4. It was known that Mr O'B[redacted] stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'B[redacted]'s secretary did not flag that dictation was not coming back to her from clinics. Mr O'B[redacted]'s secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'B[redacted] indicated that he did not see the value of dictating after each care contact.

3. Mr O'B[redacted] was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'B[redacted]'s clinical ability with patients.

- There are clear issues of concern about Mr O'B[redacted]'s way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'B[redacted]'s reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'B[redacted] had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'B[redacted] did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'B[redacted]'s practice.

- Mr O'B[redacted] did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'B[redacted] has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'B[redacted] returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'B[redacted] worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'B[redacted]'s administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'B[redacted] for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'B[redacted]'s Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'B[redacted]'s practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'B[redacted] at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'B[redacted] has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'B[redacted] to adhere to known and agreed Trust practices and that there have also been failures by Mr O'B[redacted] in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'B[redacted]'s own individual professional responsibilities.

During the MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'B[redacted]'s conduct rather than his clinical ability. I have sought advice from

Practitioner Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'B[redacted] include:

- Failing to undertake non red flag triage, which was known to Mr O'B[redacted] to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'B[redacted], as a senior clinician had an obligation to ensure this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'B[redacted]'s failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'B[redacted]'s health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'B[redacted]'s clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'B[redacted]'s administrative practices. The report highlights the impact of Mr O'B[redacted]'s failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'B[redacted]'s clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'B[redacted]. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'B[redacted] which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'B[redacted]. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'B[redacted].

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

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CONFIDENTIAL: PERSONAL

NHS
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

6 November 2018

PRIVATE AND CONFIDENTIAL

Dr Ahmed Khan
Medical Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Ref: Personal Information redacted by the USI **(Please quote in all correspondence)**

Dear Dr Khan,

Further to our follow up telephone conversation of 31 October 2018 in which Ms Siobhan Hynds and Mr Simon Gibson also participated, and your email of 5 November 2018 to me, I am writing to summarise the issues we discussed and my understanding of the position for all of our records. Please let me know if any of the information is incorrect.

I rang to apprise you of conversations which I had over a period of time with Dr Personal Information redacted by the USI (and his son), and to ascertain whether you felt that a meeting would be helpful. Dr Personal Information redacted by the USI had consented that I would share details of our conversations.

I told you that Dr Personal Information redacted by the USI has recently become aware of correspondence between what was then NCAS – now Practitioner Performance Advice – and the Trust in September 2016. Dr Personal Information redacted by the USI felt that between September 2016 and December 2016, he was not afforded an opportunity to address the concerns which had been raised, and this may have avoided the need for a formal investigation. Dr Personal Information redacted by the also told me that he was never supported to address the concerns, and that whilst he accepts some of the criticism in the investigative report, he also considers that the management failure identified should be scrutinised before he is subject to a conduct hearing.

You explained that prior to the September 2016 telephone call, Dr [redacted] had been made aware of the concerns, and that the situation had not improved. Ms Hynes also queried whether there was always a requirement under MHPS to manage issues first under local informal processes, or whether there were occasions when a matter was so significant that it would proceed directly to formal investigation. I advised that there is scope to move directly to formal processes, if the matter is deemed sufficiently serious, but that this is a judgement call for an employer. In this case, you considered that the threshold had been passed. As Dr [redacted] was a consultant, it was considered that he should have been more proactive in raising issues. It was also reported that since February 2017 Dr [redacted] has been able to undertake his work satisfactorily without additional support.

The investigative report has upheld concerns about Dr [redacted] practice. Whilst it is accepted that there were management failings, the findings are such that the Trust believes the threshold for putting the matter to a hearing has been reached. You pointed to the negative effects of the situation on patients noted in the report, and did not consider it would be appropriate to manage the matter informally. The Trust considered that it would be for any hearing to consider the evidence and the mitigation put forward by Dr [redacted]

We discussed whether a meeting with all parties should be convened, and you took some time to think about the issues which I had raised to consider the case again and to think about whether a meeting would be useful. Having reviewed the situation, the Trust considered that the points raised with me by Dr [redacted] had already been comprehensively managed, that there were grounds for a formal investigation and for putting the matter to a hearing (notwithstanding some of the criticism made of how the case had been managed). You were unsure of the purpose therefore of any meeting. In these circumstances, I agreed that it was difficult to see what a meeting would add and I will inform Dr [redacted] of this.

Dr [redacted] should continue to be offered support from the Trust (such as from OH, staff counselling, mentoring) at what is likely to continue to be a stressful time for him.

I will review the case with you again in approximately 6-8 weeks.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern NHS (MHPS)
- The Medical Profession (Responsible Officer) Regulations 2010 and Amendment 2013

Review date: 31 December 2018

Yours sincerely,

Personal Information redacted by USI

Grainne Lynn
Adviser
Practitioner Performance Advice

AOB-15308

L-C

Corrigan, Martina

From: Corrigan, Martina
Sent: 19 July 2017 15:04
To: Carroll, Ronan; Weir, Colin
Subject: RE: FW: triage not returned

Meeting 25.07.17

Ronan

I have run a fresh report there now – there are 75 charts now tracked to Mr O'Brien's office. A reduction of 30 from the last time I ran this. The longest is 3 February 2017 and comment is 'private patient cabinet'. Then 24 February x 3 charts with comments – Result for Mr O'Brien to see, and 2 x Mr O'Brien's admin. Below is the change in what is being returned to records since last time I ran this which is 45 – and then there has been 15 additional for July,

Aidan will be off-site tomorrow AM pre-viewing for MDT and then he will be at MDT tomorrow afternoon, Friday AM he has an oncology clinic and then Audit in the PM, so really only availability to meet would be between clinic and audit on Friday lunchtime?

Can you let me know what suits to meet with him?

Date Chart Borrowed	Total as of June 2017	Total as of 19 July 2017	Total charts returned
Jan 2017	1	0	1
Feb 2017	5	4	1
March 2017	11	9	2
April 2017	37	15	22
May 2017	35	16	19
June 2017	16	16	0
July 2017	NA	15	N/A
Total Charts	**105**	**75**	**45**

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Changed My Number
INTERNAL: EXT Personal Information redacted by the USI *if dialling from Avaya phone. If dialling from old phone please dial* Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Carroll, Ronan
Sent: 19 July 2017 12:31
To: Corrigan, Martina; Weir, Colin
Subject: FW: FW: triage not returned

Any update

Ronan Carroll
Assistant Director Acute Services

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Personal Information redacted by USI

L-8

Personal Information redacted by USI

Mrs. Esther Gishkori
Director of Acute Services,
Craigavon Area Hospital
Craigavon.
BT63 5QQ

7th November 2018.

Dear Mrs. Gishkori,

On 6th September 2018, I submitted a completed claim form for payment of Personal Information redacted by USI due and owing for work as locum consultant urologist during July and August 2018. This claim was made to Mrs. Martina Corrigan on 6th September 2018. I received an automated email response from Mrs Corrigan, confirming receipt.

On failing to receive payment in September 2018, and upon further enquiry, Mrs. Corrigan advised by text that the claim had been approved by Mr. Mark Haynes, Associate Medical Director, and the Director.

When the payment was not been received in October 2018 either, upon further enquiry, Mr. Haynes confirmed, both by text and verbally, that he had it approved immediately upon request in early September 2018.

Yet, two months following the date of claim, I still have not received this remittance. I now regard this as an unauthorised deduction of wages, pursuant to Article 45 of the Employment Rights (NI) Order 1996 {as amend}.

I now require you to remit this amount forthwith.

Yours sincerely,

Personal Information redacted by USI

Aidan O'Brien

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Copy

Personal Information redacted by USI

30 January 2012.

Dr. Gillian Rankin,
Director of Acute Services,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Rankin,

I wish to take this opportunity to formally submit, in writing, a grievance regarding the deductions made to the payments owed to me on foot of a claim for extra contractual work. These deductions amount to a breach of agreement with management regarding the rate of remuneration for the sessions claimed, a rate subsequently reaffirmed to me by management.

In the autumn of 2010, it was agreed by the Head of ENT and Urology that I would be remunerated one additional sessional payment for conducting combined urodynamic studies and oncology reviews all day Fridays in the Thorndale Unit. I enclose a copy of the claim form submitted 2nd March 2011, consisting of a claim for 15 such sessions in addition to 4 sessions of Inpatient Operating and 2 sessions of Urodynamic Studies completed on Saturdays.

When I received payment of Personal Information redacted by the gross in April 2011, I was unable to recognise the amount. In contacting the Payroll Department, I was advised that payments for additional Friday sessions had been halved, whilst the remaining sessions had not been paid at all. When I enquired why deductions had been made, the Payroll personnel informed me that they were unable to decipher the signature of the person who had made the deductions. For that reason, I was provided with a copy of the claim form (enclosed). It was evident to me that the deductions were made by Mr. Eamon Mackle. I subsequently received payment for the unpaid Saturday sessions in May 2011.

To date, I have not received full payment in respect of these sessions, nor have I received any communication regarding same, apart from verbal confirmation of the agreement.

This has occurred against the background of an earlier claim for urodynamic studies submitted 17th January 2011. I made monthly enquiries until August 2011 regarding lack of payment, only to be advised by Payroll on each occasion that a claim had yet to be received. I wrote to the Head of ENT and Urology in August 2011 to express my concerns. I was advised that the claim had been authorised by Ms. Corrigan, by Ms. Trouton and then by Mr. Mackle, but had been mislaid thereafter. I had to submit yet another claim for those sessions in September 2011, payment received in October 2011, nine months after the initial submission.

The deductions referred to above were a breach of an agreement, and to compound matters, the deductions were made without my authority or knowledge. I am making a formal request to have this matter investigated and to be provided with an explanation as to why these deductions have been made. At the time of writing, I have completed further claim forms for extra contractual work which I have not submitted as I simply do not have the confidence that they will be processed in a proper and timely manner. Finally, I am requesting that management honour the agreement that was made with me by providing full remuneration for the additional sessions that I have undertaken,

Yours Sincerely,

Aidan O'Brien.

23 July 2020

For the Attention of the Members of the Grievance Panel,

Re: Addendum to the Formal Grievance

The purpose of this correspondence is to provide an addendum to the Formal Grievance that was submitted by me and which remains outstanding.

1. Introduction

A Formal Grievance, dated 27 November 2018, was submitted to Mr. Shane Devlin, Chief Executive of the Southern Health & Social Care Trust, in writing and in person on Friday 30 November 2018. The Grievance pertained to a Formal Investigation initiated on 22 December 2016, and of which I was informed on 30 December 2016. It concluded in September 2018 and I was informed of its Determination on 01 October 2018. The Grievance included an appeal of the Determination, and a request for information.

On 03 July 2020, I received a letter from Ms Zoe Parks, Head of Medical Human Resources, advising me that a meeting had been arranged with the Grievance Panel on 30th July 2020 to discuss my grievance and inviting me to provide any further details I wished to add to my grievance in advance of that meeting.

Since submitting my grievance, I have obtained parts of the documentation and information that I have requested (as detailed below). Having had the opportunity to consider these materials, I write this addendum to address matters that have been raised in my Grievance but which have been further informed by this documentation. At the outset however, there are issues regarding the handling of this grievance that I have set out below.

2. Delayed Handling of my Grievance.

I refer to the Trust's Grievance Policy and in particular to Part 7 therein which states that the Human Resources Department should acknowledge receipt of a grievance and arrange for a Grievance Panel to hear the grievance, normally within fifteen working days.

Receipt of my Grievance was acknowledged in writing by Ms. Vivienne Toal, Director of Human Resources & Organisational Development, on 14 December 2018. A copy of this letter is attached at Appendix A. Ms. Toal advised in that letter that arrangements were being *finalised*[1] to set up a grievance panel, that the panel would include a member external to the Trust, and that I would be notified of the final arrangements as soon as was practically possible.

Ms Toal also undertook to have the requested information provided to me by Friday 21 December 2018 or as soon as possible thereafter. I received some of the requested information on Friday 21 December 2018, and further information on 11 January 2019. Not all requested information was provided.

[1] Emphasis added

I wrote to Ms. Toal on 12 March 2019 (attached at Appendix B) to advise her that I had provided all documentation arising from the Investigation, including the Investigator's Report, my Comments relating to the Investigator's Report, the Case Manager's Determination and the Grievance to the Medical Protection Society for its consideration. The Society requested that I submit the same documentation to a legal representative appointed to act on my behalf. The legal representative provided to me a dossier of further information to be requested, and which I provided to Ms. Toal on 12 March 2019.

On 03 April 2019, I was advised by Mr. Mark Haynes, by text message, of a requirement that I attend a meeting with the Case Manager on 04 April 2019. On attending on 04 April 2019, I was advised by the Case Manager that a Fitness to Practice referral had been made to GMC by the Medical Director. It is important to note that the Case Manager had concluded in his determination that no referral would be made to GMC. I had submitted a grievance which included an appeal of the Case Manager's determination detailing the multifarious procedural failings and breaches of contract that had occurred leading up and during the Formal Investigation. I was fully compliant with the return to work plan and there had been no issues raised with my work between the time of the Case Manager's determination of 01 October 2018 and this referral to the GMC on 04 April 2019. It is my belief that the decision to make this referral was a consequence of the Trust being informed that I had instructed my defence union and had instructed legal representation. I was simply pursuing my Grievance and asking relevant questions about the processes that had taken place. There is no other discernible precipitating event that would cause this change in approach.

As a consequence of this decision to make a referral to the GMC, when I attended my scheduled Revalidation meeting on 05 April 2019, I was advised that Revalidation had been deferred because of the referral. I have still been unable to be revalidated with all the prejudicial and deleterious effects that this has on my ability to practice outside of my employment with the Trust.

Having not received the requested information, I wrote again to Ms. Toal on 03 June 2019 (attached at Appendix C), indicating that I considered it reasonable to expect that the information be provided by 30 June 2019, at the very latest, and particularly as all of the requested information had been previously referenced. In replying by letter also dated 03 June 2019 (attached at Appendix D), Ms. Toal indicated that the information request was extensive in nature and that it would require significant time and resources to compile. She requested that I refine and clarify the specifics of my request. She undertook to commence the Grievance process immediately following provision of the requested information, in order to avoid "*any further undue delay*". In response on 24 June 2019 (attached at Appendix E), I requested two further items of information, in addition to specifying the information as requested. I was provided with *some* of the requested information in October 2019.

The continued delay in dealing with this Grievance has now ultimately resulted in the Trust terminating my employment. In January and February 2020, I had cause to give consideration to withdrawing from full time employment with the Trust and moving to part time employment. I discussed this intent with my clinical line managers, Mr. Michael Young, Lead Clinician in Urology, and Mr. Mark Haynes, Associate Medical Director, both assuring me of their support in my returning to part time employment with the Trust. I was particular in ensuring that I also discussed my intent with Mrs. Martina Corrigan, Head of Service, who assured me that she was entirely supportive of my returning to part time employment. I then completed and submitted to the Directorate of Human Resources & Organisational

Development on 06 March 2020 an Application for Scheme Retirement Benefits, detailing withdrawal from full time employment from 30 June 2020, and returning to part time employment with the Trust on 03 August 2020.

Still awaiting parts of the information that I had requested, I again wrote to Ms. Toal on 26 April 2020 (attached at Appendix F), highlighting the information requested in March 2019 and in June 2019, and expecting it to be provided by Friday 15 May 2020. When further information was provided on 22 May 2020 (attached at Appendix G), it did not include a number of items of information on the grounds that the information was personal to others. On 22 May 2020, Ms. Toal advised that arrangements were being made to convene the Grievance hearing.

On 08 June 2020, I received a phone call from Mr. Mark Haynes, Associate Medical Director, who was accompanied by Mr. Ronan Carroll, Assistant Director, confirming that I had discussed returning to part time employment with him and with Mrs. Corrigan. Mr Haynes advised me that I would not be allowed to move to part time employment because the Trust have *"a practice of not re-engaging people with ongoing HR processes"*. I was advised that this decision was made following recent discussions with the Medical Director and Human Resources. I had not previously been advised of such practice when I sought advice in early 2020, as detailed above and it came as a complete shock. The only ongoing HR process that I have is this Grievance. I appreciate that the Case Manager's Determination remains extant but that is subject to the appeal contained in my Grievance and therefore not ongoing.

The delay in dealing with this Grievance has resulted in the Trust terminating my employment with effect from 17th July 2020. I did not want to finish my employment at this time. I only wished to move to part-time employment.

3. Additional Concerns

At the time of writing my grievance, I was not in possession of critically important documents. I have reviewed the additional material provided to me and a number of matters arise from these documents which are detailed below. I intend that this addendum can be read alongside my Formal Grievance and I will refer to the numbers of the related parts contained therein.

(i) Events before 30th December 2016

At Part 2.3 of my grievance, I detailed my concerns about the Trust's handling of the concerns they had about my administrative practice throughout 2016. At Part 2.3.3., I referred to the meetings that were held by the Oversight Committee on 13th September and 12th October 2016. I have now received copies of minutes of these meetings which I have attached to this correspondence at Appendix H and I respectively. Additionally, I have received some email correspondence between Mrs Esther Gishkori, Dr Richard Wright, Dr Charlie McAllister, Mr Colin Weir and Mr Ronan Carroll between 15th September 2016 and 22nd September 2016 which are also attached. I will refer to each in turn (attached at Appendix J).

The Minutes of the meeting of 13th September 2016 do not record that it was recommended to the Oversight Committee that a formal investigation should take place. This is contrary to

what was stated in the Minutes of the meeting on 22nd December 2016, and which I referred to with such alarm in my Grievance. I note that the Minutes of the meetings of 22nd December 2016 were included in a word document that was only created by Mr Gibson on 21st October 2018 and last modified by Ms Siobhan Hynds on 21st October 2018, who had not attended the meeting on 22nd December 2016. Given the delay therefore, it may be possible that those Minutes do not accurately reflect the content of the meeting on 22nd December 2016.

In any case, if such an approach was recommended on 13th September 2016, it is not clear who made the recommendation or on what authority. The Minutes do not mention that advice had been received from NCAS on 7th September 2016 by Mr Simon Gibson, despite the fact that Mr Gibson was present at the Committee meeting and the content of that advice was that a supportive, remedial approach should be taken to resolve the issues (as detailed at Part 2.3.3. of my grievance). This advice does not appear to have been transmitted to the Oversight Committee or considered by it.

The Oversight Committee made a decision to commence an informal investigation. It was directed that a meeting should take place with me the following week and I should be provided with a letter informing me of the intention to commence an informal investigation and this should have included an action plan to address the concerns over a four week period. It was decided I would also be informed that a formal investigation *may* be commenced if sufficient progress was not made within the four week period.

