Diane Corrigan

From: Diane Corrigan
Sent: 29 March 2011 17:25
To: Lyn Donnelly
Subject: FW: UROLOGY
Attachments: 20110311_Ltr_dcorrigan_urology_PLABlw_.doc

Lyn
For the file
Diane

-----Original Message-----
From: White, Laura [mailto Personal Information redacted by the USI
Sent: 11 March 2011 13:04
To: Corrigan, Diane
Cc: Rankin, Gillian; Mackle, Eamon; Brennan, Anne
Subject: UROLOGY

Dear Dr Corrigan

Please find attached letter from Dr Loughran in relation to the above.

Laura

Ms Laura White

Personal Assistant to

Dr Patrick Loughran

Medical Director

Southern Health & Social Care Trust

FIRBANK HOUSE

Craigavon Area Hospital

68 Lurgan Road

PORTADOWN

BT63 5QQ

Tel: Personal Information redacted by the USI

Fax: Personal Information redacted by the USI

E-mail: Personal Information redacted by the USI

P Please consider the environment before printing this e-mail.

Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Part of 28

Southern Health and Social Care Trust

Medical Directorate

[redacted]
Dr D Corrigan
Consultant in Public Health Medicine
Public Health Agency
Southern Office
Towerhill
Armagh
[redacted]

Dear Dr Corrigan

The following is an updated position of the Trust's investigation and resolution of clinical matters within our urology services, about which we have spoken and corresponded. I refer to your letter of 01st September 2010.

[redacted]
IV fluid and anti-biotic patient group

All of these patients have been formally reviewed and the clinical management of each member of the cohort taken forward within a multi-disciplinary team chaired by the Clinical Director of Surgery [nursing, urological surgery and microbiology]. Patients are reviewed if symptomatic, and then managed on an agreed clinical pathway, which is initiated by a specialist nurse. Admission to the ward is possible but only if outpatient or day case management fails – usually in cases of severe sepsis. Antibiotic use is determined by surgeon and microbiologist in agreement and in line with the Trust's guidelines. The two patients with central venous access have had the venous cannulae removed last autumn.

There are no patients therefore remaining in the old group which was treated with episodic IV fluids and antibiotics.

[redacted]
Review of cystectomies.

The Trust has already confirmed that all urology patients with the potential for radical resection of the bladder for malignant disease are referred to the Belfast Trust for definitive treatment and follow up.

Also since last September 2010 all patients with benign disease and potential for cystectomy are referred to the Belfast Trust. The Southern Trust, therefore does not do any cystectomies, and this has been the position since last September 2010.

[redacted]

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

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 07 February 2016 21:22
To: Corrigan, Martina; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: RE: Standard Operating Procedure for Fluid Management during Urology surgery

Dear All,

I suspect that any comments from me will be perceived to have been prejudicial.
However, I honestly did approach using the much hailed Olympus with a view to giving it a fair wind.
And was I bowled over?
No!
I resected two small prostates.
I found it deficient in two respects:

1. It is my understanding that there is no blended current on cutting with the result that haemostasis was inferior to monopolar during cutting
   You resect, it bleeds and you coagulate.
   This slowed the resection.
   It also had me wondering whether one would have increased fluid absorption as a consequence.

2. The rate of irrigation was much slower than with the monopolar resectoscopic, with the result that there was an intermittent fog which I had to stop resecting to wait for it to clear.

I was so glad that neither prostate was large, as I certainly would not have used the Bipolar.

The Audit asks the question whether the trialist would be 'happy' to use it.
My answer was a definite 'No'.
I will do if I have to.
I just do hope that the Operating procedure will allow me to continue to use Monopolar, as it is very much superior,

Aidan

From: Corrigan, Martina
Sent: 07 February 2016 17:55
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: Standard Operating Procedure for Fluid Management during Urology surgery

Any comments?

Martina

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

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

Introduction
in advance of
Workshop

Handling a Concern about a doctor or dentist to Maintain High Professional Standards

Zoë Parks – Head of Medical HR.
2023

WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY

Aim following workshop

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

- Provide an overview of MHPS Framework
- Set out practical steps for handling low level concerns about a doctor/dentist & understand when a concern may need escalated.
- Clarify how concerns should be reported and recorded to meet statutory needs of the Responsible Officer.
- Explore techniques to promote handling of concerns in a fair way in an open & just learning culture.

Overview of MHPS

- Introduced by DHSSPS Circular
- Effective from 1st December 2005
- Formal departmental direction require all Trusts to comply with MHPS
- MHPS incorporated into contracts of employment of individual doctors
- Legal Challenges can occur (particularly within formal process)
- Doctors in training – involve Postgraduate Dean from outset

Overview of MHPS continued

"A framework for the handling of concerns about doctors and dentists in the [HSC]"

SECTION I: Action when a concern first arises

SECTION II: Restriction of practice & exclusion from work

SECTION III: Guidance on conduct hearings and disciplinary procedures

SECTION IV: Procedures for dealing with issues of clinical performance

SECTION V: Handling concerns about performance arising from a practitioner's health

SECTION VI: Formal Procedures – General Principles

Flowcharts: Informal Process & Formal Process

Received from SHSCT on 12th April 2024. Annotated by the Urology Services Inquiry.

