodyns & Oncology: 33 clinics; Total Spec. Clinics 50 clinics Total Job Planned Clinics: 88.5 clinics Actual Clinics: 87 clinics **Total additional clinics in 2016: - 1.85 clinics** **Total additional clinic session time in 2016: - 7.4 hours** **Mean additional administrative time per clinic: 1 hour** **Total additional time allocated to clinics; - 9.25 hours** **Mean Additional time allocated to clinics per week: - 0.3 hours**	
2016	Elective Inpatient Operating 2016	AOB's analysis of Elective Inpatient Operating 2016 **Elective Inpatient Operating 2016** Wednesday 06 January — Urologist of the Week Wednesday 13 January — 9 am – 8 pm — 2.75 Wednesday 20 January — 12 noon – 8 pm — 2.0 Wednesday 27 January — 12 noon – 8 pm — 2.0 Wednesday 03 February — 12 noon – 8 pm — 2.0 Wednesday 10 February — 12 noon – 8 pm — 2.0 Wednesday 17 February — Urologist of the Week Wednesday 24 February — 9 am – 8 pm — 2.75 Friday 26 February — 1.30 am – 5.30 pm — 1.0 Saturday 27 February — 9 am to 1 pm — 1.0 Wednesday 02 March — Professional Leave: expert witness Wednesday 09 March — 12 noon – 8 pm — 2.0 Saturday 12 March — 9 am – 1 pm — 1.0 Wednesday 16 March — 9 am – 8 pm — 2.75 Wednesday 23 March — 12 noon – 8 pm — 2.0 Wednesday 30 March — Urologist of the Week Wednesday 06 April — 12 noon – 8 pm — 2.0 Wednesday 13 April — 9 am – 8 pm — 2.75 Wednesday 20 April — Audit Wednesday 27 April — 12 noon – 8 pm — 2.0 Wednesday 04 May — 12 noon – 8pm — 2.0 Wednesday 11 May — Urologist of the Week Wednesday 18 May — 12 noon – 8 pm — 2.0 Wednesday 25 May — 12 noon – 8 pm — 2.0 Wednesday 01 June — 12 noon – 8 pm — 2.0 Wednesday 08 June — Urologist of the Week Wednesday 15 June — 12 noon – 8 pm — 2.0 Wednesday 22 June — Professional Leave: expert witness Wednesday 29 June — 9 am – 8 pm — 2.75 **Sessions**	2017 Appraisal page 347 & 348 AOB-23225 - AOB-23226

		Wednesday 06 July 9 am – 8 pm 2.75 Wednesday 13 July 9 am – 8 pm 2.75 Monday 18 July 1.30 pm – 5.30 pm 1.0 Wednesday 20 July 9 am – 1 pm 1.0 Wednesday 27 July 9 am – 8 pm 2.75 Wednesday 03 August Urologist of the Week Wednesday 10 August 9 am – 8 pm 2.75 Wednesday 17 August 12 noon – 8 pm 2.0 Wednesday 24 August 9 am – 8 pm 2.75 Friday 26 August 9 am – 5 pm 2.0 Saturday 27 August 9 am – 1 pm 1.0 Wednesday 31 August 9 am – 8 pm 2.75 Wednesday 07 September 12 noon – 8 pm 2.0 Wednesday 14 September Urologist of the Week Wednesday 21 September 9 am – 8 pm 2.75 Wednesday 28 September 9 am – 8 pm 2.75 Wednesday 05 October 12 noon – 8 pm 2.0 Wednesday 12 October 12 noon – 8 pm 2.0 Wednesday 19 October Audit Wednesday 26 October Urologist of the Week Wednesday 02 November 9 am – 8 pm 2.75 Wednesday 09 November 9 am – 8 pm 2.75 Total = 83.25 sessions Plus 1.5 hours of perioperative patient care for each date: 58.5 hours = 14.625 sessions Plus 1 hour of administration time per session: 83.25 hours = 20.8125 sessions **Total =118. 6875 sessions** **Number of elective inpatient sessions contracted at per Job Plan = 58**	
28.10.2016	Zicardian	Job plan change DCC has increased by 0.104 (25 minutes)	TL6 page 2249 AOB-78334
07.11.2016	Zicardian	Job plan change DCC increased by 0.018 (13 minutes) SPA increased by 0.164 (40 minutes)	TL6 page 2255 AOB-78340
01.12.2016	Mr Haynes Job Plan	Total PA: 11.921 Total Hours: 47.09 Category / Total PAs / Total Hrs **Direct Clinical Care** 9.143 36:04 Day surgery 0.298 1:11 New patient Clinic 0.794 3:10 Patient related admin (reports, results etc) 0.992 3:59 Planned in-patient operating sessions 1.587 6:20 Post-op ward round 0.266 1:04 Pre-op ward round 0.248 1:00 Predictable Emergency Work 0.000 0:00 Review Outpatients clinic 0.794 3:10 Surgeon of the week 2.167 8:40 Surgery MDT 0.998 4:00 Report date: 31/07/2024 Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry. Page **TRU-102** Unpredictable Emergency Work 1.000 3:30 **Supporting Professional Activities** 1.786 7:07 Continuous professional development. 1.488 5:56 Departmental meeting 0.298 1:11 **Additional NHS Responsibilities** 0.000 0:00 **External Duties** 0.000 0:00 **Fee Paying Services** 0.000 0:00 **Private Professional Services** 0.000 0:00 **Medical School** 0.000 0:00 Total 10.929 43:11	TRU-102320 – TRU-102327
30.12.2016	Meeting with Dr Wright, Mr O'Brien	Page 14 (Section H) – Page 15 (Section A – D) "Dr Wright: It is probably a lot (inaudible) consolation but there would be at any	Transcript FILE 1

	and Mrs O'Brien	one time quite a few of these investigations going on in the Trust, which to be fair (inaudible) majority of (inaudible) for yourself but it is not that unusual. (inaudible). The process it's one that (inaudible) so we have to follow (inaudible). But what I will undertake is to make sure that the timetable is ramped up as quickly as possible. (Inaudible). It may well be that it turns out that the work we are asking you to do is far too much. Your job plan is unrealistic. Mrs O'Brien: No, Aidan's job plan is realistic. It is just the job plan – he can't stay to his job plan because things are allocated to SPA, or whatever they are – Dr Wright: Then may be the job plan is not realistic. It is on (inaudible) what is on written down on paper and what actually happens in practice. Mr O'Brien: My job plan – Dr Wright: The job plan doesn't (inaudible). Mrs O'Brien: No, (inaudible), because when he got his first, when they come on to the new consultant contract, Aidan's first job plan was for 15.5. Then now it is down to 12. But when he was doing the 15, when it was ascertained, it was really 18 but that was unrealistic. Dr Wright: But the real answer is to find other ways to get that work done. Get other people as opposed to (inaudible). Mr O'Brien: You can't. You can't. Mrs O'Brien: You would need then consultants then. That's what it needs. Dr Wright: then that is what we do."	AOB-56014 - AOB-56015
30.12.2016	Meeting With Dr Wright, Mr O'Brien and Mrs O'Brien	Page 15 (Section F) "Dr Wright: It seems what we are saying this is an investigation. It is not – we haven't got an outcome. I have no doubt the Trust is going to be criticized as a result (inaudible). Mrs O'Brien: I certainly hope that that is the conclusion. It is the Trust that will be criticized.	Transcript 1 FILE 1 AOB-56015
January – December 2017	HSCNI Career Grade Medical Staff Appraisal Documentation	HSCNI Career Grade Medical Staff Appraisal Documentation	2017 Appraisal Page 5 AOB-22883

		<table><tr><td>2.1 Please give a short description of your work, including the different types of activity you undertake</td><td>My work includes • Clinical and operative management of acute urological admissions and referrals when urologist of the week • Clinical management of all elective admissions when urologist of the week • Elective inpatient & day case surgery • New and review outpatient clinics • Urological cancer outpatient clinics • Chairing Urological Cancer MDM • Urodynamic Studies & Flexible Cystoscopies</td></tr><tr><td>2.2 List your main sub-specialist skills and commitments / special interests</td><td>• Acute Urology • Urological Oncology • Urinary Tract Stone Disease • Lower Urinary Tract Dysfunction</td></tr><tr><td>2.3 Please give details of any emergency, on-call and out of hours responsibilities</td><td>I participate in the Urologist of the Week rota for a period of one week every six weeks. The primary commitment is the provision of clinical and operative management of all patients acutely admitted to Craigavon Area Hospital, in addition to advising on the management of patients acutely admitted to Daisy Hill and South West Acute Hospital, taking over their management if necessary following patient transfer.</td></tr><tr><td>2.4 Please give details of out-patient work if applicable</td><td>• General urology review clinics in Craigavon Area, Armagh Community and South West Acute Hospitals on Mondays • New patient clinics on Tuesdays • Urological Cancer review clinics on Fridays • Urodynamic clinics on Fridays</td></tr><tr><td>2.5 Details of any other clinical work</td><td>• Triage of referrals, including review by telephone, requesting investigations, initiating treatment, etc. • Administrative scheduling of elective admissions, flexible cystoscopy and urodynamic studies, and oncology reviews • Previewing and chairing Urology MDM</td></tr></table>	
January – December 2017	HSCNI Career Grade Medical Staff Appraisal Documentation	Extract from 2017 Appraisal CURRENT JOB PLAN If you have a current job plan, please attach it. If not, please explain below at which stage of the approval process your job plan is currently:- My Current Job Plan is almost ready for Sign Off, just awaiting clarification of the amount of predictable time to be allocated for week-end ward rounds when urologist of the week.	2017 Appraisal Page 6 AOB-22884
January – December 2017	Job Plan Description	Extract from 2017 Appraisal	2017 Appraisal page 9 AOB-22887

		Discussion My Job Plan does not adequately reflect the amount of work that I undertake each week, and the work which I do each week is inadequate relative to the need. The more patients one attends to, the more work it generates, and the inadequacy increases. Nevertheless, I do read the urological literature on a weekly basis. I do believe that I am up to date with regard to knowledge. Since my regional leadership of the Clinical Reference Group in Urological Oncology, I am entirely aware of all relevant guidelines. I believe that I do apply that knowledge and resulting competence in practice for the benefit of patients, usually with multidisciplinary consensus and scrutiny. I do believe that I have always recorded my work clearly, accurately and legibly. Mr O'Brien has been absent for 3 weeks at begin of year and has not had opportunity to fulfill CPD requirements. **Actions Agreed** Mr O'Brien will D/w Line manager his Job Plan and plans to reduce workload by 1 clinic per week. He will focus on his CPD and attend a national meeting. He will review his mandatory training as per Trust guidelines	
24.01.2017	Meeting with Mr Weir, Ms Hynds and Mr O'Brien	Page 8 (Section H) – Page 11 (Section A – D) "Mr O'Brien: The letter was just telling that others shared my concerns. And the biggest concern that I had then and had for years and had since then was the big elephant in the room, which is not on any of these things, and that is the sheer numbers of patients awaiting admission and re-admission for procedures and operations and suffering poor clinical outcomes as a consequence. Siobhan Hynds: Can I ask who you were raising that with at a point? Mr O'Brien: At a point. Siobhan Hynds: No, I mean at the various points, who was it you were raising that with? Mr O'Brien: I have raised that with everybody that I can think of over 20 years. This is – I have raised this with – the titles have changed it's that long. Clinical directors, Ivan Sterling, Liam McCathy, John Templeton, Michael Young. And they, sort of, cliched response that these are Trust issues. Except for the fact, regrettably, the Trust doesn't make than an issue. It is – I mean, I do have already prepared, I have gone through all of my operating over recent years, and in fact whilst I would like to have the opportunity at a subsequent time when meeting both to share these with you, but like, for example in 2013, as far as the job plan would go, I would have been expected to do 84 sessions. I did 113 elective sessions that year. Colin Weir: Is that operating? Mr O'Brien: Operating. I would have been expected to do 79 session in 2014 as the urologist of the week was introduced that year and I did 101. 2015, 70	Transcript FILE 3 AOB-56040 - AOB-56043

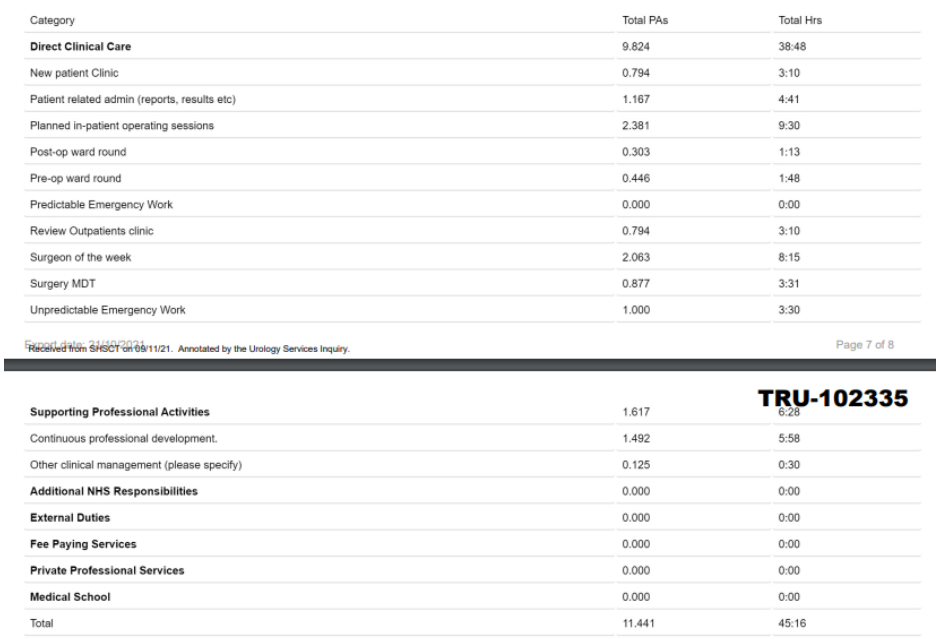
		sessions according to my job plan, I actually did 95.5 four hour sessions. You multiply that by four for every hour. In 2016, up until I left, I would have been pro rata expected to do 61 sessions. I did 83.25 And in the doing of that and the organisation of that – that's just operating I mean, I am not talking about other activities as well, like extra clinics and so forth, I have been directing in a sense in a lonely manner without any response to raising the concerns with regard to the inequity involved in such lists. Like in October of last year when performance data were published, which is a contradiction in itself because they didn't publish performance data they published the things that still needed to be performed you know, and when I had 233 I think patients on my in-patient waiting list at that time one of my colleagues had 29. Can you get that addressed? No. And just to – Ill do this all in detail in due course, but I do think actually two things about it. One is, when you have been raising it and talking about it and worrying about it and trying to get a response for 20 odd years, you know, you stop talking about it. And lastly, do you know, I was – I must say after these 25 years I was so disappointed. On 7 November I sent Martina and my colleagues a list of 10 patients whom I really wanted to have done next and come the end of December they weren't even addressed. I was coming back after having my prostate resected too early. Why? Because of the need to address this. … Colin Weir: So, Aidan, issues over these 20 years are just that; the workload and the capacity to do the workload. Is that what you – the gist of it? Mr O'Brien: Colin, if I were to put my case in one sentence, if I had not been overworked, if I hadn't agreed to be overworked, I wouldn't be in this position today and others are not in this position today. Colin Weir: Because they manage – Mr O'Brien: because they didn't overwork Colin Weir: Control Mr O'Brien: no, they wouldn't Colin Weir: Okay. … Colin Weir: Just to get the general tenor of what you are saying about workload and you tried to engage with the Trust's management over an extended period of time to help manage that in some way. Mr O'Brien: Yes. Colin Weir: but the work has just kept coming Mr O'Brien: and a failure of management to deal with it. Colin Weir: To deal with it. Right ok.	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 18 (Section H) – Page 19 (Section A – B) "Colin Weir: … I am also conscious of the fact that I – and this is difficult because – the difficult bit of this and is why I didn't want to do it, is because I know what your – clinically, and do you know what I mean, I know what you do in the things that you have just said, urologist of the week and your operating, those extended operating days that you do, remember we've done your job planning not that long ago, so I've been part of that process as well so …	Transcript FILE 3 AOB-56050 - AOB-56051

		Mr O'Brien: I mean, this is all – up until I met with Colin, in October, all un-job planned, unremunerated work. I am not here to talk about money"	
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 28 (Section A – G) "Michael O'Brien: But one of the issues was the review back log and I think you will be able to show as well that the review back log has been cleared. One of the things that occurred to me, and you did the job plan recently, there is a very limited amount of time in that job plan associated with administration work. …. Mr O'Brien: I cant even recall actually. Michael O'Brien: it might be three or four hours a week of admin. Now if you're – if you have three or four hours per week of admin, and lets just say in a crazy world there is an idea that the Trust would actually require their consultants to work to their job plan and no more than what they are actually contracted to do, and you have an administrative back log and the you undertake additional operating and additional review clinics, how can you clear (inaudible). Colin Weir: Somebody might say, okay, lets be an advocate from the other side. Well, you don't work as quickly as the other person. You don't see as many patients as most consultants. Your through-put isn't as much as another person. All I am saying is being from another – Michael O'Brien: It could be, yeah – Colin Weir: -- from another view, is it, or somebody might – you know, you're working in a factory and the person who is not making as many cars is going to be – say you're not making as many cars as the next person. There are lots of ways of looking at that and how you work. And this is nothing to do with job plan, but we did – it is a two way process and I thought you had a job plan that suited your extended operating dates and things that you wanted to do Michael O'Brien: Because it is just competing demands Colin Weir: So I think we have to, you know, so a long term process might look at (inaudible) practices and conditions and all of those things"	Transcript FILE 3 AOB-56060
24.01.2017	Meeting with Mr Weir, Ms Hynds & Mr O'Brien	Page 34 (Section D – H) – Page 35 (Section A – E) "Mr O'Brien: Nobody has been more concerned about the issues raised that I have been. I mean, I have worked night and day to try to cope with all. I am regretful that I didn't regard, as my colleagues do, all of those patients suffering as Trust issues. Because they do. In fact, it is even written on my appraisal of last month. Michael O'Brien: Do you think that you have (inaudible)? Colin Weir: Sorry, your appraisal has been, who signs off your – Mr O'Brien: It was Michael and – Colin Weir: and so that was satisfactory? Mr O'Brien: My professional development plan raised the issue of – … Mr O'Brien: because I used all my SPA time reviewing people and operating on people. … Colin Weir: That is very naughty actually. SPA, you've got to do SPA. Michael O'Brien: He is doing SPA. He is just doing other things.	Transcript FILE 3 AOB-56066 - AOB-56067

		Colin Weir: You've got to do SPA. Mr O'Brien: I told Richard I spent four whole dates of what was passing clots post TURP, yes, doing actually – getting my appraisal together Colin Weir: Yes, but you've got to build SPA in your (inaudible) week. … Mr O'Brien: Yes, I had three professional development plans, which almost sounds like a contradiction because they are nearly a professional – personal—what do you call it? Personal recreation plans. One was to address the long waiting list. Colin Weir: That was your PDP? Mr O'Brien: to reduce the gross inequity that there is for patients and to significantly reduce the number of new patients that I would see. You know, Michael's – Michael O'Brien: It is really startling the idea – two of the five consultants have been there a long time: dad the longest and Michael Young's been there, what 15 years now at this stage? Mr O'Brien: 98 Michael O'Brien: Sorry even longer then. The three newer consultants they come in because, obviously , it is decided that the service provision requires an expansion. But the legacy of 20 years of practice remains with the two consultants who are in place. SO they are seeing new patients and not sharing the workload of the massive legacy. I think (inaudible)"	
01.02.2017	Mr O'Brien's Job Plan starting on 01 February 2017	In discussion stage. Direct Clinical Care 9.328 Supporting Professional Activities 1.623 Total 10.951	Doc File 2 Pages 515 – 520 AOB-01408 - AOB-01413
09.02.2017	Meeting with Mr O'Brien in relation to return to work plan	Return to work plan/job plan meeting with Mr OB – with conditions "To return to his full job plan and to include safeguards and monitoring around the 4 main issues. An urgently job plan review will be undertaken to consider any workload pressures to ensure appropriate supports can be put in place. Mr O'Brien's return to work is based upon his Strict compliance with Trust Policies and Procedures in relation to Triaging of referrals Contemporaneous note keeping Storage of medical records Private practice Agreement to comply with the monitoring measures put in place to assess is administrative processes On return Mr OB will be primarily undertaking clinics and clinical validation of his reviews, his inpatient and day case lists. This work will be monitored by the Head of Service and reported to the Assistant Director. .. A deviation from compliance with this action plan must be referred to the MHPS case manager immediately	Doc File 2 Pages 533 – 535 AOB-01426 - AOB-01428
15.02.2017	Email correspondence	Ms Toal notes that "*Meetings regarding his job plan are scheduled as this is vital to agreeing his level of core activity going forward."*	Doc File 2 Page 549

	between Ms Toal and Mr Wilkinson	Also of note she refers to "*Our solicitor is on leave early part of this week"* and they were to "*take her advice on how we can best consider his representations made to you."*	AOB-01442
24.02.2017	Meeting with Mr Weir and Mr O'Brien:	Page 7 (Section F – H) MR O'BRIEN: … Now the one thing that Dr Khan did emphasis very, very strongly is that, you know, this doesn't pertain so much to the SWAH clinic as it would to the Armagh clinic. Because I do the Armagh clinic on a Monday morning and literally – and the numbers that I would normally see are 12 and they are reviews. Come 1 o'clock, and certainly by quarter past 1, the next person using that room is standing outside the door clicking their heels. I think – I can't remember whether it is dermatology. I think it is. So I said to him. Logistically he recommended that I just reduce the numbers at that clinic in order to ensure that the dictation is done within time. COLIN WEIR: So ten? MR O'BRIEN: So ten or something of that nature COLIN WEIR: And is ten reviews for clinic the going rate for your colleagues? MR O'BRIEN: Yes. It's 12. COLIN WEIR: Alright.	Transcript File 6 AOB-56153
24.02.2017	Meeting with Mr Weir and Mr O'Brien	Page 18 (section D – H) MR O'BRIEN: Just the other thing from a job plan point of view, is that I do – urodynamics and oncology review on a Friday morning and I will not be doing Friday afternoon, which is my SPA time, which I have used consistently, leaving myself with no SPA time. COLIN WEIR: Remember when we did a job plan before I said you have got to. You have got to have some SPA. MR O'BRIEN: And we will leave all of this, as Michael Young says, Trust issues, except the Trust that we work for never makes them an issue. COLIN WEIR: We have got to protect your – you know, if it is seeing less patients or doing something to do SPA then that is the way it has got to be.	Transcript File 6 AOB-56164
09.03.2017	Meeting in relation to return to work with Mr O'Brien, Mr Weir and Ms Corrigan	Discussions between Mr O'Brien, Ms Corrigan and Mr Weir re his return to work. During that the following issues were addressed:- ***"3. New Outpatient Clinics*** *Mr O'Brien advised Mr Weir and Mrs Corrigan that he no longer felt it was fair that he would continue to see New Outpatients. Mrs Corrigan advised that this was not feasible as all Consultants needed to see New Outpatients. Mr O'Brien clarified that the reason he felt this was because he had the most patients waiting to be operated on with the longest waiting times and that it wasn't fair for him to continue to see new patients and adding to his waiting list as he couldn't deal with them.* *Mrs Corrigan clarified that Mr O'Brien didn't have the most nor the longest waiting times for In and Day patients:* *Mr Young - 228 patients (162 weeks)* *Mr Suresh - 267 patients (93 weeks)* *Mr O'Brien - 257 patients (152 weeks)* *Mr Haynes - 191 patients (143 weeks)* *Mr Glackin - 146 patients (62 weeks)* *Mr O'Donoghue - 134 patients (101 weeks)*	Doc File 2 Pages 576 – 581 AOB-01469 - AOB-01474

		Mrs Corrigan gave further detail on Mr O'Brien's total waiting with their longest waiting times: *Daycases: 37 Urgent (longest waiting 110 weeks)* *25 Routine (longest waiting 137 weeks)* *Inpatients 124 Urgent (longest waiting 148 weeks)* *71 Routine (longest wailing 152 weeks)* *Mr O'Brien advised that he didn't agree with classifications of an Urgent or of a daycase and that whilst these were the numbers waiting they should be classified differently.* *Follow-up note - Mrs Corrigan to work with Mr O'Brien to get these validated and classified accordingly…..* *Mrs Corrigan shared Mr O'Brien's Review Urgent Outpatient backlogs:* *CAOBUO (oncology reviews) - 2014 = 89* *2015 = 77* *2016 = 46* *End of March 2017 = 32* *Total = 244* *EUROU = Enniskillen Urgent 2014 = 1* *2015 = 1* *2016 = 25* *End of March 2017 = 32* *Total = 63* ***1. MDT*** *Mr O'Brien raised about the Urology Oncology MDT and advised Mr Weir and Mrs Corrigan that he was no longer prepared to operate on a Wednesday until 8pm then go home and preview for the next day's MDT as he had done in the past. He advised Mr Weir and Mrs Corrigan that he hadn't quite made up his mind if he was going to continue with chairing this MDT group but if he did continue then he Wouldn't be coming into work on a Thursday morning but the time would be spent previewing for the MDT. Mr O'Brien advised that he spends considerable time preparing for the meeting if he is going to Chair and that he went through all patients in great detail including all their images. He also advised that in the past he had spent considerable time after the MDT correcting the outcomes i.e. grammar etc. He advised that he prided himself on having one of the best-prepared and well-run MDTs."*	
13.03.2017	Letter to Mr O'Brien from Dr Wright dated 13 March 2017	**[Please note AOB indicates he never received this letter.]** It replies to AOB's queries in relation to amendments to the Minutes. Generally it accepts his amendments but says in relation to the Job Plan:- "I *do clearly recall that when I asked if your job plan was unrealistic, your initial response was to state that it was OK but that things were allocated to your SPA time that was not administrative work. I do recollect that in reply to this statement, I said that if the job plan does not cover all work that you have to do, then it mustn't be right and this would need to be reviewed. We then went on to discuss the amount of sessions allocated in your job plan."*	Doc File 2 Pages 582 -583 AOB-01475 - AOB-01476
19.04.2017	Email correspondence between Mr Weir and Mr Khan	Notes "*Job Plan revised and submitted to Aidan for sign off."*	Doc File 2 Page 631 AOB-01524
23.04.2017	Mr Haynes job plan	Total PA: 12.434 Total hours: 49.14	TRU-102328 – TRU-102335

		 Category / Total PAs / Total Hrs **Direct Clinical Care** 9.824 38:48 New patient Clinic 0.794 3:10 Patient related admin (reports, results etc) 1.167 4:41 Planned in-patient operating sessions 2.381 9:30 Post-op ward round 0.303 1:13 Pre-op ward round 0.446 1:48 Predictable Emergency Work 0.000 0:00 Review Outpatients clinic 0.794 3:10 Surgeon of the week 2.063 8:15 Surgery MDT 0.877 3:31 Unpredictable Emergency Work 1.000 3:30 Received from SHSCT on 04/11/21. Annotated by the Urology Services Inquiry. Page 7 of 8 TRU-102335 **Supporting Professional Activities** 1.617 6:28 Continuous professional development. 1.492 5:58 Other clinical management (please specify) 0.125 0:30 **Additional NHS Responsibilities** 0.000 0:00 **External Duties** 0.000 0:00 **Fee Paying Services** 0.000 0:00 **Private Professional Services** 0.000 0:00 **Medical School** 0.000 0:00 Total 11.441 45:16	
08.05.2017	Email correspondence between Mr Weir and Mr O'Brien	Email to AOB noting Mr Weir had "*changed your job plan some weeks ago and you should have received an email asking you to review and approve."*	Doc File 2 Page 652 AOB-01545
25.05.2017	Email correspondence between Ms Corrigan and Mr Carroll	Noted that at lunchtime meeting with Aidan today "*Colin and Aidan have agreed to meet to try to finalise his job plan."*	Doc File 3 Page 16 AOB-01584
19.06.2017	Email correspondence between Mr O'Brien and Mr Weir	Email exchange AOB and Mr Weir in relation to Job Plan. Includes a number of issues including: *"Am I correct in my interpretation that the total time allocated to patient administration is 2.19 hours per week?* Also notes that he was taken off Fridays on leave following his week as Urologist of the Week to complete advanced triage on red flag referrals.	Doc File 3 Pages 64 – 65 AOB-01632 - AOB-01633
16.08.2017	Email to Mr Brown	Email to Robin Brown notes:- "*Mr Weir, Colin cancelled the request for Mr O'Brien, Aidan to sign off his/her job plan."* – automated alert.	Doc File 3 Page
30.08.2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page 8 (Section E – H) – Page 9 (section A – B) MR O'BRIEN: What I will do to help you understand this, I have brought a folder which actually I have spent quite some time doing, looking at the additionality that I have done in recent years in terms of operating and review clinic. DR CHADA: Extra clinics and extra --- MR O'BRIEN: Operating. Absolutely. And the time that is required to organise those. DR CHADA: Okay. Sorry, those extra things that you are talking about, are those clinics that you have asked to be added on? Is that what you mean? Were they clinics over and beyond what your job plan was asking you to do? MR O'BRIEN: Yes, Yes. Certainly, yes. DR CHADA: Okay. … I suppose that is what – so you are saying that you were	Transcript FILE 11 AOB-56252 - AOB-56253

		not able to do the admin but you were fitting in extra theatre time? MR O'BRIEN: Yes, yeah. I mean, because that is the greatest priority of all, is to operate on people.	
30.08.2017	Meeting with Dr Chada, Ms Hynds and Mr O'Brien	Page 10 (section G- H) – Page 12 (section A) Dr CHADA: … You were just telling me that there was a clinical admin morning arranged after the SWAH clinic. That is what I understood. What I understood was that you were not to do day surgery alternate weeks when you were doing SWAH and I understood that was for you to get caught up with your admin from SWAH. MR O'BRIEN: Yes. Not necessarily from SWAH. … It's not additional. There is nothing additional to it. No more additional than if you did a SWAH clinic and then you did day surgery the following morning and then two weeks later all I was doing was doing it that way. There is nothing additional to it. What is additional? DR CHADA: Okay. But you asked for the change, so what were you asking for, the – were you asking for things to be brought forward or changed in terms of the order that they were done in? Sorry, I may be – I am not clear about this. I thought that after the SWAH clinic on a Monday you had asked not to do day surgery on a Tuesday. MR O'BRIEN: Yes, that's correct. DR CHADA: Because you needed to get caught up on things from this SWAH clinic? MR O'BRIEN: Yes, that's true. … DR CHADA: Yes, so when you were getting caught up on things, so when the day surgery has been cancelled for the Tuesday – MR O'BRIEN: It wasn't cancelled…. It's not moved. You have got to understand – If you do a SWAH clinic once a month on a Monday it's an all day clinic…. And you do day surgery on alternate Tuesdays… All I asked is that, do you know, can we organise it – we don't do day surgery on alternate Tuesdays. That is not quite true. It is two per calendar month, and I have detailed that. So in the calendar month of August, and I will be in South West Acute hospital on 21 August this month, all I have done is that I will not doing day surgery, any one of my two, for the month of the August on the morning of Tuesday the 22nd. DR CHADA: So you still do the two day surgeries? MR O'BRIEN: Absolutely.	Transcript FILE 11 AOB-56254 - AOB-56256
30.08.2017	Meeting with DR CHADA, MS HYNDS AND MR O'BRIEN	Page 35 (Section H) – Page 38 (Section A - B) DR CHADA: Can I ask you, you talked about additionality. So are you saying that your additional waiting list and additional review lists and additional theatre lists? MR O'BRIEN: Yes. DR CHADA: In the space of what time? What were you not doing when you were supposed – do you see what I mean? What did you not do – MR O'BRIEN: Well, SPA time was sacrificed for example. DR CHADA: SPA time. Okay. Anything else? So it was all of these additional things were done instead of SPA time?	Transcript FILE 11 AOB-56279 - AOB-56282