It is striking how disconnected my Clinical Manager, Mr Weir, was from this process. Pursuant to the Trust Guidelines (Tab 4 of my Grievance), the decision making regarding whether any such processes should take place should be made by the Clinical Manager. As I have stated in my Grievance, Mr Weir and Dr McAllister (as Associate Medical Director) were best placed to assess the issues of concern and the best way to approach them. It is unclear why Mr Weir was not involved in this meeting or this decision making at all. **It is a clear breach of the Trust's Guidelines to bypass this critical part of the Maintaining High Professional Standards (MHPS) framework.**

Additionally, I was not informed of the Oversight Committee's decisions in the week commencing 19th September 2016 or at all. I did not even find out that this meeting had taken place until October 2018. There was a clear failure to work with me in a collaborative manner and an opportunity to resolve these issues, without the trauma of a formal investigation and exclusion, was lost.

I next refer to the emails attached from 15th September to 22nd September 2016. These emails detail the approach that my clinical manager intended to take to approach these issues and the extent to which Senior Management was aware of this approach. Mrs Gishkori wrote to Dr Wright and Ms. Toal on 15th September 2016 to outline an alternative approach that was preferred by Mr. Weir and Dr McAllister. It was outlined that they had plans to deal with the Urology backlog in general, including in my practice and that they wished to be given a three month period to resolve the issue.

Mrs Gishkori reasoned that *"given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round."*

It appears that Mrs. Gishkori was asking for an approach that would not invoke the MHPS framework, even the informal processes, but would be a more collaborative approach within the Department, an approach that was also consistent with the approach that NCAS had independently advised to take in their oral communication of 7th September 2016, and confirmed in writing on 13 September 2016.

Dr. Wright sought clarity around the plans before he would deviate from the direction of the Oversight Committee. In response to this, Mr Weir set out a detailed action plan on 16 September 2016 which included a series of face-to-face meetings between Mr Weir and myself, with the aim of resolving the concerns or a plan for resolution within three months, with monitoring and the drawing up of clear plans to clear the backlogs. Dr McAllister approved of this plan on 21 September 2016 and emphasised that it would be *"important to do this in a positive / constructive / supportive role and that Mr O'Brien be aware of this."* Mr. Rice, then Chief Executive, gave his approval. Mr Carroll also appeared to approve of the plan, offering suggestions on how to monitor the progress.

I next refer to the Minutes of the Oversight Committee meeting on 12 October 2016. At this meeting, Mrs. Gishkori set out the new approach that her team had set out and also appraised the Oversight Committee of the fact that I was scheduled [redacted] in November 2016 and would likely be off work [redacted] for a considerable period. The Committee was informed that I had not yet been told about the concerns that the Trust had and that it was Mrs. Gishkori's intention that I would be informed of the concerns upon my return to work. It was also communicated that there was a plan in place to deal with the range of backlogs in my absence.

As far as I am aware, **none** of these plans were put into action. There were no meetings held between my Clinical Manager and I. Mr Weir has described in his witness statement that he was instructed not to meet with me, apparently by Mr Carroll, as there was going to be a formal investigation.

It is important to emphasise how distressing it is to learn of all of these meetings and discussions over two years after I was excluded from work and a formal investigation was commenced. In early 2017, I made several representations requesting detail about the origins of this investigation. I provided a list of concerns and questions on 7th February 2017 (see Tab 23 of the Grievance) which requested detail on what investigations had taken place prior to 30th December 2016 and what consideration had been given to a more informal approach amongst other issues. Dr Khan, Case Manager, replied on 24th February 2017 and made no reference to any of these matters.

I set out a further list of questions on 6th March 2017 (see Tab 26) and received a response from Dr Wright on 30th March 2017 (Tab 27). Dr Wright advised that the information collated regarding un-triaged referrals and undictated clinics, "was collated initially as a result of the concerns emanating from the ongoing SAI". In response to a question asking when the concerns had been brought to the attention of the Medical Director, he stated. "Week Commencing 19th December 2016." The documents that I have received since submitting my grievance make clear that these answers were simply not true. The lack of candour from the most senior management of the Trust is deeply concerning.

The decision that the Oversight Committee made to escalate this matter to a formal investigation on 22nd December 2016 was clearly in breach of the Trust Guideline's and my contract of employment. There were clear opportunities to approach these matters in a more constructive manner in line with the advice sought and provided by NCAS in September 2016, and with the opinion of the appropriate Clinical Manager and Associate Medical Director, and approved by the Medical Director, the Director of Human Resources, the Director of Acute Services and the Chief Executive. The formal investigation should not have commenced.

Unknown to me at the time, Dr. Wright subsequently agreed to meet with my wife on 13th September 2018, following his retirement, and at the request of Mr. Devlin, Chief Executive, in August 2018. Dr. Wright advised that he had "naively assumed" that management had been working with me to address and resolve the concerns, during the months preceding the meeting of 22nd December 2016, but without success. He advised that if he been aware that that was not the case, matters could have been addressed differently in December 2016

(ii) An Unfocused Trawl

At part 2.5 of my Grievance, I detailed my concerns about how the scoping exercise became an unfocussed trawl contrary to the advice of NCAS. I gave examples of my concerns. The additional documents have provided further information in relation to this issue.

In the Minutes of the meeting of 22nd December 2016, Mr. Gibson recorded that an ongoing SAI had identified further issues of concern. This is untrue, as no issues of concern further to those already known, were identified. Mr. Gibson also recorded that Dr. Boyce reported that part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. The nature of this potential additional SAI was and has never made clear to me.

The additional documents make clear that this additional SAI was in fact a patient complaint made by the patient's daughter and the problem had arisen because of a lack of communication from another department. It was completely unconnected to Triage or any of the other concerns and did not arise from the "ongoing SAI." I refer to an email from Dr. Boyce in which it is suggested that this complaint received by the hospital could be added to the concerns that were being investigated (attached at Appendix K).

It is clear that in late December 2016, this investigation became a free-for-all. A completely unconnected complaint could be added to the investigation. An issue around missing notes from as long ago as the 1990s (as detailed in my grievance at Part 2.5.2) was added. Indeed, the Trust undertook a trawl through all of the complaints made in Urology between 2011 and 2016.

The most serious and vexatious complaint was related to my private practice and this is detailed below.

(iii) Private Patients

At Part 2.7 of my grievance, I raised my concerns about the manner in which the investigation was expanded to include a concern about how I scheduled operations in the NHS for patients who had had a private consultation.

Mr. Mark Haynes, Consultant Urologist, sent an email to Mr. Ronan Carroll at 10.39 am on 23 December 2016 (attached at Appendix L). The subject was entitled 'Management of PPs / non chronological listing'.

The text of the email begins by stating that

'I mentioned in discussion the management of PPs by Mr. O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events, I feel this practice should also be looked into.'

It continues:

'Attached is a PP letter from Mr. O'Brien. The patient was seen by Mr. O'Brien on 5th September 2016 privately (given the headed paper the letter is on) and placed on his NHS theatre list on wed (sic) 21st September, waiting a total of 16 days.....I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

Do you think this should be fed into the overall investigation?'

This email gives rise to a number of concerns, *viz*:

(a) Firstly, Mr. Haynes was not my clinical manager at that time and had no role whatsoever in the investigation of concerns about my practice. Yet, within 24 hours of a decision of the Oversight Committee to launch a Formal Investigation, Mr. Haynes, in correspondence with Mr. Carroll, felt that my private practice should also be looked into, in view of 'recent events', and enquired whether it should be fed into the investigation. Mr Haynes knew about an investigation into my practice before I did. This is unacceptable breach of confidentiality, if not a breach of Data Protection law.

(b) Secondly, Mr. Haynes was wrong to conclude that I had seen the patient privately on the date upon which the letter was dictated, 05 September 2016. The patient did not attend privately or was seen privately by me on 05 September 2016. The patient had attended privately once, on Saturday 04 July 2015, when it was decided that he would be better managed by prostatic resection. The patient had waited 444 days until his admission, and which had been expedited due to his deteriorating symptomatic status.

(c) Thirdly, and equally importantly, it is clinically inappropriate to insist that all patients are destined to be admitted in chronological order, and without reference to their changed clinical status or circumstances, and particular in the context of long waiting times. There have only been two categories of urgency for patients on waiting lists for many years (category 2 - urgent, and category 4 - routine). There is no separate category of urgency for Red Flag patients. They have to be differently labelled on the urgent waiting list. My waiting list at that time was over three years long. I believe that it was entirely justified to have this patient's admission expedited as had been detailed in the letter of 05 September 2016.

Then, entirely based upon his wholly mistaken conclusion arising from his misreading of one letter regarding one patient, Mr. Haynes exhorts Mr. Carroll to scrutinise my theatre lists of the previous year to support his belief that a significant number of similar admissions would be identified, and fed into the investigation.

Mr. Carroll forwarded Mr. Haynes' email to Dr. Boyce, to Dr. Wright and to Mr. Gibson, stating that Mr. Haynes' email was self-explanatory. In doing so, he failed to appreciate that my letter pertaining to the patient was indeed self-explanatory. Instead, he appeared to take Mr. Haynes' mistaken conclusion to be self-explanatory. He related that *he* had commissioned a report on all prostatic resections completed by me to see whether there were others listed in the same manner. Mr Carroll did not apparently consider it necessary to relay the concern to my Clinical Manager as the newly appointed Case Investigator. He did not even consider it necessary to consult the Oversight Committee.

By 15.34 on 28 December 2016, Mr. Gibson had already drafted a letter (attached at Appendix M), purporting to have been written by Dr. Wright, and to be given to me at the meeting scheduled with Dr. Wright on 30 December 2016. Mr. Gibson had included the issue of management of private patients as a fourth issue of concern in the drafted letter. Mr. Gibson also asserted that this fourth issue was included in those discussed by the Oversight Committee at its meeting of 22 December 2016. **It is indeed evident that this assertion was also untrue**. This fourth issue was also included in Terms of Reference drafted on 28 December 2016.

(d) Conduct of the Investigation

At Part 2.5.1 of my Grievance, I set out my concern that the Case Investigator did not carry out the Investigation. Since submitting my grievance, I have received a copy of the Minutes of the meeting of the Oversight Committee on 10th January 2017. A copy is attached at Appendix N.

It is once again striking that Mr Weir, who was appointed as Case Investigator by this time, was so disconnected from these discussions. He was not in attendance at this meeting and was not involved in updating the Oversight Committee on an investigation that he was purportedly carrying out.

Furthermore, it is clear that the individual actually conducting the investigation was Mr Carroll. It was Mr Carroll who was charged with actioning the review of untriaged referrals, the tracking of notes to my home and investigating issues around dictation and it is stated that it was Mr Carroll who "would continue to lead the operational team in working through the issues identified to reach clear outcomes for all patients."

This is further demonstrated by an email from Mr Gibson to Mr Carroll, Mrs Gishkori, Ms Hainey, Mrs Corrigan, Dr Wright and Dr Boyce on 30th December 2016 (attached at Appendix O). In that email, Mr Gibson writes to Mr Carroll, *"As part of your plan, there will need to be a clinical note review of all charts/referral letters returned by Mr O'Brien to assess whether patients have a clinical management plan or require a clinical review with a Urologist"*. This is described as a critical factor in the scoping exercise and yet the Case Investigator had no role in this factor and did not appear to even be part of the discussion around it.

I note again Paragraph 8 of MHPS which states that the Case Investigator "is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager." This did not occur in my case. The Case Investigator could not possibly establish the facts in my case when he was not even involved in investigating them.

Finally, in relation to this point, it is concerning that Mr Weir was asked to step down as Case Investigator by the Case Manager. This was communicated to me by Dr Khan by letter dated 24th February 2017 (See Tab 25). The reason for this was that it was clear that Mr Weir would have to provide information to the investigation on the issue of management follow-up in 2016. Here, the Case Manager was recognising a potential conflict of interest as the Case Investigator, charged with investigating the role of management in addressing these concerns in 2016, would in effect be investigating himself. However, no such problems were voiced about the role that Mr Carroll in investigating these concerns though the same conflicts of interest arise as Mr Carroll was even more intimately involved in Management's handling of the concerns in 2016.

There is no evidence that Dr. Chada, the Case Investigator then appointed, was informed of the events of 2016, as clarified above, leading up to the meeting of 30 December 2016. She failed to interview members of the Oversight Committee - Dr Boyce, Dr Wright, Mrs Gishkori, Ms Toal, Mr Gibson and Mr Clegg.

Given the nature of the concerns and the handling of those concerns in 2016 by management, the investigation needed to be conducted independently. It could not possibly be conducted in a fair manner and it was not conducted in a fair manner.

(e) Data Protection Issues

The final issue that arises out of the additional documentation relate to issues around privacy and Data Protection.

I have referred above to the fact that Mr Haynes was informed of an ongoing investigation in my practice by 23 December 2016. In fact, he was informed before I was. Mr Haynes had no role that would require or justify this information being provided to him. The context of the discussion referred to in that email between Mr Haynes and Mr Carroll is unclear but it should not have happened. I am concerned that this encouraged Mr Haynes to add erroneously a new issue in relation to Private Patients to the investigation. This is clearly inappropriate.

I also noted that this stands in stark contrast to the approach taken by the Trust in relation to reasonable requests for information made by me about the qualifications of the individuals involved in this investigation. I requested details of the qualifications and training undertaken by Dr Chada and Dr Khan to conduct an investigation of this nature. I attach a response dated 22nd May 2020, in which Ms Toal explained that this information cannot be provided due to Data Protection regulations. Ms Toal failed to cite or particularise any of the Data Protection regulations she sought to rely on. This is a matter that raises grave concern, and should raise

serious questions to be answered by Ms Toal and the Trust's servants and agents in due course.

I have also asked for detail of the administrative time allocated to my colleagues so that I may understand if there was difference between their allocation and my own. This could have been provided in anonymized form. However, I have been informed in that same correspondence that this information cannot be provided for Data Protection reasons. Likewise, this is a matter that raises grave concern, and should raise serious questions to be answered by Ms Toal and the Trust's servants and agents in due course.

Plainly, there is a manifest double standard afoot in relation to Confidentiality and Data Protection between the treatment of an employee who is subject to MHPS proceedings and those who are not.

I also noted with alarm that in the course of providing me the documents requested, the Trust has breached the confidentiality of Personal Information redacted by the USI of Personal Information redacted by the USI and of Personal Information redacted by the USI Personal Informatio n redacted I refer to the note of the meeting of the Oversight Committee on 12 October 2016 in which details of allegations are set out relating to these doctors. This information should not have been provided to me in unredacted form. I repeat, this raised deeply disturbing issues of breach of Data Protection, and it must be ascertained if these individuals have, likewise, been improperly and unlawfully been apprised of the issue I faced at that time.

I seek your written assurance that the Trust did not similarly breach its obligations in relation to confidentiality and Data Protection owed to me by providing records of this investigation to other members of staff.

4. Duty of Clinical Care Update

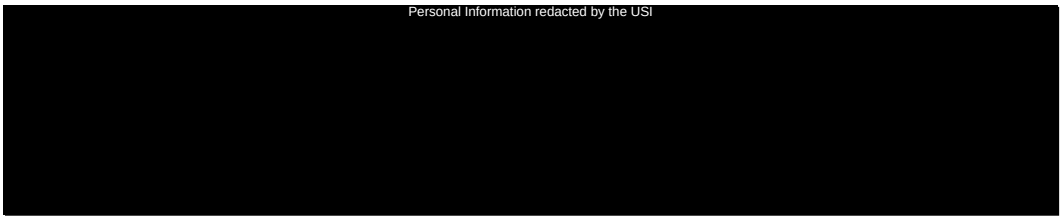
In the Grievance submitted in November 2018, I included my concerns with regard to the Trust's duty of clinical care to urological patients, and the perverse, negative impact that the Investigation had upon that duty of care. In doing so, I had indicated that the delayed triage of patients subsequently found to have malignancies would have been entirely avoided had the Trust approached their concerns in a collaborative manner, as obliged by its own policy and advised by NCAS. Scheduled reviews of patients during the early months of 2017 were cancelled due to the Trust's insistence that an Investigation be conducted. As a consequence, patients known to have malignancy suffered disease progression due to further delay in their review. Meanwhile, at that time, there were almost 600 patients awaiting admission for urgent surgery, up to a maximum of four years, while only 28 patients were waiting a maximum of 11 weeks for urgent gynaecological surgery.

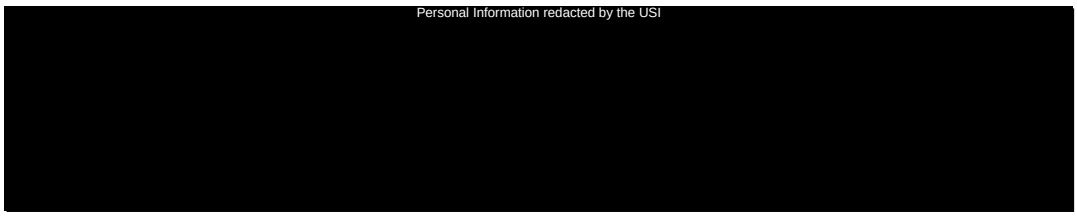
Two years later, only 21.9% of urological cancer referrals throughout Northern Ireland have their first definitive treatment within 62 days. There were 7,887 patients awaiting admission for surgery throughout Northern Ireland at the end of March 2020. Of these, 1,700 were patients of the Southern Health & Social Care Trust, and of these, 935 were waiting for more than one year. There are currently 352 patients awaiting admission under my care. Of these, 252 patients are awaiting admission for urgent surgery, dating back to August 2014.

In the Grievance of November 2018, I referred to the incidence of prostatic carcinoma found on endoscopic resection of the prostate gland. The incidence has been reported to vary widely

from 1.4% at a single, tertiary referral centre in New York, to 13.4% in men aged up to 65 years and 28.7% in men aged over 65 years, in a multicentre study in Melbourne. Having reviewed the literature, there is no reference at all to the relationship between the length of time awaiting admission for surgery, and the incidence of carcinoma, probably an indication of how unique the length of times our patients await admission.

Currently, as of July 2020, some 650 patients await admission to our department for prostatic resection. By August 2020, some of those patients will have been on waiting lists for six years, and some will have been waiting over four years with indwelling urethral catheters, with the attendant uroseptic risks. There are currently 153 patients awaiting admission for prostatic resection under my care. Of these, 44 (29%) are aged up to 65 years, and 109 aged over 65 years. By extrapolation, the majority (71%) of those awaiting admission to our department are aged over 65 years. Therefore, up to 25 patients aged up to 65 years, and up to 132 of those aged over 65 years, will be found to have prostatic carcinoma, if they ever do get admitted. These numbers of delayed diagnoses of prostatic carcinoma are of a magnitude which dwarfs that arising from any of the concerns subject to investigation from 2016 to 2018.





By 17 July 2020 I had 25 patients awaiting new clinic appointments at my clinic at Craigavon Area Hospital, and 434 patients awaiting new clinic appointments at my clinic at South West Acute Hospital in Enniskillen, dating as far back as February 2015. There is a total of 544 patients awaiting oncological and general urological review at my clinics at Craigavon Area Hospital, dating back to February 2017, another 110 awaiting review at my clinic at Armagh Community Hospital dating back to December 2015 and a total of 365 patients awaiting review at my clinic in Enniskillen, dating back to December 2017.