At the heart of the framework

Whatever the source of information, the response must be the same (MHPS para 10 intro):

1. **Ascertain quickly what has happened and establish facts**
2. **Be quick to determine if there is a continuing risk**
3. **Consider if immediate action is required to manage risk to ensure the protection of patients**
4. **Decide on action to address any underlying problem.**

At any stage:

NHS Resolution | Practitioner Performance Advice

Guidance around MHPS

- MHPS = legally binding contractual document.

1. Adhering to best practice
2. Applying a rigorous decision-making methodology
3. Ensuring people are fully trained and competent to carry out their role
4. Assigning sufficient resources
5. Decisions relating to the implementation of suspensions/exclusions
6. Safeguarding people's health and wellbeing
7. Board-level oversight

NHS England 2019

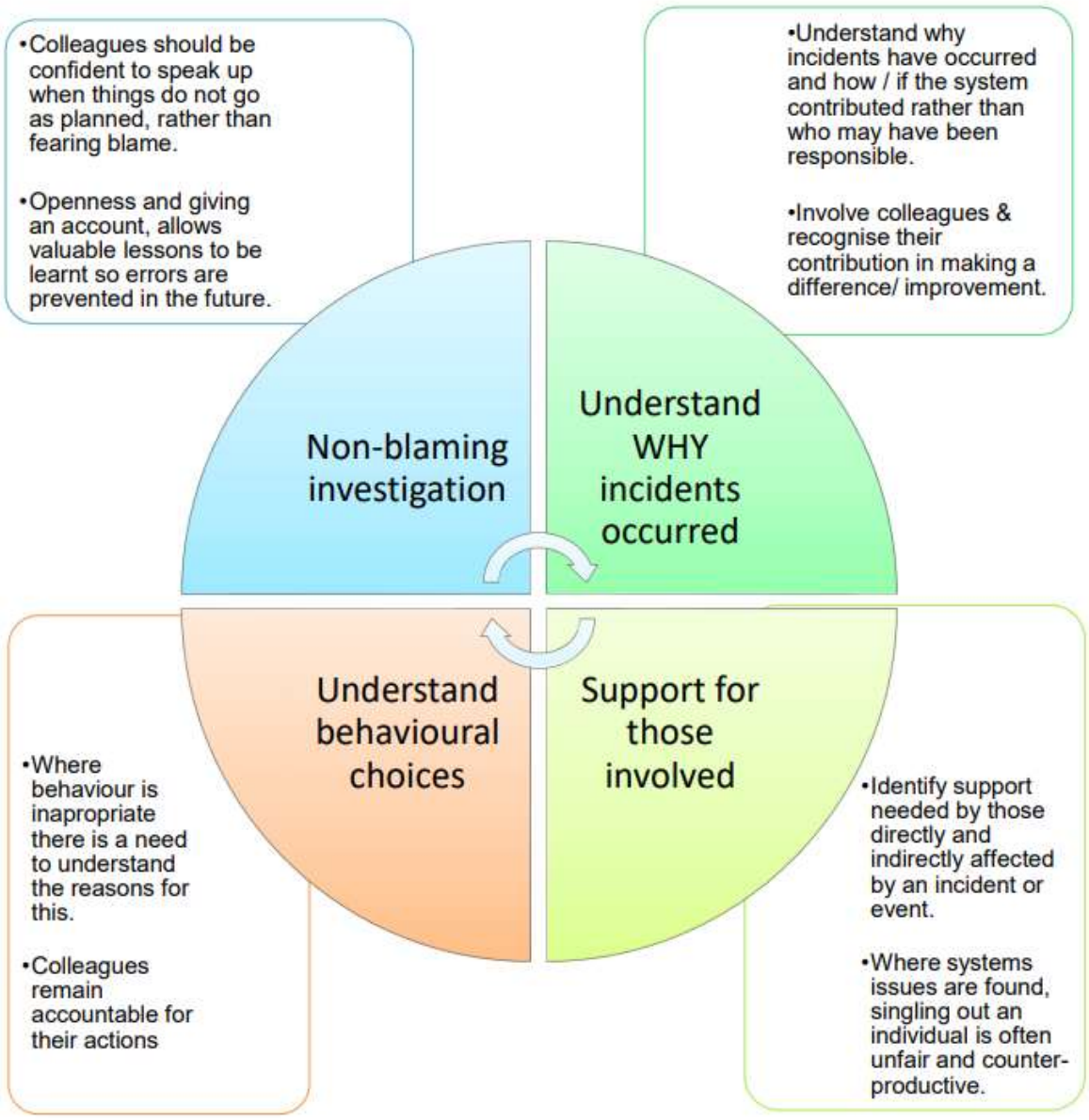
Maintaining High Professional Standards in the NHS - NHS Resolution

Exclusions - NHS Resolution

Woodview (england.nhs.uk)

GMC Link

Medical HR - Doctors-in-Difficulty-HUB (pagetiger.com)



Culture

NHS-Resolution-Being-Fair-Report.pdf

Being Fair 2 Report - Published **30 March 2023**

MHPS Section I: When concerns first arise…

- Immediate response sets direction
- Opportunity to protect, support, improve.
- Engagement a key factor.
- Immediate and ongoing assessment of risk
- Consideration of restriction/exclusion
- Involve Medical Director as RO and/or PPA/NHS Resolution

Restrictions / Exclusion

- MHPS Framework – Section II
- Imperative that exclusion is not misused or seen as only course of action.
- Two types of Exclusion: Immediate & Formal
- Subject to much debate in Case Law