		MR O'BRIEN: Not only SPA time. There could have been done at other times. Administrative time, you know. … DR CHADA: Can I ask you. Do you think that's a good thing to do, to do additional clinical work instead of SPA time? MR O'BRIEN: I wish to God it was otherwise. Is it good for the patients? Yes. …. It is better that I actually relieve someone's discomfort, such as I was suffering, and such – rather than learning, once again, how to move and handle someone again for the nth time. Yes…. It is immeasurably better. Do you know we have lost the purpose, Neta. It is all replaced by process now. I know the GMC wouldn't give a damn. But anyhow, I have – in terms of operating anyhow I have done all of the operating, including, you know, I routinely work until 8 o'clock in the evening and I do long days from 9.00am to 8.00pm. DR CHADA: Is that part of your job plan? MR O'BRIEN: Well, for years it wasn't. We weren't remunerated for working late in the evening. Michael Young is the only other person who has done it. My colleagues don't do it. DR CHADA: But is that part of your job plan?.. MR O'BRIEN: It is, yes. DR CHADA: It is part of your job plan to work until 8 o'clock in the evening? MR O'BRIEN: It is part of my job plan to do two session per week but I do more than that. So they were done Wednesdays, there was Saturday, Tuesday. Like 8.00am to 12 noon…. DR CHADA: So are these additional clinics – sorry, additional surgeries on top of normal surgeries? MR O'BRIEN: … these are all of the additionalities that have been done… so I have calculated through the years 2012, 12, 14, 15 and 16 the additional hours per week spent in in-patient operating for example. 4.47 hour per week additional… To the job planned activity. … DR CHADA: Has been in place of SPA time or clinical admin time? Mr O'Brien: Yes, all of that… any my own time. … MR O'BRIEN: I had to do that appraisal for 2015 when I was recovering from my prostate operation. DR CHADA: But that's not how it should be…. Do you think it is reasonable to be using your CPD time and your SPA time to be doing clinical work? … .. MR O'BRIEN: When you are faced with these back logs, how else is it going to be done? The management didn't offer any support. The management actually were quite content to hand me a letter which Dr Khan has found enabling. What is enabling about a letter amazes me.	
01.12.2017	Minutes from Medical meeting	Notes that the average SPA is 2.5	TL6 (2018) page 306 AOB-80594

			– AOB-80599
16.03.2018	Email correspondence between Ms Corrigan and Mr Weir	Ms Corrigan notes "*Mr O'Brien's job plan has still never been approved/signed off."* Noted "*This will need actioned urgently."*	Doc File 3 Page 219 AOB-01787
April 2018	Mr O'Brien's job plan "started April 2018"	Job Plan stated to be started on 1 April 2018. Job Plan status "*Locked down".* **[Note Job Plan not locked down until 9 December 2019.]** Direct Clinical Care 10.271 Supporting Professional Activities 1.462 Total 11.733	Doc File 3 Pages 236 – 241 AOB-01804 - AOB-01809 TRU-102253 – TRU-102260
01.04.2018	Mr O'Donoghue Job Plan	Total Pas: 11.560 Total Hours: 47.55 Category / Core PAs / APAs / Total PAs / Core Hrs / APA Hrs / Total Hrs **Direct Clinical Care** 8.997 0.000 8.997 36:00 0:00 36:00 Admin other (please specify) 0.208 0.000 0.208 0:50 0:00 0:50 Consultant of the week 1.667 0.000 1.667 6:40 0:00 6:40 Day surgery 0.500 0.000 0.500 2:00 0:00 2:00 Grand Round 0.083 0.000 0.083 0:20 0:00 0:20 New patient Clinic 1.271 0.000 1.271 5:05 0:00 5:05 Patient related admin (reports, results etc) 0.938 0.000 0.938 3:45 0:00 3:45 Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry. Page 8 of 9 **TRU-102420** Planned in-patient operating sessions 1.250 0.000 1.250 5:00 0:00 5:00 Post-op ward round 0.208 0.000 0.208 0:50 0:00 0:50 Pre-op ward round 0.208 0.000 0.208 0:50 0:00 0:50 Predictable Emergency Work 0.000 0.000 0.000 0:00 0:00 0:00 Sub Specialty clinic 0.729 0.000 0.729 2:55 0:00 2:55 Surgery MDT 0.649 0.000 0.649 2:36 0:00 2:36 Triaging of new patients referrals 0.286 0.000 0.286 1:09 0:00 1:09 Unpredictable Emergency Work 1.000 0.000 1.000 4:00 0:00 4:00 **Supporting Professional Activities** 1.563 0.000 1.563 6:15 0:00 6:15 Core SPA 1.563 0.000 1.563 6:15 0:00 6:15 **Additional NHS Responsibilities** 0.000 0.000 0.000 0:00 0:00 0:00 **External Duties** 0.000 0.000 0.000 0:00 0:00 0:00 **Fee Paying Services** 0.000 0.000 0.000 0:00 0:00 0:00 **Private Professional Services** 0.000 0.000 0.000 1:40 0:00 1:40 Private Professional Services 0.000 0.000 0.000 1:40 0:00 1:40 **Medical School** 0.000 0.000 0.000 0:00 0:00 0:00 Total 10.560 0.000 10.560 43:55 0:00 43:55	TRU-102412 – TRU-102420
01.04.2018	Job Plan 1 April 2018	Please see Mr O'Brien's appraisal for 2017 which includes a Job Plan "*started 1 April 2018"*	2017 Appraisal pages 20 – 24 AOB-22898 - AOB-22902
05.04.2018	Email correspondence between Mr Weir, Mr O'Brien and Ms Corrigan	Email to AOB from Colin Weir. Mr Weir indicating that he wanted Job Plan finalised before he goes for surgery.	Doc File 3 Page 242 AOB-01810

19.04.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has increased by 0.094 (0.14 minutes) SPA has increased by 1.587 (6.20 hours)	SUP 460 AOB-03956
19.04.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has decreased by 1.307 (5.13 hours) Mr Weir added the following comment: *"Aidan we have changed your job plan to reflect the changes after discussion and your return to work. I have changed it to a 12 week cycle to cover 2 lots of urologist of the week in this cycle and monthly activity in SWAH"*	SUP 461 AOB-03957
14.06.2018	Email from Mr O'Brien to Mr Clegg	Mr O'Brien noted that he wanted to reduce his clinical commitments by one session by eliminating one outpatient clinic session.	TL6 page 798 AOB-81091
August 2018	Mr Matthew Tyson: Consultant Urologist Job Description	Notes staffing in Urology: Mr M Young Mr A O'Brien Mr A Glackin Mr M Haynes Mr J ODonoghue Vacant Post 2 Specialist Registrars 0.5 Specialty Doctor – Ms L McAuley 1 Specialty Doctor (currently vacant) 1 Temporary Specialty Doctor (currently vacant) Supported by: 4 Nurse Practitioners PA Breakdown **PA Breakdown** | | Main Employer PAs | Total PAs | Core hours | ATC hours | Total hours | | Direct Clinical Care (DCC) | 9.240 | 9.240 | 36:57 | 0:00 | 36:57 | | Supporting Professional Activities (SPA) | 1.724 | 1.724 | 6:54 | 0:00 | 6:54 | | Total | 10.964 | 10.964 | 43:51 | 0:00 | 43:51 | **On-call summary** Details consultant activities	TRU-101655 – TRU-101665
20.09.2018	Email from Mr O'Brien to Mr Weir	The most important of these is that I wish to reduce the number of days on which I have fixed clinical sessions from five to four per week (with the exception of when I am 'urologist of the week') and to achieve that objective by reducing the number of weekly clinics from three to two. This will enable me to have fixed clinical commitments on either Monday or Tuesday of each week, but not both. My colleagues have all agreed to my doing so, and indeed indicated that they may consider doing likewise. Each calendar month, I have a SWAH clinic, usually on the second Monday of the month. Each calendar month, I have a Monday morning clinic in Armagh. On the Mondays when I will be in either SWAH or Armagh, I will not have any fixed clinical commitment the following day, Tuesday. On all of the other weeks, I will not have a fixed clinical commitment on Mondays. However, I will have on Tuesdays. Tuesdays will consist of Day Surgical Unit list in the morning, and a clinic in the afternoon. Regarding Wednesdays, there are no longer any extended operating days, and I gather that they are unlikely to resume. Operating will be from 09.00 am to 05.00 pm. The day will commence at 08.30 am and finish at 05.30 pm.	TL6 page 1146 – 1147 AOB-81439 – AOB-81440

		Regarding Thursdays, there are a number of issues: • On the Thursday mornings of Week 2 and Week 8, the Handover Round starts at 09.00 am (not 10.00 am) and ends at 12.00 noon. • On three Thursdays of each 12 week cycle, I preview and chair MDM. That cannot be done when 'urologist of the week' (Weeks 1 and 7) or on the Thursday after being 'urologist of the week' (Weeks 2 and 8). Therefore, it could be done in Weeks 3, 9 and 12, for example. The amendment that is required to the Job Plan is that time will be allocated to previewing MDM on the Thursday morning of those three weeks, from 09.00 am to 12.00 noon. Regarding Fridays, I will continue to have a Specialist Clinic each Friday morning. However, in addition, • On one Friday each month, I am offered the opportunity of doing so in the afternoon as well, and have done so, and would wish to continue to do so. • On another one Friday of each month, I will attend the Northern Ireland Reconstructive Urology Network (NIRUN) MDM in Lagan Valley Hospital Regarding Urologist of the Week, • There should be one predicted session for Ward Round on Saturday morning and one for Sunday morning. • There should be predicted time required for triage, whether it will continue to be conducted while 'urologist of the week' or at another time. These are the main issues.	
21.09.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has decreased by 4.987 (19.42 hours) SPA has decreased by 0.860 (3.26 hours)	SUP 502 AOB-03998
21.09.2018	Meeting with Mr Weir and Mr O'Brien	Page 2 (section C-F) Mr WEIR:… Either we just work at this as a 12 – week cycle or because it is a bit complicated and the other way of doing is to annualize your entire job plan. So what you say is that you – basically you do your urologist of the week sessions 1 and 6 but all your other clinical sessions you deliver 42 sessions here. MR O'BRIEN: Yes MR WEIR: And that's it, So just work through each day and saying, right, I will, but the 42 Mondays some whatever, you know, you take the SWAH. You're doing about what, about a third. It is sort of every second Monday of the month. Is that right? So once a month basically. Something like that. So you would say of the 42 weeks I would deliver you know, I don't know, maybe eight SWAH clinic or nine SWAH clinics a year. MR O'BRIEN: No. The way we do it is I am delivering 12. COLIN WEIR: But you're there irrespective of annual leave. MR O'BRIEN: I fit my annual leave in and around it. MR WEIR: Right. Okay. Doing it annualize …	Transcript FILE 15 AOB-56366
21.09.2018	Meeting with Mr Weir and Mr O'Brien	Page 3 (Section D – G) Mr WEIR: So if we said and then at the end what I am suggesting, what I have done with others, is the MDM chair and the triage thing is annualized, so we don't have to fit that in around anything. It's just something. If you say, you were sitting at home doing that, it means you get recognized. You get paid for doing that even though you are sitting at home, you're just delivering that activity. MR O'BRIEN: That's where I do it, at home. I get up early on a Thursday morning when I am doing it. MR WEIR: So it doesn't have to appear at Thursday at 2 o'clock or something. It just says annualized activity and you're just doing it and that is it. Again, it means it recognizes what you do. It's flexible for you. You decide when and where you do it as long as you do it….	Transcript FILE 15 AOB-56367

21.09.2018	Meeting with Mr Weir and Mr O'Brien	Page 5 (Section A – B) MR O'BRIEN: That's one quibble I have with you. I thought that we had last tine had agreed that the clinic would run to 5.30 rather than the 5. Now, the clinic should end at 5 because that is the clinic ending time but it certainly does require me to stay that to order up the scans and so forth that I may not have had time to do. Particularly when you are reviewing cancer reviews and you're organizing CTs and MRIs, they're time consuming. So I would be happier still if you put down that I will leave home at 8.30. The clinic starts at 10 but it ends at 5.30 and then I'm home at 7. MR WEIR: Okay. It's quite a long day	Transcript FILE 15 AOB-56369
21.09.2018	Meeting with Mr Weir and Mr O'Brien	Page 6 (Section F – G) MR WEIR: So on one of those 12 weeks I am going to have put in urologist of the week, SWAH, Armagh, urologist of the week, SWAH, Armagh. Then I am going to have put an extra Armagh clinic in that 12 week cycle.	Transcript FILE 15 AOB-56370
21.09.2018	Meeting With Mr Weir and Mr O'Brien	Page 7 (section C – H) & Page 8 (Section A – B) MR O'BRIEN: I am just thinking there on your behalf because I thought, whilst I have said that the SWAH clinic for clinical reasons is really important that I do three of them I am just thinking out loud, that in a 12 week cycle you have ten extra – ten weeks left after you take the two urologist of the week, If I am going definitely do three in SWAH and another three, that only leaves four Mondays, Tuesdays left in a 12 week cycle which mightn't be enough. So there is always that possibility that I could just do two Armagh clinics in a 12 week cycle because the waiting times are – they are the shortest for that. That's just a little flexibility item. Because then on those weeks, when I am either in Armagh or in SWAH, I will not be here on a Tuesday. MR WEIR: No activity. MR O'BRIEN: No clinical activity. No fixed clinical commitments MR WEIR: All right. So okay. MR O'BRIEN: Because I will tell you what happens. What I am doing is – the whole digital dictation thing just does not work from South West Acute hospital. Michael doesn't use digital dictation at South West Acute hospital. I have tried and it is unreliable. It is a pain in the butt. They haven't provided us ever, you see, with access or we don't have .. MR WEIR: Okay so. MR O'BRIEN: On a Tuesday MR WEIR: You just do the dictation MR O'BRIEN: No, I do my SWAH clinic dictations from home remotely. MR WEIR: But, Aidan, but – that's you're having an extended day, haven't done any dictation on a Monday, that's for a lengthy, generous day. And then you have additional, like, so like that's like a day and half for 19 patients. Is that not a bit too much in terms of your – in terms of the efficient – could not the Trust not look at that and say that's very inefficient to work with? MR O'BRIEN: They can do whatever they like but that's the reality for me and, you know, that's— MR WEIR: And Michael is the same? MR O'BRIEN: Michael – my understanding of it is that Michael – he dictates on the day but he dictates into a Dictaphone.	Transcript FILE 15 AOB-56371 - AOB-56372

21.09.2018	Meeting with Mr O'Brien and Mr Weir	Page 11 (Section B – H) Mr O'BRIEN: Yes. So you work from 9 to 5 anyhow. What's different about weeks 2 and 8, those are the start of the week, is that you have to do the handover round. MR WEIR: That's what I'm saying to you. There are two people who commit – who are committed twice. MR O'BRIEN: Absolutely, yeah. So, on weeks 2 and 8, which are normal working weeks, on those Thursday mornings you have to do the handover round. You are handing over to the person who is coming on. MR WEIR: So, I don't know, maybe you don't have any – nobody has got anything else on a Thursday. MR O'BRIEN: Now you've hit a – MR WEIR: Oh, really. MR O'BRIEN: Yes. So you see, we're having an away day on Monday in the Seagoe and there's a lot of stuff that needs to be sorted out. MR WEIR: Okay. MR O'BRIEN: Particularly with regard to urologist of the week. … There's a lot of discontentment at the moment. A lot of clarification is required and, I might say, the Trust at senior management level needs to actually decide what it is and that it expects its clinicians to do when you are urologist of the week. …	Transcript FILE 15 AOB-56375
21.09.2018	Meeting with Mr O'Brien and Mr Weir	Page 14 (Section B – H) – Page 16 (Section A – H) MR O'BRIEN: It is more, but, Colin, the secret in this is the word "it". What is it? MR WEIR: Okay. MR O'BRIEN: You're saying okay. Do you appreciate what I'm talking about? MR WEIR: Yes. MR O'BRIEN: What am I talking about? MR WEIR: Well, you're saying, as I understand it, because we've stopped doing it. We have stopped doing E triage because it's so time consuming. MR O'BRIEN: Why did you stop doing E triage? MR WEIR: Because it, for us, and looking at the volumes that we were getting, it became a nightmare. And because we're not one specialty, because colorectal and there's general and to get one surgeon of the week to do something like 100 plus referrals trough E Triage, it was not working. And then – MR O'BRIEN: Explain to me, I am interested in the whole thing of triage. Why did it not work? MR WEIR: I would be doing it then. A lot of them we have to direct so you can actually, as I recall – MR O'BRIEN: Assign another consultant	Transcript FILE 15 AOB-56378 - AOB-56380

		MR WEIR: To another consultant. Then how were we going to do that? And how has that been – and that wasn't being reflected in anybody's job plan. So it could be directed to another consultant who wasn't a surgeon of the week but it was going to their specialty. The Trust, the management, just hadn't figured out how to direct those patients to the right consultant at the start of the process. MR O'BRIEN: But you all you do is name the consultant MR WEIR: Yes. But then – it's then like a triaging twice then. You are actually – one person doing and then it goes to another person MR O'BRIEN: True, but we do that. … MR O'BRIEN: So why – explain to me why it works better on paper as opposed to – obviously if you get a paper – the same referral comes on paper MR WEIR: When we do it on paper takes about ten seconds. MR O'BRIEN: How does it take ten seconds? MR WEIR: If you look at it – because there's no other thing other to direct where that patient goes. There's a box that's stamped on it, where do they go and the urgency. Red flag routing. And then specialty. There's only two things to tick. MR O'BRIEN: So why was that not apparent on the E triage? On the E referral? MR WEIR: You've done it. I recall the number of clicks and mouse clicks and buttons to press. I mean, it just – it took a lot longer. It takes a lot longer. And then, I don't know, but you are – MR O'BRIEN: Does it mean – MR WEIR: Requesting investigations and such. MR O'BRIEN: Leave that aside for a moment. But does – if the referral comes in as an E referral, does it – and you're – obviously it's on ECR, did that come with an expectation that you would be looking at that person's previous history or anything that was more time consuming, whereas you couldn't do that on the paper one? MR WEIR: NO. MR O'BRIEN: You could do it on a paper one if you wished. You could go on to ECR but obviously you don't do that.	
21.09.2018	Meeting with Mr Weir and Mr O'Brien	Page 21 (Section F – H) Mr O'BRIEN: … As a matter of interest actually, can I ask you one question. The historically or whatever job plan I am currently operating on, do I get more administrative time than others? MR WEIR: I don't think so. No I don't think so. I mean, I don't know. I would need to look at it carefully just to – MR O'BRIEN: No, but have I had more administrative time? Mr WEIR: No. I don't think you have.	Transcript File 15 AOB-56385

21.09.2018	Email from Mr O'Brien to Mr Weir	Thank you for this morning's meeting. Since then, I have reviewed the number of Day Surgical Unit operating sessions I have had on Tuesday mornings this year to date. I will have had 15 to the end of October 2018. Pro rata, I will have done 18 during this calendar year. More importantly, it will be 18 during a 42 week working year. Therefore, I think that it would be better to have me here on Tuesdays in 5 of the ten elective weeks in the 12 week cycle. So, the only change is that during each 12 week cycle, • I will have a SWAH clinic on three Mondays • I will have an Armagh clinic on two Mondays (rather than three) • I will not have a fixed clinical commitment on the Tuesdays of those five weeks • I will have DSU lists in the morning of and a clinic in the afternoon of the Tuesdays of the remaining five weeks (rather than four) • I will not have any fixed clinical commitment on the Mondays of those five weeks. I think that this is a better balance than previously,	TL6 page 1151 AOB-81444
24.09.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has increased by 1.539 (6.14 hours) SPA has increased by 0.713 (2.50 hours)	SUP 503 AOB-03999
24.09.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has increased by 2.098 (8,23 hours) SPA has decreased by 0.417 (1.40 hours)	SUP 504 AOB-04000
24.09.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has increased by 1.263 (5.00 hours) SPA has increased by 0.551 (2.13 hours)	SUP 505 AOB-04001
24.09.2018	Email to Mr O'Brien	Re changes to Job Plan DCC has increased by 0.536 (2.08 hours)	SUP 506 AOB-04002
21.10.2018	Email from Mr O'Brien to Mr Weir	1. Firstly, it should be recorded that I do undertake private practice. 2. For the sake of accuracy, I think the handover ward round following completion of 'urologist of the week' should be from 09.00 am to 12.00 noon on Thursdays of Weeks 2 and 8, as one is 'urologist of the week' on weeks 1 and 7. 3. Further to my last email, we have had a further discussion concerning predictable work during the weekend when 'urologist of the week'. The consensus, including that of Mark Haynes, was that we should commit to 3 hours of predictable work at weekends, and which will hopefully translate into undertaking a ward round on Saturdays. Michael was to or will write to you with that agreement. I presume that you may not be able to include that in my Job Plan at this time as it has not been approved as yet. If not, when will it be possible to include it? 4. I would appear that You have me doing 10.5 morning clinic per year in SWAH and 10 afternoon clinics per year in SWAH. I will have done 12 this year. Maybe I should allow myself some annualised flexibility, and go for 11 per year. 5. It would appear that two hours has been allocated to previewing MDM. I had thought that it had been agreed that it would be three hours.	TL6 page 1282 AOB-81575
31.10.2018	Email correspondence between Mr Weir and Mr O'Brien	Surgeon of the week is recorded as weeks 1 and 7 9 to 17:30 AND Weeks 6 and 12 of 12 week cycle from 9 to 12, this is your handover round. It really doesn't matter if it is weeks 2 and 8 as long as we have the 2 weeks of the cycle recorded I have changed your SWAH to ALL day annualised 12 per year to be on the safe side and includes travel time I have increased your MDT time to 3 hours I will await Michael's and the department's agreed decision around weekends. I appreciate not all Consultants do the same thing and if it is the case that some of you come in and spend time doing ward rounds on both days as a predictable commitment then I will include this	TL6 page 1304 – 1305 AOB-81597 – AOB-81598
31.10.2018	Email from Zicardian	Re Job plan change DCC increased by 0.022 (0.06 minutes)	TL6 page 1306 AOB-81599
31.12.2018 – 10.06.2020	ISCP	Intercollegiate Surgical Curriculum Programme Requests from trainees to have appraisals and assessments reviewed etc.	SUP2 page 1 – 5 AOB-04254 – AOB-

<table>
<tr><td></td><td></td><td></td><td>04258</td></tr>
<tr><td>08.11.2018</td><td>Meeting with Mr Weir and Mr O'Brien</td><td>Page 5 Section G – Page 6 Section A

Mr O'Brien: One was, one of the things that had been alleged during the course of the investigation, as I said to you last time, was that I had more allocated more, much more administrative time historically than anybody else.

Mr Weir: Okay

Mr O'Brien: And I had asked you whether or not that was the case and you had hinted that maybe you had no knowledge that it was. I have no interest in thejob plans of any other person even though it seems that everybody else had an interest in mine. So all I wanted you –

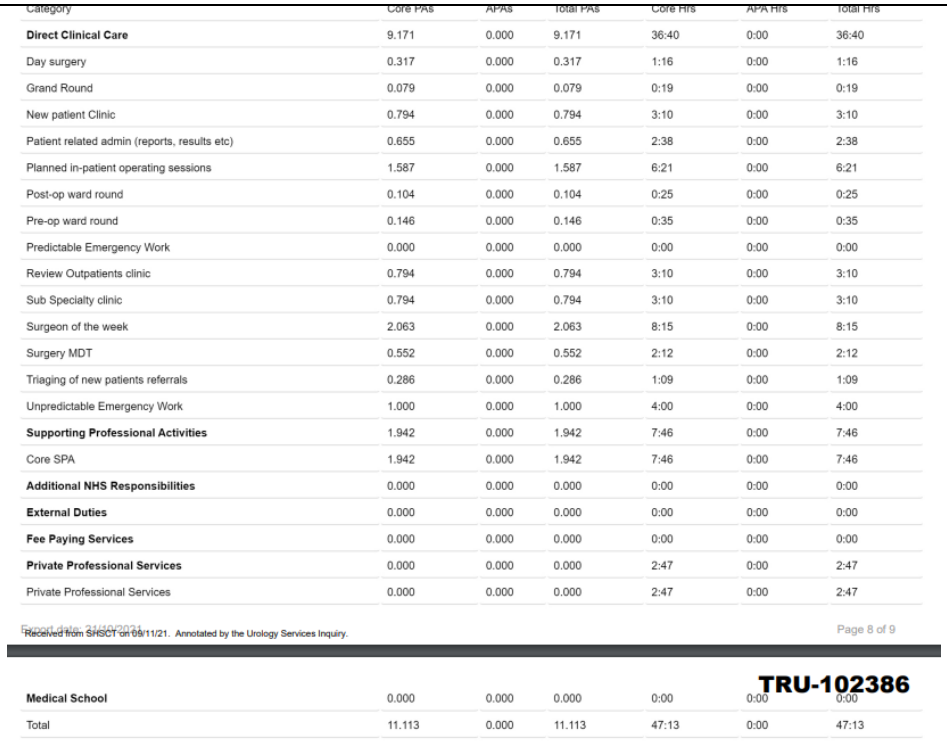
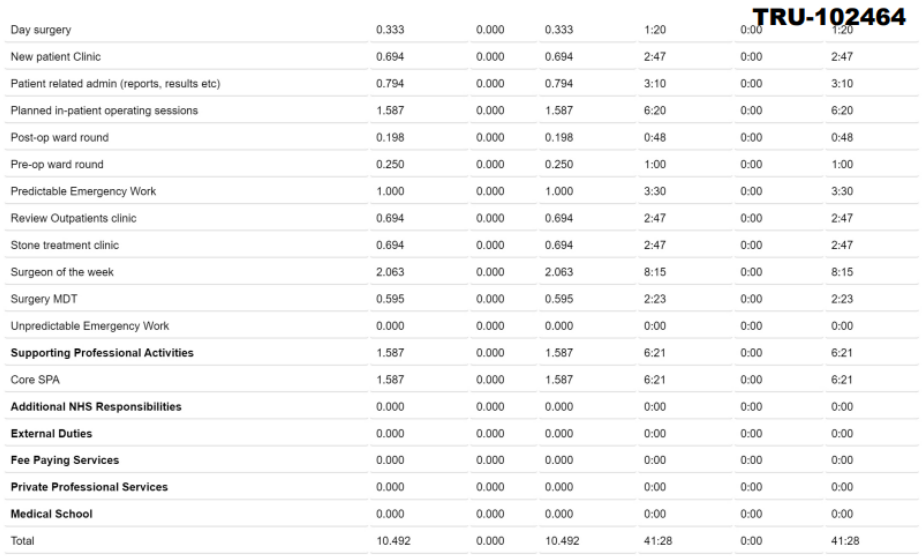
Mr Weir: Your job plan is what's agreed between you and me. If I don't agree it, then I will tell you. So you have ajob plan that we have spent hours working on.