The totality of this outstanding urological need, and the attendant risks to patients, is directly and largely a consequence of the inadequacy of the service provided by the Trust. The magnitude of the risk to patients far exceeds any potential harm that arose from any of the concerns subjected to investigation in 2016 to 2018. Indeed, as indicated above, the investigation further exacerbated that risk. The greatest risk posed to urological patients is by the Trust itself. After 28 years of dedicated service, I am at a loss to understand whether the Trust lacks insight into the abdication of its responsibility, or is entirely insightful and indulges in transference of its responsibility to the individual clinician instead, seemingly with the intent of absolving itself of its institutionalised neglect.

Nevertheless, since December 2016, I have made reasonable effort, in conjunction with my colleagues, to have the Trust come to an agreed policy and practice concerning the duties and expectations of urologist of the week (UOW), the conduct and extent of triage, and the relationship between both. In August 2018, we agreed to not arrange any clinical activity on Monday 24 September 2018 so that we could meet with senior management to discuss these and any other issues that may have been raised. I provided in writing to our department's governance lead, the concerns which I wished to have addressed, namely, UOW, triage and waiting times for December 2018. Senior management did not attend this crucial meeting on 24 September 2018, and never explained why it did not attend.

Mindful of the increasing disparity between urological need and service provision, and mindful of the consequent risks to so many patients, I ~~have~~ had every intention to continue to positively contribute to mitigating those risks, by returning to part time employment in August 2020, as described above. I most certainly would not have withdrawn from full time employment had I known, or been informed, of any impediment to my returning to employment. Instead, the Trust saw fit to continue its campaign against me and prevented me doing so, owing to the "ongoing HR processes"!

Yours sincerely

Aidan O'Brien
23 July 2020

RESPONSE TO REPORT OF FORMAL INVESTIGATION

I am writing this report in response to the report of formal investigation from Dr Neta Chada. My response is structured in parallel to the Dr Chada's report. In responding to the report, I have considered to set the reasons for the investigation in an historical context. Thereafter, I have commented upon the investigative process and the report itself. Lastly, I respond directly to the five terms of reference.

Historical Context

Igraduated in Medicine from the Queen's University of Belfast in 1978. After basic, postgraduatea surgical training in Northern Ireland, including a year as Demonstrator in Anatomy, and duringa which time I had spent some time in every surgical specialty, except for Urology, I applied for aa post as a Registrar in Urology at Belfast City Hospital in 1984. During my tenure in that post froma August 1984, I became increasingly impressed with Urology as a surgical specialty for a number ofa reasons: the greater ability to apply objective diagnostic tools to assessment of urinary tracta pathology, such as renography and urodynamic studies; the rapidly increasing role of endoscopica and minimally invasive surgery, and most importantly at that time, the varied spectrum ofa malignancies of the urinary tract. I became increasingly interested in new diagnostic tools in thea assessment of bladder carcinoma, such as nuclear image analysis and DNA flow cytometry.a

As DNA flow cytometry was unavailable in Northern Ireland at that time, I applied for and was appointed to the post of Registrar in Urology at St. James' Hospital, Dublin in July 1985, followed by a Research Fellowship at the Meath Hospital, Dublin, in 1986. I was appointed a Senior Registrar in 1988, and completed Higher Surgical Training in Urology on 30 June 1991. During that training, I was particularly aware that it pertained exclusively to adult Urology. As a consequence, I applied for and was appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol, taking up that post on 01 September 1991.

In May 1991, I received a phone call from Mr. Ivan Stirling, (now retired) Consultant Vascular Surgeon at Craigavon Area Hospital, to advise that Mr. W. Graham, Consultant Surgeon at Craigavon Area Hospital, was due to retire on 30 June 1991. He was a general surgeon who had developed an interest in urological surgery. Mr. Stirling advised me that there had been some discussion among colleagues as to whether he should be replaced by a general surgeon or by a urologist, and sought my view. I immediately advised that he should be replaced by a general surgeon and by a urologist. Some days later, I was invited to meet with him, his consultant colleagues and with the Chief Executive, Mr. John Templeton, over lunch. It was during that meeting that they appreciated that I had a two month hiatus prior to taking up the post in Bristol. I was asked whether I would spend some time during that two month period as a Locum Consultant at Craigavon Area Hospital, as Mr. Graham had 77 patients on his waiting list for elective admission for prostatic resection (TURP). After a one week break, I came to Craigavon Area Hospital, performing 77 TURPs, and a left ureteric reimplantation for ureteric stenosis, in seven weeks.

On Wednesday 28 August 1991, I was invited once again to meet with the Chief Executive and the remaining three Consultant General Surgeons, Mr. John O'Neill, Mr. Osmond Mulligan and Mr.

Ivan Stirling. I was earnestly requested to remain as a Locum Consultant Urologist with the intent that I would be appointed to a substantive post when approval was granted. However, as I passionately believed in the importance of a period of training in Paediatric Urological Training, I declined. However, the Chief Executive then advised me that obtaining approval would require a long battle, and which he was not prepared to embark upon, without my promise to apply for the post, if successful. I pledged to apply for the post, without fully understanding how it could possibly require such a battle to gain approval.

The only specialist urological service in Northern Ireland at that time was provided by the Department of Urology at Belfast City Hospital, led by five consultant urologists. I did anticipate that there would be strong resistance from that Department to the appointment of a Consultant Urological Surgeon, and indeed there was. I did not anticipate at all that the greater battle would be with the Director of Public Health at the South Health and Social Services Board, and who did not believe that there would be enough work for one consultant, and at a time when Northern Ireland had the least adequate urological services in the 34 EBU countries and in the 42 OECD countries!

In any case, the struggle was successful, the battle was won. I was appointed by competitive interview on 11 June 1992, and took up post 26 years ago, on Monday 06 July 1992. Mr. Graham had indeed been replaced by a urologist and by a general surgeon, Mr. Eamon Mackle, who had taken up post earlier in 1992.

On taking up post, I was provided with four inpatient beds in Ward 2 South, one inpatient operating session per week, one outpatient clinic per week, and the assistance of half a Registrar, Mr. Shamim Khan, who was then embarking upon the third year of a four year work visa in the UK. It was only after some time that I came to appreciate the reason for struggle to gain approval for the appointment in the first place, followed by such minimal provision of capacity on appointment. It was because in the minds of the majority of clinicians and managers, 'Urology' was spelt 'TURP'. However, during that first year, I had introduced ureteroscopic lithotripsy to Northern Ireland, performed the first and only radical prostatectomies in Northern Ireland, and on 15 December 1992, performed the first radical cystectomy and orthotopic bladder replacement in Ireland, and one of the first to be performed on a female in the UK. By 31 March 1993, the end of that first financial year, over 850 referrals had been received.

The first four years were most difficult, until the appointment of a second consultant urologist in 1996. During that four year period, I provided a continuous, 24/7, emergency urological service, except for one week when colleagues at Belfast City Hospital agreed to provide emergency cover while I attended the Annual Meeting of the American Urological Association. I did take off either two or three separate weeks from elective work each year, made possible by the continued assistance of Mr. Shamim Khan, who ensured that elective work continued, while I provided a continuous emergency service. I had also succeeded on obtaining Home Office approval for Mr. Shamim Khan to remain in the UK for one further year, from August 1994 until July 1995, as our Department's first Clinical Research Fellow.

That appointment was a necessity at that time as it had otherwise become impossible for a single consultant urologist to provide an adequate service to meet the increasing urological needs of the population of the then Southern Health and Social Services Board. By then I had secured four

inpatient operating sessions per week, and occupied 20 to 30 inpatient beds in Ward 2 South. We had begun to have outreach clinics in Armagh and Banbridge. We had urodynamic and flexible cystoscopy sessions, while still providing a continuous emergency service. It was also only made possible by the founding of CURE (Craigavon Urological Research and Education) by Mrs. Roberta Brownlee and myself in 1994. That enabled CURE to fund all of the costs of research while the Trust agreed to provide the salary of the Fellow as he provided clinical sessions in addition to undertaking research. Mr. Khan's research enabled him to be appointed a Senior Registrar in Dublin in 1995. He was appointed a Consultant Urological Surgeon at Guy's Hospital, London, in July 1999, was awarded an OBE in 2007, and was appointed Professor of Urology at King's College School of Medicine in 2017. Mrs. Brownlee progressed on several fronts, not least becoming Chair of the Southern Health and Social Care Trust Board in March 2011.

During subsequent years and much hard work, including numerous collections, charity lunches and Gala Dinners with guest speakers, including Lord Eames, Lord Trimble and Sir Kenneth Bloomfield, CURE had raised approximately £250,000, used to fund research by some five trainees, leading to their higher degrees. Our Ward Manager, Mrs. Eileen O'Hagan, since deceased, was a founding member of the British Association of Urological Nursing (BAUN). CURE still jointly sponsors with BAUN its annual keynote lecture given by an eminent international speaker, the Eileen O'Hagan Memorial Lecture. Through its collaboration with the Faculty of Health Sciences of the University of Ulster, CURE promoted the joint appointment of Mr. Jerome Marley as Lecturer Practitioner in Urological Nursing in 1998. Since then, through on site and distance learning, numerous urological nurses from around the world have been able to study academically accredited, urological nursing modules as part of their primary and higher nursing degrees. Mr. Marley was a founding member of the European Association of Urological Nurses in Brussels in 2000. In 2006, we launched the International Journal of Urological Nursing, with Mr. Jerome Marley as its first Editor in Chief. The Journal is the official organ of all national associations of urological nursing throughout the world, apart from the Society of Urological Nurses of America, which has its own Journal. I have to confess that it has been one of my proudest days was when I presented to Mr. John Templeton the first edition of the Journal on his last day as Chief Executive of Craigavon Area Hospital Group Trust.

The second Consultant Urologist, Mr. Wahid Baluch regrettably left his post at Craigavon Area Hospital in 1998, but was replaced by the appointment of Mr. Michael Young, who took up post in May 1998. By then, I had secured the approval of the Trust, with the support of the Southern Health and Social Services Board, for the establishment of first (and still only) on site, extracorporeal shock wave lithotripter (ESWL). During 1997, I had visited a number of leading on site ESWL centres in Belgium and Germany, and concluded that we should have the multipurpose Dornier Lithotripter in a setting adjacent to theatres, with anaesthetic facilities if required, but one also amenable to ambulatory access. With some resistance from other interests, I secured the current location of the Stone Treatment Centre which had been vacated by CSSD. On his appointment, I charged Mr. Young with the task of designing its interior. On his appointment, I had my first holiday with my family, outside of Northern Ireland, Personal Information redacted by the USI, since appointment in 1992.

The Urological Department at Craigavon Area Hospital had been remarkably successful in its first decade, and was widely recognised throughout Northern Ireland for being so. However, that success was achieved at the cost of much personal sacrifice for me and for my family, and also particularly for Mrs. Eileen O'Hagan, our Ward Manager, and whose death Personal Information redacted by the USI

in 2001 was, in hindsight, perhaps a harbinger of more difficult times to come. It is often said that everyone can be done without. I would add that not everyone can be done without as well. There is no doubt that the success of our Department led to some envious resentment, the Chief Executive having received complaints and delegations alleging favouritism. I believe that charge led to a long delay in further, desperately needed development of the service. It was after a commissioned, external review of urological services by Professor Sam Mc Clinton of Aberdeen that the Trust could be impressed of the dire need for further, urgent development.
Mr. Mehmood Akhtar was appointed to a third Consultant Urologist post in July 2007, facilitating the introduction of laparoscopic renal surgery. However, in 2008, we were devastated to be advised that we had lost our single inpatient department in Ward 2 South, our patients being dispersed throughout three general surgical wards. Even though our inpatients were later concentrated in one ward, Ward 3 South, it remains my contention that inpatient care has never been of the high standard it had been previously. Then, in September 2010, radical pelvic surgery for bladder and prostatic carcinoma was centralised to Belfast City Hospital. I was strongly opposed to this centralisation, in the belief that patients would suffer and die as a consequence. I submitted a written proposal that radical prostatectomy continue to be performed in both Derry and Belfast, while radical cystectomy would continue to be performed in Craigavon and Belfast. Of course, the proposal was dismissed. Meanwhile, I believe that two patients died of bladder cancer due to their not having radical cystectomies performed when they could have been, and radical prostatectomies have not been performed at all anywhere in Northern Ireland for several years. Moreover, the loss of radical pelvic surgery at Craigavon Area Hospital contributed to the departure of Mr. Akhtar in April 2012.

Mr. Akhtar had established and chaired a weekly Urology MDM in April 2010. On his departure two years later, I was appointed Lead Clinician of the Southern Trust Urology Multidisciplinary Team and Chair of the Urology MDM, in April 2012. Concurrently, my colleague, Mr. Michael Young, and I became increasingly concerned by ever increasingly long, waiting lists for elective admission for surgery, with the consequential risks of death and morbidity for those patients. We therefore embarked upon extended operating days, Mr. Young operating until 7 pm each Tuesday and my operating until 8 pm each Wednesday. After arriving home at 9 pm, and having the meal of the day, I would then typically spend three to four hours previewing the 30 to 50 cases to be discussed at MDM which I chaired the following day, finishing at 02.00 to 03.00 am. After each MDM, all clinical summaries were corrected and amended if required, and all outcomes were reviewed and signed off, with Mrs. Vicky Graham, Cancer Tracker and Coordinator, finishing by 7 pm each Thursday evening. So doing enabled formatted letters to be generated from CaPPS and sent by post to each patient's GP each Friday morning. No time was allocated in job planning for extended operating sessions, or for the previewing or reviewing patients discussed at MDM which I chaired each week.

In late 2012, I was requested by consultant colleagues and by the secretariat of NICaN to consider taking on the role of Lead Clinician of NICaN's Clinical Reference Group in Urology. I agreed to do so, if no one else offered to do so. Regrettably, no one did do so. I was appointed to that post in January 2013. Being Lead Clinician of the Southern Trust's Urology MDT and Chair of its MDM in addition to being Lead Clinician of the Regional Clinical Reference Group was a heavy burden and consumed much time and energy, particularly during the two years leading up to National Peer Review of Urological Cancer Services, both by the Southern Trust and Regionally, in June 2015. I wrote the required Operational Policy for the Southern Trust's Urology MDT, holding monthly

meetings with multidisciplinary colleagues to discuss and seek consensus for its many parts. I commissioned ongoing audits of histopathological diagnosis of prostatic carcinoma. I addressed deficiencies in input by radiology and oncology, which compromised MDM quoracy, and which still does. More successfully, I received a weekly update of those patients who were at risk of breaching cancer target timelines, undertaking to review and/or operate on these patients myself, with the result that not one patient had breached a target timeline during the previous six months by the time the Southern Trust was peer reviewed in June 2015.
It is worthy of note that there were some failures in preparedness for Peer Review. Firstly, I had sought the agreement of my consultant colleagues to advanced triage of red flag referrals to facilitate and expedite their assessment, diagnosis and management with the required timelines. It was not possible to obtain that agreement as my colleagues asserted that there was not enough time, while being urologist of the week, to do so. Similarly, they declined to provide to the Cancer Tracker a clinical summary of each patient to be discussed as is required, insisting instead that they would ask the Tracker to list patients for discussion at MDM, providing a copy of a letter dictated to a GP or other referrer, the Tracker having to compose a clinical summary for CaPPS, and which is contrary to the regulations. Once again, they declined to do so because of time constraints. Lastly, I failed to obtain the agreement of my colleagues to compile a management plan for each patient, a copy to be given to each patient and a copy to be included in the chart. This too has been a requirement of the National Cancer Plan. I do have to agree that this requirement was, and remains, entirely unrealistic, as there was simply not enough time to do so, and certainly not enough time when my colleagues had already asserted that there was not enough time to undertake advanced triage or to provide clinical summaries.

Concurrently, I was responsible for ensuring that Northern Ireland's Regional Uroiogical Cancer Services were prepared for National Peer Review by June 2015. This proved to be a significantly more complex process than preparing the Southern Trust for review. This entailed not only the Operational Policy for Regional MDM, it involved the composition of Clinical Management Guidelines for all aspects of referral pathways, investigations, diagnoses, management and review for all of the urological cancers. It entailed compliance with NICE and EAU Guidelines. It particularly included the identification of aspects of the patient pathways that could not be compliant with NICE or EAU Guidelines, either throughout Northern Ireland as a whole, or in areas within Northern Ireland. It included the commissioning of Operational Policies from Urological Surgeons, Clinical and Medical Oncologists, Pathologists, Radiologists, Clinical Nurse Specialists, Palliative Care Specialists and Nurse Practitioners. I believe that my work over a period of two years led to a successful Peer Review of Northern Ireland's Urological Cancer Services. During that time, I was also requested to join the National Peer Review Panel, being a member of the panel which reviewed the North West Urology MDT in June 2015.

Having completed the three year tenure as Lead Clinician of NICaN's Clinical Reference Group for Urology, I stepped down from that post in January 2016. I remained as Lead Clinician of the Southern Trust's Urology MDT until 31 December 2016, having completed National Peer Review updates in September 2015 and again in September 2016. With some substantial success, I addressed the chronic lack of input by Clinical Oncology to our MDM, and with much less success, the chronic inadequacy of radiological input to MDM, even though I met with the Medical Director for the first time in April 2016 to discuss the concerns of the MDT regarding this particular issue. Both these issues continue to pose an existential threat to the continuation of a Southern Trust Urology MDM.

The burden of the roles of Lead Clinician of the Southern Trust's Urology MDT, Chair of the Southern Trust's Urology MDM, Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology from 2012 to 2016, and preparing both the Southern Trust and the Region for National Peer Review in June 2015 was considerable, particularly in terms of the time and energy required, both of which were additional to continuation of the usual and preceding, clinical commitments.

Since the departure of Mr. Akhtar in April 2012, the compliment of Consultant Urologists at Craigavon Area Hospital had increased to six. However, the operating capacity allocated to the Urological Service had not been correspondingly increased. Irrespective of the number of consultant urologists, and irrespective of operating capacity, the number of referrals continued to increase annually. One obvious consequence was that increased numbers of urologists were unable to provide operative management to increased numbers of patients referred, resulting in increasing numbers of patients waiting for ever longer periods of time for admission for surgery. The cohort of patients who suffered most severely were those acutely admitted in the first place. As there was no consultant staff available to operate on these patients when required, and no theatre capacity to facilitate their surgery, these patients were attended to after elective surgery had terminated, and by staff who had already completed an elective day, and in a manner which only temporised the acute condition, those patients then being discharged to a waiting list for readmission for definitive surgery, and at risk of acute readmission due to acute morbidity as a consequence.