E.g. Kamath v Blackpool Teaching Hospital 2021

An act of [exclusion] by an employer can constitute a breach of the implied term *where, by itself or in combination with other acts or omissions it (i) destroys or seriously damages the relationship of trust and confidence and (ii) is without reasonable and proper cause.*

> Possible Criminal or Fraud concerns

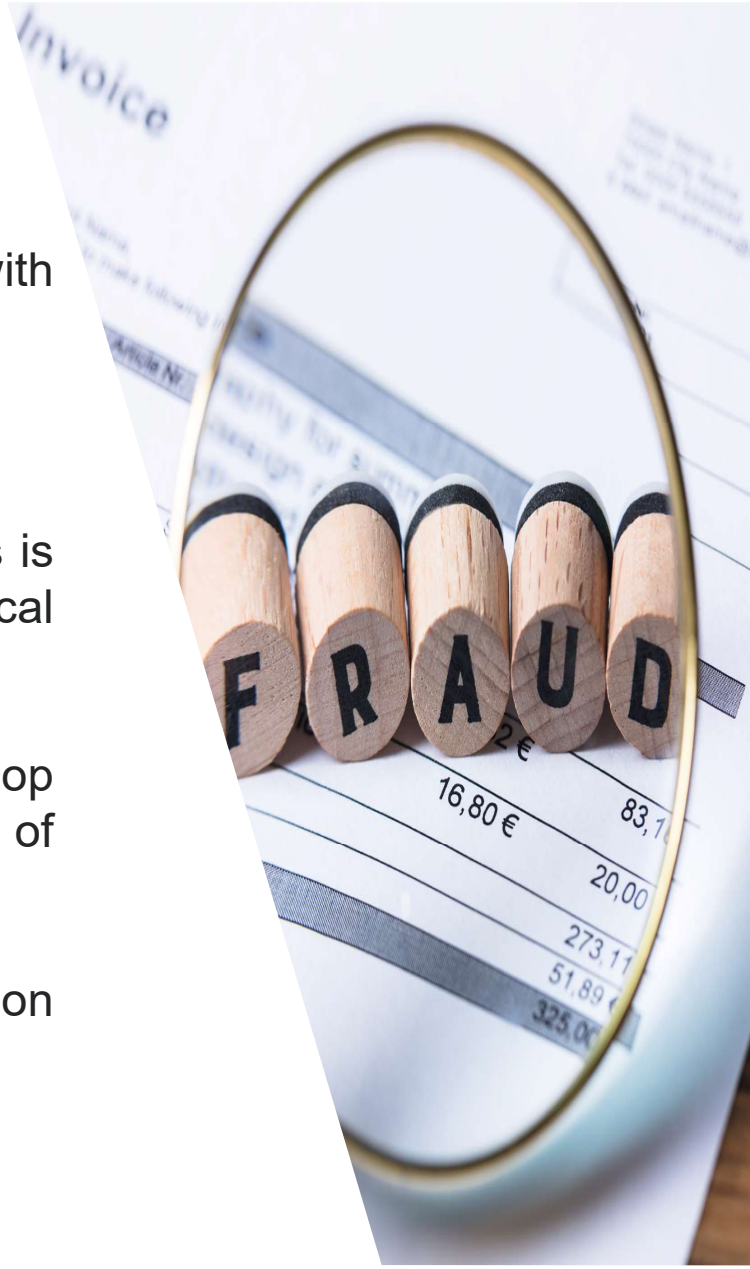
Small number of situations where ability to communicate/ engage with doctor at the outset is limited.

- Possible **criminal or fraudulent act.**

Even in these situations a conversation explaining in general terms is often possible but **only after** taking suitable advice from, Medical Director, legal colleagues, counter fraud or the police. `

Such circumstances, whilst important, are rare. Desirable to develop confidence and skills of open communication in the vast majority of cases.

- Remember: Doctor entitled to be accompanied by a companion throughout MHPS process



The Practical Steps…

1. **Prompt / Consider Risk**

2. **Exploration to establish facts**
   a. Preliminary enquiry/Screening
   b. Full formal investigation.

3. **Define and take suitable action**
   Remediation & Restorative approaches where appropriate

4. **Review & Monitor**

Remember - Record - Retain
Even if informal or no action taken

Supporting.Doctors@southerntrust.hscni.net

Received from SHSCT on 12th April 2024. Annotated by the Urology Services Inquiry.

See you at the Workshop

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

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

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 Urological 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 Information redacted 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 Information, 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 Personal Information redacted by the USI. In addition, I had undertaken to defer Personal Information redacted by the USI 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

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

penultimate day of the four week period, and that no meeting with me was scheduled to take place until after that date.
On 17 January 2017, I wrote to the Medical Director to express my concerns regarding the conduct of the Investigation to date. I requested to be advised of the identity of the non – Executive member. I requested Minutes of the Meeting of the 30 December 2016. I requested to be advised of details of when I would meet with the Case Investigator. Lastly, I requested to be advised in more detail of the reasons and justifications for the immediate exclusion imposed on 30 December 2016, so that I could prepare to offer alternatives to exclusion when I would meet with the Case Investigator. (Appendix 1: Letter of 17 January 2017).

I received a Note of the Meeting of 30 December 2016 from and approved by the Medical Director, dated 18 January 2017.