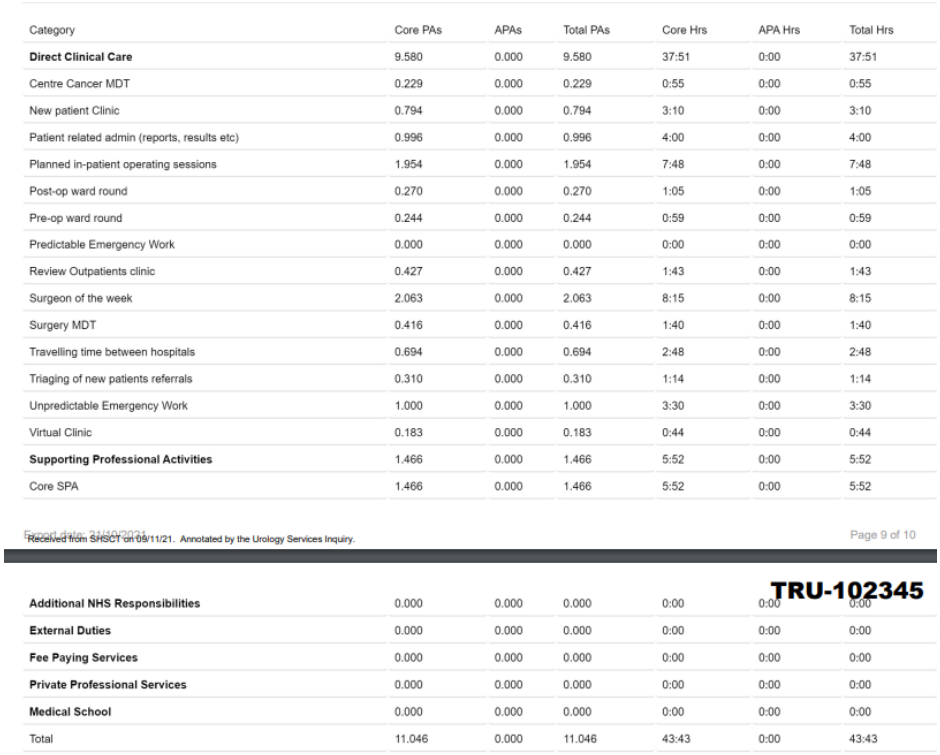
Mr O'Brien: I am not talking about this one. I am talking about historically

Mr Weir: I don't know.</td><td>Transcript File 19

AOB-56474 - AOB-56475</td></tr>
<tr><td>01.01.2019</td><td>Mr Hasnain Job Plan</td><td>Total PAS: 12.966
Total Hours: 48.13

Summary
<table><tr><th>Category</th><th>Total PAs</th><th>Total Hrs</th></tr><tr><td>Direct Clinical Care</td><td>11.975</td><td>44:15</td></tr><tr><td>Flexible DCC session (OP/SSU/Theatre)</td><td>2.349</td><td>9:24</td></tr><tr><td>Patient related admin (reports, results etc)</td><td>0.808</td><td>3:14</td></tr><tr><td>Shift on junior doctor rota OOH</td><td>4.251</td><td>13:21</td></tr><tr><td>Surgeon of the week</td><td>4.127</td><td>16:30</td></tr><tr><td>Surgery MDT</td><td>0.440</td><td>1:46</td></tr><tr><td>Supporting Professional Activities</td><td>0.991</td><td>3:58</td></tr><tr><td>Core SPA</td><td>0.991</td><td>3:58</td></tr><tr><td>Additional NHS Responsibilities</td><td>0.000</td><td>0:00</td></tr><tr><td>External Duties</td><td>0.000</td><td>0:00</td></tr><tr><td>Fee Paying Services</td><td>0.000</td><td>0:00</td></tr><tr><td>Private Professional Services</td><td>0.000</td><td>0:00</td></tr><tr><td>Medical School</td><td>0.000</td><td>0:00</td></tr><tr><td>Total</td><td>12.966</td><td>48:13</td></tr></table></td><td>TRU-102437 – TRU-102443</td></tr>
<tr><td>01.02.2019</td><td>Mr Glackin Job plan</td><td>Total PA: 12.256
Total Hours: 51.47</td><td>TRU-102378 – TRU-102386</td></tr>
</table>

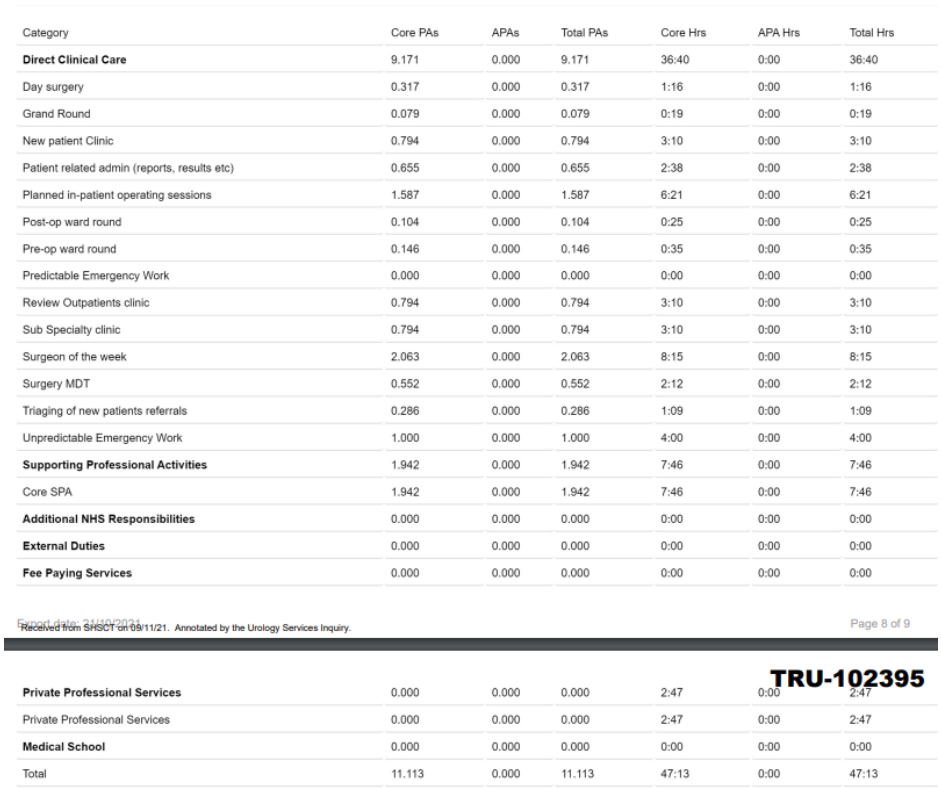
			
25.02.2019	Mr Tyson Job Plan	Total Pas: 10.492 Total Hours: 41.28 	TRU-102458 – TRU-102464
04.04.2019	Meeting with Dr Khan, Ms Hynds and Mr O'Brien	Advising that Mr O'Brien has been referred to GMC by Dr O'Kane	Transcript File 21 AOB-56495 - AOB-56496
29.04.2019	Email correspondence between Ms Corrigan and Mr Weir	Exchange of emails between Martina Corrigan and Colin Weir on the question of the need to discuss AOB's Job Plan.	Doc File 3 Pages 585 – 587 AOB-02153 - AOB-02155
30.04.2019	Email from Mr Young to Mr McNaboe	Re: Job plan Detailing that Mr O'Brien and Mr Young go to SWAH each month 2nd and 4th. Notes that generally they keep to the same week but will switch around if one	TL4 page 1026 AOB-08303

		cannot go on their allocated weeks.	
02.09.2019	Mr Haynes Job plan	Total PA: 13.920 Total Hours: 55.13 	TRU-102336 – TRU-102345
24.11.2019	Email correspondence between Mr O'Brien and Mr Young	**Re Scheduling** "You may recall my indicating that it was my intention to reduce my workload as reflected in my Job Plan. I intend to withdraw from clinical commitments on Thursdays from 01 January 2020. That means that I will not be taking up any operating sessions on Thursday mornings or attending/chairing MDM on Thursday afternoons. I have discussed the latter with both Mark and Tony, who are in acceptance, even though it will increase their MDM commitment, as it will for John as well. My withdrawal from Thursdays will not affect my commitment to UOW. I will still begin each UOW on Thursday and will still do handover at the end of each UOW. I hope to have a new Job Plan signed off during December 2019. …"	SUP2 page 54 AOB-04307
04.12.2019	Email from Mr O'Brien to Mr McNaboe	**Re: Job Plan** Mr O'Brien wishes to withdraw from clinical commitments on Thursdays. This effectively means that he will not avail of any operating sessions made available to him on Thursday mornings and will not attend or chair Urology MDM on Thursday afternoons. Mr O'Brien's colleagues are in agreement with this. This arrangement will not affect urologist of the week.	TL4 page 2768 – 2769 AOB-70038 - AOB-70039
09.12.2019	Email from Mr O'Brien to Mr McNaboe	**Mr O'Brien raises his issues re proposed job plan**	TL4 page 2814 - 2815 AOB-70084 – AOB-70085

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	9.580	0.000	9.580	37:51	0:00	37:51
Centre Cancer MDT	0.229	0.000	0.229	0:55	0:00	0:55
New patient Clinic	0.794	0.000	0.794	3:10	0:00	3:10
Patient related admin (reports, results etc)	0.996	0.000	0.996	4:00	0:00	4:00
Planned in-patient operating sessions	1.954	0.000	1.954	7:48	0:00	7:48
Post-op ward round	0.270	0.000	0.270	1:05	0:00	1:05
Pre-op ward round	0.244	0.000	0.244	0:59	0:00	0:59
Predictable Emergency Work	0.000	0.000	0.000	0:00	0:00	0:00
Review Outpatients clinic	0.427	0.000	0.427	1:43	0:00	1:43
Surgeon of the week	2.063	0.000	2.063	8:15	0:00	8:15
Surgery MDT	0.416	0.000	0.416	1:40	0:00	1:40
Travelling time between hospitals	0.694	0.000	0.694	2:48	0:00	2:48
Triaging of new patients referrals	0.310	0.000	0.310	1:14	0:00	1:14
Unpredictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Virtual Clinic	0.183	0.000	0.183	0:44	0:00	0:44
Supporting Professional Activities	1.466	0.000	1.466	5:52	0:00	5:52
Core SPA	1.466	0.000	1.466	5:52	0:00	5:52

Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	0:00	0:00	0:00
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	11.046	0.000	11.046	43:43	0:00	43:43

		Thank you for the proposed Job Plan. As expected, I have a number of issues' I have reviewed my activity of the past year in doing so. Regarding Mondays: I have done 11 Clinic days in SWAH during the past year, having been there each calendar month with the exception of October 2019. I have given going to SWAH priority over going to Armagh as it has been more important for many older patients, and particularly cancer patients, to be reviewed in SWAH, as the distance to travel can often mean the difference between receiving care or not at all. A SWAH clinic day is available on either the second or fourth Monday of the month. So, on occasion, I have gone to SWAH on the second rather than the fourth, if I was unable to go there on the fourth Monday for whatever reason. While it does not make any difference to Job Planning, the clinic composition is a mixture of new patients and review patients. I increased the number attending during the past year, so that the clinic is scheduled to commence at 09.30 am and is supposed to end at 05.00 pm, but usually does not end until 05.30 pm. You have not included travelling time which has been included previously, one hour each morning and one hour to return each evening. So, I would be grateful if you would increase the number of SWAH clinics to 11, or indeed 12 per year as in the current Job Plan, as that number is vitally needed. I would be grateful if you would have the clinic start at 09.30 am and end at 05.30 pm, and add in one hour of travelling time, each way, as at present. Regarding operating sessions: I greatest concern with the proposed Job Plan is the sparsity of inpatient operating sessions included. At 1.18 sessions per week, the Job Plan is more akin to that of a physician, with a little operating added in. During 2019, • on one Wednesday, I had an operating session in the morning only, as there was a PSM in the afternoon • on ten Wednesdays, I had an operating session in the afternoon only • on 26 Wednesdays, I had all day operating, morning and afternoon • on 12 Thursdays, I had an operating session in the mornings only • in addition, I have had another 12 operating sessions while being urologist of the week, though perhaps this activity should be regarded as predictable emergency activity while urologist of the week, as it is done in addition to the unpredictable. The proposed Job Plan implies that I would have only 40.33 operating sessions per year. In 2019, I had 75 sessions, plus another 12 when UOW, plus 3 paediatric urological sessions in DHH, a total of 90 sessions! I think the number included in the proposed Job Plan in clinically untenable. If necessary, I will take up any operating sessions available on Thursday mornings (12 during the past year). In any case, my primary intent in reducing my clinical commitment was by excluding MDM on Thursday afternoons from my working week. I would intend to do three paediatric operating sessions during 2020, on the fifth Monday in March, June and November 2019. Regarding Urologist of the week: The proposed Job Plan implies that one would do seven per year, presumably one in every six weeks during a 42 week year. But I will have done eight in 2019. Six urologists still do have to be urologists of the week for a 52 week year. If annual leave coincides with a scheduled week of UOW, your turn is brought forward or later. It is not cancelled. It would appear that you may not have included the session for handover on each Thursday morning on completion of UOW. Increasingly we have been undertaking operating sessions when UOW. These are undertaken in addition to all the other duties of UOW, including emergency surgery. I will have undertaken 12 such sessions, a mean of1.5 for each UOW. Should these not be regarded as predictable emergency work? In our last round of Job Plans, it was also agreed that each of us would be allocated one session for a weekend ward round. That would appear not to have been included in the proposed Job Plan. Lastly, it was agreed during the last round that we would be allocated six additional hours of predicted time for triage while UOW. It would appear that this may not have been included in the proposed Job Plan. Regarding Administration Time: The proposed Job Plan provides for a total of 18 hours every six weeks. It has been my understanding that we should have one session per week provided for administration. I do hope you will find these points to be of further assistance.	
01.01.2020	Mr O'Brien's Job Plan starting on 01 January 2020	**[Please note this is in a different format to previous Job Plans]** Provides Direct Clinical Care PAs as 8.201 and Supporting Professional Activities at 1.466 Total 9.668 Administration specified to be 0.897.	Doc File 4 Pages 129 - 131 AOB-02290 - AOB-02292
01.01.2020	Mr Glackin Job	Total PA: 12.256 Total Hours: 51.47	TRU-102387 –

	plan		TRU-102395
10.01.2020	Email from Mr McNaboe to Mr O'Brien	Re: Job Plan 2020 Mr O'Brien query of whether Mr McNaboe was able to make adjustments to the proposed job plan since meeting in December 2019. Mr McNaboe was to make adjustments on his review.	TL2 Page 86 AOB-04543
16.01.2020	Email from Mr O'Brien to Mr McNaboe	Re: Job Plan Were not able to meet to discuss job plan. Proposed job plan of 09 Dec 2019 included a total of 9.669Pas. Having agreed additional activities to be added, the total Pas in the draft referred to below is 6.314. I note you have adopted a 12 week cycle, but there is no activity documented for weeks 7 to 12.	TL2 page 106 AOB-04563
16.01.2020	Email from Mr McNaboe to Mr O'brien	Re: Job Plan Didn't get back to office until after 5 and needed to leave. Have been working on tonight and looking at ways to make it work. Ignore my automatic emails. … It is a difficult task so bear with me….	TL2 page 107 – 108 AOB-04564
20.01.2020	Email from Mr McNaboe to Mr O'Brien	Re: Job Plan … I have taken all your points on board and as far as possible tried to accommodate them. I need to be sure there is uniformity between you and your colleagues… I did talk to Michael as Lead Clinician for Urology and he confirmed that there was agreement about the SAT. WR during oncall weeks so I have built it in. It is not in any of the others JPs so I will need to adjust them as well. … It was quite a job trying to get it to fit. .. "	TL2 page 110 – 111 AOB-04567 – AOB-04568
13.02.2020	Email correspondence between Mr O'Brien and Mr Clegg	AOB forwards Martin Clegg forms in relation to retirement and documentation regarding prospect of returning to work following retirement.	Doc File 4 Pages 140 – 165 AOB-02301 - AOB-02326

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	9.171	0.000	9.171	36:40	0:00	36:40
Day surgery	0.317	0.000	0.317	1:16	0:00	1:16
Grand Round	0.079	0.000	0.079	0:19	0:00	0:19
New patient Clinic	0.794	0.000	0.794	3:10	0:00	3:10
Patient related admin (reports, results etc)	0.655	0.000	0.655	2:38	0:00	2:38
Planned in-patient operating sessions	1.587	0.000	1.587	6:21	0:00	6:21
Post-op ward round	0.104	0.000	0.104	0:25	0:00	0:25
Pre-op ward round	0.146	0.000	0.146	0:35	0:00	0:35
Predictable Emergency Work	0.000	0.000	0.000	0:00	0:00	0:00
Review Outpatients clinic	0.794	0.000	0.794	3:10	0:00	3:10
Sub Specialty clinic	0.794	0.000	0.794	3:10	0:00	3:10
Surgeon of the week	2.063	0.000	2.063	8:15	0:00	8:15
Surgery MDT	0.552	0.000	0.552	2:12	0:00	2:12
Triaging of new patients referrals	0.286	0.000	0.286	1:09	0:00	1:09
Unpredictable Emergency Work	1.000	0.000	1.000	4:00	0:00	4:00
Supporting Professional Activities	1.942	0.000	1.942	7:46	0:00	7:46
Core SPA	1.942	0.000	1.942	7:46	0:00	7:46
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00

Private Professional Services	0.000	0.000	0.000	2:47	0:00	2:47
Private Professional Services	0.000	0.000	0.000	2:47	0:00	2:47
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	11.113	0.000	11.113	47:13	0:00	47:13

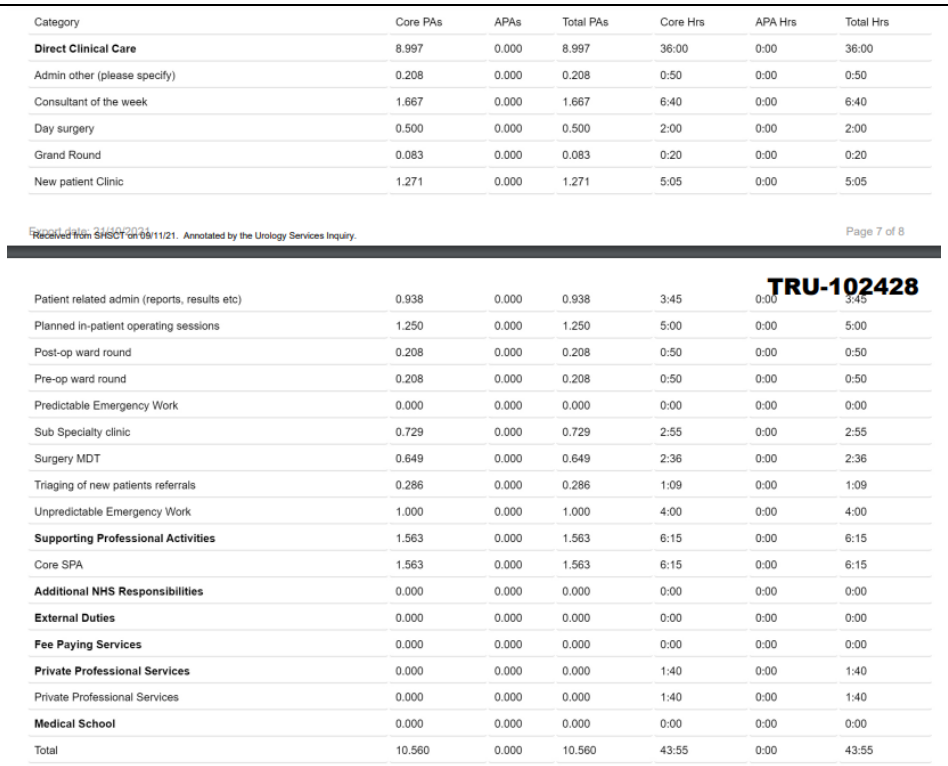
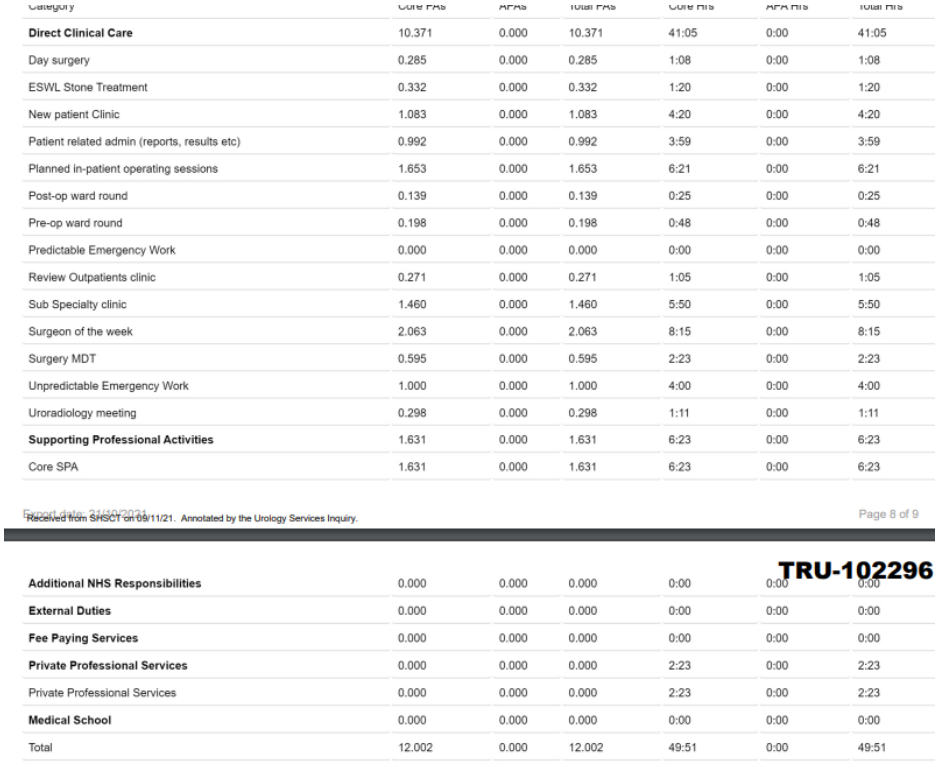
14.02.2020	Email from Ms McNeice to Mr Clegg	Forwarding on Mr O'Brien's documentation – AW6 form	TRU-01720 – TRU-01729
06.03.2020	Mr O'Brien's application for retirement	Form completed by AOB for scheme retirement benefits. Indicates proposed date of retirement 30 June 2020.	Doc File 4 Pages 190 – 199 AOB-02351 - AOB-02360
06.03.2020	Email from Ms McNeice to HSCNI	Sending through Mr O'Brien's medical retirement documentation	TRU-01731 – TRU-01742
31.03.2020	Timeline of Retirement	References a text message screenshot between Ms Corrigan and Mr O'Brien in relation to acknowledgement of retirement [**Document of this]**	TRU-01718 TRU-01743
01.04.2020	Mr Tyson Job Plan	Total PA: 10.492 Total Hours: 41.28	TRU-102465 – TRU-102471
01.04.2020	Mr O'Donoghue Job Plan	Total Pas: 11.560 Total Hours: 47.55	TRU-102421 – TRU-102428

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	8.905	0.000	8.905	35:07	0:00	35:07
Day surgery	0.333	0.000	0.333	1:20	0:00	1:20
New patient Clinic	0.694	0.000	0.694	2:47	0:00	2:47
Patient related admin (reports, results etc)	0.794	0.000	0.794	3:10	0:00	3:10
Planned in-patient operating sessions	1.587	0.000	1.587	6:20	0:00	6:20
Post-op ward round	0.198	0.000	0.198	0:48	0:00	0:48
Pre-op ward round	0.250	0.000	0.250	1:00	0:00	1:00

Report date: 18/04/2021 Page 6 of 7
Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

TRU-102471

Predictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Review Outpatients clinic	0.694	0.000	0.694	2:47	0:00	2:47
Stone treatment clinic	0.694	0.000	0.694	2:47	0:00	2:47
Surgeon of the week	2.063	0.000	2.063	8:15	0:00	8:15
Surgery MDT	0.595	0.000	0.595	2:23	0:00	2:23
Unpredictable Emergency Work	0.000	0.000	0.000	0:00	0:00	0:00
Supporting Professional Activities	1.587	0.000	1.587	6:21	0:00	6:21
Core SPA	1.587	0.000	1.587	6:21	0:00	6:21
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	0:00	0:00	0:00
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	10.492	0.000	10.492	41:28	0:00	41:28

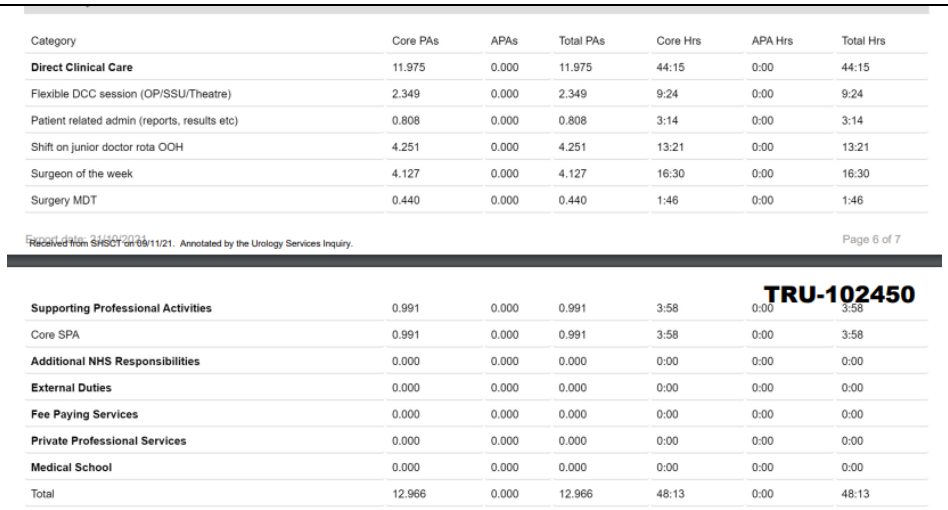
			
01.04.2020	Mr Young Job plan April 2020	Total PA: 12.46 Total Hours: 51.41 	TRU-102288 – TRU-102296
01.04.2020	Mr Hasnain Job Plan	Total PA: 12.966 Total Hours: 48.13	TRU-102444 – TRU-102450

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	8.997	0.000	8.997	36:00	0:00	36:00
Admin other (please specify)	0.208	0.000	0.208	0:50	0:00	0:50
Consultant of the week	1.667	0.000	1.667	6:40	0:00	6:40
Day surgery	0.500	0.000	0.500	2:00	0:00	2:00
Grand Round	0.083	0.000	0.083	0:20	0:00	0:20
New patient Clinic	1.271	0.000	1.271	5:05	0:00	5:05

Patient related admin (reports, results etc)	0.938	0.000	0.938	3:45	0:00	3:45
Planned in-patient operating sessions	1.250	0.000	1.250	5:00	0:00	5:00
Post-op ward round	0.208	0.000	0.208	0:50	0:00	0:50
Pre-op ward round	0.208	0.000	0.208	0:50	0:00	0:50
Predictable Emergency Work	0.000	0.000	0.000	0:00	0:00	0:00
Sub Specialty clinic	0.729	0.000	0.729	2:55	0:00	2:55
Surgery MDT	0.649	0.000	0.649	2:36	0:00	2:36
Triaging of new patients referrals	0.286	0.000	0.286	1:09	0:00	1:09
Unpredictable Emergency Work	1.000	0.000	1.000	4:00	0:00	4:00
Supporting Professional Activities	1.563	0.000	1.563	6:15	0:00	6:15
Core SPA	1.563	0.000	1.563	6:15	0:00	6:15
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	1:40	0:00	1:40
Private Professional Services	0.000	0.000	0.000	1:40	0:00	1:40
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	10.560	0.000	10.560	43:55	0:00	43:55

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	10.371	0.000	10.371	41:05	0:00	41:05
Day surgery	0.285	0.000	0.285	1:08	0:00	1:08
ESWL Stone Treatment	0.332	0.000	0.332	1:20	0:00	1:20
New patient Clinic	1.083	0.000	1.083	4:20	0:00	4:20
Patient related admin (reports, results etc)	0.992	0.000	0.992	3:59	0:00	3:59
Planned in-patient operating sessions	1.653	0.000	1.653	6:21	0:00	6:21
Post-op ward round	0.139	0.000	0.139	0:25	0:00	0:25
Pre-op ward round	0.198	0.000	0.198	0:48	0:00	0:48
Predictable Emergency Work	0.000	0.000	0.000	0:00	0:00	0:00
Review Outpatients clinic	0.271	0.000	0.271	1:05	0:00	1:05
Sub Specialty clinic	1.460	0.000	1.460	5:50	0:00	5:50
Surgeon of the week	2.063	0.000	2.063	8:15	0:00	8:15
Surgery MDT	0.595	0.000	0.595	2:23	0:00	2:23
Unpredictable Emergency Work	1.000	0.000	1.000	4:00	0:00	4:00
Uroradiology meeting	0.298	0.000	0.298	1:11	0:00	1:11
Supporting Professional Activities	1.631	0.000	1.631	6:23	0:00	6:23
Core SPA	1.631	0.000	1.631	6:23	0:00	6:23

Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	2:23	0:00	2:23
Private Professional Services	0.000	0.000	0.000	2:23	0:00	2:23
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	12.002	0.000	12.002	49:51	0:00	49:51

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	11.975	0.000	11.975	44:15	0:00	44:15
Flexible DCC session (OP/SSU/Theatre)	2.349	0.000	2.349	9:24	0:00	9:24
Patient related admin (reports, results etc)	0.808	0.000	0.808	3:14	0:00	3:14
Shift on junior doctor rota OOH	4.251	0.000	4.251	13:21	0:00	13:21
Surgeon of the week	4.127	0.000	4.127	16:30	0:00	16:30
Surgery MDT	0.440	0.000	0.440	1:46	0:00	1:46

Supporting Professional Activities	0.991	0.000	0.991	3:58	0:00	3:58
Core SPA	0.991	0.000	0.991	3:58	0:00	3:58
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	0:00	0:00	0:00
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	12.966	0.000	12.966	48:13	0:00	48:13

13.04.2020	Timeline of Retirement	References the following: *"email from Martina Corrigan to ZP attaching copy of AOB's retirement letter which was emailed to her on 26 March 2020 @23.17, "each day my intent to send you a letter of retirement has fallen by the wayside. I have managed to remember to do so this evening. It's a surreal moment, after 28 years!".* *In Martina's covering email she advises that she had acknowledged receipt of AOB's retirement letter – no indication by what means this was acknowledged as not shared with HR"*	TRU-01718 TRU-01744 – TRU-01745
15.04.2020	Timeline of Retirement	References the following: *"MC responded to Martina's email advising that Mr O'Brien's application for pension benefits is in hand and will be processed as a leave for 30 June 2020. He also advised that Martina would need to inform HR if it has been agreed for Dr O'Brien to return to work following his retirement so he can be reinstated on the payroll"*	TRU-01718
08.06.2020	Phone call with Mr Haynes, Mr Carroll and Mr O'Brien	Page 2 Section B – Page 3 Section F Mr Haynes: *Obviously I know you have spoken to myself and you have spoken to Martina about coming back after July, haven't you?* *Mr O'Brien: Yes I have, and Michael* *Mr Haynes: Yes. I've taken that forward with a number of conversations within the Trust, with HR and at Medical Director level. Unfortunately the practice of the Trust would be that they don't re-engage people while there's on going HR processes* *Mr O'Brien: I see* *Mr Haynes: Which means from my perspective I can't take it any further forwards at present* *Mr O'Brien: So the reason for – so who has made this decision?* *Mr Haynes: But that's what I have been advised by both the medical director and by enquiring with HR* *Mr O'Brien: So it's because of – because they haven't yet the grievance and all of that thing?* *Mr Haynes: Yes. So as I understand it there's the grievance and there's also – so the grievance is it from you to the Trust I think, isn't it?* *Mr O'Brien: Yes*	Transcript File 22 AOB-56498 - AOB-56499

<table>
<tr><td></td><td></td><td>Mr Haynes: And there was a Trust thing as well, was it the maintaining professional standards investigation and everything. That's not closed off as yet.

Mr O'Brien: Well, the investigation has been closed off, yes.

Mr Haynes: Yes. And theres – from Maria I was advised there's a GMC issue process as well, that's in process

Mr O'Brien: Okay. So that's very disappointing…

..

Mr O'Brien: How do you personally reconcile this with my continued employment as I am currently this day and tomorrow with a decision that, nevertheless, I cannot be re-employed? How does one reconcile that?

Mr Haynes: … Yes but you are currently working under a current contract, whereas your return to work would be re-engagement on a new contract</td><td></td></tr>
<tr><td>08.06.2020</td><td>Timeline of Retirement</td><td>References the following: "Niamh O'Hanlon took a call from AOB – he wanted a copy of correspondence from HR acknowledging his retirement letter. No formal acknowledgement letter issued to AOB as all HR processes in relation to his pension application had been completed on 6 March 2020 and a copy of his retirement letter was not received until 13 April 2020</td><td>TRU-01718

TRU-01746</td></tr>
<tr><td>08.06.2020</td><td>Letter to Mr O'Brien from Ms Toal</td><td>In response to FOI request Ms Toal gives a table for Mr O'Brien's Job Plan details as follows:-
<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>April 11 - March 12:</td><td>2.077 PA's for patient admin</td><td>12.54 (Not signed off)</td><td>15 PA's* Reduced to 12.75 in Oct11</td></tr>
<tr><td>April 12 - March 13</td><td>0.80 PA's for patientadmin</td><td>11.275 (Not signed off)</td><td>12 PA's</td></tr>
<tr><td>April 13 - March 14</td><td>0.80 PA's for patientadmin</td><td>11.275 (Not signed off)</td><td>12 PA's</td></tr>
<tr><td>April 18 - March 19</td><td>0.771 PA's for patient admin</td><td>11.733 (Not signed off)</td><td>12 PA's</td></tr>
<tr><td>1 January 2020</td><td>1.060 PA's for patient admin</td><td>8.93 (Not signed off)</td><td>12 PA's</td></tr>
</table></td><td>Doc File 4 Pages 306 – 307

AOB-02467 - AOB-02468</td></tr>
<tr><td>09.06.2020</td><td>Letter to Ms Toal from Mr O'Brien</td><td>AOB writes to Ms Toal noting prior to submitting his application for retirement he had support from Malcolm Clegg, Mr Young and Mr Haynes in relation to his return to part-time working after retirement. Noted that he was first advised on 5 June 2020 by Mr Haynes that he would not be entitled to return as it was not practice to re-engage people who were undergoing ongoing HR processes.