After a long gestation period, the 'Urologist of the Week' was introduced in 2014. I have no doubt in asserting that the reason for the delayed introduction was the belief on the part of one or two of my colleagues that the Trust would not agree to funding its introduction as there would not be enough work to sustain it, and the reason for that belief was the failure to appreciate the distinction between 'Urologist of the Week' and 'Urologist on Call'. The latter would just have required the Consultant Urologist to be available when required and called upon by a Registrar. As a consequence, it was even proposed that we would have time to conduct an afternoon clinic each day when Urologist of the Week. It was as a consequence that it was agreed that we would be able to conduct triage when Urologist of the Week.

Even though I too agreed with the conduct of triage while being Urologist of the Week, I soon came to realise that there simply was not enough time to do so effectively and optimally whilst also delivering optimal, definitive and timely management to those patients who had been acutely admitted. I could not do so in addition to spending three to five hours conducting inpatient ward rounds with the registrar, assessing patients in the Emergency Department, advising regarding the management of acutely admitted patients elsewhere in Craigavon Area Hospital, Daisy Hill and South West Acute Hospitals, in addition to performing zero to six operations each day. It has been my belief and understanding that the primary purpose of Urologist of the Week is to optimally care for those patients acutely admitted to the above three hospitals due to urological pathology. To do this, the Urologist of the Week is required to undertake the duties described above and these are time consuming and it is therefore not possible to accommodate triage in addition to those duties without compromising the standard of care provided as Urologist of the Week, or compromising the standard of triage, or both.

In order for my colleagues to accommodate triage, it has been necessary for them to reduce the work done as Urologist of the week. For example, some do not come in to the hospital at all over the weekend. Some colleagues may not conduct a ward round during a particular day or days, letting the Registrar "get on with it." It has also recently been reported to me and other colleagues that one consultant did not do one ward round during an entire week on call. I have also observed some colleagues undertaking triage whilst the registrar "got on with it" in theatre. It has been the case that patients did not have their definitive operative management following their acute admissions, being discharged by the Urologist of the Week, only to be readmitted at a later date, suffering complication as a consequence. In outlining the above examples, it is not my intention to be critical of my colleagues but rather I am setting these out to explain that the demands of triage and the demands of the Urologist of the Week are not compatible and it has been my experience that having triage included in the workload of Urologist of the Week has compromised patient management and was therefore unsafe.

It is stated in the investigation report that I had argued for advanced triage to be employed as the method of triage by the department. It is important to point out that the reason why I believe this to be necessary is because the waiting times for first appointment for routine and urgent referrals are so lengthy that to allow that time to elapse without having directed some further investigations can lead to a compromised outcome. An example best illustrates the issue. Personal is a 63 year old man who was routinely referred in December 2017 with symptoms indicative of bladder outlet obstruction. He did not have any Red Flag symptoms such as haematuria. He had normal renal function and a normal serum PSA level. Urinary microscopy and culture were both normal. I triaged that referral and concluded that it should remain categorised as Routine. However, in addition, I wrote to the patient to advise that I would request an ultrasound scan of his urinary tract. I also wrote to the GP requesting that he prescribe Tamsulosin for the patient. When ultrasound scanning was performed at Daisy Hill Hospital in January 2018, it did indeed confirm that the patient had an enlarged prostate gland probably causative of of bladder outlet obstruction. However, it also indicated that he probably had a bladder tumour. That impression was then further assessed and confirmed by flexible cystoscopy. The patient has since had multifocal, high grade, transitional cell carcinoma with carcinoma in situ resected. He is currently undergoing intravesical BCG therapy.

If I had not taken the time to request ultrasound scanning, writing to the GP and the patient in the process, and acting upon the report, this man may not have received an appointment until 2019. I have absolutely no doubt that only one of my colleagues may have requested a scan. The probability would have been that he would have still been awaiting a routine appointment. However, it probably would have taken me a minimum of 15 minutes to review his details on NIECR, request the scan and write to both GP and patient. We currently receive approximately 160 referrals per week. Even if triage time per patient were a mean of half the time spent on the referral of Personal, that represents 20 hours of work while Urologist of the Week. Yet, to date, there has been no predictable sessional PA time allocated to triage in any of our Job Plans. Moreover, in my comments relating to the SAI report concerning Patient 10, in January 2017, I requested the Trust to address the issue of triage, determining who, when and in what manner it should be done. To date, there has been no response.

The year of 2016 proved to be difficult for several reasons. I had become increasing concerned by the morbidity, and risk of mortality, suffered by patients awaiting admission for surgery. I had

shared my concerns with colleagues and with the Head of Service on many occasions, at Departmental meetings during that year, as I had done during many years previously. I was so often advised that the waiting lists were a Trust issue, if only! It had been my experience that the Trust was either unaware of the waiting lists or times, and of the disparity between specialties, or were aware, but it was not an issue. For several years, I had not taken any leave for any reason on an operating day, or on any day when operating sessions were made available to me, when my colleagues did take leave. I continued with this practice during 2016 in an endeavour to mitigate so far as was possible the risk of harm to patients. I did so even though I was suffering increasingly from [redacted]. In addition, I had undertaken to defer [Personal Information] for as long as possible to enable me to provide backup support to Mr. Suresh, for whom we had been requested to provide such support when he was Urologist of the Week, and which some of my colleagues had declined to do. It was when Mr. Suresh confirmed to me that he was returning to a Consultant post in England in October 2016 that I decided that I should [Personal Information redacted by the USI] [redacted].

The Investigation

I received a telephone call from the Medical Director's office, also on Wednesday 28 December 2016, to advise that the Medical Director wished to meet with me the following Tuesday, 03 January 2017 at 11.00 am. I advised that I would be unable to do so as I had a Day Surgical operating list that morning. However, I advised that I was happy to speak with him by telephone before then. I then was advised that the Medical Director was of the view that he required to meet with me in person, and offered to do so on Friday 30 December 2018. I enquired whether he was aware that I was on sick leave. I was advised that he did. I telephoned later to request an agenda, which was provided by email. Otherwise, I would have attended, unaccompanied, recovering from [Personal Information redacted by the USI], while on sick leave.

The meeting was both shocking and devastating for both me and for my wife who accompanied me. It initiated the worst month in my life with serious consequences for my health. It initiated a period of trauma which still persists. Inter alia, I was advised of my immediate exclusion in accordance with the Southern Trust Guidelines for handling Concerns about Doctors and Dentists' Performance (September 2010) and Maintaining High Professional Standards in the Modern HPSS (November 2005). The exclusion was subsequently confirmed by the Medical Director in writing on 06 January 2017, when it was also confirmed that Dr. Khan had been appointed Case Manager, and Mr. Weir had been appointed Case Investigator. I was not advised of the appointment of a non - Executive member.

Cognisant of the stipulation in the Southern Trust Guidelines that the Investigation had to be completed within four weeks of the date of exclusion, and not having received any communication from the Case Investigator, I contacted Mr. Weir by telephone on 16 January 2017, when he advised me that he was equally cognisant of the significance of the four week period, but was alarmed to be advised by him that a meeting had been scheduled for him to meet with the HR Representative, appointed to assist him in the Investigation, on Thursday 26 January 2017, the

Personal Information redacted by the USI

20 December 2008

Ms. Catherine Mc Nicholl
Service Delivery Unit
Personal Information redacted by the USI

Dear Catherine,

I have reflected at length upon the direction of the Regional Review of Urological Services since attending the meeting at the Park Avenue Hotel on the 9th October 2008. I appreciated the opportunity afforded to me to share some of my concerns with you and with Mark Fordham when we last met at the same venue on 4th December 2008. I confess that it had been some years since I had once scanned 'Improving Outcomes in Urological Cancers'. I have since digested it twice. I have also had an opportunity to read and discuss the 'Models for Future Delivery' document. After all of that, I still do have genuine and grave concerns regarding the future of urological services, particularly those outside of Belfast.

In your introductory remarks on 9th October 2008, you expressed the view and desire that the Review was not about the past, or even about the present, but about the future. Whilst I understand the conceptual rationale, I believe that there is every probability that the mistakes of the past may be repeated, if not reviewed. More importantly, without a complete appreciation of the precarious journey from past to present, and the tenuous nature of the present, its simplistic replacement by the future carries with it risk of profoundly negative consequences. I am entirely honest in stating that I have not heard from anyone involved in the review to date, any sense of appreciation of how difficult it has been to achieve the present status, and how negatively the Review may impact upon it.

In 1990, there still remained a single, specialist urological department in Northern Ireland, at Belfast City Hospital, with five consultant urologists. Like many other singular specialist departments located in Belfast, it called itself the Regional Urology Service. Behind that title worked a mindset, which I often heard expressed, that they were singular out of necessity because of their specialist nature, and more significantly, that their specialist nature could only be optimally preserved if they remained singular. Moreover, that mindset completely superceded, for decades, any other considerations regarding need, demand or capacity throughout Northern Ireland. The claim to have, or the perception of the presence of, a 'first class' or 'world class' singular, specialist department, and worthy of the Regional title, blinded all to any inadequacy anywhere.

On 30 June 1991, Mr. Graham, a consultant general surgeon at Craigavon Area Hospital, and who had developed an interest in urology, retired. He did so leaving a waiting list which included 77 patients requiring TURP. On 30 June 1991, I completed higher professional training in Dublin. Surgeons at Craigavon Area Hospital learned that I had a 2 month hiatus before taking up a fellowship in paediatric urology in Bristol. I was asked if I would come to Craigavon to do some of those on the waiting list. I did all 77 in July and August 1991. By then, it was apparent to the Chief Executive and to all surgeons that there was undoubtedly a need to appoint a urologist. I was advised by them that this would entail a long and difficult battle, and I was asked to promise that I would apply if they won that battle. I was entirely unable to understand then, or since, how there could possibly be such a battle.

The battle lasted nine months, and it was very difficult. The late Mr. J. Kennedy, then senior Consultant Urologist, wrote that it was impossible to appoint a urologist at Craigavon Area Hospital as he or she would 'need special equipment'. The Board's Director of Public Health was most concerned that there would be adequate need or demand for one urologist, from a resident population of 290,000. Relentless pressure was placed upon the Board that the only safe and effective way of providing urological services at Craigavon Area Hospital was by a consultant jointly appointed by Craigavon Area and Belfast City Hospitals. However, in April 1992, the Chief Executive and surgeons at Craigavon Area Hospital gained the Board's agreement to appoint a urologist independently.

Meanwhile, I had fallen in love with paediatric urology and with Bristol, and the West Country. I had by then been offered a further year in Great Ormond Street, with the prospect of returning to Bristol as a consultant paediatric urologist. Everyone in Bristol thought that I was mad to decline that offer to return to a place in Northern Ireland, of which they had never heard. I was concerned about taking my family to Northern Ireland at that time. Even though I was born in Lurgan Hospital, the decision to honour my commitment to apply caused me great concern. I must be honest in confessing that the dominant reason I did, was to return home. I took up the post in July 1992.

This was the first appointment of a consultant urologist or urological surgeon in Northern Ireland outside of Belfast. I find it impossible to completely understand the origins or justifications of such forceful opposition to development in the face of such overwhelming need. The consultant : population ratio for Northern Ireland then was 1:260,000. If Northern Ireland was then a sovereign state, it would have had the worst or least adequate urological services in the EU or OECD countries.

I tried to tempt Colin Mulholland to come to Craigavon in 1993 as a second consultant urologist, but he preferred Altnagelvin Area Hospital, and precisely for the same reason that I had returned to Craigavon. He was returning home. All the better as there were now two fledgling departments outside of Belfast.

We appointed Mr. Wahid Baluch in 1996. Trained in Dublin and delighted to be appointed a consultant, Craigavon (in rural Northern Ireland) did not meet his aspirations. He left in 1998 for [Personal Information redacted by the USI] We offered his post to Mr. Michael Young in 1998. He did not accept until he was interviewed four days later for a consultant post in Belfast City Hospital, a post he expected to be offered and which he intended

to accept. The post at Belfast City Hospital was offered to Mr. Thomas Lynch instead, enabling Mr. Young to accept our offer. In 2004, we offered a third consultant post to Mr. Tariq Sami, who ultimately preferred to remain in his post at [redacted] Hospital, rather than return to Craigavon. Mr. Richard Batstone withdrew in 2007 because he and his family felt isolated in rural, mid Ulster. Mr. Akhtar was appointed to that third post at Craigavon in 2007. [redacted]. It has taken 15 years for us to increase our consultant complement to three, for a resident population now approx. 320,000, and there is no guarantee that the third will remain. This has been our experience in the Southern Area. With respect, it is not an experience of anyone in SDU, or elsewhere in the Department, or NICE, or even in our own Southern Board. It has been my experience, of 16 years duration, and Mr. Young's during these last 10 years, and the greatest burden is the daily struggle to compensate for the inadequacy.

Similarly, Mr. G. Lennon was appointed a consultant at Altnagelvin Area Hospital in 1997. He left three years later for the richer pastures of [redacted] Mr. Schattka was appointed in his place, and remains in post.

Mr. Robert Kernohan, Consultant Urologist at Belfast City Hospital, developed a presence in Coleraine during the nineties. He transferred to Coleraine full time, when the new Causeway Hospital opened, including a substantial investment in urological services. Mr. Paul Downey was appointed to a second consultant post in Coleraine. Mr. Downey left a consultant post in endo-urology, at the University Hospital of South Manchester, as his wife severely wanted to return home to Northern Ireland. Mr. Kapasi was appointed to a third consultant post in Coleraine earlier this year, and concurrent with the resignation of Mr. Kernohan. His resignation is the loss of one of the most talented, skilful, urological surgeons in Northern Ireland, and that loss is suffered by rural Northern Ireland in particular. I believe that there should be no doubt in anyone's mind that his resignation is the first negative consequence of the changes which have already taken place, and those considered to be imminent.

I would never have imagined in 1991 or 1992 that it would be such a painful, frustrating, disappointing and disillusioning experience to see urological services throughout Northern Ireland reach adequacy, at least for the demand, if not the need. In 1996, BAUS recommended a consultant : population ratio of 1:80,000. This was accepted by the Department of Health at Westminster, in 1997, as the standard to be aimed for in England and Wales. I participated in a Review in Northern Ireland in 1998, and chaired by Dr. Hall, then Principal Medical Officer. Due to Northern Ireland having a younger age profile than England and Wales, the Department insisted that it would aim instead for a ratio of 1:100,000, and to have reached that standard by 2008! It would appear from 'Models of Future Delivery' that the BAUS recommendation of 1996 may now be considered an appropriate hallmark of consultant numbers in Northern Ireland, as a whole. Meanwhile, in 1999, the Urological Manpower Committee of the European Board of Urology reported that the mean ratio in the 33 member, associated and affiliated countries was 1:54,000. That calculation excluded all office urologists. That ratio has since fallen to 1:45,000 by 2005.

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'. When a region is served by a singular specialist department, service inadequacy in a sense does not exist, as it is invisible, as the specialists do not work in the locations where it is visible. And so for years, it is entirely possible to have a 'first class' but grossly inadequate service. This centralising force can be powerful and influential, tempting but deceptive. The alternative attempt to proceed towards adequate capacity by establishing specialist services in locations where none have previously existed, and enhancing those which do exist, may be resisted and frustrated by several 'interests', from general surgeons with an interest in urology, to Medical Directors and Chief Executives, to Trust Boards and Health Boards, to the Department of Health, and with urologists with their own vested interests scattered along the way. It would appear that the pursuit of quality and that of quantity are perceived to be in endless conflict. The first casualty of limited resources has always been quantity, and those who have made those 'difficult decisions' to sacrifice quantity always assuaged by the reassurances given that they have ensured that the limited services provided are 'first class', 'world class', 'gold standard'.

However, the need for the long narrative has little to do with the conflicting demands of quality and quantity, of which you are entirely au fait. I believe that it is vitally important that you fully appreciate that the dominant factor in the development of specialist services outside of Belfast, ab initio to date, has been the existence of a few trainees preferring to be appointed to consultant posts outside of Belfast. I did not apply for a post at Craigavon Area Hospital in 1992 because it was advertised. In fact, the post would never have materialised without my commitment to apply. Similarly, the post at Altnagelvin Area Hospital was advertised in the rare belief that a highly desirable appointee actually wanted to be appointed there, and to stay there. Indeed, when Mr. Kernohan began services in Coleraine, there was not even a post to go to. The development of services in all three locations has been chiefly frustrated by the preference of the overwhelming majority of potential applicants to be appointed to posts in Belfast or other cities in UK and Ireland.

It had been intended that centralisation of complexity would have been facilitated by the introduction of a two-tier training, producing consultant urologists after three years of training, and consultant urological surgeons after six years. Thankfully, in my view, it took only a short time for those committed to this concept, to realise and acknowledge that the concept was flawed. Now, we have reverted to a five year training programme, and with the option of applying for one additional year in a fellowship. Future training will be substantially similar to that of previous years, and possibly structurally better. I would expect that the overwhelming majority of competitive, ambitious, future trainees will complete fellowships, either in UK or elsewhere. I believe that urological departments in hospitals in rural Northern Ireland will face the same difficulties in recruitment and retention of consultants in future years as in past years. If those departments are to become deskilled, I fear that those difficulties will become impossibilities.

I have been advised that the number of trainees in UK is expected to significantly exceed the number of available posts for some years to come, and thus reassured that the prospect of unemployment on completion of training should ensure that all posts will be filled. If so, I fear once again that Colchester will come before Craigavon. I believe that there is a significant risk that the future status of urological service provision outside of Belfast will be so relegated.

It is for all of these reasons that I believe that the Regional Review of Urological Services should not arrive at any conclusions that put at risk the gains which have taken so long to achieve.

It may come as a surprise to read that I found much in 'Improving Outcomes in Urological Cancers' of merit. However, I do have grave concerns regarding the weakness of the evidence, particularly that upon which empirical recommendations are made regarding institutionalised work load. I am profoundly concerned that the authors saw fit to do so, even though they had reported that 'little direct research has been carried out on the organisation and delivery of services...Research designs which might be regarded as of relatively poor quality for evaluating a clinical intervention, may therefore be the most reliable available for assessing the organisational issues'. I would strongly recommend that you read 'Volume-outcome relationship in surgical urology: myth or reality?' by Erik K. Mayer et al., in the British Journal of Medical and Surgical Urology, Volume 1, Issue 2, September 2008. The authors report that the 'methodological quality of volume-outcome research does not appear to have vastly improved...with the implication that, at best, existing study design is only modest. This potentially limits the transferability of existing studies' reported correlations to clinical practice, and also raises the question whether much of the volume-outcome relationship will be voided by more methodologically robust research'. In particular, there are strong justifications for dissociating volume-outcome relationships pertaining to individual surgeons from the volume-outcome relationships pertaining to the institutions in which they work. In fact, more recent awareness of the multitude of factors contributing to institutional outcomes would question the legitimacy of that association in the first instance. Yet, the chief recommendation pertaining to complex pelvic surgery relates to the institution rather than the surgeon! I believe that the selective referral hypothesis is the determinant of individual volumes and outcomes in Northern Ireland, and should remain so.