I then received a telephone call from Mr. Weir on 19 January 2017 to advise that a meeting had been scheduled for Tuesday 24 January 2017 to discuss alternatives to immediate exclusion. I did not receive any detailed reasons or justifications for immediate exclusion from the Medical Director prior to the meeting. I returned a telephone call on 19 January 2017 to clarify whether the meeting of Tuesday 24 January 2017 required me to state my case. I was assured by Mr. Weir that it was not. I subsequently received a letter from Mr. Weir, dated 20 January 2016 (sic), advising of the time and venue of the meeting of Tuesday 24 January 2017, advising that he meeting would provide me with an opportunity to state my case and to propose alternatives to exclusion.

I then received a letter from Mr. Weir, dated 23 January 2017, requesting my knowledge of the hospital charts of 13 patients and which had been tracked out to me, and which had not been included in the charts that had been returned from my home. I provided a detailed account of each patient, including those who had never been a patient of the hospital at any time, or had never been a urological patient, or had been discharged from urological review 15 to 20 years previously. One patient whose chart was tracked out to me and whose chart was missing, I operated on six months later, in July 2017, her chart made available for her admission by Medical Records in the usual fashion.

I met with Mr. Weir and with Ms. Hynds, the HR Representative, accompanied by my son, Michael, on 24 January 2017. In addition to the three issues of concern already identified, I was advised of a fourth arising from a review of TURP patients, identifying nine patients who had been seen privately as outpatients, then had their procedure within the NHS, their waiting times being significantly less than for other patients.

The Oversight Group met on Thursday 26 January 2017, concluding that immediate exclusion be lifted with effect from Friday 27 January 2017, subject to advice from Occupational Health regarding fitness to return to work, and to agreed conditions relating to work practices. I was advised of that decision by Dr. Khan, by telephone, later that day. I received written confirmation of that decision, dated 06 February 2017. The conditions relating to my return to work were detailed at a further meeting with Dr. Khan and Ms. Hynds on Thursday 09 February 2017, and I returned to work in a phased manner later that month, as advised by Occupational Health.

On 06 February 2017, I received by email from Ms. Hynds, the Note of the Meeting of 24 January 2017 with Mr. Weir.

On 07 February 2018, I met with Mr. Wilkinson, non – Executive Director, to raise a number of Concerns Regarding the Investigation Process, (Appendix 2). The Case manager replied to those concerns by letter on 24 February 2017, (Appendix 3).

On 14 February 2017, I wrote to the Medical Director, detailing a number of errors and omissions in the Note of the Meeting of 30 December 2016, requesting that amendments be made, (Appendix 4).

On 01 March 2017, I received from Ms. Hynds an acknowledgement of the letter to the Medical Director, advising that she would arrange for an amended Note to be sent to me, taking into consideration my comments.

On 06 March 2017, a list of Questions to be Asked were provided to Mr. Wilkinson, non – Executive Director (Appendix 5).

On 16 March 2017, I was provided with the List of Witnesses to date (seven persons) and the Terms of Reference. The Terms of Reference should have been provided when it was decided to have a Formal Investigation, in accordance with NCAS Guidelines.

On 28 March 2017, I submitted to Ms. Hynds a list of Amendments to be made to the Note of the Meeting of 24 January 2017, requesting that she return a copy of the amended Note.
I received no response.

On 30 March 2017, the Medical Director replied to the Questions to be Asked, and which had been submitted on 06 March 2017 (Appendix 6). In response to Question 13, the Medical Director asserted that an initial verification of the issues by the Clinical Manager was not required, as the information was being collated by Mr. Carroll and Mrs. Hogan (sic).

On 19 April 2017, I sent to Ms. Hynds an email to remind her that I still awaited an amended Note of the Meeting of 30 December 2016.
I received no response.

On 14 June 2017, I received a letter from Dr. Chada, the Case Investigator, inviting me to meet with her on Wednesday 28 June 2017. Due to my having scheduled operating that day, and my son's unavailability to accompany me, I made myself available on Saturday 01 July 2017. However, that date did not suit Dr. Chada, and the meeting was eventually rescheduled for 03 August 2017 to avoid cancellation of scheduled clinical commitments and to facilitate Dr. Chada's leave, as outlined in email correspondence (Appendix 7).

On 29 July 2017, I was provided with a list of 61 outpatient clinics which the Case Investigator had been advised had not been dictated (Appendix 8).

On 30 July 2017, I wrote to D. Khan, Case Manager, detailing my concerns regarding the Investigation to date (Appendix 9).
I did not receive a response.

On 31 July 2018, I submitted to Ms. Hynds, by email, a request for a copy of the minutes of the meeting of the Oversight Group in December 2016, a copy of the correspondence / communication with NCAS in December 2016, an amended copy of the Note of the Meeting of 30 December 2016 (previously requested), an amended copy of the Note of the Meeting on 24 January 2017 (previously requested), a copy of the Trust's Policy and Procedure regarding Triage (previously requested) and a list of the Witnesses and their Statements (Appendix 10).
I did not receive a response until 28 September 2017 when I was provided with a list of Witnesses and their Statements. I was not provided with any of the other requested documentation.

On 03 August 2017, I met with Dr. Chada and Ms. Hynds, accompanied by my son, who wished to advise that we would have considered it reasonable to expect that the Witness Statements would have been provided prior to the Meeting, to enable me to address and respond to them, but he was advised initially that he was not permitted to speak.