Revokes his application for retirement benefits.</td><td>Doc File 4 Pages 312 - 313

AOB-02473 - AOB-02474</td></tr>
<tr><td>09.06.2</td><td>Timeline of</td><td>References the following: "Letter issued to AOB from Medical HR advising that</td><td>TRU-01718</td></tr>
</table>

020	Retirement	*all HR processes had been completed in relation to his pension application.* *Follow up email from AOB to AMcN following telephone call requesting a copy of his AW6 form – copy sent @12.47* *In confidence email sent from ZP to March Haynes [not attached]*	
10.06.2020	Letter from Ms Toal to Mr O'Brien	Acknowledging receipt of Mr O'Brien's letter	SUP2 Pg 104 AOB-04357
10.06.2020	Email from Mr O'Brien to Mr Dougherty	Re Retirement and Pension deferment "Following our telephone conversation today, I write to confirm that I have notified my employer, southern Health and Social Care Trust, of my decision not to withdraw from full-time employment on the 30 June 2020. As a consequence I have asked you to suspend payment of pension benefits until the actual date of retirement has been clarified"	SUP2 Pag 105 AOB-04358
10.06.2020	Letter to Mr Devlin from Mr O'Brien	AOB advises of the issue with his retirement. Asks for his Grievance to be resolved by 26 June 2020 with confidence that the appeal from the MHPS would be successful and there would be no outstanding HR processes.	Doc File 4 Page 319 AOB-02480
11.06.2020	Email from Mr Devlin to Mr O'Brien	Acknowledgement of receipt of letters	SUP2 Page 106 AOB-04359
11.06.2020	Timeline of Retirement	References the following: *"Initial Response from V Toal to Mr O'Brien*	TRU-01719 TRU-01752
12.06.2020	Letter from Mr O'Brien to Ms Toal	Dear Mrs. Toal, Thank you for your email of 11 June and prompt reply. I wish to clarify that I have not tendered *my resignation* as you suggest, nor has the Trust formally accepted the end of my full time employment. I note your proposed time scale for a more detailed response but would ask to hear from you by 5.00 pm on Monday 15 June 2020. I also await a copy of the Trust's policy requested in my letter of 9 June.	TRU-01753
18.06.2020	Letter to Mr O'Brien from Ms Toal	Trust states the position that there is no automatic right to return to employment following retirement. Notes Mr Young, Ms Corrigan and Mr Haynes do not agree with his recollection when he said that he confirmed their support for his return post retirement. Indicates that it is not open to him to withdraw his notice of termination unilaterally.	Doc File 4 Pages 326 – 327 AOB-02487 - AOB-02488
23.06.2020	Letter to Mr O'Brien from Ms Toal	Letter from Ms Toal to AOB indicating that his grievance had not been progressed due to the volume of information he had requested. Noted now that was completed they would meet with him to consider his grievance.	Doc File 4 Page 328 AOB-02489
23.06.2020	Letter to Ms Toal from Tughans	Tughans write on behalf of Mr O'Brien to the Trust requesting confirmation the Trust will continue to employ Mr O'Brien after 30 June to avoid the matter being dealt with by way of legal proceedings. Contends that Mr O'Brien was entitled to withdraw his notice and the Trust was obliged to accept it.	Doc File 4 Pages 329 – 333 AOB-02490 - AOB-02494
30.06.2020	Email from Mr O'Brien to Ms Poland	Re Secretarial Support "I have been advised that my secretary, Noleen Elliot, is being moved to another post today. I write to advise you that the Trust has agreed to my continued employment until at least Tuesday 14 July 2020. I believe that it is inappropriate that Noleen's tenure as my secretary has been terminated today. I would be grateful if you would ensure that Noleen remain in her current post as my secretary until at least Tuesday 14 July 2020"	SUP 2 Page 116 AOB-04369

29.07.2020	Email from GMC to AOB	Re undertaking not to undertake private clinical work Request for AOB to confirm whether AOB has any intention to seek employment elsewhere (including locum work) or whether AOB is currently working elsewhere	SUP2 Page 134 AOB-04387
30.07.2020	Email correspondence between Ms Parks and Mr Brammall (GMC) dated 30 July 2020 enclosing job plans	The Trust email GMC Job Plans for AOB. Attached two Job Plans neither of which they say were signed. The first one is stated to start "*1 April 2013"* and ended "*31 March 2018"* and the second started on "*1 April 2018"*.	Doc File 5 Pages 17 – 32 AOB-02589 - AOB-02604
01.04.2021	Mr Tyson Job Plan	Total Pas: 10.492 Total Hours: 41.28 	Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
---	---	---	---	---	---	---
Direct Clinical Care	8.905	0.000	8.905	35:07	0:00	35:07
Day surgery	0.333	0.000	0.333	1:20	0:00	1:20
New patient Clinic	0.694	0.000	0.694	2:47	0:00	2:47
Patient related admin (reports, results etc)	0.794	0.000	0.794	3:10	0:00	3:10
Planned in-patient operating sessions	1.587	0.000	1.587	6:20	0:00	6:20
Post-op ward round	0.198	0.000	0.198	0:48	0:00	0:48
Pre-op ward round	0.250	0.000	0.250	1:00	0:00	1:00 | Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry. Page 6 of 7 **TRU-102478** |						
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Predictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Review Outpatients clinic	0.694	0.000	0.694	2:47	0:00	2:47
Stone treatment clinic	0.694	0.000	0.694	2:47	0:00	2:47
Surgeon of the week	2.063	0.000	2.063	8:15	0:00	8:15
Surgery MDT	0.595	0.000	0.595	2:23	0:00	2:23
Unpredictable Emergency Work	0.000	0.000	0.000	0:00	0:00	0:00
Supporting Professional Activities	1.587	0.000	1.587	6:21	0:00	6:21
Core SPA	1.587	0.000	1.587	6:21	0:00	6:21
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	0:00	0:00	0:00
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	10.492	0.000	10.492	41:28	0:00	41:28		TRU-102472 – TRU-102478
01.04.2021	Mr Hasnain Job plan	Total PA: 11.145 Total Hours: 42.55 **TRU-102457** 							
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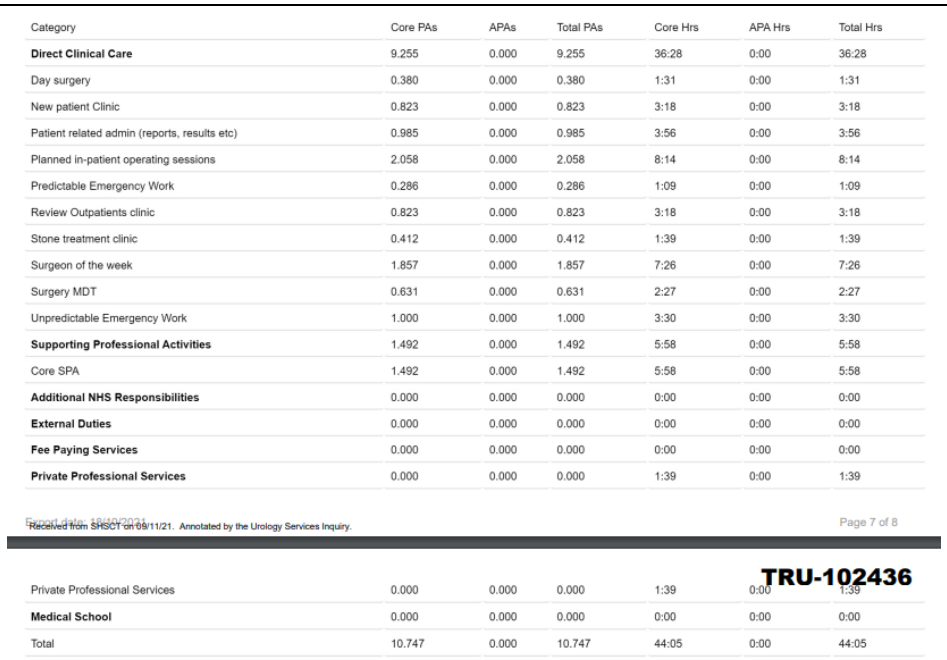
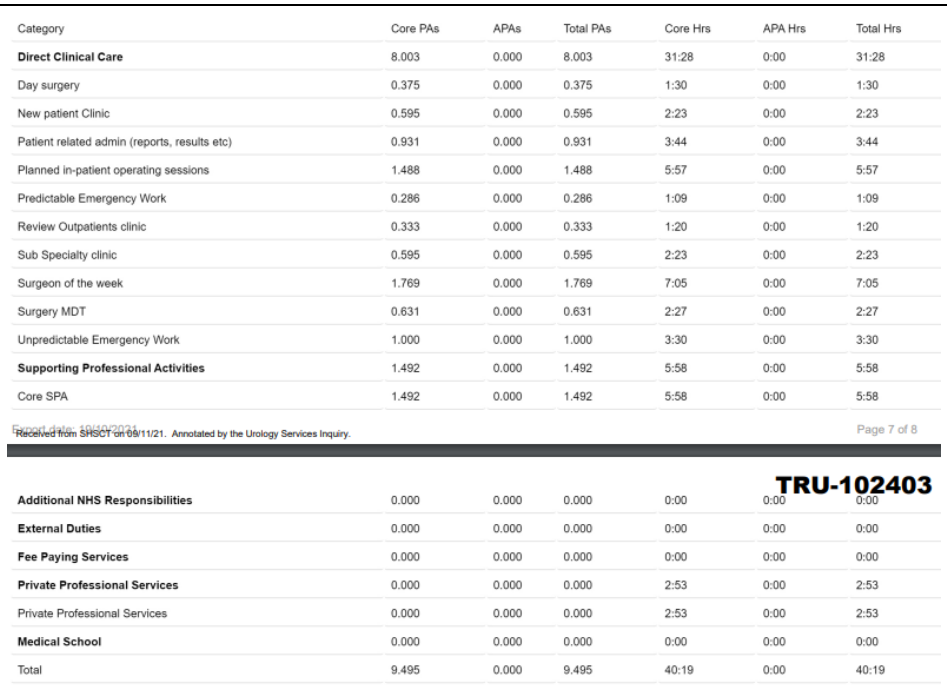
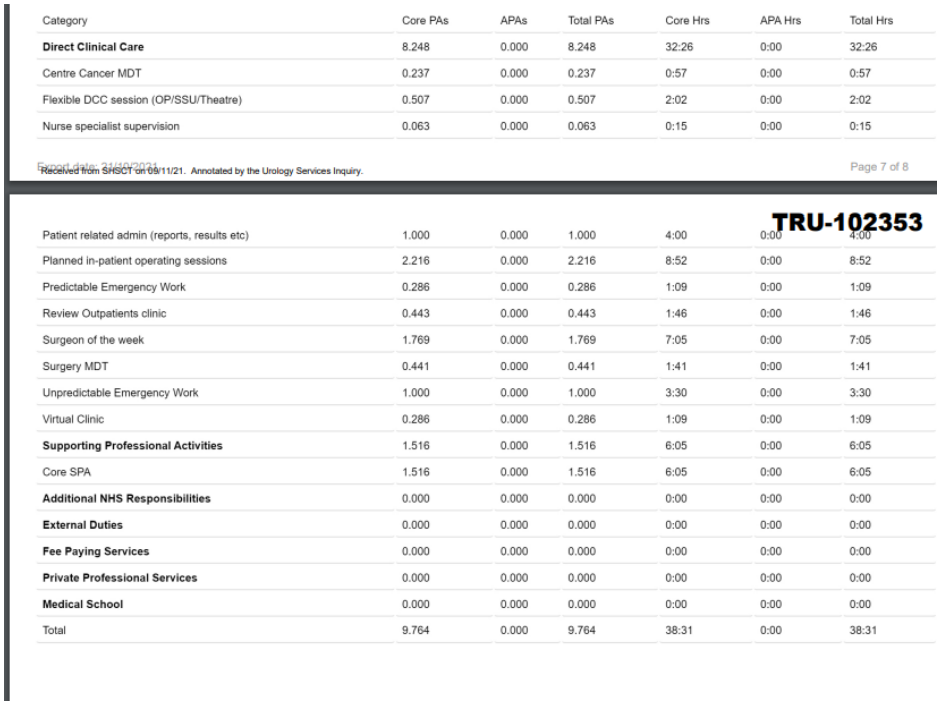
Direct Clinical Care	9.645	0.000	9.645	36:55	0:00	36:55
Day surgery	1.000	0.000	1.000	4:00	0:00	4:00
Flexible DCC session (OP/SSU/Theatre)	1.750	0.000	1.750	7:00	0:00	7:00
New patient Clinic	1.875	0.000	1.875	7:30	0:00	7:30
Other ward rounds	0.125	0.000	0.125	0:30	0:00	0:30
Patient related admin (reports, results etc)	0.750	0.000	0.750	3:00	0:00	3:00
Shift on junior doctor rota OOH	2.270	0.000	2.270	7:25	0:00	7:25
Urodynamics	0.875	0.000	0.875	3:30	0:00	3:30
Virtual Clinic	1.000	0.000	1.000	4:00	0:00	4:00
Supporting Professional Activities	1.500	0.000	1.500	6:00	0:00	6:00
Core SPA	1.000	0.000	1.000	4:00	0:00	4:00
Teaching - undergraduate	0.500	0.000	0.500	2:00	0:00	2:00
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	0:00	0:00	0:00
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	11.145	0.000	11.145	42:55	0:00	42:55		TRU-102451 – TRU-102457
01.04.2021	Mr O'Donoghue Job Plan	Total PA: 12.236 Total Hours: 50.02	TRU-102429 – TRU-102436

			
01.04.2021	Mr Young's job plan	Total PA: 10.431 Total Hours: 44.39 	TRU-102297 – TRU-10203
01.06.2021	Mr Glackin job plan	Total Pas: 11.486 Total hours: 48.17	TRU-102396 – TRU-102403

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	9.255	0.000	9.255	36:28	0:00	36:28
Day surgery	0.380	0.000	0.380	1:31	0:00	1:31
New patient Clinic	0.823	0.000	0.823	3:18	0:00	3:18
Patient related admin (reports, results etc)	0.985	0.000	0.985	3:56	0:00	3:56
Planned in-patient operating sessions	2.058	0.000	2.058	8:14	0:00	8:14
Predictable Emergency Work	0.286	0.000	0.286	1:09	0:00	1:09
Review Outpatients clinic	0.823	0.000	0.823	3:18	0:00	3:18
Stone treatment clinic	0.412	0.000	0.412	1:39	0:00	1:39
Surgeon of the week	1.857	0.000	1.857	7:26	0:00	7:26
Surgery MDT	0.631	0.000	0.631	2:27	0:00	2:27
Unpredictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Supporting Professional Activities	1.492	0.000	1.492	5:58	0:00	5:58
Core SPA	1.492	0.000	1.492	5:58	0:00	5:58
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	1:39	0:00	1:39

Private Professional Services	0.000	0.000	0.000	1:39	0:00	1:39
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	10.747	0.000	10.747	44:05	0:00	44:05

Direct Clinical Care	8.409	0.000	8.409	33:11	0:00	33:11
Day surgery	0.261	0.000	0.261	1:03	0:00	1:03
New patient Clinic	0.823	0.000	0.823	3:18	0:00	3:18
Patient related admin (reports, results etc)	1.080	0.000	1.080	4:20	0:00	4:20
Planned in-patient operating sessions	2.058	0.000	2.058	8:14	0:00	8:14
Predictable Emergency Work	0.286	0.000	0.286	1:09	0:00	1:09
Review Outpatients clinic	0.632	0.000	0.632	2:32	0:00	2:32
Stone treatment clinic	0.412	0.000	0.412	1:39	0:00	1:39
Surgeon of the week	1.857	0.000	1.857	7:26	0:00	7:26
Unpredictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Supporting Professional Activities	1.508	0.000	1.508	6:02	0:00	6:02
Core SPA	1.508	0.000	1.508	6:02	0:00	6:02
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	3:23	0:00	3:23
Private Professional Services	0.000	0.000	0.000	3:23	0:00	3:23
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	9.917	0.000	9.917	42:36	0:00	42:36

			
11.12.2021	Mr Haynes Job Plan	Total PA: 13.550 Total Hours: 53.39 	TRU-102346 – TRU-102353

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	8.003	0.000	8.003	31:28	0:00	31:28
Day surgery	0.375	0.000	0.375	1:30	0:00	1:30
New patient Clinic	0.595	0.000	0.595	2:23	0:00	2:23
Patient related admin (reports, results etc)	0.931	0.000	0.931	3:44	0:00	3:44
Planned in-patient operating sessions	1.488	0.000	1.488	5:57	0:00	5:57
Predictable Emergency Work	0.286	0.000	0.286	1:09	0:00	1:09
Review Outpatients clinic	0.333	0.000	0.333	1:20	0:00	1:20
Sub Specialty clinic	0.595	0.000	0.595	2:23	0:00	2:23
Surgeon of the week	1.769	0.000	1.769	7:05	0:00	7:05
Surgery MDT	0.631	0.000	0.631	2:27	0:00	2:27
Unpredictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Supporting Professional Activities	1.492	0.000	1.492	5:58	0:00	5:58
Core SPA	1.492	0.000	1.492	5:58	0:00	5:58

Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	2:53	0:00	2:53
Private Professional Services	0.000	0.000	0.000	2:53	0:00	2:53
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	9.495	0.000	9.495	40:19	0:00	40:19

Category	Core PAs	APAs	Total PAs	Core Hrs	APA Hrs	Total Hrs
Direct Clinical Care	8.248	0.000	8.248	32:26	0:00	32:26
Centre Cancer MDT	0.237	0.000	0.237	0:57	0:00	0:57
Flexible DCC session (OP/SSU/Theatre)	0.507	0.000	0.507	2:02	0:00	2:02
Nurse specialist supervision	0.063	0.000	0.063	0:15	0:00	0:15

Patient related admin (reports, results etc)	1.000	0.000	1.000	4:00	0:00	4:00
Planned in-patient operating sessions	2.216	0.000	2.216	8:52	0:00	8:52
Predictable Emergency Work	0.286	0.000	0.286	1:09	0:00	1:09
Review Outpatients clinic	0.443	0.000	0.443	1:46	0:00	1:46
Surgeon of the week	1.769	0.000	1.769	7:05	0:00	7:05
Surgery MDT	0.441	0.000	0.441	1:41	0:00	1:41
Unpredictable Emergency Work	1.000	0.000	1.000	3:30	0:00	3:30
Virtual Clinic	0.286	0.000	0.286	1:09	0:00	1:09
Supporting Professional Activities	1.516	0.000	1.516	6:05	0:00	6:05
Core SPA	1.516	0.000	1.516	6:05	0:00	6:05
Additional NHS Responsibilities	0.000	0.000	0.000	0:00	0:00	0:00
External Duties	0.000	0.000	0.000	0:00	0:00	0:00
Fee Paying Services	0.000	0.000	0.000	0:00	0:00	0:00
Private Professional Services	0.000	0.000	0.000	0:00	0:00	0:00
Medical School	0.000	0.000	0.000	0:00	0:00	0:00
Total	9.764	0.000	9.764	38:31	0:00	38:31

CHRONOLOGY

TRUST CONCERNS/CONSULTANT CONCERNS (EXCLUDING AOB)

MR AIDAN O'BRIEN

3911.100

NB – the screening reports are not clear as to dept, may need AOB to confirm whether urology or not.

Date	Document Name	Comments	Document No.
11.02.2009	Email Correspondence	Noting a workshop to launch review of Urology services	TL1 Page 182 AOB-82223
13.02.2009	Memo from Alison Porter to	Re: Cancer Review Appointments	TL1 page 185

	Consultants	During my recent meetings with the cancer teams the issue of delays with outpatient cancer review and the potential clinical risks has been a common issue. Following discussions with Catherine Weaver we have agreed that it would be helpful if the medical staff could be specific regarding the time frame for review so that the appointments staff can allocate accordingly.	AOB-82226
24.03.2009	Email from Colin Weir to Staff	Re: Endoscopy List and Ward Reconfig I think I write in agreement with some of my colleagues in saying that the endoscopy sessions was not to be configured as a fixed daily session. How on earth can SOW function with the juniors if we are tied up doing a morning endoscopy list? SOW work and seeing patients comes first. Unless it is reflected in job plans…. There is widespread concern regarding ward reconfiguration. This is another example of how things are not negotiated anymore. We all have concerns how this will work. When did we have a detailed discussion about it? When did we talk through the implications of it? How are we going to do a ward round when everyone including urology are in attendance? Tell me what the benefits are to quality of care and how you see this working in the real world? Maybe I have missed those discussion too and I am sorry I have. Maybe I am out on a limb here but our team of nurses are not happy and neither am I. Anyone else?/	TL1 page 188 AOB-82228 – AOB-82229
01.06.2009	Letter from Ms Youart to Mr O'Brien	Re Urology Services and Surgical Reconfiguration Many thanks for your letter dated 29 May 2009 regarding the recent response to the consultation on the surgical reconfiguration of beds and making the time to come and see me directly on Friday …	TL1 page 190 AOB-82230 – AOB-82233
19.06.2009	Minute of MDM Meeting	Re: Any Other Business Mr Mackle raised a discussion regarding a patient admitted via A&e with ?upper GI bleed. Admitted to ward 16:15, seen by surgical team at 17:45. There were no obs done between these times. Amylase 1201 T 37.9 P 116 BP 93/33 RR 40 mews score at handover was 6. This was not communicated to the ward. Patient admitted to ICU and died. There is a problem with MEWS and lack of training, however, there would not have been any different outcome for this patient. .. It was queried whether bowel ischaemia? – Maybe .. It was queried whether there had been pressure to remove patient from A&E ? No … It was queried whether A&E use MEWS? Don't know	TL1 page 305 AOB-82339 – AOB-82344

		.. It was queried whether there were guidelines for patients needing obs done within a certain time frame when they are admitted to the ward? It was commented that obs should be done routinely on admission	
07.12.2009	Meeting re Urology Service with Dr Loughran, Mr Mackle, Dr Rankin and Mr O'Brien	Key Points 1. Those patients on Mr O'Brien's list as clinically urgent may not be clinically urgent. No agreed process in place with Consultants and junior staff on what is urgent or routine. If juniors designate as urgent wrongly, the patient status is not amended to routine. 2. Current problems perceived in system: (a) Patients are getting letters of offer from IS even though they have already received an in-house appointment (b) Clinical management plans are not accurately put on PAS (c) Suggestion of separation of dictation and onward management/booking 3. Red flag system – the NI standard is that patients with potential cancer are tracked by the red flag system to ensure they are seen within designated timescales. This system is not used at all at present, mainly on principle because the system is blunt and does not grade the degree of clinical priority across all red flags; nor does it reconcile with non-cancer clinically urgent. The use of red flags is mandatory and reflects clinical evidence 4. Confidence in Trust is destroyed due to ward reconfiguration	TL1 page 396 – 397 AOB-82435 – AOB-82436
24.05.2010	Email correspondence between Ms Murphy and Consultants	Re setting up meeting to discuss backlog review. Meeting was scheduled for 17 June 2010	TL1 page 414 AOB-82453
06.04.2011	Meeting re Patient 130 held in DUP Office Personal Information redacted by the USI	Re: Issues 1. Nursing care issues a) Sitting out of bed with a "paper apron" and feet on cold floor. No drink available b) Mrs Personal Information came to visit Patient 130 with her cousin and found Patient 130 hanging out of bed 2. General Nursing issues 3. Medical Care issues a) Transferred to ICU post-operatively Mrs Personal Information was not aware surgery was a major surgery	TL3 Page 67 – 74 AOB-05745 – AOB-05752
11.04.2011	Email patient complaint	Re: Personal Information redacted by the USI	TL3 page 36

		"*The above named constituent has been waiting for a prostate operation at Craigavon Hospital and now informed a 6 month waiting list. He is in considerable pain and discomfort at present and grateful if this operation could be treated as a priority due to the discomfort he is experiencing. He is currently under* [Personal Information redacted by the USI] *".*	AOB-05714
19.05.2011	Letter from Ms Davidson to Mr O'Brien	Re: Adverse Incident *"Dear Mr O'Brien* *I am writing to you regarding incident reported to me by way of an IR1 form.* *The above patient was referred by Dr A Gray under your name for an MRI scan of prostate.* *On the e-request Dr Gray has recorded that the patient had a cardiac pace maker, but he continued to refer the patient into MRI under your referral name.* *This is a contradiction to the MRI and this patient should not have been referred for this examination. If this scan had have went ahead the patient would have been put at serious risk of death.* *Could you please speak to Dr Gray as it seems he has no understanding of the dangers involved with metal when referring patients to MRI"*	TL3 page 59 AOB-05737
01.06.2011	Email from Ms Corrigan To Mr O'Brien	Re: Patient Complaint – [Patient 71] Formal complaint re her treatment and care in A&E and the delay in her admission for Urology/Gynae surgery. Martina from PAS I see she was added to Aidan's waiting list for surgery on 7/2/11 and was prioritise as urgent… to check with Aidan when he plans to admit this lady.	TL3 page 61-62 AOB-05739 – AOB-05740
26.07.2011	Memorandum re complaint	Re: Ms [Personal Information redacted by the USI] enclosing patient complaint *"I was recently admitted (11.6.11) with renal colic. I found the whole experience very upsetting and traumatic, and after speaking to my line manager and several of the A/E consultants, I am writing to you of my disappointment at the care given to me by 3 South.* *I was made to feel like I was exaggerating my pain, only waiting morphine, as you can see from my discharge letter. When I read this letter, I burst into tears. I have been given the usual analgesics expected, but without effect. The next step would have been morphine, but was offered 2x paracetamol. I think I was in my right to refuse same.*	TL3 Page 158 – 165 AOB-05836 – AOB-05843

		If any of the nursing staff had ever experienced renal colic, they wouldn't have been so dismissive of my pain. It saddens me that nursing staff would treat fellow colleagues in such a distained manner. *…"*	
27.07.2011	Email correspondence between Ms Trouton, Ms Corrigan & Consultants	Re: Results "*Dear all,* *I know I have addressed this verbally with you a few months ago, but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and the one does not wait until the review appointment to look at them"*	TL3 page 130 AOB-05808
05.08.2011	Email from Mr Mackle to Ms Corrigan	Re: Cystectomies in the Southern Trust "*Diane,* *Following the concerns regarding the number of benign cystectomies being performed in the Southern Trust I met with Mr Marcus Drake, Senior Lecturer in Urology, University of Bristol and discussed the concerns raised …* *Conclusions:* *…* *He essentially did not have any major concerns regarding the overall practice. He felt that this group of patients can be very complex and difficult to manage. He stated that often the problem can be getting a surgeon to take them on patients because they can become albatross. He did feel that for a couple of patients he would have preferred more comprehensive notes but didn't feel that this was sufficient grounds to warrant serious concerns. He also expressed concerns the in-patient management of infection in one of the cases and I pointed out that this has already been addressed and that the Urologists are involving the Microbiologist and the CD as part of a treatment plan when the use of antibiotics is being considered"*	TL3 page 135 AOB-05813
04.10.2011	Email from Mr O'Brien to Ms Farrell	Re: Complaint re Ms [Personal Information redacted by the USI] *Dear Roisin,* *I had not appreciated that this letter of complaint was directed to me for response, and I remain unsure that it is intended to be. It would appear that the complaint pertains to the attitude of nursing staff on Ward 3 South. It seems rather inappropriate that I should have to investigate this matter.*	TL3 page 174 – 175 AOB-05852 – AOB-05853

		Would it not be more appropriate that the Ward Manager do so? Let me know"	
26.10.2011	Email from Ms Davidson to Mr O'Brien	Re: RIQA "*Dear Mr O'Brien* *I have filled in an IR1 Form and have informed the Radiation Protection advisor for the trust about the gentleman that had a CT scan and Bone scan done by mistakes. He has informed me that we will have tor eport this incident to RQIA so I need you to investigate the incident from your end. RQIA will be asking the questions about who referred and where and how the mistake happened and is there any adverse effect on the patient. I need to know how you were informed etc of the mistake. The patient eventually will need to be spoken to but that will be for the AMD or AD I think. I presuming that a full RCA and SAI will be conducted by the Trust"*	TL3 page 199 AOB-05877
28.11.2011	Letter from Dr Rankin to Patient (Ms Personal Information redacted by the USI	"*Dear Ms* Personal Information redacted by the USI *I refer to your complaint in respect of your disappointment with the care given to you whilst you were a patient in Ward 3 South in June 2011.* *At the outset please accept my apology for the delay in responding to you.* *Thank you for sharing your experience with us. We are continually trying to ensure that our patients are treated with the utmost respect and care and we are sorry that this was not your experience during this admission. Please be assured that we have addressed your concerns with all staff involved to ensure this experience is not repeated.* *I trust that this letter addresses the issues you have raised.* *If however you remain unhappy please do not hesitate to contact a member of the Clinical and Social Care Governance Team on* Personal Information redacted by the USI *who will discuss the options available to you"*	TL3 page 236 – 237 AOB-05914 – AOB-05915
19.12.2011	Letter from Patient re complaint	"*Dear Sir/Madam* *I am writing to express my extreme disappointment at how I have been treated by whoever makes the appointments for Mr O'Brien's at the Urology Department in Craigavon Area Hospital.* *I was last seen on 6/5/2011 and was told I would be put on the next surgical list. After a couple of months I phoned his secretary since I had not received an appointment and was told I would be put on the next month's list, I phoned again and was told the same story and the next month and the next. The last time I phoned the lady said she would check and phone me back – I have still not heard from her.*	TL3 Page 246 AOB-05924

		I also work for the Southern Trust so I understand how busy staff must be but I really need this surgery as the condition is having a very negative impact on my quality of life and I keep having my expectations raised that it won't be for much longer only to be disappointed month after month. *I would like you to review my notes and please contact me as soon as possible to let me know when I can expect to be seen."*	
28.12.2011	Email from Ms Corrigan to Mr O'Brien	Re: Patient complaint Complaint in relation to inappropriate discharge by SHO. Ms Corrigan requested Mr O'Brien to provide a response to this. Memo of this complaint was generated on 17 November 2011 but Mr O'Brien was not made aware of this at this time	TL3 page 252 – 259 AOB-05930 – AOB-05937
17.02.2012	Email from Ms Corrigan to Consultants	Re: PTL [Relating to AOB, Michael Young and Mahmood Akthar] Total Daycases with no dates are 24 patients AOB = 1 MY = 17 MA = 6 Total Inpatients with no dates are 67 patients AOB=34 MY = 33 MA = 0 I know you are all working at scheduling for March so I expect to see a change on Monday's PTL but wanted to let you see the overall picture	TL3 page 320 AOB-05998
02.03.2012	Email correspondence between Ms Roberts, Mr Weir and Others	Re: Mr Personal GMC referral	TLSUP page 3 – 10

Personal Information redacted by USI

We have received information about Dr Personal Information redacted by the USI who I understand is on a trainee programme at NI Medical & Dental Training Agency. A copy is enclosed.