Similarly, and with particular relevance to Northern Ireland, I do not believe that there is robust evidence to combine radical prostatectomy with radical cystectomy in institutionalised complex pelvic surgery. Apart from the fact that they both involve viscera in the anatomical pelvis, and that radical cystectomy includes removal of the prostate when performed in the male, they have little else in common. They are performed for radically different pathologies, with different urgencies, in very different patient cohorts (for whom geographical access have relatively different import), with entirely different complication and adverse risks, and requiring entirely different surgical experience and expertise. Cystectomy performed for bladder cancer may not always necessitate being radical, may be sexuality-preserving, and followed by orthotopic bladder replacement or by continent diversion. I do therefore find it somewhat alarming and deeply worrying that urological cancer service provision in Northern Ireland would be compelled to be compliant with Guidelines which give precedence to institutional volumes of two different operations for different

pathologies in different patient cohorts, without any justifying evidence, while relegating the experience (volume) of individual surgeons to a secondary status of transitional import, and their expertise to that of hypothetical aspiration. As there is no statutory or similarly binding obligation to be compliant, I would indeed agree that one should be pragmatic and sensible in the application of the Guidelines.

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.

I believe that the above configuration would largely preserve the current skill status at Altnagelvin Area and Craigavon Area Hospitals, without compromising the future enhancement of Belfast City Hospital. I do also believe that it would enhance the rationale for the Three Team Model of Regional Service Delivery.

Whilst I believe that the Three Team Model will probably become the preferred model, it does remain my view that urological need at Antrim Area Hospital will not be adequately met by providing outreach services of an outpatient, diagnostic and day surgery nature alone. If a presence is to be provided 7 days per week, the only point of so additionally doing is to be able to provide emergency and urgent care. Such will inevitably require inpatient surgery. It is my view that such surgery should be provided at Antrim Area Hospital, and that it would not be appropriate to have to transfer such patients to Belfast City Hospital. Therefore, it is my view that two or three consultants should be appointed to Antrim Area Hospital, irrespective of the Model option chosen. If part of Team East, those appointments may be of greater immediate priority than the next two appointments at Belfast City Hospital.

While all of the contents, views and recommendations contained in this letter are mine and mine alone, I can advise you that I have discussed my views with my two colleagues at Craigavon Area Hospital, and that they are supportive of my recommendations. In seeking your consideration of them, I do earnestly believe that these recommendations, and any others, should be submitted to another meeting of all consultant urologists early in the New Year. I therefore formally request that the above recommendations be so,

Yours most sincerely,

Aidan O'Brien,
Consultant Urological Surgeon.

100.7126264.1

Aimee Crilly

From: Young, Michael <[redacted]>
Personal Information redacted by the USI
Sent: 26 November 2012 11:13
To: Connolly, David; O'Brien, Aidan; Pahuja, Ajay; Glackin, Anthony
Subject: RE: Emergency list

What exactly is this = completely unaware of this Will investigate MY

From: Connolly, David
Sent: 25 November 2012 12:30
To: O'Brien, Aidan; Pahuja, Ajay; Young, Michael; Glackin, Anthony
Subject: Emergency list

Hi,

Was anyone aware of the way that emergency lists are now running? What I was told is 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 prioritised. Just slightly annoyed that this seems to have happened without any input from the other specialities which also use the emergency list.

David

THE

FUTURE DEVELOPMENT

OF

UROLOGICAL SERVICES

SUMMARY

During the past 30-40 years, Specialist Urological Services in Northern Ireland were concentrated in the Regional Urological Service at Belfast City Hospital, Belfast. In 1992, the Southern Health and Social Services Board recognised the need to provide a locally based, Specialist Urological Service. As a consequence, a Consultant Urologist was appointed to Craigavon Area Hospital in July 1992. Since then, the urological requirements of the Southern Area's population increased so rapidly that a second Consultant Urologist was appointed by Craigavon Area Hospital Group Trust in December 1995.

This document provides an outline of the nature and extent of urological services currently being provided by Craigavon Area Hospital Group Trust for purchasers of services for the Southern Area's resident population. It also defines the extent to which the demand for urological services far exceeds the extent to which those demands can be met by the current level of service provision. Increase in the size and length of waiting lists also clearly defines the rate by which the demand for urological services continues to increase. The future concentration of urological cancer service and of urinary stone disease management at Craigavon Area Hospital will only all the more contribute to the ever increasing demand for urological services.

The overriding ambition of the trust for the future provision of urological services is to provide services of the highest international standard, in a manner which is most readily accessible to patients, and in a manner which is both efficient and cost effective for purchasers, always in pursuit of the optimal clinical outcome for the maximum number of patients. In line with current national guidelines, the population of the Southern Area requires a service provided by at least 4 Consultant Urologists, with a full compliment of supporting service staff. Such staff will include the appointment of a Clinical Assistant or Staff Grade in urology as well as the appointment of Nurse Practitioners, the latter facilitated by the joint appointment at University of Ulster of a Lecturer Practitioner in urological nursing. By so doing, the Trust is particularly committed to the development of more clinically efficient and cost effective methods of delivering urological assessment, investigation and management. The recent decision of the Trust Board to support the provision of on-site ESWL reflects strongly its commitment in this area.

In addition to the development of urological services of the highest standard, the Trust as its Department of Urology are strongly committed to the further development of education and training of junior urologists and of urological nursing staff. In addition, through the establishment of CURE, the Trust is wholly committed to supporting the further development of urological research.

BACKGROUND

Until the 1950s, Urological Surgery in Northern Ireland had a characteristic which it shared with many other areas of surgical practice that were not regarded as distinct and separate surgical specialties. This characteristic was that urological care was provided throughout the province by General Surgeons. Since then, many areas of surgical practice such as Neuro Surgery, Cardiac Surgery, Thoracic Surgery and Plastic Surgery, have long since become areas of specialist expertise concentrated in specialist departments. Specialist Urological Surgery saw its development evolve at Belfast City Hospital, during the late 50s and 60s. Up until the early part of this decade, specialist Urological Surgery remained concentrated at what became known as the Regional Urology Service at Belfast City Hospital, Belfast. During that period of over 30 years, the Regional Urological Service at Belfast City Hospital developed into a large specialist department, led by 6 Consultant Urologists, who contributed to the development of renal transplantation, in addition to establishing a tertiary referral centre for Urological Surgery for the Province. However, throughout the rest of Northern Ireland, the care of patients suffering from urological pathology, was still being provided by General Surgeons, with in many cases, limited training and expertise in Urological Surgery.

By 1992, the Southern Health and Social Services Board had concluded that there was a need to develop a specialist urological service, located in its area, for its resident population. A beginning was made in the process of that development by the appointment of a Consultant Urologist to Craigavon Area Hospital in July 1992. During the following 3 years, it became equally apparent that the need for urological services far exceeded that which could be provided by a single Consultant Urologist. A second Consultant Urologist was therefore appointed by Craigavon Area Hospital Group Trust in December 1995. In January 1997, the Department of Urology at Craigavon Area Hospital obtained approval from the Specialist Advisory Committee in Urology to have one Specialist Registrar post for urological training.

GENERAL DESCRIPTION OF CURRENT SERVICE

Even though the urological service provided by the Trust has developed, particularly with the appointment of a second Consultant Urologist, the need for urological services by the resident population of the Southern Area has far exceeded the service that can be provided. Particularly as a consequence, urological services have thus been targeted at those patients in most need of urological care. Whilst an analysis of the urological pathology necessitating inpatient care does not adequately portray a global view of the spectrum of urological problems suffered by patients, such an analysis however does focus of the areas of urological pathology that services are concentrated upon. These core services can readily be categorized into urological oncology, urinary tract stone

disease, urinary tract infection and lower urinary tract dysfunction inclusive of urinary outflow obstruction secondary to prostatic pathology.

Urological oncology comprises over 40% of inpatient admissions. The 3 main areas of urological oncology that are managed by the department are those of renal cell carcinoma, prostatic carcinoma, and both upper and lower urinary tract transitional cell carcinoma. It is worthy of note that it is increasingly our experience that the Department of Urology at Craigavon Area Hospital Group Trust is increasingly functioning as a urological cancer unit for the Southern Area, and as a consequence, radical surgery for carcinoma increasingly occupies a growing proportion of operative time.

Urinary tract stone disease comprises over 20% of inpatient admissions. The management of urinary tract stone disease has to date been largely restricted to either endoscopic or open surgical methods. With the introduction of on-site ESWL to Craigavon Area Hospital in the coming months, the management of stone disease will change considerably and will increasingly attract referral of patients for management of stone disease by Purchasers outside of the Southern Area.

Adult inpatient urological beds are located in ward 2 south in Craigavon Area Hospital, at which location, urological services, including videourodynamic assessment studies are largely based. Paediatric inpatient urological beds are provided in the paediatric ward at Craigavon Area Hospital. Daycase flexible cystoscopies are conducted in the Day Surgical Unit, there being one session of flexible cystoscopies conducted each week. Two outpatient urological clinics are conducted each week in the outpatient department of Craigavon Area Hospital, in addition to out-reach urological clinics in both Banbridge and Armagh Community Hospitals. There are 2 urological clinics in each of these out-reach locations each month.

Referral of patients by Purchasers from outside of the Southern Area comprises less than 5% of total referrals. GP Fundholding Purchasers from within the Southern Area refer approximately 15% of total new outpatient referrals to our department. Finished Consultant episodes pertaining to elective inpatient admission of patients from GP Fundholders comprises 18% of the total elective finished Consultant episodes. Similarly, 12% of all flexible cystoscopies are conducted on patients from GP Fundholding Practices. Nevertheless the Southern Health and Social Services Board continues to purchase over 85% of total urological services provided by the Trust.

The services as outlined above are provided by two Consultant Urologists, a Urological Registrar, a Senior House Officer, a Pre-Registration House Officer in addition to some clinical and on-call commitment provided by a Clinical Research Registrar. In addition to leading the provision of the above services, the 2 Consultant Urologists are actively involved in a structured teaching and training program for junior medical staff. All medical staff in the Urological Department have worked closely with senior nursing staff in the Department over the past years

to promote techniques and methods of imparting clinically appropriate information to patients both at inpatient and outpatient levels, so that patients are increasingly aware and better informed of their underlying condition and the management of it. Both Consultant Urologists are actively involved in lecturing to very many different groups including Nurses, GPs, Health Visitors, Incontinence Advisors and Health Centre Nursing Staff.

ACTIVITY

The average number of inpatient episodes in urology over the past 3 years is approximately 1,150. The projected total number of finished Consultant inpatient episodes for the current year is 1,166. It is projected that the total number of daycases (flexible cystoscopies) will approximate to 700 cases. The projected total number of outpatient episodes at all 3 outpatient locations will exceed 4,700.

There are currently 18 adult urological inpatient beds and 2 paediatric inpatient beds, allocated to the Urological Department. The projected inpatient through-put per bed this year will be 58. The Urologists have 4-6 operating sessions made available per week, in addition to one flexible cystoscopy session per week.

Waiting lists for both inpatient and daycase management continue to increase in size. There were 451 patients awaiting inpatient admission in January 1997, an increase of 51% since March 1996. Patients have been awaiting inpatient management as far back as May 1993. There were 370 patients awaiting flexible cystoscopies in January 1997, an increase of 42% since March 1996, patients awaiting flexible cystoscopic investigations since November 1995. There were 75 patients awaiting urodynamic assessment in January 1997 an increase of 94% since March 1996. These figures not only confirm that the urological need far exceeds the potential of the current service to meet that need, but that the need is growing much faster than the service developed. The rapidly increasing urological need cannot be ignored by any Purchasers. Urological services provided by the Trust require further urgent development in order to meet a rapidly increasing need.

DEVELOPMENTS

The Collins' Report of 1990 recommended that there should be one Consultant Urologist for every 100,000 populatation. Each such notional Consultant Urologist should preferably be based in a Urological Department, staffed by 2 or 3 Consultant Urologists, servicing a population of 200,000-300,000. The Department of Health accepted these recommendations of the Collins' Report for England and Wales in 1992. As every attempt has been made to increase the numbers of Consultant Urologists in England and Wales since then, it has become increasingly apparent during this process that the objective being aimed for, was itself inadequate. The British Association of Urological Surgeons have

since recommended in 1995 that there should be one Consultant Urologist for every 80,000 population. This recommendation has since been accepted for the Department of Health for England and Wales. There are currently only 8 Consultant Urologists for the total Northern Ireland population of 1.6 million. Northern Ireland would require Consultant services provided by 20 Consultant Urologists in order to meet the above objectives. By the time Northern Ireland as a whole moves towards that objective, it is generally believed that it will become realised that Northern Ireland will require a Consultant Urological compliment similar to that which pertains throughout most of Western Europe, one Consultant Urologist per 50,000 people. One important factor which will promote and necessitate such a significant increase in the number of Consultant Urologists in Northern Ireland will be the increasing centralisation of cancer services as defined in the Campbell Report.

The Southern Health and Social Services Board Area had a resident population of 297,000 at the last census of 1991. This population is not only set to increase in total but significantly, is predicted to see an increasing proportion of elderly people amongst its population, a group of people who will require increasingly urological services. Undoubtedly, by currently accepted standards, the populatation of the Southern Area requires a urological service provided by 4 Consultant Urologists. The concentration of urological cancer services and on-site Lithotripsy at Craigavon Area Hospital, will ensure that a Department staffed by 4 Consultant Urologists will be a minimal requirement. It is therefore expected that the Trust will appoint a third Consultant Urologist in 1998.

Concurrently, the Department is critically examining methods of implementing changes in clinical practice to ensure that services can be provided more effectively and efficiently. The emphasis in this area will be to implement methods of more rapid and more accessible patient investigation and non surgical management. It is the intention of the Department to introduce as rapidly and as practically possible, nurse lead assessment clinics in the clinical areas of symptomatic prostatic disease, haematuria, incontinence, impotence and infertility. It is the firm commitment of the Department to see the implementation of a prostatic assessment clinic during the current year, and a one stop haematuria assessment clinic during 1998. These developments will coincide with the introduction of Nurse Practitioners who will play a critical primary role in patient assessment and in the co-ordination of that assessment.

The decision by the Trust Board to support the introduction of on-site Lithotripsy during the current year will ensure an increased referral for stone management to Craigavon Area Hospital. This too has been identified as an area for the application of a Nurse Practitioner in the co-ordination of stone management.

By the time on-site Lithotripsy has been established, an increasing feature of the urological services will be those of increased flexible cystoscopy sessions, urodynamic sessions, in addition to Lithotripsy. It is the belief of the Department that

such services will be optimally provided by the appointment of a Staff Grade or Clinical Assistant in Urology. Therefore, by the end of 1998, the Department expects to see appointed, a third Consultant Urologist, a Clinical Assistant or Staff Grade in Urology and Nurse Practitioner.

The developing Department of Urology at Craigavon Area Hospital is totally committed to contributing fully to urological training and to the education and training of urological nurses. As the Department moves in the direction of being staffed by 4 Consultant Urologists, it is expected that the Department will obtain SAC approval for 3 Specialist Registrar training posts. The commitment of the Department to urological training is reflected strongly in the fact that the Trust has funded the appointment of a Clinical Research Registrar, most of whose time is spent in urological research for the third consecutive year. The Trust has also played a critical role in the establishment of CURE (Craigavon Urological Research and Education) whose objective is to promote and fund urological research conducted by both medical and nursing staff.

Formalised structured urological nurse education and training is non existent in Northern Ireland. The Trust is currently committed to the appointment of a Lecturer Practitioner post in urological nursing in conjunction with the University of Ulster. In so doing, the Trust is wholly committed to supporting and facilitating the Development of formal, structured urological nurse training and education, not only in the Southern Area but throughout Northern Ireland.

ISSUES FOR PURCHASERS

The dominant fact facing all Purchasers is that of the rapidly increasing demand for urological services, not only in the Southern Area, but throughout Northern Ireland. The Southern Area specifically requires a service provided by at least 4 Consultant Urologists with full supportive staff. It is fully appreciated that Purchasers will have to purchase increased urological services from within a finite budget. However, the Purchasers cannot ignore that no other demand for acute hospital services have increased more rapidly than that for urological services during the past 5 years. Not all of this increase is due to a new demand not previously existent or met. Much of the apparent increase is as a consequence of a less urological service being provides by General Surgeons as was the case previously, particularly as specialist urological services are introduced locally. In addition, it would be very much in the interests of Purchasers to fully support changes in urological practice as have been outlined above, changes which will ensure that urological services will be provided less expensively per head of population.

ISSUES FOR PROVIDERS

Urological services throughout the Southern Health and Social Services Board Area are currently provided by Specialist Urologists at and from the Department or Urology at Craigavon Area Hospital. In addition, however significant quantities of service are also provided by General Surgeons at Daisy Hill Hospital, Newry and at South Tyrone Hospital, Dungannon. As urological cancer services become concentrated at Craigavon Area Hospital, and as stone management becomes centralised at Craigavon Area Hospital with the introduction of on-site lithotripsy, progressively less urological services will be and should be provided at other hospitals within the Southern Area.

ISSUES FOR PATIENTS

Since the introduction of Specialist Urological Services at Craigavon Area Hospital in 1992, the resident population of the Southern Area have become increasingly aware of the potential significance of genito-urinary tract symptoms. This increased awareness has been facilitated through the medium of increased awareness on the part of General Practitioners since the introduction of Specialist Urological Services. As greater media attention is directed particularly at mens' health issues, the general awareness of the resident population is certain to increase. As patient awareness increases, increased pressure will be exerted by the general population on Purchasers to purchase increased, more accessible, more efficient urological services on their behalf.

AMBITIONS FOR THE FUTURE

The overriding ambition of the Department of Urology at Craigavon Area Hospital is to provide a service of the highest standard, as effectively and efficiently as possible, to the resident population of the Southern Area, so that the optimal clinical outcome can be achieved for the maximal number of patients. In order to achieve this ambition, the services currently being provided and purchased from Craigavon Area Hospital Group Trust, require urgent and significant expansion. It is the ambition of the Department and of the Trust to ensure that these objectives are achieved with the minimum cost implications to all Purchasers.

Moreover, the Trust and its Department of Urology are fully aware that increased and improved urological services can only be achieved by paying full attention to aspects of training and education of both urological and nursing staff. Both the Trust and the Department are wholly committed to support a flourishing Academic Department as well as a clinical service.

These Developments will result in an ever increasing concentration of inpatient urological services at Craigavon Area Hospital. However, the Trust is wholly committed to extending and expanding the outreach facilities provided from Craigavon

Area Hospital. With the appointment of 4 Consultant Urologists, it is intended that outreach, outpatient clinics will be conducted at Daisy Hill, Banbridge, Armagh Community and South Tyrone Hospitals. In addition, the Department of Urology will be particularly flexible in examining ways of providing daycase urological surgical facilities at both Daisy Hill and South Tyrone Hospitals in the future. As these developments do take place, the traditional provision of adult and paediatric urological services by General Surgeons will be progressively eliminated.