On 03 August 2017, I also submitted to Dr. Chada and Ms. Hynds, detailed documentation of all additional inpatient and day case operating during the years 2012 to 2016, and all additional outpatient clinics during 2012 to 2016, in addition to all additional time spent in the roles of Lead Clinician of Urology MDT and of Chair of Urology MDM from 2012 to 2016, (Appendix 11).
None of this documentation has been included in the Report of the Investigation.

At the meeting of 03 August 2017, I was provided with a list of 11 patients who had attended privately, had been added to the waiting list and had been admitted after a short time frame. I was surprised to find that another two TURP patients had been added to the list, as I was certain that only nine patients had been admitted for TURP during 2016, having previously attended privately. Upon review, it was evident that the new list provided on 03 August 2017 contained only three patients who had TURP performed during 2016, the remaining eight patients having other diagnostic or surgical procedures performed. I then reviewed all 46 patients who had TURP performed during 2016. This figure included the 9 patients who had previously attended privately and 37 who had not. The mean time on waiting list for the nine patients who had attended privately was 202 days whilst the mean time for the remaining 37 patients was 219 days. In fact, 5 (56%) of those who attended privately had waited more than 100 days while 14 (38%) of the remaining 37 patients had done so.

On 06 November 2017, I met for the second time with Dr. Chada and with Ms. Hynds to discuss the issue of the private patients. I submitted a detailed account of the management of each of the eleven patients. I also shared my conviction that an analysis of all the TURP patients of 2016 had not complied with the anecdotal allegation that those who had attended privately, had had their surgery performed after a significantly shorter period of time, and that this finding had laid those compiling the information for the Case Investigator to find patients who had had other procedures performed following prior private consultation, and who better fitted the allegation. Regrettably, I

have not since had the opportunity to undertake a similar comparative analysis for those patients and their procedures.

On 06 November 2017, I also provided a spreadsheet addressing the issue of Term of Reference 3, (Appendix 12). This clearly established that not all of the patients who had attended 51 clinics had not letters dictated, and not 61 clinics as the Case investigator had been advised by those collating the information. The total number of patients who had attended those 51 clinics had been 450 patients. Moreover, 261 patients had had letters dictated. These 261 patients were those who were more clinically urgent. This left a total of 189 patients who had not had letters dictated, and not 668 as had been advised by those who had informed the Case Investigator, and whose data the Medical Director found no need to validate. This detailed information submitted on 06 November 2017 was not included in the Report of the Investigation.

On 02 April 2018, I submitted an email to Ms. Hynds, attaching my comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2017, and my comments relating to the Statements of Witnesses, (Appendix 13). It was the earliest date that I could do so. Mindful that I had been advised that Dr. Chada had intended to begin writing the Report on 30 March 2018. I also reminded her that I still awaited amended Notes of the Meetings of 30 December 2016 and of 24 January 2018. I particularly requested that she would clarify whether it was intended to provide amended Notes, and if so, when I might expect to receive them.
I did not receive an acknowledgement or a response.

On 10 June 2018, I sent an email to Ms. Hynds, requesting an update on progress of the Investigation, and responses to the requests submitted previously, (Appendix 14). Having received her response, I determined that I would not enter into further communication. I was also most concerned to find that my comments relating to Witness Statements and to proposed Respondent Statements, submitted on 02 April 2018, may not have been duly considered in the Report which was not submitted to the Case Manager until 12 June 2018.

Investigation Report

The first comment regarding the Investigation Report is that it is entitled ‘Investigation Report under the Maintaining High Professional Standards Framework’. There has been no reference whatsoever to the Southern Trust’s Policy and Procedure for Handling Concerns about Doctors’ and Dentists’ Performance (September 2010). I have submitted my views previously concerning this issue. The Southern Trust’s Policy and Procedure was obliged of it in response to the Maintaining High Professional Standards Framework. It is the Term and Condition of Employment.

In Section 1, the report states that the team work a ‘Consultant of the Week On-call’ model, with the consultant of the week responsible for triage of all referrals during their period on-call. I believe that this is, by definition, and crucially, incorrect, and not just a matter of semantics. The model is a ‘Consultant of the Week’. As I have already described, I believe the presence or absence of ‘on-call’ in the perceptions of participants has been critical to the feasibility of triage.

In Section 4, it is stated that Mr. Mackle and Mrs. Trouton met with Mr. O'Brien on 23 March 2016. This is incorrect, as it were Mr. Mackle and Mrs. Martina Corrigan who met with Mr. O'Brien. More importantly, it is stated that Mr. O'Brien was provided with a letter detailing concerns, and asking him to respond with an immediate plan to address the concerns. This is absolutely untrue. As stated previously, Mr. O'Brien asked what he was to do in response, the answer to which was a shrugged silence.

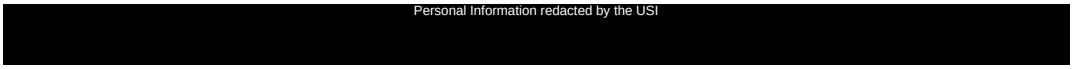
In Section 4, referring to the period April to October 2016, the Report states that considerations were ongoing about how best to manage the concerns raised with Mr. O'Brien and it was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. In addition to failing to identify those who had done the consideration and determination, the Report does not include the allegation in a Witness Statement that those who were prepared to help in a supportive manner, had been instructed not to do so.