As part of our enquiries into the complaint, we are contacting Dr Personal Information redacted by the contracting bodies, to establish whether there is any further information you can provide to assist us with our enquiries. We have informed Dr Personal Information that we will be contacting you.

I would be grateful if you could let us know if you have any further information about this particular complaint or any other concerns about Dr Personal Information practice. In particular, could you please provide:

- details of any other concerns or previous complaints (if any) about Dr Personal Information
- any audit findings (or other quality assurance measures) which might indicate problems with Dr Personal Information practice;
- any data (e.g. in relation to prescribing patterns) which might indicate poor practice;
- any other information which you think may be relevant to our enquiries;
- confirmation of the capacity in which Dr Personal Information is employed by you.

If you are already carrying out your own enquiries, could you please provide details? It would be helpful if you could confirm in writing even if you do not have any comments or further information you wish to submit.

When considering the allegations, we may take account of any evidence that indicates whether the alleged failings are easily remediable, whether they have been addressed and the likelihood of any repetition. It would be helpful if you could also provide details of any remedial action Dr Personal Information may have taken in respect of the allegations.

Dr Personal Information remains fully registered with a licence to practise whilst we complete our enquiries. We will contact you immediately should that change. We will also keep you informed of any significant developments, including the outcome of our enquiries.

It would be extremely helpful if you could provide a substantive reply by **Friday 9 March 2012**. We appreciate your cooperation, which will help us deal with this matter as quickly as possible.

Dear Sir/Madam

DR Personal Information redacted by the USI SPECIALTY DOCTOR IN UROLOGY
GMC REGISTRATION NUMBER:-

I write with regard to the above named doctor.

12.03.2012	Email from Mr O'Brien to Ms Corrigan	Re: Urology Patients in Knightsbridge "*From a governance perspective I, and am sure the other consultants, would appreciate to have a list of our patients who were transferred to the independent sector and knowledge of their outcome and letters of correspondence on their therapy. Although this was a Trust decision and their responsibility, I would appreciate to know what has happened to patients who were previously under my wing"*	TL3 page 848 AOB-06526
15.03.2012	Email from Mr O'Brien to Mr Simpson and Others	Re: Mr Perso nal	TLSUP page 11 – 12

Apologies for delay in reply.

I hope that it is not inappropriate to detail events since we last spoke Monday afternoon. I was particularly concerned then regarding my failure to have adequately enquired into the reported concerns of the senior nurse to whom you have referred. I therefore since spoke to the anaesthetist involved in the incident which gave rise to the expression of concern. She conversely was of the view that Dr. Personal Information did not pose safety risk to the patient at all. Her concerns were due to her not having the case history clearly presented to her in a clear and concise manner, and which can be difficult in any acute situation. As intimated previously, the case was complex and difficult. It took some time subsequently for several specialists to arrive at a diagnostic consensus of post-polio syndrome. The impression of incompetence may have been further exacerbated by Dr. Personal Information redacted by slow delivery of speech.

On Monday evening, I had discussions with our other registrar, Mr. Keane, for whom I have highest regard. Again conversely, he expressed concerns regarding Dr. Personal Information focus. He felt that he was more occupied by his current pay structure and by being allowed to do the FEBU (Fellowship of European Board of Urology) exam than sorting out, or helping to sort out, the care of patients. He do has had to listen to Dr. Personal Information Personal Information redacted by estimated narration of his previous difficulties, etc., and repeatedly. On the other hand, he considered that Dr. was highly knowledgeable of urology.

Following your concerns regarding the potential risk of his adverse reaction, I deferred meeting with Dr. Personal Information until Tuesday evening when I could be accompanied by Mr. Akhtar as witness. The meeting went very well indeed. After all of the conflicting reportage, I had mixed feelings regarding the imposition of restrictions on his practice. I advised him that it had been brought to my attention by the Programme Director in Urology, by the Sub-Dean and by the Trust that he had been referred to the GMC by the Medical Director of the Trust where he had last been employed, and that enquiries had formally been made as to whether we had any concerns regarding his competence or performance. In addition, I had also been made aware of concerns raised by staff in this hospital. As a consequence, I had come to the conclusion that it would be prudent to restrict his practice. I advised him that he would no longer be on call for a period of time. I have advised him that he would not be at call at any time, night or day, during the forthcoming period. Thirdly, I advised him that Mr. Keane would conduct inpatient ward rounds, and that Dr. Personal Information would accompany him doing so. I advised him that these restrictions were being imposed by me, but without prejudice. I emphasised that we were and would continue to be supportive of him in his professional development. Lastly, I intimated that hopefully we would be able to incrementally withdraw these impositions after a period of time, and when we were confident of his competence. Dr. Personal Information redacted by had no difficulty in accepting these impositions. He did so graciously. In fact, it seemed to me that he was relieved and reassured that anyone should take such an interest.

Finally, the more I have listened to Dr. Personal Information and others about Dr. Personal Information the more circumspect I would regard the views of all. Whether perception or reality or both, I believe that he has been severely traumatised by his past experiences. In that regard, I believe that he needs to leave the past behind, as it is currently destroying him, and I advised him so. Perhaps more pertinent to our concerns, I believe that it may very well be the case that he has not received any training during recent years as he was considered not to be entitled to any training as he occupied purely service posts. That is, at

7

		least, his perception. The reality now is of a highly knowledgeable doctor with little operative experience or skill, and possibly inadequate clinical skills in acute situations. I believe that he may very well be capable of development in a supportive environment. I do hope so, and hope that I am not naively wrong. Sorry for long reply, Aidan. From: Simpson, John Sent: 13 March 2012 11:30 To: Brown, Robin; O'Brien, Aidan; Rankin, Gillian; Rice, Francis Cc: Parks, Zoe Subject: re staff grade urology Robin/Aidan, Further to discussions re Dr [redacted] could you provide me with something in writing regarding any concerns re performance. Aidan, Could you provide something in writing re your discussion today with said doctor. In particular please detail any proposed restrictions on his practice. Gillian, Concerns were expressed verbally to Robin by a senior nurse. Is it possible to have this documented. Gillian/Francis, It is a matter for concern that a senior nurse would have significant concerns about the performance of a doctor that don't seem to have been followed through. I think there must be some learning here re clinical governance. John	
05.04.2012	Email correspondence between Ms McCann, Ms Corrigan, Mr Brown and others	Re: Mr [redacted]	TLSUP page 13

		Dear Mr Brown, As discussed, please see attached and below from Ward Manager in 3 South who has advised that this is a regular occurrence and is upsetting the staff on the ward. Many thanks Martina Martina Corrigan Head of ENT and Urology Craigavon Area Hospital Tel: Personal Information redacted by the USI (Direct Dial) Mobile: Personal Information Email: Personal information redacted by the USI From: McCann, Emma Sent: 05 April 2012 15:21 To: Corrigan, Martina Subject: FW: Message from KMBT_C220 Hi Martina Please find attached Personal Information redacted by the USI and Personal Information redacted by the USI statement in relation to Dr Personal Informatio this morning. As discussed previously the way in which Dr Personal Information continually speaks to nursing staff is totally unprofessional and inappropriate. Kind Regards Emma Mc Ward Manager (A) 3 South	
19.04.2012	Patient complaint	Re: Personal Information redacted by the USI *"Mr Personal Information states that he had a PUJO surgery procedure carried out on Tuesday 6 March 2012, Mr Young, Consultant Urologist initially was to perform the operation but he had to attend a funeral that day and so a member from his team by the name of Mr Ho performed the operation.* *Mr Personal Information states he was told that his stent would be in situ initially for 4 weeks but after the operation he was told by Mr Ho the stent would be insitu for 6 weeks. Mr Personal Information advised Mr Ho that he was getting married on Personal information redacted by USI Mr*	TL3 Page 396 – 399 AOB-06074 – AOB-06077

		Personal Information *states that Mr Ho said this shouldn't be a problem.* *Mr* Personal Information *states that to date he hasn't received an appointment date to have the stent removed so he telephoned Mr Young's secretary who informed him that due to the Easter holidays Mr Young has had to reschedule his lists as he will be on holidays himself on the 11 May 2012. Mr* Personal Information *advised that Mr Young's secretary gave him a new appointment date for the 27 May 2012.* *Mr* Personal Information *states that he is not covered by medical insurance and therefore like the stent removed as soon as possible. Mr* Personal Information *states that he doesn't mind which doctor removes the stent and that he is prepared to work with the medical team and is willing to come in at any time to have the stent removed.* *Mr* Personal Information *states that all the plans have been made for his wedding* Personal information redacted by USI *and he would like the stent removed* Personal information redacted by USI *.* *Issues of concern:* *1. Unhappy with rescheduling of surgery* *2. 4 weeks has now gone to 6 weeks"*	
30.04.2012	Email from Mr McKeown to Ms Carson	Re: Review patients and clinic outcome sheet Few complaints. It was noted that the doctors should not fill in extra paper work. Doctors role to see patients and that administrative duties should be carried out by admin staff or a health care assistant. This is what happens at other hospitals	TL3 page 400 – 403 AOB-06078 - AOB-06081
10.05.2012	Email from Ms Corrigan to Mr O'Brien and Mr Young	RE: Patient complaint Personal Information redacted by the USI - Referred to Mr Akhtar - Attended Mr Akhtar 5/12/11 - Had various investigations to which Mr Akhtar said were all fine - Continued to feel unwell and complaining of neck pain and increasing fluids - GP advised that Mr Akhtar had told GP that was build up fluid in abdominal space but not related to his previous cancer. Query of clot - A&E told him no clot - Patient admitted to MAU when informed that neck gland was cancerous and would need to start treatment with Mr Akhtar. No treatment was commenced - Mr Akhtar saw patient on ward and advised would need to have a look at bladder. Told would carry out on 11/4/12	TL3 page 417 – 422 AOB-06095 – AOB-06100

		- On 11/4/12 Patient notes that contacted Mr O'Brien's secretary as still not received confirmation of investigation. Put through to nurse who advised patient's wife that husband should have attended for procedure but he had DNA. - Patient's wife advised that had received no letter informing of procedure and therefore patient did not know to attend this day - Patient's wife contacted Mr O'Brien's secretary and tried to obtain another date but was advised she was not responsible for re-booking appointments - Patient deteriorated and MRI done showed that he had a blockage and FRCP but stent could not be inserted. - Patient is concerned about delay in diagnosing and treating condition. Also querying how Mr Akhtar could advise that everything was fine and that swelling of both legs was not related to previous cancer.	
17.05.2012	Patient Complaint Letter	Re: Patient 131 "*I wish to make a formal complaint in regard to my treatment over the last few months.* *Consultant Name: Mr O'Brien but Mr Young looked after me.* *On 6th January I was diagnosed as having kidney stones and was admitted to the urology ward Craigavon Area Hospital.* *On the 9th January I had a stent inserted.* *I was discharged from the ward on the 10th January to attend the stone treatment centre for ESWL and was given an appointment for the 6th February.* *This appointment was subsequently cancelled.* *As I was in so much pain/distress I had to attend the GP and was then given an appointment to attend on the 8th February.* *I was reviewed by Mr Young on the 12th March and was told the stone had got bigger, but advised they would try a further treatment of ESWL this was performed on 30th April.* *The report of the USS showed the stent had moved and an urgent appointment was required with Mr O'Brien, to date (17th May) no appointment has been received.* *During the interim period my GP sent me for an ultrasound which showed the stent had moved, and I was referred to A&E.*	TL3 Page 412- 414 AOB-06090 – AOB-06092

		They did an x-ray and I was told the stent hadn't moved, I am frustrated and dissatisfied with the conflicting information I am receiving. *The A&E doctor's attitude towards me was hardly professional as he stated "you can stay if you want, but you probably wont be treated until Tuesday".* *As this was over a weekend period I felt it was unreasonable and unjustified to take up a hospital bed especially when news reports day and daily state the number of trolley wait patients to be seen.* *I am in constant distress because of the continuing back pain, stomach pain, weight loss, urinary incontinence and pain on passing urine.* *All of these symptoms have affected my sleeping pattern and impact on my daily work/home activities.* *My home life has suffered because of the psychological affect this is having on me.* *I am worried that there might be long term damage to my kidneys, and really all I want is to have the necessary treatment in a timely manner.* *I appreciate the demands on the health service are ever increasing, but I do feel January to mid-May is a long time to be in constant pain".*	
06.07.2012 – 09.07.2012	Email correspondence between Ms Breen, Ms Kearney, Ms Corrigan and Mr O'Brien	Re: Mr Personal Information redacted by the Urology Services Inquiry	TLSUP page 1 - 2

		Just following recent conversation in regards to Mr [Personal Information redacted by the HSE] conduct in DSU on the 6th July. I feel it is necessary to make a complaint to highlight the rudeness and inappropriateness of his behaviour in relation to both staff and patients. We had a flexible cystoscopy list Which Mr [Personal Information] arrived late for. He had to consent his patients on the ward, which posed an issue to him because in all other areas he consents them in the procedure room. The staff in theatre stated he was unsure of the endoscopes and how to connect the bung and giving set, staff willingly instructed him how to do this. He then stated the scopes where "crap" in front of patients. The staff for the sake of the patients tried to continue to make light of this and to help with the running of the list set up the rest of the endoscopes for him, which again he wasn't happy with either. He said he didn't like here as there was too much "red tape". There were also infection control issues, as he left following a procedure with a dirty apron on which he had used for the previous patient and when he went to consent the next patient a staff member discreetly asked him to remove it before consenting and he said "Jesus Christ" and ripped the apron off and threw it into the bin in full display of other patients. I was Asked (SR Breen) to go into the procedure room by one of the staff nurses and I spoke with Mr [Personal Information] and asked was everything alright he said there was too many patients on the list and he would only do 6. I said the secretary made the lists out and we had no control over the number of patients. He then proceeded to contact the secretary, with whom he had a discussion. At the end of the list the staff asked him was he back for the afternoon list and he told them he wouldn't be coming back, he also told this to the ward clerk . At 2pm I contacted Eva as no one had turned up for afternoon cystoscopy list, I had doubts after that morning he was going to turn up. I contacted the secretary who put me through to the thorndale and I spoke to a nurse who stated that with persuasion Mr [Personal Information redacted by the HSE] was coming over to us in dsu. He arrived for the list and again staff were subjected to insults throughout the afternoon. He informed the staff in theatre with him that he hoped they were better than the staff that morning as they were "crap". He again started to complain about the "crap" scopes in front of highly anxious patients, and when the girls suggested to not say this in front of patients he said sure he's "deaf anyway". The Gentleman in question did wear a hearing aid but certaintly was able to hear what had been said. When asked again to remove apron before consenting he stated if anyone tells him what to do "they can fuck off and make sure you warn them I said that" He then proceeded to cancel a patient I was asked again to come into theatre as he refused to give a reason for tms purposes I asked him what would he like recorded and he stated" it was his preference and he doesn't need to give a reason and you can write it in capitals if you like and tell them I said it" I told him i would record this on tms if he wanted but then he stated that the procedure was not necessary I explained that this was different to what he had previously sayed he again was rude and I informed him that I wouldn't tolerate him speaking to neither myself or other staff members in this way as it was inappropriate. He said he had never seen a hospital with so much red tape and it was "bullshit" I informed him that I would be speaking to my line manager Sr Kearney in relation to this. 3 patients were cancelled 2 with nitrates in their urine 1 patient who did not require procedure as per Mr [Personal Information] He also stated that the ward manager who wasn't on duty at either time was and he pointed to the floor and said "way down there and he himself was above her as he had a medical degree". I feel it is necessary to report this behaviour as do all staff involved in the events outlined above. Staff were upset and annoyed when they had went out of their way to make him welcome as he was new to the department they introduced themselves to him and treated him with respect from the moment he arrived unfortunately this was not recriprocated. Staff were annoyed for the patient's that witnessed the behaviour as it was a poor reflection not only on the the service we provide as a unit but also on the trust as a whole. We feel this is not the image we would like to promote to the general public	

		Dear Aidan I would welcome your advice on the email below…. I did highlight this to Michael on Friday afternoon as a number of staff were very upset and had walked out crying which I am sure you will agree is not acceptable. I believe that Michael spoke to him after my conversation. I had spoken to Personal Informatio myself earlier in the day and he had expressed his dissatisfaction about the scopes (I advised that this had not been raised before) he was refusing to do the PM list but I had explained that the patients would be there and he needed to attend – he did say to me that in future if he is doing a flexi list that there are only to be six patients on list. I have checked with Kate O'Neill and to date they have had no issue with him in Thorndale. As this has also been raised as an IR1 we are going to have to respond to this. Happy to discuss	

30.08.2012	Antibiotic ward round	• Epanomeritakis: 25 patients. CURB score appropriate in 1 patient, **not recorded**.
		  ○ **Choice inappropriate in 1 patient**:
		  ▪ 1 pt on IV tazocin 4.5g TID for CAP (originally started on IV co-amoxiclav 1.2g TID), IV amoxicillin 2g TID +/- IV/PO clarithromycin BD recommended.
		• Hewitt: No patients.
		• Lewis: 7 patients. CURB score n/a.
		  ○ **Choice inappropriate in 1 patient**:
		  ▪ 1 pt given IV co-amoxiclav for appendectomy, IV benzylpenicillin, gentamicin and metronidazole recommended.
		• Mackle: 1 patients. CURB score n/a.
		• McFall: No patients.
		• McKay: 5 patients. CURB score n/a.
		• Weir: 1 patients, CURB score n/a.
		• Yousaf: 8 patients. CURB score n/a.
			SUP Oct page

06.09.2012	Letter from Trust to Patient re Complaint	Re: Patient 131 *I refer to your complaint in respect of the treatment and care provided to you firstly at the Emergency Department of Craigavon Area Hospital and in general the service provided to you by Urologists.* *At the outset I would like to apologise that you feel your treatment in the Emergency Department did not meet your expectations and I fully appreciate your concerns over the conflicting information given. I also regret the length of time it has taken to respond to your complaint.*	TL3 Page 448 – 450 AOB-06126 – AOB-06128

		In relation to your comment that "they did an x-ray and told me the stent hadn't moved", I sincerely regret that you were given conflicting information whilst in the Emergency Department. I have asked Dr Feenan to make a comparison of the two most recent x-rays available to him and sincerely regret any misunderstanding which has arisen. At the stage Dr Feenan provided you with information I understand he had already spoken to the Urology on-call team who had accepted your care. I believe the only reason he told you this piece of information was to keep you up to speed with your progress through the Emergency Department and to ensure you did not feel forgotten about. I apologise that this has led to distress for you. *With regard to your comments that "the A&E doctor's attitude towards you was hardly professional as he stated "you can stay if you want, but you probably wont be treated until Tuesday". Our investigation has confirmed that this was not Dr Feenan. Nonetheless it was unacceptable for the doctor who said this to do so and I sincerely apologise for how it made you feel.* *Moving on to your complaint in respect to the waiting time for your procedure in Urology. I have asked Mrs Corrigan, Head of Urology to investigate this delay. I can confirm that you were admitted under Mr O'Brien, Consultant Urologist on 8 January 2012 and that you were discharged with an appointment arrange for you to attend the Stone Treatment Centre on 8 February 2012 under Mr Young's care. You attended this and a further appointment in the Stone Tretament Centre on 30 April 2012. As you state in your correspondence you were advised that you had been placed on the waiting list for further treatment. Mrs Corrigan advises that you have since been admitted under Mr O'Brien's care on 13 June and that you have had your procedure completed and that you are scheduled to be reviewed again in one year.* *I apologise that you have had to wait longer than you had expected for your procedure and for the pain and discomfort you experienced during this wait. There has been an increase in the demand for urology within the Southern Health and Social Care Trust. The Commissioners are working with the Trust and Consultant Urologists to address this increase.* *…."*	
14.09.2012	Email correspondence between Mr Young, Mr Fawzy and others	Re: Renal Colic Out of Hours To seek clarification. Patients who present with probably diagnosis of renal stone disease out of hours who don't settle with appropriate analgesia. Radiology won't perform a CT KUB out of hours unless the patients U&E is abnormal or they have a history of obstructed kidney. Urology Reg on call refused to admit anyone without definitive diagnosis of renal stone disease i.e.	TL3 page 460 AOB-06138

		without scan. Unless there is some middle ground found, the Emergency Dept staff have no alternative but to admit these patients under the General Surgical Stema for diagnostics the following morning.	

27.09.2012	Antibiotic ward round	• Epanomeritakis: 10 patients. CURB score n/a.
		  ○ **Choice inappropriate in 1 patient**:
		  ▪ 1pt given IV Teicoplanin, gentamicin and metronidazole as prophylaxis for hepato-biliary surgery, IV benzylpenicillin, gentamicin and metronidazole recommended (no history of penicillin allergy or MRSA).
		
		• Hewitt: 16 patients. CURB score n/a.
		  ○ **Frequency inappropriate in 1 patient:**
		  ▪ 1pt on Iv Benzylpenicillin 1.2g QID (+ IV flucloxacillin) for cellulitis, 4 hourly dosing recommended.
		
		• Lewis: 32 patients. CURB score n/a.
		  ○ **Choice inappropriate in 1 patient**:
		  ▪ 1 pt given PO ciprofloxacin 500mg BD for cholecystitis (penicillin allergy), PO metronidazole also required for anaerobic cover.
		
		• Mackle: 3 patients. CURB score n/a.
		
		• McFall: 1 patient. CURB score n/a.
		
		• McKay: 2 patients. CURB score n/a.
		
		• Weir: 5 patients, CURB score n/a.
		
		• Yousaf: 6 patients. CURB score n/a.
			SUP Oct Page

03.10.2012	Email from Mr O'Hare to Urology Consultants	Re: Urology Doctor Complaint *"Dear all,* *I have once again had a bad experience with a particular Urology Doctor. It involved a* Personal informatio *old who he was asked to see who had sudden severe right testicular pain needing IV opiate. Your doctor diagnosed with epididymo-orchitis and discharged him. The pt was not well enough to go home. I say him and was clinically not epid-orc but not obviously torsion either.* *…* *I called the urology reg back who came down, did not introduce himself, was abrupt and rude (again)*	TL3 page 500 AOB-06178

		and discharged the pt against my wishes. The pt reattended later last night in agony and was eventually admitted. This was not good pt care. *The missed diagnosis is not the main problem on this occasion but rather his poor communication skills, rudeness, lack of insight and lack of respect for Senior staff in other depts.* *This is not an official complaint about this doctor but I fear that will not be far away if he continues in the same vein"*	
10.10.2012	Email from Ms Ritchie to Dr Rankin	Re: Patients transferring from DHH to CAH **Ms Ritchie –** *"has there been some change in policy on use of cases notes for patients transferred from DHH to CAH? A patient who was transferred to ICU from DHH and then to my care in 2N had all his stay in CAH recorded in DHH notes – No set of CAH notes were issued. The ward clerk in ICU tells me she has been told indirectly by head of medical records that this is a new policy, but clinical staff and many of the ward clerks in other wards are unaware of it, and there will be logistical problems – will discharge letter ever be done for the CAH stay if all the notes return with the patients to DHH? Do staff in DHH know about this – the ICU ward clerk tells me a patient returning from DHH for a second spell in ICU had had all her previous CAH notes removed from the DHH notes, and bundled up separately. It looks as if some group somewhere have made an ill-thought through decision without consulting or informing the users of the hospital notes"* **Ms Carroll –** *"Patients can have multiple hospital chart numbers and some work has taken place to reduce the number of hospital charts a patient can have – in that we have stopped creating charts in southern Tyrone Hospital, Armagh Community Hospital or Banbridge Polyclinic charts – and at present new charts are only issued for CAH and DHH.* *With regards to admissions:* 1. *If a patient is admitted to CAH via the ED then a CAH hospital number is allocated to the patient and a CAH chart used for that patient's episode in CAH (regardless if they have a chart in DHH or STH), and that's the case in DHH and this has never changed* 2. *One change which did take place from January is fi a patient is an in-patient in DHH and is transferred to ICU CAH their DHH chart will be sent with them and they will be admitted to ICU under their DHH number and their DHH chart used for that episode which contains all the patients history for that episode. This was to avoid sending a CAH chart to ICU which did not contain any relevant history for admission* *Unfortunately this has not been properly communicated in the system by my team and I have spoken to Helen with regards to this and I have advised her that any future changes must be channelled*	TL3 page 579 – 582 AOB-06257 – AOB-06260

		through me and I will discuss with yourself. *…..”*	
25.11.2012	Email from Mr Connolly to Consultants	Re: Emergency List **Mr Connolly –** *“Was anyone aware of the way that emergency lists are now running What I was told is that the Surgeon of the Week reviews the list and prioritises it, giving time limits that the cases need to be performed in (1 hour, 4 hours, 12 hours, 24 hours etc). I did not receive any communication about this as far as I know but it appears to have been implemented from last week.* *I have just had a case bumped down the list without any communication from the surgical team – bilateral ureteric stones with hydro, luckily she is not septic and renal function is ok – but when I went down, I was told that their case had to be done within 4 hours so got priortised. Just slightly annoyed that this seems to have happened without any input from the other specialties which also use the emergency list”* **Mr Young –** *“What exactly is this = completely unaware of this. Will investigate”*	TL3 page 586 AOB-06264

30.11.2012	Antibiotic Ward Round	• Connolly: 1 patient. CURB score n/a.
		• Glackin: No patients.
		• O’Brien: 13 patients. CURB score n/a.
		  ○ **Indication not recorded and choice and dose inappropriate in 1 patient**
		  ▪ 1pt given IV meropenem 500mg TID (1g TID recommended), switched form IV tazocin after 2 doses, no indication documented.
		  ○ **Choice inappropriate in 3 patients**
		  ▪ 1pt given IV gentamicin 480mg OD + PO ofloxacin for epididymo-orchitis, PO ciprofloxacin recommended.
		  ▪ 1pt given IV co-amoxiclav 1.2g TID on elective admission for catheter removal, no evidence of infection. If prophylaxis for catheter change, 1 dose IV gentamicin recommended.
		  ▪ 1pt given PO trimethoprim 200mg BD for UTI, no clinical evidence of infection (patient had catheter in situ-may lead to resistance).
		• Pahuja: 3 patients, CURB score n/a.
		• Young: 7 patients. CURB score n/a.
		  ○ **Choice and frequency inappropriate in 1 patient**
		  ▪ 1pt given IV co-amoxiclav 1.2g BD (TID recommended) post-surgery (uretic resection)-?need to continue antibiotics post-surgery, if required IV gentamicin recommended.
			SUP Oct page

12.12.2012	Email from Mr Connolly to Urology	Re: Unsigned Bloods **Ms Glenny –** *“..Raised concern about the volume of unsigned bloods on 3 South in particular. Is there anyway you could discuss with the clinicians so that they can raise with the junior staff The junior doctors don’t see this as their priority on the ward, but if the bloods are not signed then this delays the*	TL3 Page 682 – 683 AOB-06360 –

		charts leaving the ward and discharge letters being dictated. It also leads to duplicates being printed as the originals do not be filed in the chart until such times as they are signed." **Mr Connolly –** *"… They believe that as the bloods are signed off online that they do not then also have to sign the printed copy (I think the printed copy is not provided unless it is already signed off online as far as I am aware). If this is the case, then the unsigned copy can just be filed away. If not, then the JHOs need to be aware of the need to sign them as well"*	AOB-06361
27.12.2012	Antibiotic Ward Round	• Connolly: No patients. • Glackin: No patients. • O'Brien: No patients. • Pahuja: No patients. • Young: 7 patients. CURB score n/a.	SUP Oct Page

31.12.2012	Antibiotic Ward Round	• Dr Ahmed: 46 patients, CURB score appropriate for 15 patients, **recorded in 11**.
		  ○ **Indication** not recorded in 4 patients, **choice** inappropriate in 6 patients, **dose** inappropriate in 2 patients and **frequency** inappropriate in 3 patients.
		• Dr D Morgan: 37 patients, CURB score appropriate for 10 patients, **recorded in 6**.
		  ○ **Choice** inappropriate in 8 patients and **frequency** inappropriate in 2 patients.
		• Dr Harty: 5 patients, CURB score appropriate for 1 patient, **not recorded.**
		• Dr Hayes: 9 patients, CURB score appropriate for 1 patient, **not recorded.**
		  ○ **Choice** inappropriate in 1 patient.
		• Dr Magee: 38 patients, CURB score appropriate for 10 patients, recorded.
		  ○ **Choice** inappropriate in 2 patients and **dose** inappropriate in 1 patient.
		• Dr McGleenon: 24 patients, CURB score appropriate for 6 patients, **recorded in 5**.
		  ○ **Choice** inappropriate in 3 patients.
		• Dr McKeveney: 6 patients, CURB score appropriate for 1 patient, **not recorded**.
		• Dr Moan: 28 patients, CURB score appropriate for 13 patients, **recorded in 7**.
		  ○ **Choice** inappropriate in 2 patients.
		• Dr N Morgan: 2 patients, CURB score n/a.
		• Dr O'Brien: 32 patients, CURB score appropriate for 4 patients, **recorded in 3**.
		  ○ **Choice** inappropriate in 6 patients.
		• Dr S Murphy: 29 patients, CURB score appropriate for 5 patients, **recorded in 4**.
		  ○ **Choice** inappropriate in 1 patient.
			SUP Oct Page

01.02.2013	Antibiotic Ward Round	• Connolly: 1 patient. CURB score n/a.
		  ○ **Choice inappropriate in 1 patient:**
		  ▪ 1 pt on IV co-amoxiclav 1.2g TID post op, no documented evidence of infection.
		• Glackin: 1 patient. CURB score n/a.
		  ○ **Choice inappropriate in 1 patient:**
		  ▪ 1 pt on PO co-amoxiclav 625mg TID post op, no documented evidence of infection.
		• O'Brien: 2 patients. CURB score n/a.
		  ○ **Choice inappropriate in 1 patient:**
		  ▪ 1 pt on IV benzylpenicillin 1.8g BD for post op infection, IV gentamicin recommended.
		• Pahuja: No patients.
		• Young: 2 patients. CURB score n/a.
		  ○ **No indication documented and choice inappropriate in 1 patient:**
		  ▪ 1 pt on PO co-amoxiclav 625mg TID, no documented indication or evidence of infection.
			SUP Oct Page