Lastly the Trust and its Department of Urology will critically and positively examine methods of increasing the sharing of urological care with community based, primary health care providers. Such developments should include established protocols for urological assessment and for urological follow up.

[redacted]

MARCH 1997

Southern Health
and Social Care Trust

Medical Directorate

Our Ref: PL/RF

12 April 2009

PRIVATE AND CONFIDENTIAL

Mr A O'Brien
Personal Information redacted by USI

Dear Mr O'Brien

Re: Southern Trust Clinical Excellence Awards 2008/09

The Local Clinical Excellence Awards Committee met on 23 March 2009 to consider all Consultants who submitted an application for a Clinical Excellence Award.

I am very pleased to formally confirm that as a result the Committee have decided that you should receive one award. The effective date of the award is 1 April 2008, and the necessary adjustment will be made to your salary.

Yours sincerely,

Personal Information redacted by USI

P.G. LOUGHRAN
Medical Director (obo)
MR EDWIN GRAHAM
Non-Executive Director SHSCT/
Chair Clinical Excellence Awards Committee

CC Zoe Parks, Medical Staffing Manager, Trust Headquarters, Craigavon Area Hospital

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI Fax: Personal Information redacted by USI Email: Patrick.loughran Personal Information redacted by USI

Department of Urology
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

18 January 2010

Dr. Gillian Rankin
Interim Director of Acute Services
Southern Health and Social Care Trust
Craigavon Area Hospital
Craigavon
BT63 5QQ

Dear Dr. Rankin,

It was with shock and disbelief that we learned from you on Monday 11 January 2010 that the Trust had appointed a Locum Consultant Urologist, without any consultation with us and without our participation in due process of appointment. It remains for us incredible and untenable the excuse that one of us could not be contacted when the appointment was apparently made, during the third week of December 2009. In addition, we can only conclude that the failure to inform us until Monday 11 January 2010, was with intent, rather than oversight.

Previous appointments of Locum Consultant Urologists have always been conducted in consultation with, and with the active participation of, us in the due process of the construction of job descriptions, advertising, short listing and interviewing. This involvement has proven to be an indispensable component in the time – honoured method of ensuring that any appointee is qualified and adequately experienced for the post, with the ultimate objective of ensuring, so far as is possible, patient safety. In our collective experience and awareness, the manner in which the Trust has made this appointment is unprecedented.

Our concerns regarding the manner of appointment have been completed on review of the appointee's curriculum vitae. It would appear to us that the appointee did not have urological training in specialist urological departments, or in a specialist urological training programme. Since 1998, he has been employed as a Locum or Temporary Consultant General Surgeon in various locations in Ireland. Therefore, it would appear that the appointee is neither trained or qualified to be a Urologist, as a consequence of which he has not been employed as one.

As urologists, we too find ourselves unable to support the Trust's appointment, and incapable of advising the Trust on his deployment.

During the past year, and despite our expressed concerns, the Trust proceeded with its ward reconfiguration, resulting in compromised inpatient care and safety as feared, in addition to significantly diminishing the specialist status of our department. Compliance with the loss of radical pelvic surgery as proposed by the Regional Review of Adult Urological Services similarly has the potential to compromise patient care and safety, and will certainly diminish the status of our department further. The capacity to provide enhanced urological services in the future is entirely dependent upon the ability to recruit and retain specialist staff, and that is entirely dependent upon the attractiveness of the department's current status at any point in time. We would earnestly request that the management of the Trust seriously reflect upon its actions and proposals before any prospect of a future has been completely eliminated. If it is the case that only a General Surgeon can be appointed, we fear that we may have already arrived at that point,

Yours Sincerely,

Mr. Mehmood Akhtar.

Mr. Michael Young.

Mr. Aidan O'Brien.

Cc: Dr. Patrick Loughran, Medical Director, SHSCT.

20th November 2009

Heather Trouton
Assistant director of Acute Services

Dear Heather

We were grateful that you facilitated a meeting to discuss the ward changes instigated four months ago. It certainly gave the opportunity to voice concerns and put forward our thoughts. I did find it rather unusual and frankly perturbing that an individual from the floor was able to score out one of the proposals. We have had the opportunity to further reflect on the discussions and therefore wish to put forward our thoughts and requirements.

The Urology Service requires a singular completely autonomous nineteen bedded Urology Unit with its own Ward Manager and Sister. This is not unprecedented as it existed before and in fact there are examples of this currently being available in the new configuration. We also have to be mindful of the expected expansion in the Urology Service. The recent external urology review for Northern Ireland clearly documents a requirement and in fact a stipulation that there is a Urology Unit.

This is our opportunity to now get it right, so to speak, and it is unlikely that we will be able to avail of yet further changes. There will indeed be the expectation that staff changes between the wards will be occurring in any case and therefore the principal of wanting as little movement as possible is not a particularly strong argument.

It is not entirely clear that admitting emergencies to all wards is going to solve the current issues. Options to increase emergency bed numbers would undoubtedly be advantageous. Since we have lost surgical bed numbers, full utilisation of existing beds should be a prime goal.

An autonomous Urology Unit can indeed be attained by several plans, however our proposal for the ward configuration is indeed very valid. This proposal is that: we have a nineteen bedded Urology unit, defined ENT and the other surgical sub-specialties having their clinical areas also staffed by the appropriate nurses, and an admissions ward to ensure the patients are admitted on time. The area of short stay is less understood. A clear definition of twenty three hour and short stay needs to be embraced.

We appeal to you to consider and reflect again on this proposal. This configuration would be:

- 3 South having the Urology Unit on one side,
the other side of 3 South being ENT with breast surgery and short stay.
- 4 North housing gastrointestinal and emergency
- 4 South having vascular, general and emergency surgery. On the other side of the ward would be the Admissions Unit with twenty three hour stay.

This enables the vast majority of General Surgery to be on the one floor. This would provide the advantage of keeping the admissions and twenty three hour stay unit open continuously and catering for a full week to include the planned weekend work considerations. The ENT and breast admissions would be directly to their own specialised unit. This would ease the load on the admissions ward, where there would be a focus on the principal of twenty three hour surgical patients. Also the principal of a 'clean' surgical floor combined with potential future quality issues may well be an attractive proposition for the breast surgeons. The top floor would therefore concentrate the emergency surgical patients which will aid the medical and nursing staff. This principle also would cater more for the potential weekend workload.

We do believe that this proposal for a configuration is as valid as any other. The primacy of a urology unit in a defined area, staffed by urologically trained nurses with a ward sister and a urology manager is absolutely essential.

Yours sincerely

MRA Young MD FRCS(Urol)

COMMENTS AND CONCERNS REGARDING PROPOSED JOB PLAN

In preparation for Meeting of Facilitation

There are several areas of concern arising from the proposed Job Plan, giving reason for my being unable to agree to it. These are

- Inadequate time for administration relating to direct patient care
- Lack of lunch / rest breaks
- Specialist clinics on Friday mornings
- Availability whilst on – call
- Date of effect of Job Plan

Inadequate time for administration relating to direct patient care

The total amount of time allocated, in the proposed Job Plan, to administration relating to direct patient care is grossly inadequate for the provision of an effective, efficient and safe service, and is markedly divergent from the reality of the total time required. Moreover, the severity of that inadequacy is reflected in there being days when no time at all is allocated for administrative tasks that cannot or should not be deferred. Indeed, the Job Plan includes weeks when several days will pass before time is allocated to administration that needed to be carried out previously. In order to appreciate the totality of administration required, I have detailed below the range of administration required of the Job:

Arrangement of Admissions and Attendances

This consists of the arrangement of all

- Inpatient admissions
- Admissions to Day Surgical Unit
- Flexible cystoscopies
- Urodynamic studies
- Ward attenders for
    - Intravesical therapies
    - Intravenous therapies
    - Trial removals of catheter

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

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

2.1 Please give a short description of your work, including the different types of activity you undertake	The work includes elective and non-elective inpatient operating, elective day case operating, and non-operative management of inpatients admitted electively and as emergencies. This provision entails an extended, ten hour, inpatient operating session each week, in addition to two, elective, day surgical sessions each month. Outpatient activity includes conducting one, general urological, outpatient clinic per week at Craigavon Area Hospital and one, general urological, outpatient clinic per month at each of Armagh Community Hospital, Banbridge Polyclinic and South West Acute Hospital. As a consequence of commitment to urological oncology, I conduct an Oncology Review clinic at Craigavon Area Hospital each week, in addition to providing a one-stop urodynamic service once weekly. 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 each GP, and other specialists to whom a case may be referred, receives that communication one day later.
2.2 List your main sub-specialist skills and commitments / special interests	Urological Oncology Lower Urinary Tract Functional and Reconstructive Urology Paediatric Urology
2.3 Please give details of any emergency, on-call and out of hours responsibilities	I participate in a 1 in 4 on-call rotation I provide additional elective operating sessions at weekends Virtually all administrative work in conducted out of hours
2.4 Please give details of out-patient work if applicable	As detailed above, I conduct one clinic per week in non-oncological urology at Craigavon Area Hospital, one similar clinic per week at an outreach location and two clinic sessions per week in urological oncology, or a combination of urological oncology and urodynamic studies.

Name: Aidan O'Brien GMC Number: 1394911 Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.7.3 List any work you undertake for regional, national or international organisations.	Lead Clinician and Chair of Northern Ireland Cancer Network Site Specific Group in Urology External Assessor to the Royal College of Surgeons in Ireland for Specialist Registrar Appointments in Urology in Republic of Ireland
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Provision of expert medicolegal reports.

CURRENT JOB PLAN

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

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.

ADDITIONAL INFORMATION

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

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.

Aimee Crilly

From: Trouton, Heather [redacted]
Sent: 18 July 2013 16:32
To: Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc: Corrigan, Martina; Leeman, Lesley; Burns, Deborah; McCorry, Monica; Dignam, Paulette; Glenny, Sharon; Clayton, Wendy; Hanvey, Leanne; Troughton, Elizabeth; Cowan, Anne; Robinson, Katherine; Carroll, Anita
Subject: Todays meeting

Dear All

Thank you Aidan and Tony for seeing us today at very short notice. Michael I appreciate you had [redacted] and Ajay that you were on annual leave but Aidan and Tony have said that they will fill you in on discussions had.

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. To make that happen Martina / Sharon will provide an up to date waiting list for a monthly meeting where patients will be actually scheduled to lists by the team of consultants to ensure that the long waiting patients are continually been listed in chronological order. The first meeting of this will take place tomorrow afternoon at 3.30 pm. (of course slots will be left for red flag and clinically urgent patients)

2. It was agreed that all vasectomy referrals will now be triaged to the vasectomy service led by Paul Hughes in DHH. For the 16 vasectomy patients currently listed, these will be transferred to Paul's service with immediate effect.

3. The current triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar system to that used in 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. We plan to explore this further.

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 . To that end as advised I am preparing a paper which clearly sets out our current service constraints which I will share with you. As discussed we agreed that we need to come up with a short, medium and long term strategy as to how we are going to deliver the whole service inclusive of ICATS to deliver the volumes required. All ideas are required even those that may appear quite radical , at least for discussion. I know Debbie has been trying to get such a meeting set up to discuss the Urology Service.

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.

Thanks again and feel further face to face meetings on such operational issues would be very valuable.

Heather

Corrigan, Martina

From: Aidan O'Brien [redacted]
Sent: 17 August 2014 23:08
To: Young, Michael; Corrigan, Martina; [redacted] Glackin, Anthony; Haynes, Mark; [redacted] O'Brien, Aidan; odonoghuejp [redacted] [redacted] Suresh, Ram; aglackin [redacted]
Subject: Re: 'Capacity'

Martina et al,

I too take this opportunity to share my condensed reflections regarding the Sullivan challenge.
In doing so, I greatly welcome Michael's email of this afternoon.

Firstly, I believe that 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!
I believe that I am correct in asserting that this is the first time since 1992 that this has happened.
Whilst I acknowledge that there were times when development was facilitated, notably by the Trust, equally well I have vivid memories when our advice, requests and pleas were undermined by Clinical Director, Medical Director, Director of Acute Services, Chief Executive, Director of Public Health and Board.
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 or could be provided.
On this occasion, we have not only been provided with that opportunity, but additionally with the possibility that we have been granted the power to manage demand.
I still personally believe that this is the most important aspect of this new opportunity.

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.
I also believe that it is crucial that we appreciate that we are being requested to design such a service which will be provided by both primary and secondary care.
My only criticism of the thought processes that we collectively may have had to date, is that we have been more occupied by the configuration of the service that we in secondary care will provide, rather than the universality of care.

I believe the future design should therefore be based upon three conceptual planks:

- Demand Management, achieved by increasing investigation and management in primary care, thereby reducing referral to secondary care
- Advanced Triage rendering the the subsequent processing of assessment and management in secondary care to be maximally predictable
- New Clinic: the processing legitimate referrals to secondary care in such a effective, safe and efficient manner that it can be determined whether the patient requires further assessment or management in secondary care, or discharged to primary care for further assessment or management or neither.

I believe that demand management is the foundation upon which we can build a sustainable service.
I have absolutely no doubt that we should be able to achieve a significant reduction in demand, as manifest in the number of referrals, and I would venture to say that the speculated reduction of 20% is an underestimate.
I asked a retired (and excellent) GP just yesterday why chronic / recurrent urinary infection in females was not investigated and managed adequately in primary care.
His reply was instant and stark: it was because they had not been told to do so by those in authority, such as ourselves.
I have no doubt that we can agree upon how male and female LUTS, male and female infection, male and female abdominal pain suspected of being related to the urinary tract, erectile dysfunction etc., could be investigated and managed in primary care.
In each and all of these clinical presentations, there will be thresholds above which referral is not only justified, but warranted.
We have already agreed on some clinical presentations.
I believe that we can work progressively on others.
When we have done so, we should then dictate to primary care what to do in each scenario.

Angela Kerr

From:
Sent:
To:

-----Original Message-----
From: Aidan O'Brien < Personal Information redacted by the USI >
To: mfordham Personal Information redacted by the USI
Sent: Mon, 26 May 2014 19:57
Subject: Draft Narrative Report of Stock-take of Regional Review of Adult Urological Services in Northern Ireland

Dear Mark,

I received a copy of your Draft Report on Saturday, with the advice that you would welcome comments for discussion. I do hope that it is appropriate to do so, and as they say on X Factor, I do so in no particular order.

- I do think that the concept of ignoring or transgressing Trust Board boundaries did have merits and continues to do so. For example, we in the Southern Trust have assumed the provision of urological services for County Fermanagh since January 2013. For the first time, the population of this county has a urological presence in the county, even though it consists only of all day, outpatient clinics, twice monthly to date. On conducting these clinics, you appreciate how critically significant distance is for a proportion of patients needing care. I believe that this factor may not fully be appreciated by decision makers in Belfast, even though officially it is entirely concordant with Transforming Your Care. With recent consultant appointments, our next priority will be to establish flexible cystoscopy lists, followed by day surgical lists.

- However, the three team model simplistically and naively glossed over some significant inadequacies. For me, the greatest inadequacy in urological services in Northern Ireland has been the lack of a urological service based at Antrim Area Hospital. I find it incongruous that an acute hospital of the stature of Antrim Area Hospital should not have a urological department / service based there. To my mind, it should be completely irrelevant in which Trust area it is located, or by which Trust it is managed, or how proximate it is to Belfast. However, I do believe that the establishment of the three team model has allowed that inadequacy to remain unaddressed. More specifically, it coming under the umbrella of Team East has allowed the provision of urological services at Antrim Area Hospital to remain as nothing other than a minimal, outreach service. Therefore, I believe that the establishment of service based at Antrim Area Hospital, by the appointment of two urologists there in the first instance, should be the first priority. If two can not be recruited, then I believe some redeployment should be explored.

- It would appear that there has been a lack of urgency or commitment to the establishment of an adequate service based at Altnagelvin Area Hospital, as related in your report. I believe that this too should be a funding priority, that the service at Causeway Hospital should be an outreach service, and that more consultant time currently spent at Causeway Hospital could be deployed to Antrim Area Hospital to help establish the service there.

- The issue of the amalgamated on-call arrangements by Team East is a no brainer. I would never have participated in such on-call arrangements. The Ulster Hospital and Belfast City Hospital should have its own on-call arrangements.

- I am party to a submission which you may have already received from Brian Duggan concerning the future provision of Female Urological, Reconstructive and Prosthetic surgical services in Northern Ireland. I too was concerned by the view in your report that Reconstructive and Prosthetic services may need to be exported. I was all the more concerned to learn in recent days that a recently proposed commission of some such procedures remaining on waiting lists at Belfast City Hospital since the departure of Brian Duggan to the Ulster Hospital less than one year ago, and to be carried out by him at the Ulster Hospital, and for which the latter had made the necessary preparatory arrangements, had then been cancelled, following concerns raised by Belfast City Hospital, and exported. If this has been the case, I believe it would never have arisen if Brian were still at Belfast City Hospital, and the issue of provision of such services would not have appeared in your report, as it would not have been an issue at all. It would appear that my colleagues at Belfast City Hospital are of the view that some services cannot be provided elsewhere in Northern Ireland if they cannot be provided at Belfast City Hospital, and that HSCB may be accepting of that view. If that is case, I believe that it will have lasting consequences, as it will do more to diminish the prospects of recruiting staff than any other measure. I believe instead that there should be an ongoing review of skills and competencies throughout Northern Ireland to ensure that they are maximally utilised.

- It would appear that there is an inadequacy of theatre capacity everywhere. Utilisation of available theatres had been increased by ourselves and other specialties at Craigavon Area Hospital in recent years, by extended days and operating on Saturdays. It has been my experience that the balance between operating and other activities has changed remarkably over these past two decades. Twenty years ago, I availed of four to six operating sessions per week, and one clinic. Now, I have two or three operating sessions per week, and four clinics. Appointing more consultants will not necessarily solve the waiting times for surgery. I believe that Trusts could increase theatre utilisation even further.

- Whilst use of the robot in radical prostatectomy has been shown to enhance operative ease, visualisation and perioperative outcomes, there has been no evidence to date of improved oncological outcomes, and recent literature has reported that the jury remains out on the cost-benefit analysis. Whilst I am supportive of the endeavour to have robotic - assisted surgery available in Northern Ireland, it would not be my first priority in next expenditure.

- In so far as I understand them, I agree with your views on SABA etc. With the current system, if it cannot be counted, it cannot be allowed to take place, and that does indeed stifle innovation. For example, if on receiving a letter of referral of a patient with haematuria, I could telephone the patient to advise that I am requesting a CT Urogram which will have been done when the patient attends for flexible cystoscopy in 8 days time, then the whole diagnostic process has been expedited, and clinical outcomes will hopefully have been improved. Slavish adherence to BAUS recommendations made over a decade ago has been equally torturing, and stifling of innovation.