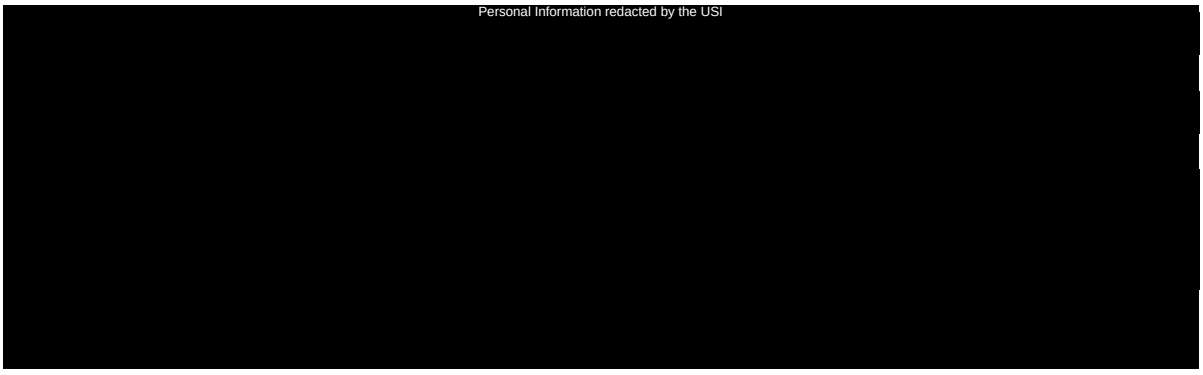
In Section 4, referring to the Meeting of 30 December 2018, the report states that Mr. O'Brien was placed on a 4 week immediate exclusion 'in line with the MHPS Framework to allow for further preliminary enquiries to be undertaken. This is of course incorrect as the instrument for doing so was the Southern Trust's Policy and Procedure for Handling Concerns about Doctors' and Dentists' Performance.

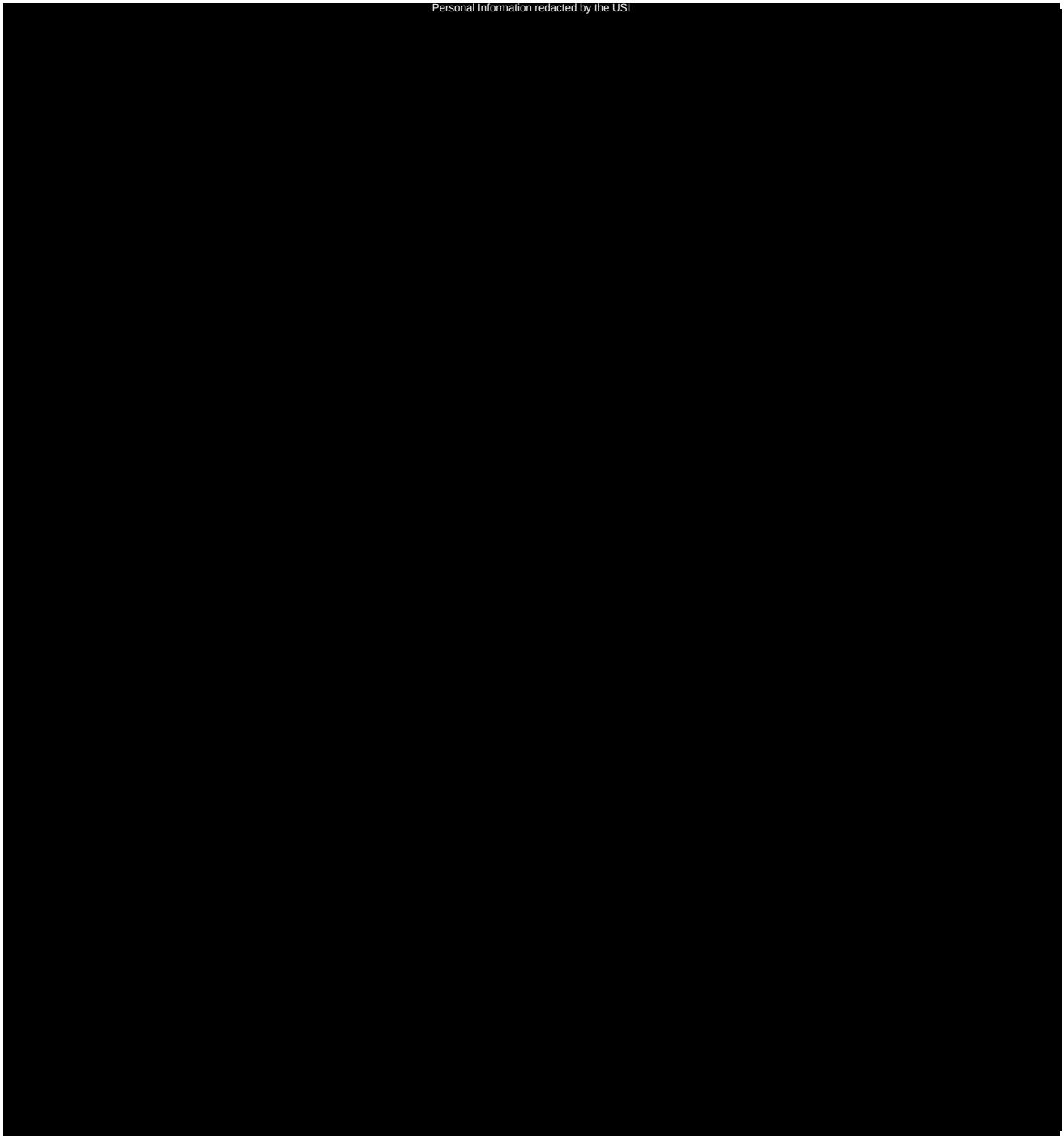
In Section 4, referring to 03 January 2017, it states that Mr. O'Brien met with Mrs. Martina Corrigan to return all case notes and all undicated outcomes. Mr. O'Brien had in fact returned all case notes on 02 January 2017 and met with Mrs. Corrigan on 09 January 2017 to return clinic outcomes.