28.02.2013	Antibiotic Ward Round	• Connolly: 1 patient. CURB score n/a.
		• Glackin: 1 patient. CURB score n/a.
		  ○ **Dose inappropriate in 1 patient:**
		  ▪ 1 pt on PO trimethoprim 200mg BD for UTI, eGFR 11, 100mg BD recommended.
		• O'Brien: 4 patients. CURB score n/a.
		  ○ **Dose inappropriate in 1 patient:**
		  ▪ 1 pt on PO fluconazole 50mg OD for treatment of fungal UTI, treatment dose of 400mg OD recommended if patient symptomatic and requiring treatment.
		• Pahuja: 4 patients. CURB score n/a.
		• Young: 4 patients. CURB score n/a.
			SUP Oct Page

04.06.2013	Antibiotic Ward Round	• Connolly: No patients. • Glackin: 6 patients. CURB score n/a. ○ **Indication not recorded and compliance not assessable in 1pt:** ▪ 1pt on PO co-amoxiclav 625mg TID, no documentation of antibiotics in notes, no documented evidence of infection. ○ **Choice non-compliant in 1 patient:** ▪ 1pt on PO nitrofurantoin 100mg QID + IV aztreonam 2g TID for urosepsis, PO nitrofurantoin not required. • O'Brien: 4 patients. CURB score n/a. ○ **Indication not recorded and compliance not assessable in 3pts:** ▪ 1pt on IV benzylpenicillin 1.2g BD, no documentation of antibiotics in notes, no documented evidence of infection. ▪ 1pt on PO amoxicillin 500mg TID, no documentation of antibiotics in notes, no documented evidence of infection. ▪ 1pt on IV tazocin 4.5g BD, no documentation of antibiotics in notes, no documented evidence of infection. ○ **Choice non-compliant in 1 patient:** ▪ 1pt on IV gentamicin, admitted for IV fluids & antibiotics, no documented evidence of infection (note: most recent MSSU resistant to gentamicin). • Pahuja: 3 patients. CURB score n/a. ○ **Indication not recorded and compliance not assessable in 1pt:** ▪ 1pt on IV tazocin 4.5g TID, no documentation of antibiotics in notes, no documented evidence of infection. • Young: 4 patients. CURB score n/a.	SUP Oct Page
14.06.2013	Email correspondence between Mr Pahuja and Ms Corrigan	Re: SWAH clinic and office space "*Unfortunately Monday – June the 19th wasn't quite a pleasant day at the beautiful SWAH! I am sure you have heard about it by now. I felt I put myself at risk by seeing these patients without clinical notes and I am not prepared to go through that again.* *I was not aware of the new flow pathways that have been drawn out regarding "patients clinical journey" from A to B…"*	TL3 page 1011 – 1013 AOB-06689 – AOB-06691
05.07.2013	Antibiotic Ward Round	• Connolly: No patients. • Glackin: 1 patient. CURB score n/a. • O'Brien: 2 patients. CURB score n/a. ○ **Indication not recorded and compliance not assessable in 1pt:** ▪ 1pt on IV gentamicin 240mg OD, no documentation of antibiotics in notes, no documented evidence of infection. • Pahuja: No patients. • Young: 5 patients. CURB score n/a.	SUP Oct Page
25.07.2013	Letter of complaint from	Re: Personal Information redacted by the USI	TL3 page 1090 –

	patient	[redacted]	1092 AOB-06768 - AOB-06770

06.08.2013	Response to Patient complaint - Mr [redacted]	Dear Ms [redacted] I refer to your complaint in respect of your brother, Mr [redacted]. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them. I would like to apologise for the delay in returning this response to you. I had asked Mrs Martina Corrigan, Head of Urology to investigate your complaint. In doing so she talked with your brother's consultant Mr O'Brien. Mr O'Brien has advised her that he has met with you about your brother's care	TL3 Page 1291 – 1295 AOB-06969 – AOB-06973

		and his treatment and Mr O'Brien feels that this meeting was beneficial and that it answers any issues or queries from his perspective and I hope that you have found this to be the case? Mr O'Brien also advised Martina that your brother has since been admitted on 16 September 2013 and had his procedure performed and I hope that this has been a success and that your brother has been keeping well since then. Martina also spoke with the Ward Manager, Sister Emma McCann who also investigated the issues surrounding your brother's stay in 3 South. Firstly, Sr McCann would like to take the opportunity to apologise for any distress caused to your brother while an in-patient in 3 South. She has went through your brother's notes from the evening of 18th March 2012 and advised that it is documented that your brother was for discharge on the 18th March 2012 following his day procedure, it is also documented that you had rang to say that you were unable to take your brother Mr Personal Informati home that evening as he was having work carried out to his house. Sr McCann would like to apologise if the nurse did not communicate with you in a manner that you deserved and at their Measure Board meetings she has reiterated to all staff the importance of being courteous and mannerly whilst dealing with patient and carer's queries. Sr McCann also advises that she has also spoken to all the Nursing staff on duty in January 2013 when your brother was a patient on the ward and there appears to be have been a mis-communication with his discharge, although it is documented that you were contacted mid-morning to arrange a collection time for Mr Personal Informatio this would appear not to have happened so Sr McCann apologises as this was not a seamless discharge. I hope that you will find this response has addressed the issues that you raised. However if you would like to discuss any aspect of this response further so that we may help in resolving any outstanding issues, please do not hesitate to contact a member of the Clinical and Social Care Governance Team on Person al Personal Informati Personal Informatio or by e-mailing AcutePatient.ClientLiaison@southerntrust.hscni.net within 3 months of the date on this letter. Alternatively, if you remain unhappy with the Trust's response and feel that further contact with the Trust will not resolve your complaint, you can refer your complaint to the NI Commissioner for Complaints (the Ombudsman) at the following address: Freepost BEL 1478, Belfast, BT1 6BR or Freephone: 0800343424 or email ombudsman@ni-ombudsman.org.uk Further information on the role of the NI Ombudsman can be found at www.ni-ombudsman.org.uk	
27.06.2014	Letter from Ombudsman to Trust	Re: Complaint on behalf of Mr Personal Information The mesh which was used during the hernia repair surgery has left him in severe pain and with severe bladder issues. Mr Akhtar made him promises which were never fulfilled.	TL5 page 961- 965 AOB-71123 – AOB-

		Mr Brown (who conducted the hernia surgery) made him promises which were never carried out. He was misdiagnosed for years when doctors insisted that he had a bladder problem. There were suggestions that there was a problem with his prudenal nerve which were never followed up by Mr Brown 1. Dr Sobicinski at the Pain Clinic reduced Mr [redacted]s pain medication by half and advised him to take twice as many. Mr [redacted] believes that this was pointless. 2. Dr Sobicinski informed Mr [redacted] that he would review him in three months time yet this did not happen 3. Mr McMullan suggested various treatments for Mr [redacted] yet informed him at his last appointment that he would do nothing and discharged him 4. Mr O'Brien's waiting times are too long 5. Mr [redacted] says that he has been left in severe pain, with severe bladder issues, he can no longer work, he cannot drive, he cannot leave the house unless it is necessary, he cannot have any more children, his marriage is therefore under stress, and his mental health is rapidly declining	71127
01.08.2014	News Release from BBC	Urology Patient Complaint – BBC Talkback *"The Trust recently advised this patient that her surgery would take place in September and that a final letter would be sent confirming the exact date as soon as the schedule had been finalized.* *The September schedule is currently being finalized and letter will be issued to patients confirming* *surgery dates today.* *As our Urology Service is experiencing very high levels of demand, we are having to prioritise cancer cases at this time.* *We apologise to any patients who are waiting longer than we would wish for their procedure"*	TL5 page 1159 – 1161 AOB-71321 – AOB-71323
October 2014	SHSCT Incident Management Procedure Policy	The purpose of this procedure is to guide all employees of the Trust in the following: 1. Identification, reporting, review, monitoring and learning from all incidents which have resulted in or had the potential to result in injury or harm to a person or damage to property or the environment, or a breach of security, confidentiality, policy or procedure 2. Analyse incident trends, root causes, associated costs and to develop appropriate action plans to eliminate or minimize exposure to associated risks	TRU-02708 – TRU-02743

		3. Enable staff to participate in, and effect change by ensuring that mechanisms are in place to learn from incidents which occur and that resulting changes in care, policy or procedures are embedded in local practice 4. Notification and recording of incidents from third party organisations from which the Trust commissions services 5. Notification of incidents where appropriate to other relevant agencies, for example the Regional Health and Social Services Board…	

October 2014	SHSCT Incident Management Procedure	***3.2 Reporting an Incident:*** **Where:** All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on 'Datix Web')** **By Whom:** This form must be completed by either the member of staff involved in or who has witnessed the incident, or by the person the incident has been reported to. **When:** All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred **or** its occurrence became known. **How:** Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:* http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager, relevant Assistant Director and the Assistant Director of Governance in an email via Datix Web. In circumstances where the incident is considered as a potential **Serious Adverse Incident (SAI),** *(see **Appendix 1** for the definition of an SAI)* immediate telephone contact should be Incident Management Procedure – October 2014 WORKING DRAFT Page 12 of 36 Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry. **TRU-02720** made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Associate Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. This group must complete a major/catastrophic incident checklist for all incidents screened as possible SAIs. This checklist, regardless of the outcome of the screening process, will be held by the Directorate CSCG Coordinator and copied to the Assistant Director of Governance via the Corporate Governance Office. **(See Appendix 6)** In the event of the incident meeting the Serious Adverse Incident criteria; **section 5.0** of this procedure should be followed and where appropriate, the Director	TRU-02719 – TRU-02721

October 2014	SHSCT Incident Management Proceudre	***4.1 Incident Review:*** The following risk assessment process should be applied to all incidents at the time of occurrence in order to decide what level of investigation is required and at what level within the Trust the investigation should be conducted. ***Step One – What was the impact of the incident at the time of the incident? (Actual Harm)*** 4.1.1 The person reporting the incident should undertake this stage of the assessment, entering it on the IR1 form (DIF1). Based on the actual impact of the incident at the time of occurrence (taking into account psychological as well as physical harm) a judgment is made as to the incident"s severity in the range Insignificant to Catastrophic. 4.1.2 Incidents assessed as causing actual **major** or **catastrophic** harm at the time of the incident must be given immediate consideration for further in depth analysis. 4.1.3 For incidents causing lesser levels of actual harm further questions need to be asked to decide on the level of investigation required. ***Step Two – What might the impact be if the incident happens again? (Potential harm)*** 4.1.4 Where the potential harm of the incident is being considered, staff must ask the following in the context of "if no further action was taken". • Was the harm caused by a chance happening? • Could the actual harm caused realistically have been a lot worse? • How many people might be hurt if it happened again? • How seriously might someone be hurt if it happened again? • What are the control measures already in place, today? 4.1.5 It is important that grading on actual harm and potential harm are completed as separate exercises. This will ensure that the most severe incidents where the level of actual harm is higher are dealt with as a priority. All incidents with a lower level of actual harm but with a potential for a higher level of harm must be managed appropriately. **Step one** Deciding what was the impact / harm of the incident today **(actual)** **Step two** Where there is insignificant to moderate actual impact/harm, deciding what might the realistic impact/harm be if the incident were to happen again under similar circumstances. **(potential impact)** **Step three** Decide what are the chances of the incident happening again under similar circumstances. At this stage consideration should also be given	TRU-02721 – TRU-02722

<table>
<tr>
<td></td>
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<td>to reviewing similar incidents that have happened in the past.
(Likelihood)
Step four Decide what the overall risk grading for the event is by plotting:
Impact multiplied by likelihood = risk grading

The level of review applied to an incident is determined by the actual severity (impact) of the incident and/or the potential impact and is as follows:</td>
<td></td>
</tr>
<tr>
<td>October 2014</td>
<td>SHSCT Incident Management Procedure</td>
<td>5.1 Procedure for Conducting a SAI Review (This procedure should also be applied when conducting an Independent Internal Review):
<table>
<tr><th>Timescale</th><th>Action</th><th>Lead</th></tr>
<tr><td>0 -72hrs</td><td>Discuss with Director, Assistant Director, AMD and CSCG Coordinator. Consider the incident against HSCB (Oct 2013) definition of a SAI and using the Major/Catastrophic incident checklist.</td><td>Director / CSCG Coordinator</td></tr>
<tr><td>0-72hrs</td><td>If above group decides the incident is an SAI they will inform the service team involved in the incident of their decision and the patient/client and/or their relatives. This group should identify nominations for the SAI review team including a Chair. (Advice for Chairpersons - see Appendix 8) Those nominated should have had no involvement in the incident for review, should be from another site / team and should be available to participate during the subsequent 12 weeks.
There is the option to nominate external independent persons from other organisations onto the review team – this is done via the Director and Chief executive. This option may be useful when there is a need to engage the appropriate expertise, the incident is particularly distressing for staff involved or is particularly sensitive, where carers and relatives have expressed significant dissatisfaction with a service team or the organisation at an early stage, where a service team is small and based on one site only, where the case may be subject to external or legal scrutiny at a later stage or at any other time where it may be deemed to offer a benefit.</td><td>Director / AD/AMD/CSCG Coordinator</td></tr>
<tr><td>0-72hrs</td><td>Following confirmation of their involvement all review group nominees will receive an email with the following information:
• Notification of their nomination and who nominated them.
• Membership and Chair of the group
• A brief description of the incident
• Timescale for completion of the report
• Guide to RCA methodology.
The relevant A/D will check and ensure the case note /records have been forwarded to the CSCG Coordinator.</td><td>CSCG Coordinator</td></tr>
<tr><td>Week 1</td><td>CSCG Coordinator and Chair of review group will agree draft terms of reference for the review.
Draft terms of reference and a copy of the case note / records will be circulated with potential dates for meeting 1 of the review.
All relevant information will be distributed to the group for consideration prior to meeting 1 of the group.</td><td>Chair/CSCG Coordinator</td></tr>
<tr><td>Week 2-3</td><td>Meeting 1 will take place. This meeting will normally agree a terms of reference – including the scope of the review. The timeline of events will be discussed - and all relevant points for further analysis identified together with any points needing further clarity from the professional team involved in the incident. It is often useful and appropriate to meet with some / all of the staff involved in the incident so they can give their account to the review team in person, indicate their thought processes at the time and clarify any</td><td>Review Team</td></tr>
</table>
Incident Management Procedure – October 2014</td>
<td>TRU-02725 – TRU-02726</td>
</tr>
</table>

		<table><tr><td></td><td>outstanding issues. The appropriate members of the review can meet those of similar profession from the team involved in the incident.</td><td></td></tr><tr><td>Week 3-6</td><td>Actions from meeting 1 will be completed, including follow up meetings with staff involved in the incident and all information can be forwarded to CSCG Coordinator.</td><td>Review team</td></tr><tr><td>Week 6</td><td>Meeting 2 can take place. It may be appropriate in less complex cases to have Draft 1 of the report tabled at this meeting for further discussion. However this meeting is more likely to pull together all information received and to analyse the incident and make conclusions, recommendations and propose an action plan.</td><td>Review team / CSCG Coordinator</td></tr><tr><td>Week 7-9</td><td>A complete draft of the report will be prepared by members of the review team and circulated to all for comment.</td><td>Review team /CSCG Coordinator</td></tr><tr><td>Week 9-10</td><td>Comments from the review team will be reviewed by the Chair and CSCG Coordinator / review facilitator and a final draft agreed and then circulated to the review team.</td><td>Chair/ CSCG Coordinator</td></tr><tr><td>Week 10-12</td><td>The final draft will be circulated / shared with all members of the service team involved in the incident for factual accuracy checking and information. The Final Draft will then be forwarded to the appropriate Director, Associate Medical Director and Assistant Director for quality assurance prior to presentation at Directorate governance meetings.</td><td>Chair/CSCG Coordinator</td></tr><tr><td>Week 12</td><td>Following approval by AD CSCG the report will be submitted to HSCB/ RQIA via the Corporate Governance Office. The report may also be submitted to SMT for information sharing / discussion and if a case involves a death being reviewed by the Coroner it will be shared with their office also.</td><td>CSCG Coordinator / Corporate Governance</td></tr></table>	
27.10.2014	Email from Ms Corrigan to Consultants	Re: complaint about patient who was admitted to SWAH and urologist was difficult to access and then refused to take the patient.	TL5 page 1674 – 1675 AOB-71836 – AOB-71837
24.11.2014	Letter of complaints	Re: Mr Personal Information Feel that level of care in relation to Mr Personal Information 's diagnosis and decisions made by medical team has fallen well below the required standards in this case, given that he was told that all tests were clean and then told he had a small amount of cancer but couldn't operate until November and then told he had high activity cancer	TL5 Page 1863 – 1866 AOB-72025 – AOB-72028
23.03.2015	Letter of Complaint	Re: Mr Personal Information *"Mr Personal Information phoned today to complain about the way he was treated in 3 South on Thursday 19th March 2015. He stated that "You wouldn't treat a dog like that!". He went on to say that "the staff had bad manners and are the most ignorant people he has ever met in his whole life".*	TL5 page 720 – 723 AOB-72915 – AOB-

		He advised me that he had a urine problem and received an operating on Wednesday 18 March under Dr O'Brein. When he woke up at 8.30am back in 3 South he was naked from the waist down and no member of staff had bothered to cover his dignity. *He was examined by a junior Dr before being discharged. Mr* Personal Information *was not happy with the advice that the junior Dr was relaying to him so he asked to see Dr O'Brien but the junior Dr informed him that Dr O'Brien was in* Personal information redacted by USI *on his holidays. Mr* Personal Information *advised me that he knows Dr O'Brien personally and he also knows that he was not in* Personal Information redacted by the USI *Mr* Personal Information *wants to know why the Junior Dr was lying to him. I asked Mr* Personal Information *for the name of the Junior Dr but Mr* Personal Information *said he did not get it but said, that the junior Dr was on duty in 3 South from 8.30 to 12.30 on Thursday and that he wore a brown shirt and glasses. He said a few other unpleasant things about the junior Dr.* Mr Personal Information further advised me that his left leg is paralysed and *no-one offered him any assistance with getting dressed. Therefore he sat around 3 south for 3 and half hours wrapped in a sheet.* *When he was discharged he was told that his medication was not ready. He said that they knew he was being lifted around 12.30 that day. What was the delay? Why was it necessary for his wife had to do a 40 mile return journey to get the medication.* *Mr* Personal Information *sounds enraged and mentioned contacting the Human Rights Organisation because of the way he was treated."*	72918
June 2015	Screening Report SEC	Re: Personal Information redacted by the USI Litigation case regarding care from 2009. Patient had Background of bladder cancer with cytectomy and urostomy. Past surgical history involves bladder cancer for which she underwent anterior exenteration procedure on 05/06/15 | Copy of Medical notes requested from Litigation.	TRU-03748
29.06.2015	Datix	Form Number: Personal information redacted by USI Description Description: Patient attended ED. He had been told by a consultant renal physician at a Western trust clinic two days before that he was being referred urgently to urology at CAH by faxed letter direct to urology secretaries. Because the patient had not heard anything in the subsequent two days, and despite the fact that he had no symptoms, he got worried and decided to attend ED. I saw him and referred hm to urology, expecting the urology team to take responsibility for whom I saw as their patient, but was immediately asked by the urology team to organise the investigation that the patient merited having (as an emergency now that he was under the trust's care, though taking	TL5 page 2372 – 2373 AOB-74567 – AOB-74568

		him under the trust's care had not seemed necessary until he self-presented). My issue is not about the appropriateness of organising the investigation, it is about the urology team's unwillingness to take ownership of this patient on my referral of him to them. I was expected to organise the investigation rather than them coming down and taking it on themselves to look after him. I am of course perfectly capable of organising a CT and cannulating and sending bloods off, as I am equally capable of asking a junior doctor to do it on my behalf. However, whichever of us does so, it is time and expertise spent away from our own emergency patients who lose out as a result of another speciality not engaging with their own patient, and expecting the ED to manage failure by another part of the system. Please go to Personal information redacted by USI view and approve it.	
20.07.2015	Email from Ms Corrigan to Consultants	Re Datix Personal information redacted by USI Patient Perso nal , Pers onal y /F, scheduled for emergency JJ stent insertion had acute on chronic renal failure secondary to obstructive uropathy and had been treated for acute hyperkalemia overnight. She came down to theatre with Hartmann's fluid (Potassium containing fluid) running intravenously. This was noted when the patient was being transferred to operating table. The infusion was stopped, the Hartmann's fluid bag discarded and normal saline bag erected in theatre. Informed Sister in charge, Urology Registrar Dr Jenny Martin who reassured me that she will feedback to staff on ward. Submitted by: Dr Shiva Kumar Arava and Person in charge at time of incident was Siobhan McArdle.	TL5 page 2507 AOB-74702
26.07.2015	Email from Ms Corrigan to Consultants	RE: Locum Problem – Mr Personal Information Thank you very much for this and really appreciate you contacting me on Saturday – unfortunately this was the third issue raised with me on Saturday re: Mr Personal Information's behaviour and attitude. I am copying Martina Corrigan into this email as she has responsibility for Urology. I'll make sure this subject is discussed at our weekly meeting with Mr Mackle. The "key urology work" being performed by Mr Personal Information is covering locum Registrar shifts on the Urology rota which are vacant due to the lack of Urology Trainees.	TL5 page 2552 – 2553 AOB-74747 – AOB-74748

		Aside from the Mr Personal Information issue you also raise valid points in relation to locum staff identification and Trust access, again I'll ensure this is addressed. Complaint: Many thanks for taking my phone call on Saturday evening regarding concerns that the Biochemistry Biomedical Scientist (Personal Informatio) had regarding a locum in Urology (Mr Personal Information). Personal Informatio had been contacted on Saturday morning by Mr Personal Information asking for laboratory results. As we have a very strict policy about giving out results to unknown individuals when the results are already available to look up on the lab system he refused to do so and advised that Mr Personal Information get these through one of the members of his junior medical team or nursing staff. Mr Personal Information told Personal Informatio that he was a very important doctor who had been brought in specially to the Trust to perform key work in Urology and he must have the results. I was contacted by the Biomedical Scientist at 10.30 am approx. and fully supported Personal Informatio's action. We had no way of verifying the identity of Mr Personal Information and whether he was indeed a locum. Personal Information had given Mr Personal Information my mobile number to discuss but he never contacted me. I was then contacted by the Biomedical Scientist again at 5.30 pm. Mr Personal Information had made his way into the lab to speak to Personal Informatio. He told him he was a very important person in the Person al who had the power to close hospitals and always travelled with security. He showed Personal Informatio his identity card which bore an Personal Information but refused to let Personal Informatio photocopy it. There was no proof that he was employed in a locum capacity by this Trust. Personal Informatio phoned me as he felt quite intimidated and was glad when he escorted him out of the lab. I simply find this behaviour bizarre and as we discussed on Saturday evening I believe he is a registrar rather than a Consultant? It also raises issues about locums having proper identity and proof of employment and authorisation by the Trust.	
27.09.2015	Mr O'Brien's response to Ombudsman complaint	Re: Mr Personal Information Having read the letter of 24 August 2015 from Ms. Claire McIlhatton, Director of Investigations, to Ms. Paula Clarke, Interim Chief Executive, I do believe that there are some inadequacies in the section entitled 'Background and History of Complaint' and which I believe to be important. In particular, it is incorrect that Mr. Personal Information redacted by the USI was first seen by Mr. Brown following his presentation with abdominal pain and increased urinary frequency.	TL5 page 3099 – 3100 AOB-75294 – AOB-

		I have detailed Mr. Personal Information redacted by the USI history, investigation and management in a letter of 08 April 2015 addressed to his family doctor, Dr. Personal Information and which I have attached. I am happy for a copy of that letter to be sent to the Director of Investigations. It does however contain one typographical error which I am unable to edit. A sentence in the third last paragraph of the letter reads: 'I also do believe that the possibility of inguinal herniorrhaphy particularly with implantation of a mesh, has not also been a contributor to the totality of his pain.' I would be grateful if you would delete the word 'not' highlighted in red before its submission to the Director of Investigations. From my perspective, I believe and hope that the Director of Investigations would find the letter to be of some benefit in the conduct of her investigation. I would subsequently be happy to be of any further assistance. If you wish to discuss before submitting attached letter, please feel free to contact me on Personal Information . Thank you,	75295
01.10.2015	Datix Personal information	Over the past few weeks it has been an area of concern that Discharge letters are not being completed on day of discharge. Informed by the ward clerk today that currently there are 13 discharge letters not done and when she approached the FY1 she was informed that they were too busy and didn't have time to do them. This is cause for concern for missed review appointments and GP follow ups. FY1s have expressed concern that they are under pressure and are unable to complete all their duties and it is usually the discharging that suffers	TL5 page 3266 AOB-75461
01.10.2015	Email from Mr Haynes	Response to Datix Personal information Our single FY1 this week is split across two wards at present resulting in significant inefficiency and difficulty in working. There is no CST supporting them in this work. At the same time I understand that there have been times when there are strikingly different levels of FY1 / jnr dr staffing levels on other	TL5 Page 3267 – 3268 AOB-

		wards (eg 4N). Indeed I do not recall seeing fewer than 2 FY1s on 4N at any point. I believe on occasion this week there have been 3. Because they are ward based the FY1s are doing the jobs on their ward and not any other. Thus while our FY1 is struggling on their own, staying late every night and working across two locations, their colleagues are leaving on time. Added to this, it is my view based upon experience of working elsewhere that our FY1s are performing duties (eg first dose IV Abx) which are not considered the duties of a doctor in any other hospital / trust that I have worked in. The result of this is that our FY1 this week is becoming increasingly disillusioned with her job and career. Her pat on the back is an IR1 form (this may not be intended to be critical of the FY1 but I am sure that is how the FY1 will interpret it). Something has to give. Either the FY1 staffing levels across all surgical wards need to be reviewed daily so that the 3 on one ward and 1 on another (that is split to two places) situation does not arise or we need to agree what the FY1 should be prioritising (should it be the bloods, the imaging, the IV access, emptying their bladder, the incomplete drug kardexs, the patient that needs reviewing, the consultant ward round, their lunch etc) and what can be left to the bottom of the priority list. If nothing can be left then we need to ensure that 'the shit flows uphill', our Registrars need to start helping out with FY1 duties and we start doing the Registrar duties, inevitably something wouldn't get done though. Long term I think the duties expected of an FY1 need to be looked at here (CAH / NI) and brought into line with the rest of the NHS (along with support nursing / auxiliary staff) as this is the only way we will have FY1s being trained and not being disillusioned by their urology experience (how many of our FY1s are finishing thinking they've experienced urology in some way and are keen to explore it as a career?). The problem is across the FY1 grade in CAH, I hear the medical FY1s dare not allowed on the medical ward round and simply get given a list of jobs by the team	75462 – AOB-75463
12.11.2015	Email from Ms Hunter to Ms Gishkori	Re: Concerns on Ward 3 South While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters. Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions. In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation.	TL5 Page 3566 – 3570 AOB-75761 – AOB-75765

		Main issues 1. Staff shortages 2. Staff Morale 3. Skills mix 4. Nursing care records 5. Cancellation of staff training 6. Staffing of ENT Clinical room during the day 7. Pharmacy cover on ward	
12.11.2015	Email from Mr Haynes to Ms Hunter	Re: Response to 3 South Concerns This is extremely concerning and in particular if patients incidents have occurred due to staffing issues already we need to act now and not wait for a more significant incident to occur. My experience of Bank / agency staffing is that while they may fill a vacant gap, they often do not perform the full role as we would see performed by a regular member of staff. The result is that the regular members of staff come under increased pressure during their shift. In addition to the Bank and agency staff you also highlighted to me that some members of our nursing team are very newly qualified and this has meant that at times the ward staffing (at staff nurse level) has been made up of bank / agency staff, a newly qualified nurse and one more experienced nurse, increasing the pressure on the regular members of staff significantly. I recently operated on the relative of a colleague and the informal feedback from this family regarding the ward was that the staff are excellent but under significant pressure and not able to attend to patients as would be expected. Where the ward is understaffed for the 31 beds continuing with 36 beds open and relying on Bank / agency staff is not safe as you highlight. In prioritising care, emergency admissions come first and so we should not be admitting elective patients while the current situation exists	TL5 Page 3571 – 3572 AOB-75766 – AOB-75767
January 2016	Screening Report SEC	Re: Personal information redacted Patient Personal had ERCP in January 2016 for CBD stones but they could not be removed, a stent was inserted and he was referred for surgery. Lap chole and CBD exploration was performed in April 2016. Over past two months he has had 3 admissions with severe sepsis due to cholangitis. MRCP showed large stones in CBD. Personal attended for ERCP to clear these stones and at the time of the procedure it was noted he still had a stent in his CBD. This was why he developed the recurrent stones and episodes of cholangitis. It should have been taken out at the time of surgery in 2016.	TRU-03051 TRU-03098

		23/10/2018- Timeline in progress. Medical notes received. 30/10/2018 - Timeline completed. For screening. 18/12/18 Discussed with Mr Haynes- probable SAI to be discussed with Dr Murphy - Andrew Murdock possible chair as on ECR group 30/10/2018 - Timeline completed. For screening. W/C 21/12/18 Discussed with Dr Murphy and Mr Haynes- for SAI. 31/12/2018 Notes reviewed by Dr Murphy and T Reid. Trudy emailed Mr Haynes re notification notification. 15/01/2019 RC approved notification. MH, AMcV and PM to approve. 16.1.19 Approved by Mr Haynes 16.1.19 Approved by Mr Haynes 22/01/2019 Notification approved by Dr Murphy. Approved by Dr Murphy 23/01/2019 Email to Dr Murphy and Mr Haynes requesting nominations for review team. Notification sent to HSCB.Paula to follwo up on review team nominations. 23.1.19 Need review team team. Notification sent to HSCB.Paula to follow up on review team nominations. 23.1.19 Need review team. 12.2.19 Mr A Lewis has been suggested by Mr Carroll, need to confirm if he has accepted. ask if a lead nurse should sit on review.	TRU-03375 TRU-03429 TRU-03479 TRU-03516 TRU-03563
11.01.2016	Email from Client Liaison to Ms Corrigan	Re Complaint – Mr [redacted] Patient was initially seen in March 2014 and to date he is still awaiting an appointment. He says this is 97 weeks that he is waiting and is going to see his MP and inform the HSCB. He would like to know the standard waiting time	TL6 page 77 – 79 AOB-76164 – AOB-76166
12.01.2016	Email from Ms Corrigan to Mr [redacted]	Re: Mr [redacted] Complaint Ms Corrigan advised Mr [redacted] that the team will keep him in mind if any cancellations but that the waiting list for non-cancer is out at 120 weeks and there is nothing more than can be done. It was also noted that this patient was a Belfast patient	TL6 page 81 – 82 AOB-76168 – AOB-76169
24.02.2016	Letter of Complaint	Re: Mr [redacted] *"This letter concerns the care my dad has received at Daisy Hill and Craigavon Hospitals since*	TL6 page 549 – 554