- I do believe that we should return to the practice of having Clinical Research Fellows as a means of attracting potential trainees to urology, of enabling them to undertake research and audit, in addition to providing some clinical sessions, thereby addressing some of the lack of staff grades. We used to have two such Fellows at any one time. All but one attained higher degrees, and are now consultant urologists throughout the UK. Whilst in their posts, they were contracted to provide a maximum of three clinical sessions per week, in addition to participating in on call rota, the rest of the time absolutely protected for research and audit. With two in our department at any one time, their contribution to clinical service provision was significant. Regrettably, the demotion of research in training resulted in their demise. I believe the HSCB should be advised to be supportive of their resurrection.

- Lastly, I am particularly appreciative of your drawing attention of the 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,

Aidan O'Brien

Angela Kerr

From:
Sent:
To:

-----Original Message-----
From: Aidan O'Brien <aidanpobrien [redacted]
To: mdhaynes [redacted]; myhillsboro [redacted]; aidan.obrien [redacted]
Michael.Young [redacted]; ksureshraman [redacted]; anthony.glackin [redacted]
CC: aglackin [redacted]; odonoghuejp [redacted]; martina.corrigan [redacted]
Sent: Sun, 6 Jul 2014 21:46
Subject: The Vision

Dear Mark et al,

I reply predominantly to your email of 27 June 2014.
I too believe that the greatest challenge is to implement changes designed to reduce referrals so that our capacity has some chance of meeting it.
One query that I had with your preamble was the number of referrals from other consultants, including A&E, from our and other hospitals?
I am not particularly surprised that it is 1000 per year.
If it is, then your calculations are incorrect, as there would be 5,900 new referrals per year.
While some would require admission, rather than an outpatient consultation, the number of referrals cum consultations required is higher than 4,900 per year, and the inadequacy of our capacity all the greater.
I agree that the first priority of our 'vision' is, in effect, to have general practitioners investigate and management much greater numbers of patients in primary care.
I don't think we should get bogged down, in the first instance, in having other consultants/hospitals following the same investigation/management/referral protocols as GPs.
Let's tackle the 4,900, and leave the 1,000 for another day.

Secondly, in doing so, I think we should not be considering the one-stop clinic as an alternative to maximising the investigation and management of patients in primary care.
I believe that we have become victims of the ready availability of the one-stop clinic.
The availability of one-stop clinics just lowers the threshold for referral.
In fact, I believe that the availability of the one-stop clinic is an open invitation to primary care to bypass all investigation and management, as secondary care will do all.
So, it does not matter whether it is one stop, or three stops, we are still doing the work!
Of course, I distinguish this from being able to deal definitively in a singular consultation/visit when that is required.

In your draft addressing demand management, these are some thoughts.
You pose the question in each section 'What tests would it be reasonable to demand of a GP?'
I appreciate that it will sound like semantics typical of O'Brien, but language can be important.
Demanding tests of a GP infers that we want the GP to do more of the investigation for us before he/she refers the patient.
Instead, I believe that our frame of mind is to advise the GP which tests are advisable for them to have done on their patients to arrive at their diagnosis and to guide their management of their patient.
All of the investigation and management of patients will be carried out by their GP, except for those things that they cannot undertake.
For example, if a 60 year old man presents to the GP reporting frank (sorry, visible) haematuria, then the GP will request a CTU amongst other investigations.
That a GP is not allowed to order a CTU when a CTU is appropriate, is ludicrous!
That such a patient has to be referred to a hospital to have a CTU requested, and for the hospital to delude itself into thinking that something great has been achieved by the provision of a one-stop clinic at which everything but the CTU is performed, is equally ludicrous!...my view!!

Secondly, and without going into specifics, whilst I would be even more radical with the default position of having patients maximally investigated and managed in GP land,

I would lower some of your suggested thresholds for referral, eg., I would hope that no man would have to have a residual volume of 500 mls before having the benefit of bladder outlet surgery.
There will be much to discuss and agree upon in each of the clinical domains.

If we can get this priority right, we will be well on our way to blowing Dean away!

Aidan.

-----Original Message-----
From: Mark Haynes [redacted]
To: MY <myhillsboro[redacted] O'Brien, Aidan [redacted] Young, Michael [redacted] Ram Suresh [redacted] Glackin, Anthony [redacted]
CC: Ram Suresh [redacted] Tony Glackin [redacted]; John O'Donaghue [redacted] (Aidanpobrien[redacted]
Sent: Thu, 3 Jul 2014 9:22
Subject: Fwd:

Thanks Michael, Morning all.
Many of the ideas outlined concern on the ground delivery of service and I certainly would suggest that all will be incorporated into the 'vision'.
One critical aspect of delivery with regards new referrals is how we want this service delivered. There are two opposing models;
1) Single stop service for all.
In this model, all referrals would be seen in the same clinic with an aim to perform diagnostics / some interventons at the same visit (Flexi, TRUS, TROC, plain film radiology, USS) such that the majority of patients are discharged or listed for intervention at that visit.
2) Multiple services for specific symptom categories.
This model would be a continuation of current practice with clinics for LUTS, female Urology, raised PSA, Haematuria etc. Again with aspects of diagnostic work performed at this visit.
With regards these models, (1) offers significant advantages in terms of service design and capacity planning as the broader the scope of patients seen, the greater the services ability to manage peaks and troughs of demand. The risk of multiple subspecialty clinics is empty slots (as highlighted in Michaels list about the haematuria / prostate services).
Once we have agreed on a model of service delivery for new referrals we then need to look at each idea for service delivery and work out how these will fit into this model - eg how will consultant of the week fit into the one stop op service? Will they have a 10 patient clinic each day (delivering 50 new patient slots per week)? Similar with non - consultant staff, how will the SPRs fit into this model of service delivery? What will the role of any GPwSI or staff grade Dr's be (if we can appoint)?
We also need to consider how we will deliver FU. Will this be along subspecialty lines? For me I think the answer would be yes and then each service would need to consider how it is to be delivered - Nurse led, protocol defined telephone FU for oncology? Stone service FU with XR arranged and phone FU?
Michael - are we likely to be able to use all next Thursday morning to work / talk through Ideas? I am happy to pull together some stuff around demand and capacity management for then, do you (and others) want to pull together some models for delivery for consideration?
Mark
Sent using CloudMagic

On Tue, Jul 01, 2014 at 7:29 PM, MY [redacted]

> Just a few thoughts
>
> Sent from M.Y. iPhone
>
> Begin forwarded message:
>
> > From: "Young, Michael" [redacted]
> > Date: 1 July 2014 15:22:36 BST
> > To: "myhillsboro[redacted]
> >
> > To forward to urology team
> >
> > MY
> > The Information and the Material transmitted is intended only for the

> person or entity to which it is addressed and may be Confidential/Privileged
> Information and/or copyright material.
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> Any review, transmission, dissemination or other use of, or taking of
> any action in reliance upon this information by persons or entities
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> Southern Health & Social Care Trust archive all Email (sent & received)
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> Corporate Governance and to facilitate FOI requests.
>
> Southern Health & Social Care Trust IT Department [redacted]
>

I have to confess that I despise the term.
Far more importantly, Michael has appreciated that all the activities expected of the Urologist of the Week cannot possibly be carried out in one session each morning, and with a fixed commitment in the afternoon.
I argued against this notion years ago, and I do so again, and for the following reasons.
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.
The second priority is inpatient care.
I disagree that it should be left to the discretion of the Urologist of the Week how to participate in inpatient care.
I disagree that the morning ward round be conducted by the registrar alone.
I believe that all inpatients should be seen by the consultant and registrar conducting a ward round together.
Such practice will be best practice for the training of trainees, as well as reassuring all the other consultants that their patients will have been assessed and managed each day by a consultant.
I also believe that the Urologist of the Week should endeavour to operate on as many people as is possible during their acute inpatient stay, including for example TURP following admission for acute urinary retention etc.
Then there is the Hot Clinic and Advanced Triage, never mind MDM preview for Mark, Tony and me when we are Urologist of the Week.
I could also add that it had previously been estimated that each Cancer Unit would require one consultant session per week to ensure that remote PSA tracking be conducted effectively.
The Hot Clinic could also entail dealing with the many queries that come in each day from patients and GPs.
I believe one of the great merits of Urologist of the Week is to ensure that all of the others are undisturbed in conducting their commitments.
To be available for all emergencies, to attend to all acute presentations (which is really what a Hot Clinic is all about), to provide inpatient care in the detail, to operate, to conduct advanced audit, to address queries, to provide advice.....it is risible that this could be conducted in one session each day!
We have been talking about Urologist of the Week for years.
I do not understand our fear of doing it fully and properly, like as if we are not entitled to do so.
Let's go for it, and make the most of it for our patients.

Lastly, I believe that we should not concern ourselves too much with regard to having all the i's dotted before any presentation to Mairead tomorrow, or even to Dean on 01 September.
Following tomorrow's meeting, we will have one week to bring together a document of consensus regarding the main principles underlining our collective view of how to move forward to a future sustainable service.
All of the work done by all to date, and led by Mark and Martina, will be included.
I have no doubt that every detail of the future sustainable service will not be available for the document to be submitted to Dean, and I will have no inhibition in advising him that much work and sacrifice has been put into the effort to date.
I also believe that some of the detail which will be included he may not like to hear...above all, the future requires a significant increase in operating capacity!

So, I, like Michael, congratulate those who have done the work to date, and at all hours of day and night, and sacrificing annual leave in doing so.
The rest of us are hugely indebted!
With so much work done, I believe we can and should move forward with confidence to meet with Dean in September, and probably again in November, and hopefully forge a relationship of trust and influence in the development of a future sustainable service,

Aidan.

-----Original Message-----
From: Young, Michael [Michael Young's email address]
To: Corrigan, Martina < [Martina Corrigan's email address] ; [Aidan O'Brien's email address]
[Aidan O'Brien's email address] ; [Michael Young's email address] Glackin, Anthony
[Anthony Glackin's email address] ; Haynes, Mark [Mark Haynes's email address]
[Mark Haynes's email address] ; O'Brien, Aidan [Aidan O'Brien's email address]
[John P O'Donoghue's email address] Ram Suresh [Ram Suresh's email address]
[Ram Suresh's email address] ; Tony Glackin
[Anthony Glackin's email address]

Aimee Crilly

From: O'Brien, Aidan [redacted]
Sent: 24 November 2015 22:40
To: Corrigan, Martina; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: RE: 62 Day ACTIVE Longest Waiters Breachers.xlsx

Dear All,

While we continue to perform very well with regard to cancer patients, I have to confess that I am increasingly aware of the cost paid by non-cancer patients,

Aidan.

From: Corrigan, Martina
Sent: 24 November 2015 08:29
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: 62 Day ACTIVE Longest Waiters Breachers.xlsx

Dear all

Please see attached Regional information on Cancer patients for each Trust.

Regards

Martina

Martina

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

Telephone: [redacted]
Mobile: [redacted]
Email: martina.corrigan [redacted]

Angela Kerr

From: O'Brien, Aidan <Personal Information redacted by the USI>
Sent: 28 June 2016 01:39
To: Corrigan, Martina
Cc: Elliott, Noleen
Subject: RE: ** Urgent ** CAH Main Theatre Lists Tuesday 28th June until Friday 1 July 2016

Martina,

I find this situation to be quite unacceptable.
I spent almost all of last Thursday rigorously reviewing all 275 patients on my inpatient waiting list, as of 28 April 2016, allocating categories of five categories of urgency to them, as opposed to the inadequate two categories formally allocated.
In doing so, I equated Red Flags patients, those cancer patients 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, including your own, to have their admissions expedited.

In doing so, I accommodated Patient 130 Patient 130 has had a stent in her right ureter awaiting replacement since 20 July 2014.
She is a brittle diabetes, is on haemodialysis four times weekly in Tyrone County Hospital which has been requesting for months that it be replaced due to recurring infections.
I contacted the staff of the Renal Unit at Tyrone County Hospital to request that they reschedule her haemodialysis from Wednesday morning to this morning which they have accommodated.
They have arranged at my request to do up to date blood tests before this morning's haemodialysis, and after, so we will not have to repeat them as her peripheral access is poor.
They have arranged transport for her, at my request, to ensure that she is back home by 1 pm today.
On Friday last, I contacted the GP Practice manager who has arranged for her to be picked up by ambulance at 2 pm to bring her to Ward 3 South this afternoon.
On the assumption that she will be able to go home on Thursday, The Renal Unit have arranged to reschedule her haemodialysis to Friday and Saturday morning.
Yet Patient 130 is not a Red Flag patient!

Patient 16 has had a stent in his left ureter for relief of left ureteric obstruction due to metastatic bowel carcinoma since 02 April 2015.
He has been awaiting its removal, reassessment of his left upper tract and possible replacement since then.
His oncologist, Dr. Harte, has requested that his admission be expedited due to increasing back pain attributed to it.
But Patient 16 is not a Red Flag patient either!

I could go on but I do not have the time to do so in the early hours of the morning.
I have already invested many hours in selecting and arranging in detail the admissions for surgery on Wednesday.
At this point in time, I do not have the stomach to contact people tomorrow to renege upon the commitments I have entered into with them.
And I do not wish to have anyone do so on my behalf.

The last patient on my list, Personal Information redacted by the USI severing his urethra, which I realigned, since when he has both suprapubic and urethral catheters in situ.
He will be attending his daughter's graduation tomorrow at 11 am.
He agreed to forego the graduation lunch to be admitted in the hope of being able to have catheters removed.
But he does not have any flag at all!

As I have said before, we cannot continue like this.
From now on, I will not,

Angela Kerr

From: Hunter, Catherine [redacted]
Sent: 02 July 2016 02:41
To: Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram; Hall, Sam; Korda, Marian; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Cc: Sheridan, Patrick
Subject: Leaving 3 South

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

I am just sending this email out to inform you all of my resignation, I know that you all probably know this already but I felt it would be remiss of me not to drop a few lines upon leaving.
I have enjoyed my sort time in post and have tried my best to keep patient safety and quality of care to a maximum at all times. This however has been one of the main reasons that I felt I needed to move on, as I'm sure you our aware we have quite a few vacancies on the ward and with the posts not being filled and being expected to keep beds open to maximum I have felt at times that patents quality of care was not present. This is through no fault of the nurses at ward level as they all try very hard but it's extremely difficult to deliver good quality care when the staff feel so exhausted and morale is in their boots.
I WILL BE SENDING Mark Haynes an email explaining in more depth how I think management could take the ward forward , but I fear that management just don't want to know.
I wish the ward success in the future and hope that the staff get the recognition that they so deserve.
Regards
Catherine Hunter

Aimee Crilly

From: Hunter, Catherine [redacted]
Sent: 12 November 2015 09:18
To: Gishkori, Esther
Cc: Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Hall, Sam; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Subject: 3 South Concerns
Attachments: Ward 3 South Concerns 2015.docx

Importance: High

Esther,

I refer to my recent e-mail correspondence with Heather Trouton, a copy of which I attach.
I have also raised my concerns with Mr Hayes and at his request, I have copied this e-mail to all the consultants attached to the ward.
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.

Catherine Hunter
Ward Manager
3 South

Angela Kerr

From: O'Brien, Aidan [redacted]
Sent: 12 July 2016 11:12
To: Cunningham, Andrea
Cc: Corrigan, Martina; Heaney, Linda; Rankin, Christine; Elliott, Noleen
Subject: Clinic Templates

Andrea,

The reason I raised this issue recently has been the progressive increase in the total numbers of patients attending my outpatient clinics.
The issue is the total number!

The clinic in SWAH is a good example.
When established in January 2013, it was a clinic conducted during the morning only, with 8 patients appointed, with the first appointment at 10 am.
As it seemed such a waste not to spend a longer period of time there, I had the clinic doubled, in 2014, to 8 before lunch and 8 after, a total of 16 patients.
At the last clinic which I did in SWAH on 20 June 2016, 21 patients were appointed, of whom 2 did not attend.
This required me to conduct a clinic from 10 am until 5.15 pm, without a break, without anything to eat, and one cup of coffee to drink.
Then the dictation and administration begins!

The last Armagh clinic had 15 patients appointed rather than 12, to which I agreed previously.
The last review clinic in Craigavon, an extended clinic at which it had been agreed only one month previously to have 15 patients appointed, had 19 patients appointed!

Moreover, this is not a new occurrence.
It has all happened before, several times.
It has been my experience before that no one has been requested to give approval, and no approval has been given.
Patients get appointed from a range of sources, under pressures to do so, and one additional patient becomes five.
Then the patients complain to the Nursing Staff for having to wait, and both complain to the clinician for keeping them all waiting, as though it were the clinician's fault.
It has also been my experience that the only effective way of limiting the total number of patients attending any clinic has been to notify that I will not attend any clinic unless the total numbers appointed have to limited to those that I have approved.

The total numbers of patients to be appointed to clinics are as follows:

- CAOBTDUR: 12 patients (say 6PR and 6R)
- AAOBU1: 12 patients (say 6PR and 6R)
- SWAH clinic: 16 patients (I do not know the clinic code or the make-up)
- CAOBTDU: 9 patients (This is the New Patient clinic on Tuesday afternoons)

I have asked Noleen to preview all clinic during the week prior to their occurrence, to notify Appointments of any excesses and to have the total numbers appointed limited to the agreed numbers,

Thank you,

Aidan

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

be undertaking any work that is associated with your job in the Trust. You know. It is in your interest obviously and everybody's interest to provide the information as requested to Dr Wright. And Dr Wright can then look at the measures that have been put in place to manage those patients.

…….silence ……

DR WRIGHT: So what happens next, Aidan, is we will write to you with a summary of ~~the (inaudible)~~ what ~~you~~was said today and to outline the process and give you the ~~(inaudible)~~various copies of the frameworks that apply. And (inaudible) in touch with during the next week or two. I am sure Colin will want to ~~(inaudible)~~set up an interview with you very rapidly.

~~FEMALE SPEAKER 1~~Ms HAINEY: Obviously we would encourage you as part of that --

MRS O'BRIEN: When this letter was sent in March~~,~~ …….I was unaware of that, I mean, what did the letter say in March? Do you have a copy of it? I mean, was there a time on it or ~~no~~?

DR WRIGHT: I think it used the words as soon as possible.

MRS O'BRIEN: All right.

DR WRIGHT: (Inaudible).

MR O'BRIEN: I wish I had ignored all of the other things. I just wish I ~~had. (**Pause**)~~ hadn't

…….silence…….

DR WRIGHT: Well, we are where we are with it. I think once we scope the size of the issue, which it may not be as bad as we initially think if what you are saying is right. Get the terms of reference agreed and let's get the whole thing done as quickly as we can (inaudible). I am sure there is going to be --

MRS O'BRIEN: I would have a problem with this person. I think he has -- I don't think he shares much -- what's the right word to say, he has caused Aidan problems in the past. That does not surprise me that that name is there. I have an issue with that. Do you have an issue with that?