In Section 6, the Report states that a large number of un-triaged referrals were subsequently located in an office drawer in Mr. O'Brien's office, by Mrs. Corrigan. In his review of those un-triaged referrals later upgrade to Red Flag status, Dr. Julian Johnston had been advised that the large number had been discovered there by Mrs. Corrigan. In fact, Mr. O'Brien had advised Mrs. Corrigan of their exact location.

In Section 6, Page 19, the Report listed eight patients to exemplify patients who had attended as outpatients without letters having been dictated:







In Section 8, page 31, the Report states that Mr. o'Brien's preference was that advanced triage should be done for red flag referrals only. This is untrue. As stated previously, I believe that it is even more important that advanced triage be conducted for urgent and routine referrals, if possible, in view of the waiting times for first appointments.

In Section 8, page 32, the Report states that Mr. Mackle reported that Mr. O'Brien had previously raised a complaint of bullying against Mr. Mackle in or around 2012. This is completely unture. Instead, I submitted a formal written grievance against Mr. Mackle when I discovered that he had

unilaterally advised Payroll to halve agreed, remunerative payments for additional clinical work. The grievance was upheld. I suspended further action [redacted] at the time.

In Section 8, page 36, the Report states that Mr. O'Brien acknowledged that there were 66 undictated clinic and no dictated outcomes for these. This is untrue. As stated above, the number of clinic incompletely dictated was 51, and the number of patients affected was 189. Even though this information had been submitted to the Case Investigator on 06 November 2017, the Report still includes the wrong information, and claims that I had agreed with it.

In Section 9, Page 45, the Report states that Mr. O'Brien has worked rigidly to the action plan out in place and has met all of requirements of the action plan on an on-going basis. However, this has been at considerable cost. IAs I have continued to find it impossible to complete triage while Urologist of the Week, I have had to take an Annual Leave Day on the Friday following completion of the Week to enable me to complete the week's triage. That has also resulted in a reduction in the number of cancer review clinics, normally conducted on Fridays.

Lastly, The Report states that Mr. O'Brien displayed some lack of insight and reflection into the potential seriousness of the above issues. This I would completely dispute this contention. I believe that this impression has been gained due to my disbelief at the lack of insight on the part of the Trust into the harm and risk of harm suffered by patients already on the longest waiting list. It has also been disappointing to read the Report, after 18 months of investigation, concluding that I did not agree with triage anyway.

Terms of Reference

1. Triage

I do accept that I was not undertaking triage of non-red-flag referrals. I have been clear since the outset of this investigation that I was not doing so because I found it impossible to do so. The background to that is explained above in detail.

I agree that triage is a vitally important process to ensure that patent management is initiated effectively and to ensure that patients are correctly categorised. It is my belief that some time with triage is necessary if the Consultant Urologist is to bring the value of his/her specialist expertise to the process and this means that triage becomes time consuming. I believe that it would be beneficial for the department to allocate sufficient time for the Consultants to complete triage effectively. I have raised this issue as part of my response to the SAI and I hope that the Trust will address the issue as soon as possible.

The investigation report states that the issue of concern relates to the fact that I failed to properly highlight to the Trust that I was not undertaking this aspect of the role. I accept that there are steps that I could have taken to more clearly state that I was not undertaking triage of routine or urgent referrals. I regret not having done so. That said, it is relevant to point out that senior management were aware of the fact that I was not completing Triage of non-red-flag referrals. This is demonstrated by the fact that everyone acknowledges that I repeatedly raised the fact that I found it impossible to complete triage, that they knew that triage was not being done and in fact a process was introduced to deal with the fact that it was not being done through the

implementation of the default system. I can quite honestly state that I believed that management knew that I was not completing triage.

The final point I wish to make about triage relates to the fact that I am completing triage since my return to work in February 2017. It is important that I point out that, in order to comply with management plan by returning triage within three days of urologist of the week, I have been taking a day off on annual leave following my week on call in order to use that Friday and the following weekend to complete triage. Therefore, whilst I am completing triage and I will continue to do so, it comes at a significant personal cost.

2. Patient Notes stored at Home

I accept that I had significant number of charts at my home. This was well known to the Trust. At the time of my meeting on the 30th December 2016, I had 288 sets of patients' notes at home which dated back to April 2015. 99 of these charts were for private patients. I accept that this could be considered not to be best practise. I have assured the trust that I have discontinued this practice and that I will not do this in the future.