		February 2014. My dad is now Personal Information *old and was initially admitted to Daisy Hill in February 2014 with acute urinary retention due to an enlarged prostate. He was subsequently discharged with a urinary catheter. After several tries without catheter Mr Brown asked his junior doctor to refer my dad to urology with view to having a TURP, surgery so that he might become catheter free. In the summer of 2014 I contacted urology but they had yet to receive the referral. On speaking to Daisy Hill, Mr Brown contacted me to explained that the referral had now been sent.* *In October 2014 I brought my dad to see Mr O'Brien and the pre assessment nurses. I was told surgery was unlikely to be this side of Christmas. So my dad would have the urinary catheter until surgery available.* *Since September 2015 my dad has had 4 hospital admissions. The first two were fairly uneventful in the Downe hospital. I did ring urology secretaries at this point explaining my dad having hospital admissions due to the catheter, recurrent urinary infections. It was explained to me that my dad was still on the urgent list for surgery but no date had yet been allocated.* On October 31st an ambulance brought my dad to Daisy Hill A&E dept. When I got there he was distressed as it was apparent his catheter was blocked. The dr, a locum I believe, wanted to put in a 3 way catheter and set up bladder irrigation. He was informed by the nursing staff that they didn't do that and my dad would have to go to Craigavon. *The A&E dr contacted urology at Craigavon. I believe they asked for a surgical opinion. I could hear the conversation at the nurses station and the telephone conversations. Soon as surgical dr stood at the nurses station. He said "frank haematuria, send him to urology". The A&E dr asked if he would like to see my dad. He said "I have seen him. Send him to Craigavon". He did not speak to my dad or me, or come near us. My dad by this point was clearly agitated, climbing off the trolley telling to get him a dr as he needed to pee and couldn't. I had to stop him leaving the cubicle. He* Personal Information redacted by the USI *and just knew he needed the toilet. I had been there a couple of hours at this point, My dad was now standing unsteadily in front of me wearing a tee shirt with his groin and legs covered in blood. When I asked a nurse for wipes and a towel so I could clean my dad she did offer to help, but I declined her offer. It felt up to that point that no-one wanted to do anything for him. There was no attempt at a bladder washout. He did get some relief if he walked. I believe it made clots move and he was able to pee an amount into the bad. At 1am when I called for help a young nurse came in. She helped me walk him round the cubicle, and he passed some urine into the bag. She was also the only one who changed his trolley, bloodstained blanket and pads. An ambulance came at 2am to take him to Craigavon* *Looking at his chart in Craigavon, it was apparent he became unwell at 6am, but this was dealt with efficiently by nursing and medical staff.*	AOB-76636 – AOB-76641

		He was discharged from urology on November 5th 2015. I discovered on the way home to Personal Information redacted *that my dad was faecally incontinent with diarrhoea. When I got him home he was wearing a nappy type pad which he had soiled on the journey. Also from washing it was apparent this was ongoing. 3-4 pairs of pyjamas were badly soiled. My dad had never been incontinent before. I had nothing in the house to deal with this so I left him alone and went to the chemist to buy pads and wipes. While doing his washing a couple of hours later I heard the front door slam. I ran out to find my dad in his pyjamas walking into two lanes of traffic. This was also something new.* *My dad was placed in a nursing home the next day as an emergency placement. He continued to have diarrhoea. By the week starting 9th Nov 2015 he looked like he would die. The GP sent him to Daisy Hill on the 13th Nov 2015. After my previous experience I was somewhat reluctant about this, but on that day the staff were excellent.* *He was moved to a medical ward. I did inform all about the diarrhoea and the IV antibiotics he had been on in Craigavon. The nurse on the ward told me he had been assess as non-infective. After a few days on the open ward they did move him to a side room as the diarrhoea persisted. He was discharged a couple of days later, back to the nursing home. They sent a stool sample which confirmed clostridium difficile.* My main areas of concerns *At pre assessment if we had been told a realistic timescale for the waiting time for surgery he would have looked into getting dad the surgery privately* *Not a lot I can say about the surgical opinion my dad received in A&E. My dad may now be an* Personal Information *old* Personal Information redacted by the USI *, but he worked his whole life. I do not remember him ever taking a day off work sick. He was the longest serving* Personal Information redacted by the USI *in N Ireland when he retired.* *An elderly man with full bladder and blocked catheter. Nothing was done to try and give him some relief.* *I was not informed that he was having diarrhoea. If I had known I would have already obtained pads etc.* *Were any stool samples sent when he was in hospital."*	
04.03.2016	Email from Ms Corrigan to	Re Actions from AMD and Urology Consultant Meeting	TL6 Page 639 – 640

	Consultants	Actions 1. Mr Young to meet with Mr Personal Information this week/early next week and explain what process are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him 2. Mr Mackle to meet with Mr Personal Information on Wednesday 16th March in AMD office 3. Mr Mackle and Mr Young to advise him that he should be seeking appropriate course that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate 4. A Multi Disciplinary feedback questionnaire should be completed and collated within the team – this will be used as constructive feedback for Mr Personal Information 5. Formalise evening cover and the purpose of this will be explained to Mr Personal Information 6. Formalise the ward rounds with one of the consultant Team accompanying Mr Personal Information each day 7. The Consultants involved in the "second on call" and ward rounds will be remunerated by ½ PA	AOB-76726 – AOB-76757
15.03.2016	Letter of Complaint	Re: Personal Information redacted by the USI *"I wish to highlight an issues regarding delays in my father's treatment plan for prostate cancer. He attended his GP in September 2015 for pain and irregular bladder movements he was placed on antibiotics for a kidney infection in which it didn't cure, in Oct 2015 he was referred to CAH to Mr Glackin who placed him on 3 months medication to reduce swelling of the prostate and was re-assisted 22 Dec 2015. My father was then referred for a biopsy to which had to be chased through many a phone call to CAH, the biopsy was done wc 11/1/16 to which this confirmed on the 8th February he had prostate cancer. Mr Glackin was then to discuss the case with a consultant in Belfast as my father suffered severe injuries during the troubles and his body is scattered with shrapnel to see if he could have an MRI scan before he got treatment. My mother had to chase this with numerous phone calls to Mr Glackin's secretary who was Personal information redacted by USI and no one was covering her Personal information redacted by USI so again no admin was being processed for cases as to what was the update on his case. My father then had a CT scan 2 March in South Tyrone Hospital and was informed the results would be sent back to Mr Glackin within 7 days, again several phone calls had to be made to see if the results was back and eventually on Monday 14 March the Secretary confirmed they had come back that morning, my mother then asked what was the next stage as he was told he would need 4 weeks radio in the city hospital Belfast. The secretary informed my mother that Mr Glackin was now off on leave for 3 weeks and no one would pick this up until he returned from leave so this means another 3-4 weeks before we have to chase this matter again. I can't believe that no one picks up his work so that patient treatment plans can go ahead.* *As a manager I fully understand absence issues but when this is interfering with patients treatment plans I find this very frustrating and also the lack of communication issues through such a serious and stressful situation my family is going through currently. My father's health is poor at the best of times*	TL6 page 712 – 715 AOB-76799 – AOB-76802

		but this has really had an impac on his health daily through pain and discomfort in which he won't leave the house because of the regular visits to the toilet. *I would really appreciate if my fathers case could be reviewed and the next stage of his plan communicated to him as soon as possible.* *I look forward to a response/resolution in this matter as I fully appreciate the stress the health service is under locally"*	
02.04.2016	Email from Ms Corrigan to Mr Personal Information	Re: Actions from AMD and Mr Personal Information Meeting To formalise, please see the notes/actions arising from your meeting with Eamon and I on 23 March 2016. Present: Mr Mackle, Mr Personal Information Mrs Corrigan. Venue: Associate Medical Directors Office, Admin Floor, Craigavon Area Hospital Mr Mackle advised that the purpose of the meeting was to follow up from the meetings that Mr Young and Mr O'Brien had with Mr Personal Information Actions agreed: 1. Mr Mackle asked Mr Personal Information to source appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate. Mr Personal Information to Source and provide details of courses to Mr Mackle/Mrs Corrigan by Friday 22 April 2016 so that arrangements can be made to approve/attend if deemed appropriate. 2. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – Mrs Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Personal Information and will be strictly confidential. 3. Formalise evening cover for all oncall weeks for Mr Personal Information Mr Young has agreed to formalise after discussions with the rest of the Team and that this will be shared with all the Team, Mr Mackle and Mrs Corrigan. Formalise the Ward rounds with one of the Consultant Team accompanying Mr Personal Information each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and Mr Personal Information and Mrs Corrigan. 4. Mr Personal Information to arrange to attend theatres with the other consultants in order to train in his surgical skills. The details of when and what cases he is involved in should be logged and shared with Mr Mackle/Mrs Corrigan – this should be provided on a monthly basis. A further meeting in 3 months to be organised in order to update on progress – Mrs Corrigan to confirm date.	TL6 Page 1367 AOB-77453
09.04.2016	Email	Re: Urology Action Plan AMD & Personal Information meeting	TL6 page

	correspondence between Ms Corrigan and Consultants	Mr Young notes that following a meeting with Mr Mackle, the rota needs to be defined to cover Mr [redacted]. Thursday 17th (holiday day) Mr Young coming off call so will be handing over – Mr Young to do rest of day and night Friday 18th – (Mr Young on Annual leave) – Needs defined Sat/Sun – Needs defined (John covered last weekend) Mon 21 – Thought Mark could cover ? Tues 22 – MY to do Wed 23 – Thought AOB could do? Day time am round Friday - ? John if free Mon – Mark Tues – MY Weds – AOB	1364 – 1366 AOB-77450 – AOB-77452
18.04.2016	Email from Mr [redacted] to Mr Mackle	Re: Action Plan Further to the meeting we had on 23rd March 2016, I would like to furnish my action plan, which I have attached to this email. I have also attached the details of the 'extra theatre sessions', I managed to attend so far. I would like to avail this opportunity to thank you and my colleagues for the kind support and help offered.	TL6 Page 1361 – 1363 AOB-77447 – AOB-77449

Action Plan

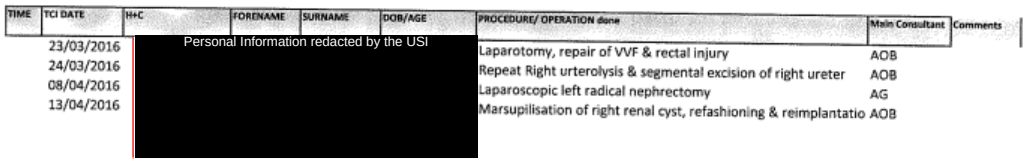
Type of Action	Details of Action	Outcome	Comments
Formal and Informal Discussions	Engaged in discussions with my consultant colleagues – Mr Young, Mr O'Brien, Mr Glackin, Mr Haynes and Mr O'Donoghue. Requested my colleagues to inform me of any major urological emergency, even if out of hours, so that I can avail the opportunity to observe and assist.	Finalised days/time to attend extra theatres for observation of major open cases	I am liaising with the secretaries to keep me up to date on current theatre schedules for major cases
Theatre Observations	Attended various theatre sessions to observe and to assist major cases	Improved my confidence and skills in open cases	All such theatre sessions attended are recorded on a separate log book
Research / Booking of Suitable courses	Engaged in independent research about suitable courses. Contacted BAUS Office of Education and the organisers to obtain course details	Identified three courses* which will enable me to gain hands on skills	To book the courses, soon after the announcement.

*Courses Identified

1. Advanced Cadaveric Trauma Emergency Surgery Course (ACTs)
   Date: September 26, 2016 Emailed Newcastle surgical training centre and is awaiting registration

2. Cadaveric Course Module 3- Male and female urinary incontinence – Probably in Oct 2016. Date yet to be announced.

3. Cadaveric Course Module 4- Emergency and Trauma Urology cadaveric course- Probably in Oct 2016, Date yet to be announced.

		CRAIGAVON AREA HOSPITAL **Mr SURESH, Consultant Urologist** **Other theatre sessions**  Personal Information redacted by the USI 23/03/2016 Laparotomy, repair of VVF & rectal injury AOB 24/03/2016 Repeat Right urterolysis & segmental excision of right ureter AOB 08/04/2016 Laparoscopic left radical nephrectomy AG 13/04/2016 Marsupilisation of right renal cyst, refashioning & reimplantatio AOB	
07.06.2016	Email from Ms Corrigan to Mr Young	Re: rota to fit around Mr Suresh plan – relates to further supervision on Mr Suresh *Formalise evening cover for all oncall weeks for Mr Suresh.* *Mr Young has agreed to formalise after discussions with the rest of the Team and that this will be shared with all the Team, Mr Mackle and Mrs Corrigan*	TL6 page 1360 – 1367 AOB-77446 – AOB-77453
12.06.2016	Email from Mr O'Brien to Ms Corrigan	Re: Mr Suresh *"In Michael's absence, I am unaware of any support having been offered. In any case, I have provided Ram with support since Thursday morning when he came on call. I have over the management of each inpatient with him, as I have done again today. I take this opportunity to share my opinion that Ram has made every effort to improve his management of inpatients while on call and that he has succeeded.* *In fact, I have been impressed this weekend with his diligence, picking up one or two omissions of mine last week. I think that he is now up to speed and as good as the rest of us.* *Ram's ability to undertake major open surgical intervention, particularly in a very acute setting, is distinct from his general clinical management of inpatients.* *I believe that we had better get used to the fact that only a proportion of urologists completing their training these days would be able to do so, and would not be expected to do so.*	TL6 page 1401 – 1404 AOB-77487 – AOB-77492

		So, I do believe that Ram has been made progress and is keen to improve his open surgical competence. I also believe that he deserves and has earned our ongoing support."	
05.08.2016	Ombudsman Report	Re: Mr [redacted] Conclusion *"My conclusion is that this is a very typical complex plain case with the frustrations and dissatisfaction expressed by the patient not only understandable from his perspective but an important indicator of the potential underlying complex issues. The pain service could have been at risk of causing iatrogenic harm but wisely avoided this and I think managed this patient safely and sensibly.* *The greater learning point from this case is the urgent need for clinicians of all disciplines to recognise promptly the markers of complexity and to assess patients more fully as only by doing so will we be able to support patients with distressing and disabling symptoms appropriately."*	TL6 page 1675 - 1719 AOB-77760 – AOB-77804
22.11.2016	Letter of Complaint	Re Mr [redacted] On [redacted] my father [redacted] died unexpectedly whilst in the care of Craigavon Area Hospital. The aim of this letter is to bring to your attention a summary of the standard of care we witnessed my father receiving, which in my opinion fell dramatically short of what should reasonably be expected. Having successfully been treated for bowel cancer some years ago, my father was diagnosed with bladder cancer in 2014 after a long period of assessment. This latest cancer was treated under the excellent supervision of Mr O'Brien who over the past few years has done a great deal to treat my father, culminating in the successful surgical removal of the bladder tumour aided by radiotherapy. Following post-surgery discharge the bleeding did not stop and so after several blood transfusions and further scans he was re-admitted to Ward 3 South (Urology) in Craigavon Hospital on 8 September 2016 from South West Acute Hospital to undergo further assessment. The outcome of these scans and exploratory inspections identified no remaining evidence of a tumour, but that areas of the bladder wall had thinned considerably; a result of associated radiotherapy. A further surgical procedure was undertaken to stem the bleeding on 14 September, after which my father was left to recover in the hospital with an expected discharge date of 5th October. Notwithstanding the excellent care given by Mr O'Brien, his fellow consultants and surgical teams, the care on the wards throughout his stay was appalling. On the first visit by my mother she arrived to find my father unshaven and wearing a hospital gown rather than pyjamas. When asked why, a nurse replied, "we didn't know he shaved everyday" and that "he had no clean pyjamas". Upset with the	TL6 page 2348 – 2351 AOB-78433 – AOB-78546

		dishevelled state in which she found my father, my mother pointed out to the staff the suitcase sitting adjacent to the bed complete with several pairs of clean, unworn pyjamas and proceeded to shave and dress my father in pyjamas herself. This unfortunately was to be the start of a long saga of woeful care over the next 2-3 weeks. Over nearly 3 weeks my mother struggled enormously to get any information from hospital staff as to my father's condition. Availability of nurses on the ward was sadly lacking, and those she could find did not have or did not wish to share any information. Despite asking on a visit by visit basis to see a Ward Doctor, this was not possible. She was informed doctors would be available during their normal rounds which unfortunately for our family did not coincide with bus times and so we remained in an information vacuum. My mother was limited to being visiting during fixed. Indeed as a last result both my mother and I had to call the Consultant directly on his mobile in order to get any information, this despite my mother spending several hours every other day at my father's beside; her pleas to speak to someone with knowledge falling repeatedly on deaf ears. It is ridiculous that we had to chase, and to be honest, waste the time of a highly skilled professional consultant simply to be able to get basic information. To his credit Mr O'Brien was splendid and deserves to be congratulated. My mother last visited my father on Personal Information redacted by the USI to find him in good spirits and expecting to be released from hospital the following week. She phoned him on the morning of the Personal Informati and again he was in good spirits, a fact later confirmed when speaking to Mr O'Brien who saw him at tea-time on the Ward and again reported him well. Just after mid-night on Personal Information my mother received a telephone call at home to say that the "Crash Team" had been called. My father died at Personal informatio before any family could arrive. As you will no doubt be aware yourself the shock and sadness causes thoughts to become confused, but my mother is not aware of having received a full account of what had caused his death by those on duty that evening. Only on receiving his death certificate and reading it fully the next day did we for the first time learn that my father had Hospital Acquired Pneumonia; indeed this is stated as the primary ailment connected with his death. It is unforgivable that the family were at no times made aware of this condition. A secondary condition of kidney disease was also printed on the certificate and again reading the document was the first time these words had been mentioned. It was on reading the Certificate that a depressing connection was made. On Person al whilst visiting, my mother overheard a Physiotherapist mention to my father that she had heard he had a 'bit of a chest infection'. My mother thought nothing more of it, after all this was just conversation by one of the staff and not a nurse or Doctor treating my father, and as a smoker for most of his life this was not the first time he had suffered a chest infection. This was all in addition to dehydration that was also mentioned	

		on the certificate which may or may not be connected to my mother repeatedly asking the staff to make my father drink more during the period of his stay as he would tend not to if not reminded. Then on the Personal Information an entirely separate and chance event took place. My father was to discharge into a residential home for a few days whilst my parents undertook a planned house move. As per normal practice the care home rang the hospital to check on my father's condition and to check on any needs he may have. That phone call identified that my father was on the 4th day of treatment for pneumonia i.e. the anti-biotic had commenced on the Personal Information The phone call also identified that my father's weight was not being monitored as is required due to the Ward not having any working scales. My mother had visited on 2 occasions since the commencement of anti-biotic treatment to fight his chest condition and did not receive a single word as to his condition or medication. I flew overseas on Monday Personal Information blindly unaware that my father health had taken a downturn. I was to receive a phone call he had died during the night upon landing in Personal Information on the Personal Information morning. I could go on about numerous other areas of more minor shortcomings but I won't. I hope the point has been made that throughout the entire time my father was under your care, the levels of on Ward care fell terribly short of what is expected by those needing your care and their families needing to be involved. The unbelievable difficulty in finding someone to speak to not over a short period but frequently over several weeks resulting in learning of his ailments by reading a Death Certificate is disgraceful. Leaving family members and indeed the patients themselves in the dark just makes periods of hospitalisation much more stressful than necessary and in the case of those patients who don't make it home, makes the experience of their families a hundred times worse. In this particular case the lack of communication and patient/family liaison ultimately led my mother and I to lose the closest of family to a complication connected with a hospital acquired condition we didn't even know he had. There is nothing that can be done to rectify our painful experiences of being completely let down, but hopefully this letter may make you consider re-looking at the care given in Craigavon in the hope that others receive a better experience. Finally I would like to request under Freedom of Information a copy of my Fathers medical records for the period in Personal Information redacted by the USI during which he was being treated at Craigavon, along with a description and reasons behind how my father was exposed to the virus/bacteria that gave cause to pneumonia which by the description in the Death Certificate was 'acquired' during the period he was being treated in hospital.	
08.12.2016	Response to	Re: Mr Personal Information redacted by the	TL6 2378

	complaint		– 2380 AOB-78463 – AOB-78465
01.06.2017	Email from Mr Haynes to Consultants	Re: DTR Notes that the process needs to be stopped as it is putting patients at a clinical risk and is disadvantaging patients. Notes that patients who need to be seen in clinics but need an investigation which has been arranged in advance, are being added to an OP waiting list pending outcomes from their investigations.	TL6 page 674 AOB-79261
26.09.2017	Policy	Financial Memorandum between the Department of Health and Southern Health and Social Care Trust	TRU-01824 – TRU-01863
26.09.2017	Policy	Management Statement between the Department of Health and Southern Health and Social Care Trust *Details the responsibilities and accountability of:* 1. *The Minister* 2. *The Accounting Officer of the sponsor Department* 3. *The DoH Executive Board Member, The Sponsor Team and Finance Directorate* 4. *The SHSCT Board* 5. *The Chairman of the SHSCT* 6. *The Chief Executive's role as Accounting Officer* 7. *The Chief Executive's role as Consolidation Office* *The Chief Executive's role as Principal Officer for Ombudsman Cases*	TRU-01864 – TRU-01887
November 2017 – September 2018	Screening Report	Re: Patient [Personal Information redacted by the USI] ? Delay in Diagnosis of Recto-sigmoid adenocarcinoma. Issued raised by Mr Mc Kay. Patient had a US Abdomen 7/4/17 – Conclusion - Fatty Liver; CT Abdomen & Pelvis with Contrast 22/7/17 – Conclusion - Severe sigmoid colitis with evidence of localised perforation 24/07/2018- email to I Yousuf on 13/7/18 + 24/07/18 re discrepancy report. Mr Carroll updated 31.7.18 Wait discrepancy report from Dr Yousuf. 21/08/2018 reminder to Dr Yousef 11/09/2018-as above 25/09/2018- still to be discussed at radiology discrepancy meeting	TRU-02909
22.12.2017	Screening Report	Re: [Patient 138]	TRU-03121

		Patient had TURBT 22/12/17 was listed for MDM 28.12.17 (virtual MDM) patient was closed on cancer tracker system and not followed up until GP phoned to enquire 25/10/18. Histology report 28/12/17 showed Transitional cell carcinoma. For screening. Red Flag team investigating for timeline 19.11.2018 For screening. 18/12/18 Discussed with Mr Haynes, probably human error, to discuss with Sharon regarding where the issue was for learning , patient came to no harm - not SAI 15/01/2019 Email to Sharon Glenny & Trudy for update. 22.1.19 Email from Ronan to discuss at performance meeting on 17.1.19 30/01/2019 see emails from Trudy Reid and Sharon Glenny. 30/01/2019- Datix feedback. This issue was raised at the Regional Cancer Performance meeting and it was agreed that the AD for cancer services would place the responsibilities of trackers on the regional Cancer meeting and an agreement shared with all Trusts. agreement shared with all Trusts. 4.2.19 Email from Sharon Glenny who advises she "discussed with Vicki and *Vicki met with the Trackers and discussed failsafe measures and have agreed a Standard Operating Procedure – attached. This has been circulated among the tracking team and fully implemented. Also is on the agenda for next Cancer Ops Meeting".*	TRU-03375 TRU-03516 TRU-03538
July – September 2018	Screening Report Radiology SEC	Re: Patient Personal Information redacted by the USI **Background**: ? Delayed diagnosis of tumour **Screening update**: (CT Abdomen and Pelvis dated 22/07/2017) This may not be unusual from a colorectal surgeon's perspective but highly unusual for a general radiologist reporting a variety of scans in a day. Initial appearances are highly in keeping with the report's conclusion. I DONOT believe this is a reporting error. We will discuss this in our discrepancy meeting and take it from there. We have to have an approach in which such cases are discussed locally prior to escalation for further governance! 30/04/2018 awaiting discrepancy report 21/05/2018 – Report to be drafted 07/06/2018 update given ? Delay in Diagnosis of Recto-sigmoid adenocarcinoma. Issued raised by Mr Mc Kay. Patient had a US Abdomen 7/4/17 – Conclusion - Fatty Liver; CT Abdomen & Pelvis with Contrast 22/7/17 – Conclusion - Severe sigmoid colitis with evidence of localised perforation 24/07/2018- email to I Yousuf on 13/7/18 + 24/07/18 re discrepancy report. Mr Carroll updated 31.7.18 Wait discrepancy report from Dr Yousuf. 21/08/2018 reminder to Dr Yousef 11/09/2018-as above 25/09/2018- still to be discussed at radiology discrepancy meeting	TRU-02905 TRU-02927 TRU-02987

		Admitted perforated diverticular disease and small bowel obstruction. Delay to surgery needs reviewed and discussion. Subsequently never recovered and died. I believe there is a coroners inquest. Requesting urgent case review meeting and SAI will need to take place Died - Personal Notes requested (with Litigation) 3.7.18 Timeline to be complete and notification to be completed. 13/07/018 – Discussed at screening Mr McKay to be contacted to review what the exact issue is- email sent to Mr McKay 17/07/2018 Reviewed by Mr McKay delay in getting to theatre in 1st 24 to 72 hours email to Mr Carroll & Mr Haynes 30.7.18 – Discuss with Ronan - Delay to surgery needs reviewed and discussion. Damian has confirmed our thoughts that the patient should have had early surgical intervention based on his original CT scan or review and surgery with 72 hours as per the NASBO report with recommendations are attached. There were also issues with the level of staff review etc. 31.7.18 Mr Carroll & Dr Scullion asked for incident to be referred to Surgical M&M, Paula to follow up 31.7.18 Paula referred incident to Dr Thompson for Surgical M&M 14.8.18 Confirm if SAI and if so nominations of review team 21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr McIlvenna to chair. 11/09/2018- Timeline completed. Need review team for meeting. 26/09/2018- Email to screening team for nomination 09/10/2018- Discussed with Mr Carroll who suggested Mr McArdle DHH for review team. Email to Mr Haynes to confirm he is in agreement. Ir 24/07/2018- email to I Yousuf on 13/7/18 + 24/07/18 re discrepancy updated 31.7.18 Wait discrepancy report from Dr Yousuf. 21/08/2018 reminder to Dr Yousef 11/09/2018-as above 25/09/2018- still to be discussed at radiology discrepancy meeting 22.10.18 Trudy emailed Dr Imran Yousuf re CT Abdomen and Pelvis has been discussed at discrepancy yet. Gail Lindsey replied not dis expedite it. 5.11.18 To be discussed at coming audit day, Friday, 16th Novembe discrepancy meeting.	TRU-03165
January 2018 – September 2018	Screening Report SEC	Re: Patient Personal Information redacted by the USI Delay in tumour management . Emergency admission with abdominal pain- initial CT 19/11/2015 showed retrocaecal appendicitis with localised perforation……soft tissue thickening is present at the base of the appendix/tip of the caecum and evaluation of this region is advised in due course to exclude other pathology- managed conservatively- Discharge letter noted RIF pain Initial Diagnosis ?appendicitis ?walled-off appendix ?malignancy. Following subsequent admission CT 2/12/2105 comment At some stage colonoscopy of the cecal pole will be required in order to exclude cecal pole mass/tumour (if not already performed). Possible caecal pole mass may be contributing to the ongoing inflammatory process as the appendix does appear distended and may be obstructed at the base. A prominent ileocaecal valve area is considered and is possible but there is not much fat in this abnormal area. Colonoscopy 4/2/2016 with subsequent pathology report stating 'The appearances are those of an adenocarcinoma. 07/02/2016 discussed at MDM for consideration of right hemicolectomy. Surgery on 08/03/2016 INTERNAL SEA – Need chair – wait for meeting minutes to be circulated then approach GH again minutes circulated request chair again 2/1/2018 - email sent requesting GH to chair 09/01/2018 - awaiting date for meeting 14/3/18 – Dr Haynes advised that Mr Hewitt to again be asked for a date for meeting this is not provided he should be advised that a meeting will be scheduled in place o one of his theatre lists (in next 6 weeks). 6/4/18 – R Farrell to contact Mr Hewitt's sec re dates re dates for meeting 6/4/18 – T Reid email Mr Hewitt re dates re dates for meeting 26/06/2018 Mr Carroll update regarding no response from Mr Hewitt 13/07/2018 Mr Haynes has agreed to cancel elective surgery to allow Mr Hewitt to Chair the SEA report 11/09/2018- as above. wait response from Mr Hewitt. Email sent to W Clayton 25/09/2018- meeting scheduled for 03/10/2018. 22 10 2018 reschedule meeting	TRU-02909 TRU-03046 TRU-03216

		22 10 2018 reschedule meeting 5.11.18 Meeting being arranged 19.11.2018 Waiting Mr Hewitt to agree dates INTERNAL SEA – Need chair- wait for meeting minutes 27.11.18 Meeting confirmed for 4.11.18 @ 11am 10.12.18 Report being drafted. Waiting on D Newell to respond to my request date for CT Chest Performed 12-Sep-2016 13:30	TRU-03343
January – September 2018	Screening Report SEC MUSC	Re: Personal Information redacted by the USI Missed subarachnoid haemorrhage. Recent case of patient attended Daisy Hill Hospital ED and was admitted as Surgical patient. Issue missed subarachnoid haemorrhage. However Dr Hampton and Mary Burke were briefed on this last week. They will discuss with Dr Murphy and Mrs Mc Vey on Monday. Transferred from DHH 31/1/18 to ward 4F RVH and Discharged from RVH 12/2/18. Timeline complete – reviewed by ED not SAI from their perspective 3.7.18 Awaiting Surgical M&M report, Medical M&M report complete 24.7.18 email from Mr Thompson "advised case was discussed in more detail at our meeting last week. I haven't released the endorsed minutes". 11/09/2018- wait surgical M&M 25/09/2018- No Surgical M&M report available	TRU-02911
January – October 2018	Screening Report SEC	Re: Patient Personal Information redacted by the USI Following review at OP where new iron deficiency anaemia was diagnosed Per was referred to for OGD and colonoscopy and subsequently CT abdomen and pelvis which was performed on 2/08/2016 and reported on 7/08/2016, there was an incidental finding of sub- segmental and segmental emboli seen in the R lung. 2/08/2016 reported 7/08/2016. This result was emailed to the referring consultant and a [illegible]lty doctor wrote to the consultant highlight this finding on 23/08/2016. Pe was also reviewed at a number of OP clinics where there was no documentation of CT findings CT showed PE not actioned INTERNAL SEA – Need chair- wait for meeting minutes to be circulated then approach GH again minutes circulated request chair again 2/1/2018 - email sent requesting GH to chair 09/01/2018 - awaiting date for meeting 14/3/18 - Dr Haynes advised that Mr Hewitt to again be asked for a date for meeting if this is not provided he should be advised that a meeting will be scheduled in place of one of his theatre lists (in next 6 weeks). 6/4/18 – R Farrell to contact Mr Hewitt's sec re dates for meeting 6/4/18 – T Reid email Mr Hewitt re dates re dates for meeting 26/06/2018 Mr Carroll update regarding no response from Mr Hewitt 13/07/2018 Mr Haynes has agreed to cancel elective surgery to allow Mr Hewitt to Chair the SEA report 11/09/2018- wait response from Mr Hewitt. Email sent to W Clayton 25/10/2018- Meeting scheduled for 03/10/2018 09/10/2018- Mr Carroll updated meeting had taken place and report was in progress. 09/10/2018- Mr Carroll updated meeting had taken place and report was in progress. 5.11.18 - Report being drafted 07/01/2019 Report sent today to Mr Hewitt and Wendy Clayton for approval. 08/01/2019 Approved and for presentation at ACG 11/01/2019 08/01/2019 Approved and for presentation at ACG 11/01/2019 15.1.19 Check with Tracey Boyce if need to contact family. 16.1.19 Emailed Tracey Boyce asking if need to contact family.	TRU-02910 TRU-03024 TRU-03451 TRU-03476
January – September	Screening Report SEC	Re: Patient Personal Information redacted by the USI (M&M)	TRU-02910