MR O'BRIEN: He is no longer in that role anyhow.

MRS O'BRIEN: ~~He~~It doesn't matter~~.~~ ….. I am very much aware of this gentleman~~.~~ ~~(**Pause**)~~……. silence……..

~~FEMALE SPEAKER 1~~Ms HAINEY: It is a lot to take in certainly (inaudible) occupational health.

MRS O'BRIEN: It is horrible beyond words. ……. *distressed* ……

~~FEMALE SPEAKER 1~~Ms HAINEY: Would you like a glass of water, a cup of tea or coffee?

MRS O'BRIEN: No~~.~~…… I just think it is~~—~~ …….. I just think the health service, as it is

being run at the moment, I mean, I view it as an outsider and I can quite honestly say that things like this are -- this seems to be like the sticking plasters that the organisation puts in place to cope with problems without really coping with the problem itself. It's layers of bureaucracy, layers of investigation. And that doesn't solve the problems. It is only a way of —……

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. …… *silence* …… 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).~~personal responsibility…….. It is a Trust issue.~~-~~ 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 of not being able to undertake what you have pledged to do and then you spend every additional operating ~~session~~second 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 issue. It has come ~~(inaudible)~~….. I'd prefer not to be having this 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 you— …….. there's just not enough hours in the day to be faultless and ~~I~~I've 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. …… *silence*……..

—— I am devastated, Richard. …..... …*silence* …….. 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 that unusual. (Inaudible). The process it's

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 70 year 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.

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.

Ieam happy to meet to discuss timescales to implement the changes required.e

Yours Sincerely

Mark Haynes

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);

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waitin
Urology	596	208	237	225	378	173	541	212
ENT	29	1x38 19	142	64	64	23	923	80
General Surgery	113	147	75	139	437	131	901	121
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128
Gynae	28	11	168	50	26	1 x 26 6	106	44

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, [illegible] 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

Angela Kerr

From: Corrigan, Martina [redacted]
Sent: 22 January 2019 11:00
To: Hasnain, Sabahat; Evans, Mark; Hiew, Kenneth; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; McCourt, Leanne; McMahon, Jenny; ONeill, Kate; Young, Jason
Subject: FW: RF 1st Appointment Longest Wait.xlsx
Attachments: RF 1st Appointment Longest Wait.xlsx

Importance: High

Good morning

FYI

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
[redacted] (Internal)
[redacted] (External)
[redacted] (Mobile)

From: Graham, Vicki
Sent: 21 January 2019 11:44
To: Nelson, Amie; Carroll, Kay; Clarke, Wendy; Clayton, Wendy; Conway, Barry; Corrigan, Martina; Devlin, Louise; Glenny, Sharon; McAreavey, Lisa; McVey, Anne; Reddick, Fiona; Scott, Jane M
Cc: Carroll, Ronan
Subject: RF 1st Appointment Longest Wait.xlsx
Importance: High

Morning,

Please see attached updated waiting times for RF 1st OPD's.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT [redacted]

Angela Kerr

From: O'Brien, Aidan [redacted]
Sent: 07 May 2019 22:51
To: rf.appointment
Cc: Elliott, Noleen
Subject: Additional Appointments to SWAH Clinic on Monday 13 May 2019

Dear RF Appointments,

You will receive paper Red Flag referrals returned to you today, Tuesday 07 May 2019.
They include two elderly patients unable to attend CAH in immediate future.
I have requested that you arrange appointments for both of these patients at my clinic at SWAH on Monday 13 May 2019.
The patients are

- [redacted]
- [redacted]

I write as these two patients will be additional as the clinic is already full.

Thank you,

Aidan.

Angela Kerr

From: Elliott, Noleen [redacted]
Sent: 23 May 2019 09:44
To: O'Brien, Aidan
Subject: SWAH CLINIC SCHEDULED FOR THE 24th of June 2019

Aidan,

I have had to overbook the SWAH clinic. I have added 2 slots early morning to try and fit everyone in. List as follows:

09.30 [redacted] PR
09.40 [redacted] PR
10.00 RED FLAG APPOINTMENT SLOT TO BE FILLED BY RED FLAG OFFICE
10.20 [redacted] PR
10.30 [redacted] PR
11.00 [redacted] PR
11.20 RED FLAG APPOINTMENT SLOT TO BE FILLED BY RED FLAG OFFICE
11.50 [redacted] PR
12.10 [redacted] PR
12.30 [redacted] PR
12.50 [redacted] R

13.40 RED FLAG APPOINTMENT SLOT TO BE FILLED BY RED FLAG OFFICE
14.00 [redacted] PR
14.00 [redacted] PR
14.20 [redacted] NU
14.40 [redacted]
15.00 RED FLAG APPOINTMENT SLOT TO BE FILLED BY RED FLAG OFFICE
15.20 REV APPOINTMENT SLOT BOOKED BY THE BOOKING OFFICE
15.40 [redacted] NU
16.00 [redacted] PR

As you can see there are 4 Red Flag slots and 1 review slot to be filled. When filled there will be 20 patients on the clinic.

Noleen

Noleen Elliott
Mr A. O'Brien's Secretary
Level 2 (Beside Bed Lifts)
CRAIGAVON AREA HOSPITAL

Changed My Number

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dia*** [redacted]
EXTERNAL [redacted]

Angela Kerr

From: O'Brien, Aidan [redacted]
Sent: 31 May 2019 18:20
To: Corrigan, Martina
Cc: Elliott, Noleen
Subject: SWAH Clinic Template

Martina,

As you may imagine, it continues to be a struggle to be able to review all of the patients one would like to review at any clinic.
I think that I find this acutely so at SWAH clinic.
In recent months, up to twenty patients have been appointed.
I have found this to be too many, even with starting the clinic at 09.30, and has meant going right through without a break for a sandwich.
However, by starting at 09.30 am, it is possible to have 18 patients appointed, rather than the 16 for which the template has been established to date.

The current template is for 4 Red Flags, 2 New Urgent, 2 New Routine and 8 Protected Reviews.
In order to be able to review more oncology patients at the clinic, I would like to have the number of Protected Reviews increased to 10.

Therefore, would it be possible to have the template changed to the following?

MORNING	AFTERNOON
09.30	13.10
09.50	13.30
10.10	13.50
10.30	14.10
10.50	14.30
11.10	14.50
11.30	15.10
11.50	15.30
12.10	15.50

If you agree to this change, would it be possible to have it in place for the clinic of Monday 22 July 2019?

Aidan.

Aimee Crilly

From: O'Brien, Aidan [redacted]
Sent: 24 September 2019 17:22
To: Clayton, Wendy
Cc: Devlin, Louise; Haynes, Mark; Corrigan, Martina
Subject: RE: [redacted]

Wendy,

I do appreciate you providing this information.
In essence, the most important word in these documents is the discharge criterion of the procedure / review / appointment not being 'required'.
The examples provided prove again, as proven before, that the patient does not know whether the procedure / review / appointment is advisable or 'required'.
Administratively driven validation exercises are unsafe.
I note that the documents do include a provision for review of the process in September 2019.
I believe that it would be prudent to advise David Mc Cormack of our concerns.
Lastly, not all of the exercise is unsafe or inappropriate.
If the patient is deceased, has changed address, has had the said procedure performed elsewhere etc, such information would be worth pursuing.
I just think that the criterion '....is not required' should be excluded,

Enough said!

Aidan.

From: Clayton, Wendy
Sent: 24 September 2019 16:57
To: Haynes, Mark; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan; Devlin, Louise
Subject: RE [redacted]

Please see original communication from the Board to the AD's and HOS on the 16 July. I am unsure if there was communication with the primary care AMD.

We are concentrating on OPD admin validation and have nearly completed sending letters to all urgent and routine patients who are waiting over 52 weeks. If they decide they do not want their appointment then a letter is sent to their GP to advise same.

I will discuss your concerns with Louise who is the Trust led and the link with HSCB.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: [redacted]
Mob: [redacted]

From: Haynes, Mark
Sent: 24 September 2019 16:29
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

With regards the outpatient validation, what communication / agreements have been made with my primary care AMD colleagues (to whom the patients are being discharged back to) regarding the process and similarly with the clinical teams whose patients are being contacted?

Mark

From: Clayton, Wendy
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

Hi Martina

I confirm that the inpatient/daycase admin validation for urology has ceased, no letters or phone calls are being made to patients.

My team are working on the outpatient admin validation which includes urology. If no response from 2 x admin validation letters then they will discharged back to the care of the GP. This is the same process for non-responders to outpatient partial booking letters. A letter will go their GP advising same.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: [redacted]
Mob: [redacted]

From: Corrigan, Martina
Sent: 23 September 2019 06:40
To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: [redacted]

Good morning Aidan and Mark

I have copied Wendy into this email as she will be able to advise on your patients that were contacted and will also be able to assure that for Urology validation that this has ceased.

Wendy can you please assist?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal Information redacted by USI (Internal)
Personal Information redacted by USI (External)
Personal Information redacted by USI (Mobile)

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: Personal Information redacted by USI

Thanks Aidan

As I have stated before I was not aware of the process until it had started and when I became aware had requested it cease.

Where the process is administrative only (ie checking patient not deceased, and checking they haven't had it done elsewhere), then it is fine. This process went beyond that and asked if patients wanted the operation (no-one wants an operation), and then I believe offered them an opportunity of an OP review to discuss. Not only does this mean informed decisions are not possible by the patient (as no one is re-discussing the pros and cons of surgery) but is also offering something that we cannot deliver ie a timely review appointment. I believe the process also raises false hope in patients that they may get a date for their surgery in the near future.

Martina – do you know who led this work and are they able to provide the urologists with the details of all the patients who have either asked to be removed from the WL, or requested a review OPA?

Mark

From: O'Brien, Aidan
Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: Personal Information redacted by USI

Martina,

I write to you regarding this 69 year old, diabetic man who had a stone obstructing his upper right ureter in 2015.
He was managed by ureteroscopic laser lithotripsy.
He was noted to have a grossly enlarged prostate gland on endoscopic assessment.
I advised him that he would be better served by having his prostate resected.
He was placed on the waiting list on 08 October 2015.

On reviewing my waiting list during August, I noted that he had been removed from the waiting list in July 2019.

When I contacted him by telephone, he advised that he had received a letter enquiring whether he wished to remain on the waiting list, or words to that effect.
As his only symptoms was that of nocturia, he replied that he did not wish to proceed with surgery.

I requested an ultrasound scan which has since indicated that he may have recurrence of stone in his right kidney, that he has inadequate bladder voiding with a residual volume of 190 mls, and would appear to have formed a stone in his bladder.
I have again spoken to the patient by telephone, advising him of the above findings.
I have requested a CT Urinary Tract to more clarify his stone status.
He has agreed to being returned to the waiting list for admission for TURP.
I have dictated a letter to the GP requesting that he be prescribed Tamsulosin until admission for TURP, in addition to requesting optimisation of diabetic control prior to admission.

I hope that you will agree that it is appropriate that I bring such a case to your attention.
I believe that it is entirely inappropriate that non-clinical staff should correspond with patient to enquire whether they wish to remain on a waiting list, and entirely for the purpose of reducing the numbers of patients on waiting lists.
Patients have the right to decline proposed management, but should be empowered to make decisions informed by clinical advice.

I would be very reassured if this practice has been discontinued, as you had recently indicated.
I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with.

Thank you,

Aidan.

Aimee Crilly

From: Haynes, Mark [redacted]
Sent: 24 September 2019 20:44
To: O'Brien, Aidan
Subject: RE: [redacted]

In 2 weeks time I am in a quarterly liaison meeting between primary care and the trust. I can guarantee that at that meeting I will have major concerns raised to me and demands to know why I organised this – with the medical director looking to me to provide the answers. Pisses me off, but at least on this occasion I know beforehand (I didn't at the last one where a different speciality 'validation exercise' was raised).

Mark

From: O'Brien, Aidan
Sent: 24 September 2019 16:37
To: Haynes, Mark
Subject: RE: [redacted]

Mark,

I have experienced all of this many times before during these past 27 years.
The bizarre aspect of outpatient revalidation is that a letter is sent twice to the patient.
If a response is not received, a letter is then sent only to the GP advising that their patient has been discharged back to their care.
Now I know this to be a fact that the GP is of the belief that their patient has been discharged with their consent, while the patient may be oblivious to that being so!
You couldn't write the script!

Aidan

From: Haynes, Mark
Sent: 24 September 2019 16:29
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

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Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

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Cc: Carroll, Ronan
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Head of ENT, Urology, Ophthalmology & Outpatients
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Telephone:
EXT Personal Information (Internal)
Personal Information redacted by USI (External)
(Mobile)

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Cc: Haynes, Mark
Subject: [redacted] Personal Information redacted by USI

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Patients have the right to decline proposed management, but should be empowered to make decisions informed by clinical advice.

I would be very reassured if this practice has been discontinued, as you had recently indicated.
I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with.

Thank you,

Aidan.

Aimee Crilly

From: Haynes, Mark [redacted]
Sent: 24 September 2019 21:35
To: O'Brien, Aidan; Clayton, Wendy
Cc: Corrigan, Martina
Subject: RE: [redacted]

I think we will have to see the patients in OP but agree they should be reinstated on the WL.

I also agree, our colleagues also need to be made aware.

Not wishing to add to things... but, have any other specialities IPWL been validated in this way, and have the respective clinicians been made aware of this?

Mark

From: O'Brien, Aidan
Sent: 24 September 2019 17:11
To: Clayton, Wendy
Cc: Haynes, Mark; Corrigan, Martina
Subject: RE: [redacted]

Wendy,

I think that I would be happier with that.

Mark,

What do you think?
I also do think that it would be courteous if not prudent to advise Michael, Tony an John of our exchanges,

Aidan.

From: Clayton, Wendy
Sent: 24 September 2019 17:00
To: Haynes, Mark; Corrigan, Martina; O'Brien, Aidan; Hanvey, Leanne
Cc: Carroll, Ronan
Subject: RE: [redacted]

We can reinstate the patients back on the list with their original dates, would be easier for you all and contact the patients again to let them know.

Regards

Wendy

Wendy Clayton
Operational Support Lead

ATI CS/SEC
Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: Haynes, Mark
Sent: 24 September 2019 16:26
To: Clayton, Wendy; Corrigan, Martina; O'Brien, Aidan; Hanvey, Leanne
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by USI

Thanks

The removals from the waiting list all need to come to clinic for review.

I have looked through those from my waiting list and none of the decisions are free of clinical consequence, all carrying at minimum a risk of emergency admission, most a risk of gram negative sepsis, and in the case of one (staghorn renal stone, xanthogranulomatous pyelonephritis), the clinical consequence is a risk of life threatening sepsis / death. This was probably predictable given that these patients were on the urgent waiting list.

Mark

Leanne – the numbers for my patients are;

Personal Information redacted by USI

From: Clayton, Wendy
Sent: 23 September 2019 15:33
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by USI

See below comment and attached list of patients. IPDC admin validation for urology has ceased, no urology routine patients have received a letter. The attached patients are all urgents

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: Corrigan, Martina
Sent: 23 September 2019 14:41
To: Clayton, Wendy; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

Thanks Wendy

Also as per Mr Haynes and Mr O'Brien's requests below can you please update?

[redacted] *(Mr Haynes) – It was the admin IS/validation team that started this piece of work – urology IPDC urgents only, no routine patients. There were 48 urology patients that advised they did not want the surgery (attached). Patients details attached.*

I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with. ***(Mr O'Brien)*** *2nd attachment is a list of every patient of AOB's that received an admin validation letter. There were 17 patients that belong to Mr O'Brien requested to be removed. List attached.*

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT [redacted] (Internal)
[redacted] (External)
(Mobile)

From: Clayton, Wendy
Sent: 23 September 2019 11:14
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Carroll, Ronan
Subject: RE: [redacted]

Hi Martina

I confirm that the **inpatient/daycase admin validation for urology has ceased**, no letters or phone calls are being made to patients.

My team are working on the outpatient admin validation which includes urology. If no response from 2 x admin validation letters then they will discharged back to the care of the GP. This is the same process for non-responders to outpatient partial booking letters. A letter will go their GP advising same.

Regards

Wendy

Wendy Clayton
Operational Support Lead
ATI CS/SEC
Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: Corrigan, Martina
Sent: 23 September 2019 06:40
To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by USI

Good morning Aidan and Mark

I have copied Wendy into this email as she will be able to advise on your patients that were contacted and will also be able to assure that for Urology validation that this has ceased.

Wendy can you please assist?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal information (Internal)
Personal Information redacted by USI (External)
(Mobile)

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: Personal Information redacted by USI

Thanks Aidan

As I have stated before I was not aware of the process until it had started and when I became aware had requested it cease.

Where the process is administrative only (ie checking patient not deceased, and checking they haven't had it done elsewhere), then it is fine. This process went beyond that and asked if patients wanted the operation (no-one wants an operation), and then I believe offered them an opportunity of an OP review to discuss. Not only does this mean informed decisions are not possible by the patient (as no one is re-discussing the pros and cons of surgery) but is also offering something that we cannot deliver ie a timely review appointment. I believe the process also raises false hope in patients that they may get a date for their surgery in the near future.

Martina – do you know who led this work and are they able to provide the urologists with the details of all the patients who have either asked to be removed from the WL, or requested a review OPA?

Mark

From: O'Brien, Aidan
Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: [redacted] Personal Information redacted by USI

Martina,

I write to you regarding this 69 year old, diabetic man who had a stone obstructing his upper right ureter in 2015.
He was managed by ureteroscopic laser lithotripsy.
He was noted to have a grossly enlarged prostate gland on endoscopic assessment.
I advised him that he would be better served by having his prostate resected.
He was placed on the waiting list on 08 October 2015.

On reviewing my waiting list during August, I noted that he had been removed from the waiting list in July 2019.
When I contacted him by telephone, he advised that he had received a letter enquiring whether he wished to remain on the waiting list, or words to that effect.
As his only symptoms was that of nocturia, he replied that he did not wish to proceed with surgery.

I requested an ultrasound scan which has since indicated that he may have recurrence of stone in his right kidney, that he has inadequate bladder voiding with a residual volume of 190 mls, and would appear to have formed a stone in his bladder.
I have again spoken to the patient by telephone, advising him of the above findings.
I have requested a CT Urinary Tract to more clarify his stone status.
He has agreed to being returned to the waiting list for admission for TURP.
I have dictated a letter to the GP requesting that he be prescribed Tamsulosin until admission for TURP, in addition to requesting optimisation of diabetic control prior to admission.

I hope that you will agree that it is appropriate that I bring such a case to your attention.
I believe that it is entirely inappropriate that non-clinical staff should correspond with patient to enquire whether they wish to remain on a waiting list, and entirely for the purpose of reducing the numbers of patients on waiting lists.
Patients have the right to decline proposed management, but should be empowered to make decisions informed by clinical advice.

I would be very reassured if this practice has been discontinued, as you had recently indicated.
I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with.

Thank you,

Aidan.