2018		<table><tr><td>Urology complaint - coroners case - awaiting M&M report</td><td>09/01/2018- information sent to litigation 14/3/18 – Not discussed 25/09/2018- Internal Meeting 08/10/2018 prior to family meeting. (Dr Glackin).</td></tr></table> 09/10/2018- Initial complaint meeting held	TRU-03025
February – September 2018	Screening Report	Re [redacted] <table><tr><td>Delay in diagnosis diverticular tumour</td><td>Mr [redacted] H&C [redacted] you highlighted that his results had been discussed at the discrepancy meeting and that you would forward me the outcome for the screening file Reminder email re discrepancy meeting outcome - INTERNAL review - Discrepancy, cognition and perception. Abnormality was felt to be solid and represented malignancy as opposed to a diverticular abscess. Arranging date of 2nd meeting as 1st cancelled 21/05/2018- need meeting arranged 07/06/2018 – update given 11/06/2018- Meeting to be organised, dates circulated 7.7.18 - Dates of meeting circulated for September</td></tr></table> <table><tr><td>Patient admitted with? Diverticular perforation. CT Shows likely perforated tumour. Not reported by radiology. Discharged home. Delay in diagnosis significant.</td><td>Discrepancy meeting outcome - Discrepancy, cognition and perception. Abnormality was felt to be solid and represented malignancy as opposed to a diverticular abscess. 01/02/2018 with Discussed Dr Yousaf The initial request highlighted abdominal pain, diarrhoea, tender LIF, previous unremarkable endoscopy, CRP 200, WCC 14.9,? Diverticular abscess,? localised perforation- the reported stated .... Briefly collection/inflammatory exudate along descending colon – sigmoid in LIF likely to be cause of symptoms and signs. Gold standard for diagnosis is endoscopy not CT. This case has been discussed at the discrepancy meeting Follow up endoscopy – on 23/11/2017 – haemorrhoids – GI registrar 16/01/2018 CT CAP showed ...suggestive of locally advanced, perforated tumour of the distal descending colon/proximal sigmoid colon..... From Radiology perspective does not meet the criteria for SAI 16/01/2018 CT CAP showed ...suggestive of locally advanced, perforated tumour of the distal descending colon/proximal sigmoid colon..... From Radiology perspective does not meet the criteria for SAI 11/09/2018- Meeting being arranged. 13.9.18 Meeting arranged for Monday 12 November</td></tr></table> 13.9.18 Meeting arranged for Monday 12 November 13.11.18 Further meeting to be arranged. 19.11.2018 Meeting 28 November	TRU-02905 TRU-02927 TRU-03215
Feb-October 2018	Screening Report M&M SEC	Re: Patient [redacted] <table><tr><td>Patient deteriorated on the 9/2/18 and underwent a CT Scan which showed small bowel obstruction secondary to femoral hernia. Patient sadly passed away. Coroner notified.</td><td>09/02/2018 – Notes reviewed by Dr Hampton and Dr Murphy (no time line) no obvious lapse in care – surgery to review 12/04/2018 provisional M&M on ICU - ECR SOM1 was satisfactory there were no particular learning lesions - Discussed at screening – awaiting Surgery M&M 11/07/2018 Email from litigation shared with MUSC and SEC for comment 18/07/2018 Needs discussed again, share Dr letter, also need SEC M&M 23/07/2018- Email to Dr R Thompson re surgical M&M 01/08/2018- wait Surgical M&M 21/08/2018 PM result sent to Dr Thompson as requested for presentation at surgical M&M 03/09/2018 to be presented at M&M 10/09/2018- as above 24/09/2018- wait surgical M&M 01/10/2018 Waiting surgical M&M</td></tr></table> 11/09/2018- wait surgical M&M 25/09/2018 No surgical M&M report available	TRU-02899 TRU-03006
March – September	Screening Report SEC	Re: Patient [redacted] (SAI)	TRU-02911

2018		Delay in diagnosis and treatment of prostate cancer - Review commenced | 14/3/18 - Not discussed Acknowledgement letter sent 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 14/3/18 – Not discussed Acknowledgement letter sent. 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 23.11.18 Further meeting arranged for 11.12.18 @ 2pm 25.2.19 Mr Haynes advises he is to review reports advises he is to review reports . 07/05/2019 Patricia to email Mark Haynes for an update. Letter from Patient 16 daughter for an update ongoing from 2016. 14/05/2019 Ronan and Patricia to discuss. Patricia to meet with Trudy 01/07/2019 Report with Julian Johnston to amend and Trudy to liaise with Dr Johnston. 16/07/19 Wait update from Trudy 08/10/2019 Email sent to Trudy for update on report 09/10/19 Connie spoke with Trudy Reid. DR J Johnston is to send the report to M Haynes then to Mr O'B for factual accuracy. Then Carly and David divide one report into 5 reports. 29.10.19 Report shared with Mr O'Brien yesterday. 05/11/19 Await Mr O'Brien's response. 19/11/19 No update 03/03/2020 Patricia to meet with Mark Haynes re letters to family 03/03/2020 Patricia to meet with Mark Haynes re letters to family.09/06/2020 Report shared with HSCB, letters to be sent to family. 07/07/2020 Discussed at screening advised letter need signed off. 21/07/2020 Letters posted to Patient 13 and Patient 11 Letter t be sent to other 3 patients. 04/08/20 - Patricia to follow up with Mark Haynes letter to be issued. 21.10.2020 – Notes that it can be taken off SAI list	TRU-03610 TRU-03922 TRU-04935 TRU-07149 TRU-08703
March – September 2018	Screening Report SEC	Re: Patient 14 (SAI) Delay in diagnosis and treatment of prostate cancer - Review commenced | 14/3/18 - Not discussed Acknowledgement letter sent 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 26/11/2018 Meeting with Dr Johnston 11/12/2018 14/3/18 – Not discussed Acknowledgement letter sent. 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 23.11.18 Further meeting arranged for 11.12.18 @ 2pm 25.2.19 Mr Haynes advises he is to review reports	TRU-02911 TRU-03193 TRU-03610 TRU-03922

		advises he is to review reports . 07/05/2019 Patricia to email Mark Haynes for an update. Letter from Patient 16 daughter for an update ongoing from 2016. 14/05/2019 Ronan and Patricia to discuss. Patricia to meet with Trudy 01/07/2019 Report with Julian Johnston to amend and Trudy to liaise with Dr Johnston. 16/07/19 Wait update from Trudy 08/10/2019 Email sent to Trudy for update on report 09/10/19 Connie spoke with Trudy Reid. DR J Johnston is to send the report to M Haynes then to Mr O'B for factual accuracy. Then Carly and David divide one report into 5 reports. 29.10.19 Report shared with Mr O'Brien yesterday. 05/11/19 Await Mr O'Brien's response. 19/11/19 No update 03/03/2020 Patricia to meet with Mark Haynes re letters to family 03/03/2020 Patricia to meet with Mark Haynes re letters to family.09/06/2020 Report shared with HSCB, letters to be sent to family. 07/07/2020 Discussed at screening advised letter need signed off. 21/07/2020 Letters posted to Patient 13 and Patient 11 Letter to be sent to other 3 patients. 04/08/20 - Patricia to follow up with Mark Haynes letter to be issued. 21.10.2020 – Notes that it can be taken off SAI list	TRU-04935 TRU-07149 TRU-08703
March – September 2018	Screening Report SEC	Re: Patient 11 (SAI) Delay in diagnosis and treatment of prostate cancer - Review commenced | 14/3/18 - Not discussed Acknowledgement letter sent 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 26/11/2018 Meeting with Dr Johnston 11/12/2018 14/3/18 – Not discussed Acknowledgement letter sent. 25/09/2018- Report sent to Julian Johnston (Chair) for approval. 23.11.18 Further meeting arranged for 11.12.18 @ 2pm 25.2.19 Mr Haynes advises he is to review reports advises he is to review reports . 07/05/2019 Patricia to email Mark Haynes for an update. Letter from Patient 16 daughter for an update ongoing from 2016. 14/05/2019 Ronan and Patricia to discuss. Patricia to meet with Trudy 01/07/2019 Report with Julian Johnston to amend and Trudy to liaise with Dr Johnston. 16/07/19 Wait update from Trudy 08/10/2019 Email sent to Trudy for update on report 09/10/19 Connie spoke with Trudy Reid. DR J Johnston is to send the report to M Haynes then to Mr O'B for factual accuracy. Then Carly and David divide one report into 5 reports. 29.10.19 Report shared with Mr O'Brien yesterday. 05/11/19 Await Mr O'Brien's response. 19/11/19 No update 03/03/2020 Patricia to meet with Mark Haynes re letters to family	TRU-02911 TRU-03193 TRU-03610 TRU-03922 TRU-04935 TRU-07149

		03/03/2020 Patricia to meet with Mark Haynes re letters to family.09/06/2020 Report shared with HSCB, letters to be sent to family. 07/07/2020 Discussed at screening advised letter need signed off. 21/07/2020 Letters posted to Patient 13 and Patient 11 Letter to be sent to other 3 patients. 04/08/20 - Patricia to follow up with Mark Haynes letter to be issued. 21.10.2020 – Notes that it can be taken off SAI list	TRU-08703
April 2018	SHSCT Policy on Raising Concerns	*"Your Right to Raise A Concern" (Whistleblowing)* *"This policy provides a procedure for all staff of the Trust, including permanent, temporary and bank staff, staff in training working within the Trust, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organization itself are at risk.* ***If in doubt – raise it!.*** *Examples may include:* 1. *Malpractice or ill treatment of a patient or client by a member of staff* 2. *Where a potential criminal offence has been committed, is being committed or is likely to be committed* 3. *Suspected fraud* 4. *Breach of standing financial instructions* 5. *Disregard for legislation, particularly in relation to Health and Safety at work* 6. *The environment has been, or is likely to be, damaged* 7. *A miscarriage of justice has occurred, is occurring, or is likely to occur* 8. *Showing undue favor over a contractual matter or to a job applicant* 9. *Research misconduct* 10. *Information on any of the above has been, is being, or is likely to be concealed"* Who to raise a concern with? *"1. Line Manager* *2. If raising with Line Manager does not resolve problem, raise with another senior person in the Trust e.g. Senior HR representative/Manager/Professional Lead* *3. If you still remain concerned, raise with, Mrs Vivienne Toal (Director of HR), Dr Maria O'Kane (Executive Medical Director), Mrs Heather Trouton (Interim Executive Director of Nursing, Midwifery & AHPS), Mr Paul Morgan (Executive Director of Social Work), Mrs Helen O'Neill (Executive Director of Finance, Procurement & Estates) Mr John Wilkinson (Lead Non-Executive Director for Raising Concerns on Trust Board)* *4. If you still remain concerned, raise with external bodies"*	TRU-21050 – TRU-21071

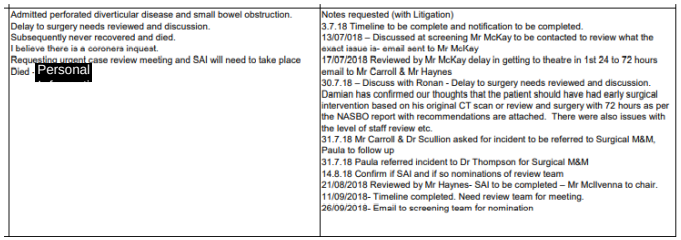
		HOW WE WILL DEAL WITH THE CONCERN **Stage 1** 1. *Any manager /Director to whom a concern is raised must arrange to meet with the employee to discuss the detail of the concern without delay* 2. *The manager/Director should be clear on the range of other Trust policies and procedures in the events that the concern raised might be more appropriately dealt with under another policy /procedure…* 3. *The manager /Director should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter. The manager should document a summary of the discussion.* 4. *The manager should explain that they will need to seek advice from their Assistant Director / Director, providing there are no specific objections raised by the employee regarding protection of their confidentiality in this regard. If there are concerns expressed as to who should be made aware, then the manager /director should seek advice immediately from the Director of HR or Deputy Director of HR Services* 5. *ALL whistleblowing concerns must be notified by the Assistant Director / Director to the HR Director's office for logging and decision on best course of action to address the concern.* 6. *If the concern is raised with the Director of HR, s/he will refer the concern to the Deputy Director of HR Services to arrange to meet with the employee to discuss the detail of the concern.* **Stage 2** *Oncer the issue(s) of concern has been established, the approach to independently investigating the concern will be discussed and agreed by an Oversight Group, chaired by the Director of HR and an Executive Director, depending on the nature of the concern. The Director of HR will advise the relevant operational Director that a concern has been raised and the nature of it. The Director of HR will withhold the identity of the individual raising the concern, if requested.* *A record should be made of the decisions and/or agreed actions which should be signed and dated. Agreed Terms of Reference for any investigation should be established.* *The Director of HR will ensure that the Deputy Director of HR Services is aware of the concern (if not previously aware) to ensure any necessary support can be provided to the employee raising the concern.*	

		Stage 3 *Within a prompt and reasonable timescale of the concern being received, the Deputy Director of HR Services must meet with the employee to:* 1. *Acknowledge that the concern has been received.* 2. *Discuss if confidentiality is to be / can be maintained throughout investigation, and ensure this is documented…* 3. *Discuss how the matter will be dealt with and by whom* 4. *Outline the support available* 5. *Provide an estimate as to how long it will take to provide a final response* 6. *A summary of the discussion will be followed up in writing* **Stage 4** A proportionate investigation will be undertaken and conclusion reached within a reasonable time frame. **Stage 5** The Oversight Group will consider the report and determine any action required based on findings **Stage 6** The HR director will ensure that feedback to the individual raising the concern is provided. …"	
June 2018	Trust Governance Committee Meeting – Quarterly Report	Standing Financial Instructions & Standing Orders including Reservation and Delegation of Powers *Details the responsibilities and delegation of:* 1. The Trust Board 2. The Chief Executive and Director of Finance 3. The Director of Finance 4. Board Members and Employees 5. Contractors and employees 6. Audit Committee 7. Director of Finance 8. Role of Internal Audit 9. External Audit Fraud and Corruption	TRU-20777
Undated	HSC Framework	*"Your right to raise a concern (Whistleblowing"* *"Whistleblowing is defined as "when a worker reports suspected wrongdoing at work". The*	TRU-21072 – TRU-

		wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences such as those highlighted in the Mid Staffordshire Report (2013). *Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:* *1. Patient safety* *2. Health and Safety at work* *3. Environmental damage* *4. A criminal offence"* *"This Framework and Policy is for staff to raise issues where the interests of others or the organization are at risk. If a member of staff is aggrieved about their personal position they must use the organization's HSC Grievance Procedure, Harassment at Work Procedure and/or The Working Well Together Policy."* *"The aim of this Framework and Policy is to ensure that under the terms of the Public Interest Disclosure (Northern Ireland) Order 1998 a member of staff is able to raise legitimate concerns when they believe that a person's health may be endangered or have concerns about systematic failure, malpractice, misconduct or illegal practice without fear of retribution and/or detriment….* *The Framework and Policy aims to improve accountability and good governance within the organization by assuring the workforce that it is safe to raise their concerns."*	21086
June 2018	Policy	Standing Financial Instructions & Standing Orders including Reservation and Delegation of Powers *Details the responsibilities and delegation of:* 10. The Trust Board 11. The Chief Executive and Director of Finance 12. The Director of Finance 13. Board Members and Employees 14. Contractors and employees 15. Audit Committee 16. Director of Finance 17. Role of Internal Audit 18. External Audit 19. Fraud and Corruption	TRU-01888 – TRU-02049
June – September 2018	Screening Report SEC (M&M)	Re Patient Personal Information redacted by the USI	TRU-02908

		[Personal Information redacted by the USI] patient undergoing chemotherapy for myeloma presented to DHH ED at 14:02 with history of being unwell for 3/52, diarrhoea 1/52 poor mobility. Seen by Dr 1. Loose green stools. Reduced oral intake. Occasional mild general abdominal pain. One loose stool today, did not take chemo med. Worsening shortness of breath. No chest pain, on examination he was noted to be cachexic, frail. Bi-basal creps. Marked bilateral lower leg oedema. ECG Sinus rhythm, 2 BBB. BP 86/51 with fluids and legs raised. Distended abdomen query ascetic. Mild generalised tenderness, no masses felt, bowel sounds present Diagnoses: diarrhoea query secondary to chemo meds, associated dehydration and ?acute LVF. Seen by Dr 4 at 23:00-Distention for 1/12. One episode of vomiting. Just completed 4 cycles of chemo for multiple myeloma. ATSP re abdominal distention. Abdomen tympanic with generalised tenderness with some guarding. Bowel sounds scant. PR: external haemorrhoids ++. Will discuss with senior and review plain films. Will add to handover list and query review in am. Fast, NGT if vomiting continues. Stool chart. IVF and anti-emetics 02:04 Seen by Dr 5. History as above. On examination: abdomen firmly distended, tympanic. Mild generalised tenderness. AXR: gross bowel dilation in keeping with obstruction. Imp: bowel obstruction query underlying cause. 06:15 Cardiac arrest, 18 min CPR- PEA/asystole. Resuscitation stopped. 06:15 Passed away. 06:45 Verbal report of Ct abdomen available from Dr 6: multiple grossly small bowel loops with dilated transverse colon. 26/06/2018 Discussed with Mr Carroll and Dr Scullion – M&M January 2018 - Statement of Management to be provided: Medicine Statement of management: 3 - contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT 21/08/2018- Report to be drafted. Management of abdominal pain ED DHH Version 1(17April 2015) sent to Dr McKay and Dr Magowan 11/09/2018- Report in draft SEC M&M waiting response from Mr Thompson Presented to Surgical PSM 17/5/2017 outcome 2 recorded. Presented to ED PSM 25/1/2017 outcome 3. contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported.	TRU-03105
June – September 2018	Screening Report SEC	Re: [Personal Information redacted by the USI] (SAI) Delay in investigation / management of a red flag cancer patient. For SAI. Protocols review CAH Notes received. Timeline to be completed. 21/06/2018- DHH notes requested. 26/06/2018 Discussed with Mr Carroll and Dr Scullion requires time line 3.7.18 Waiting on DHH notes to complete timeline. 17/07/2018 Reviewed by Mr McKay delays in many errors of referral-email to Mr Carrol & Mr Haynes 24/07/2018- DHH notes obtained for timeline Mr Carroll updated re Mr McKays discussion 30.7.18 Discuss with Ronan – Email of 17.7.18 - There appeared to multiple delays in this patients pathway despite the red flag team escalating this to the Consultant involved Referral – Red flag referral 09/10/2017 asking to exclude colon cancer. Hb noted at 73. CT colonoscopy ordered by was cancelled on 3/11/2017. It was not until the Red flag team escalated to another consultant that an endoscopy was performed and diagnosis made. Referral on to Trust upper GI surgeon, there was also a delay in being seen (change over to Belfast taking place), then referral to Belfast. From referral to surgery – resection was booked for 25/04/2018 (inoperable). 27/04/2018 referred to oncology for palliative options- 1st treatment 7/6/2018. 31.7.18 This is being followed up with Sharon Glenny & Barry Conway as admin issue within tracking. 21/08/2018- Discussed with Mrs Glenny. Escalation was appropriate at the time however new escalation guidance is being drafted. 21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr Epanomeritakis to chair. 11/09/2018- Need review team to arrange meeting 26/09/2018 Email to screening team for nomination. 09/10/2018- Discussed with Mr Carroll who suggested Mr M Yousaf for review team. Email to Mr Haynes to confirm he is in agreement. to Mr Haynes to confirm he is in agreement. 23/10/2018 Meeting to be scheduled after timeline is done. timeline is done. 5.11.18 SH Glenny completing timeline	TRU-02914 TRU-02988 TRU-03096 TRU-03143 TRU-03294 TRU-

		5.11.18 Sharon Glenny completing timeline 27/11/2018 For screening. 27/11/2018 For screening. 04/12/2018 Meeting confirmed for 17/12/2018 04/12/2018 Meeting confirmed for 17/12/2018 at 12MD. New Boardroom CAH. 18/12/18 Draft report with review team pending interview with consultant 18/12/18 Draft report with review team pending interview with consl 2/1/2019 Report complete with Mr Hewitt for factural accuracy. 15/01/2019 Report in draft. 15.1.19 Report for approval at ACG. Report for approval at ACG. (March 2019). 07/05/2019 Discussed at screening. Patricia to follow up outcome. Family have not been informed.	03320 TRU-03373 TRU-03401 TRU-03515 TRU-03897
June – September 2018	Screening Report SEC	Re: Personal Information redacted by the USI Complaint letter from patient and husband regarding her diagnosis, treatment and care. Patient treated for colitis subsequently had subtotal colectomy 14.5.18. (27.4.18 – 16.5.18) 26/06/2018 reviewed with Mr Carroll and Dr Scullion Probably not SAI as being taken through medical director process- email to be sent 26/6/2018 01/08/2018- Dr Murphy advises SEC to approve acknowledgement. Timeline to commence from 1st admission. 6.8.18 Acknowledgment approved by RC – Approved. 7.8.18 – Meeting confirmed for 3.9.18 10/09/2018- 2nd meeting being organised 11/09/2018- timeline complete. Internal review. Report to be drafted. 18/09/2018- Meeting with Dr Bhatt and Governance Team 19/09/2018. 25/09/2018- report to be drafted 24/09/2018 – Report being drafted 07/01/2019 Report being drafted by Trudy. 26/3/19 Trudy is finalising report. 9/4/19 Patricia discussed report with Trudy yesterday. Few amendments being made.	TRU-02915 TRU-03441 TRU-03771
July – September 2018	Screening Report SEC ATICS	Re: Personal Information redacted by the USI (SAI) Per Perso is a d man who attended theatre in DHH for insertion of PEG tube on 15/05/2018. There are no traceability print outs for the scope and the scope used was potentially dirty. Possibly used on previous patient who had a flexible sigmoidoscopy? It was cleaned and rinsed with water but no detoxified. 31.7.18 With Dr Brown for final approval 21/08/2018 Further request to Dr Brown for approval 11/09/2018 email to Dr Brown 07/09/2018 for approval 25/09/2018- Further amendments to report sent to review team.	TRU-02913 TRU-

		25/09/2018- Further amendments to report sent to review team. 5.11.18 - For rediscussion 27/11/2018 For discussion with Dr O Kane (MD) 28/01/2019 Report updated and approved by Dr Murphy. Tracey Boyce to speak with Medical Director. Await outcome before sending report to HSCB and family. 29.1.19 Report approved by SMT and to be shared with family and HSCB.	03514
July – September 2018	Screening Report SEC	Re: Personal Information redacted by the USI (SAI)  Admitted perforated diverticular disease and small bowel obstruction. Delay to surgery needs reviewed and discussion. Subsequently never recovered and died. I believe there is a coroners inquest. Requesting urgent case review meeting and SAI will need to take place Died - Personal Notes requested (with Litigation) 3.7.18 Timeline to be complete and notification to be completed. 13/07/018 – Discussed at screening Mr McKay to be contacted to review what the exact issue is- email sent to Mr McKay 17/07/2018 Reviewed by Mr McKay delay in getting to theatre in 1st 24 to 72 hours email to Mr Carroll & Mr Haynes 30.7.18 – Discuss with Ronan - Delay to surgery needs reviewed and discussion. Damian has confirmed our thoughts that the patient should have had early surgical intervention based on his original CT scan or review and surgery with 72 hours as per the NASBO report with recommendations are attached. There were also issues with the level of staff review etc. 31.7.18 Mr Carroll & Dr Scullion asked for incident to be referred to Surgical M&M, Paula to follow up 31.7.18 Paula referred incident to Dr Thompson for Surgical M&M 14.8.18 Confirm if SAI and if so nominations of review team 21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr McIlvenna to chair. 11/09/2018- Timeline completed. Need review team for meeting. 26/09/2018- Email to screening team for nomination 09/10/2018- Discussed with Mr Carroll who suggested Mr MrArdle DHH for review team. Email to Mr Haynes to confirm he is in agreement. 23/10/2018 Meeting to be scheduled. 5.11.18 Meeting confirmed for 8.11.18 @ 9am 12/11/2018 Mr McArdle and Mr McElvanna to interview medical staff and further meeting to be scheduled in 3 weeks. 21/08/2018 Reviewed by Mr Haynes- SAI to be completed – Mr Enapomeritakis to chair be scheduled in 3 weeks. 19/11/2018 M McElvanna has offered dates for 1st week December 2018. (Mr McArdle & Trudy Reid) 30.11.18 Meeting confirmed for 6.12.18 @ 11.30am 15/01/2019 Final report with review team. 15/01/2019 Final report with review team. 29.1.19 Paula to check with Trudy if report ready for ACG in February.	TRU-02913 TRU-03007 TRU-03118 TRU-03143 TRU-03168 TRU-03294 TRU-03478 TRU-03515 TRU-03612

		29.1.19 Paula to check with Trudy if report ready for ACG in February. 12.2.19 Roisin arranging a meeting with Patricia and Mr McElvanna (14.2.19) 19.2.19 Patricia has met with Mr McElvanna and report drafted and further meeting planned for 25.2.19. 26.2.19 Meeting did not take place yesterday. Patricia discussed case with Mr Haynes and Mr McElvanna who agreed an intensivist should sit on the review team. Patricia sent an email to Chris Clarke for nomination. ? new Chair Copy of ICU notes to be sent to R Mc Kee- same sent. 2/4/19 Meeting confirmed for 8/4/19. 9/4/19 Need an expert witness for surgery. Need external chair. 9/4/19 Need an expert witness for surgery. Need external surgical opinion. 15/04/2019 Draft report to be completed. 07/05/2019 Patricia to send reminder email to Simon Gibson for external surgical opinion. 07/05/2019 Discussed at screening. Patricia to email Dr O'Kane . Ronan to follow up also. 14/05/2019 No response from Dr O'Kane. 28.05.19 - AMD's to seek external surgical opinion from SEHSCT. Patricia to contact SEHSCT on behalfof Mark HAynes as ag	TRU-03770 TRU-03969
August - September 2018	Screening Report SEC	Re: Personal Information redacted by the USI Consultant met with the family of the patient who died after an elective colonic resection, as a result of an anastomotic failure. On talking to the family it seems there were a few signs that this may have been evident prior to discharge. The family had raised a few concerns that the Consultant agreed should be independently looked at. 1. After being seen on the ward round, the patient became unwell (vomited). No observations were done (allegedly) after discharge from 0830 - 1800. The patient was too unwell to walk out to the car (she had been walking up and down the ward the previous day) 2. No direct number of the ward was provided on discharge (in case of emergency) 3. On phoning the ward the following day, the daughter was told that despite increasing pain and vomiting, there was no way for the patient to be reassessed on the ward and the would have to go to ED and wait (the daughter felt that her mother was too unwell to wait in ED and therefore did not attend) This information is incorrect and the registrar should have been informed. 7.8.2018- email response from W Clayton- see email- 21/08/2018 – Email shared with Mr Haynes, Notes to be reviewed by D Sharpe and Governance update to Ronan and Mark –email sent to Dorothy 11/09/2018 18/09/2018- 25/09/2018- see email from Wendy Claydon re Mr Neill's response "I spoke to Adrian some months ago regarding Personal I can confirm that Adrian met with the family and at this meeting Adrian advised there were no questions from a surgical point of view. He felt that the family knew their mother was sick before she was admitted. The family phoned the ward who advised the bring their mother through ED, as it was the weekend the family didn't and then when they did bring their mother to hospital, she went to surgery and subsequently died. Adrian had nothing further to add" add" 09/10/2018- Discussed with Mr Carroll. No longer required for Clinical Governance input. CLOSE. 18/10/2018 SOM 4 from M&M for futher discussion email sent to Ronan & Mark 23/10/2018 Discussed M&M outcomes with Mr Carroll and Dr Scullion. Email to be sent to Chair (Dr R Thompson) not sure if any learning.	TRU-02912 TRU-03006 TRU-03048 TRU-03095
September	Screening	Re: Patient Personal Information redacted by the USi (SAI)	TRU-

2018	Report SEC	Pe was admitted with possible bowel obstruction on 30 April 2017, investigations included CT scan, IV access failed on route to the CT scanner. P aspirated in the CT scanner and developed respiratory failure, requiring intubation and ventilation. Pe had a subtotal colectomy and ileostomy, she was transferred to ICU post operatively but despite maximal treatment she continued to deteriorate and died on the 1 May 2017 Cause of death a) Multi-organ failure b) Small bowel obstruction. Datix reflected CT scan without IV access, NG tube or fluid resuscitation 11/09/2018- report approved by review team. 18/09/2018- Report to be finalised before sending to family 25/09/2018- Report being amended 22 10 2018 Send to HSCB 22.10.18 To Mr Gilpin for sharing with the staff involved before I circulate to the family, HSCB and the coroner. I always like to ensure those in the SAI have had a chance to review prior to wider circulation. This was passed via acute clinical governance 22.10.18 To Mr Gilpin for sharing with the staff involved before I circulate to the family, HSCB and the coroner. I always like to ensure those in the SAI have had a chance to review prior to wider circulation. This was passed via acute clinical governance. 30/10/2018- Report out for sharing, still some team members to review. 13/11/2018 Checking re factural accuracy reminders sent. (W Clayton and Dr Gilpin, Dr Campbell) Campbell) 10.12.18 Trudy emailed requesting update on discussion with staff 17/12/18 Report shared with Manos - to discuss sharing with CW 14/3/18 – Not discussed Connolly to liaise with Mr Gilpin. 19/3/19 Ronan suggested Amie Nelson to discuss with Mr Gilpin. Email sent to Amie 20/3/19. 02/04/2019 Reminder email sent to Amie. 9/4/19 Report with Mr Gilpin for final approval.	02910 TRU-03047 TRU-03069 TRU-03116 TRU-03193 TRU-03371 TRU-03769
September 2018	Screening Report SEC MUSC	Re: Personal Information redacted by the USI (SAI) Datix re missed bowel tumour 11/09/2018- Meeting scheduled 17/09/2018 with Mr S Bhatt and Mr K McElvanna 18/09/2018- Meeting held yesterday. Dr Bhatt to speak with Dr S Murphy and Dr C Hillemand. Dr McElvanna to speak with Mr G McArdle 09/10/2018- Meeting scheduled with Mr Bhatt and Dr Hillemand McArdle. Report in draft	TRU-02915 TRU-02989 TRU-03170