3. Undictated Outcomes

I accept that it was sub-optimal practice to not have dictated letters on outpatient consultations in a timely manner. In particular, I recognize that this is important so that GP will be aware of the management plan.

I had endeavoured to ensure that the clinically urgent patients were dictated upon and had succeeded in doing so in the majority of cases. As stated above, the number of undictated outcomes was 189, markedly less than the 688 which was been informed to the case investigator. I had provided the documentation that sets this out. I am unaware of harm or risk of harm of any of the 189 patients who had not had letters dictated.

4. Private Patients

Initially, it was alleged that 9 TURP patients, who had previously attended privately, had had their operations after a significantly shorter period of time than the remaining TURP patients who had not attended privately. I have provided a thorough comparative analysis of TURP patients during 2016 which conclusively demonstrates that this was not the case. I have also provided a detailed explanation of the subsequent list of 11 patients who had attended privately. There has been no comparative analysis done as part of this investigation that indicates that there has been any preferential treatment to patients who have seen me privately. I have not given any preferential treatment to any patient because they have seen me privately.

5. The Role of Management

It is my belief that Management knew of the problems that I was having with these administrative practices for all of the reasons that are detailed above. Management did not take the opportunities to assist me and it is apparent from the witness statements that when some members of management indicated that they would wish to address these issues with me

informally, they were instructed not to do so. Additionally, when the issues were raised in the meeting of March 2016, I asked for some guidance on what I could do and I received no assistance. I believe that after 25 years of employment by the Trust and contribution that I have made to the development of urological services as described in the historical context section of this response, I would have considered it reasonable to expect that the Trust would have made efforts to deal with the concerns in a collegiate and supportive manner.

This did not happen.

Aidan O'Brien
10th July 2018

Hynds, Siobhan

From: Parks, Zoe [redacted]
Sent: 15 July 2020 09:10
To: Hynds, Siobhan
Subject: Strictly Confidential - Grievance

Follow Up Flag: Follow up
Flag Status: Flagged

Siobhan – can we discuss this at some stage as I know you will closer to some of the detail on this to allow me to get them a response..

Hi Laura/Zoe

On preparing for the XX Grievance on

30 July 2020 today, can Dr Diamond and I seek the following clarifications/updates at this first stage of my preparation:

1. Which solicitor at DLS has acted as legal advisor to date in this case and may Dr Diamond and I continue with seeking their advice as we do our work?

2. Can we have dates of XX's sick leave from March 2016, please? This is just to check what I have assumed from his submission.

3. Near the bottom of page 2 of his submission , XX talks about seeking further documents and that he "*may need to amend this grievance and I reserve the right to do so*". **Can this be checked with him and that he makes any amendment to his grievance in writing no later than 12.00 noon on Monday, 27 July 2020 so that the panel have time to consider before we meet him?**

4. Dr Khan, as I understand it was covering as Medical Director for a period of time and also was Case Manager - is it possible to have a timeline for his and Dr Wright's roles and when Dr Khan was in his substantive role (formal title of this) from March 2016 to date, please.

5. The Terms of Reference for Investigation supplied to the Grievance panel, is not dated. Can this date be confirmed, please and is it the final version.

6. Have disciplinary charges been developed for a disciplinary panel for XX at this point. We don't need to see them, just gauge what stage processes are at.

7. At section 2.10.2 of his grievance letter/submission her refers to Unlawful deduction form Wages in relation to locum work. Can Aisling and I be advised of the status of this before 30 July 2020. For example, has says he has been paid? Has he been paid for everything? Or is this not relevant if all of 2.10 is related to Dignity at Work Complaint and it is the fact that it took too long to be paid in his view?

8. In Section 11 he talks about the Trust's duty of Care to its patients and how he alleges they have been affected by the actions against him. I have encountered this before in the High Court with a published case in the media about Dr Drozdowicz and the WHSCT (it had started off as an injunction hearing bot Judge Stevens decided he had seen a hint of whistleblowing. The judge decided she was Whistleblowing and said he would "try" the case on that basis. Long story but was a really big issue and I am concerned that there is a hint of this here (it was well debated at the time within the Bar Library)

9. On page 32 of his grievance letter, XX states, "*During the last two months, the Trust has engaged in further activity that I have serious concerns about and I have contend have amounted to harassment and in breach of the Trust's ''Working Well Together Policy" of July 2009".* Aisling and I need to confirm that this is outside our scope in this grievance? This needs to be communicated to him before we meet him if we are not to consider this claim under the Dignity at Work Policy

10. XX submitted his Grievance letter and submission on 27 November 2020. Is there anything that Aisling and I need to be aware of so that there are no surprises on 30 July 2020 that would lead to an adjournment or undue delay. I'd like us to have to be able to answer if he has new issues since November 2018 and if he has, he has submitted them in advance.

11. Can someone send us a copy of the Trust's Disciplinary Procedure, please – I want to cross reference the categories/thresholds of misconduct.

Aisling and I are meeting by Zoom on Thursday and at this point, I will want to speak to her about others that we will need to see as part of this Grievance.

I feel it may be necessary to adjourn when we have heard from XX in full on 30 July 2020. Can HR give some consideration as to how we would conduct that i.e. how do we give xx the opportunity to hear nay new information and comment before we make our decision. I recently did a grievance about a grievance (!) in another Trust and the key flaw was that the grievance panel went and sought information and it was entirely at odds with what had been said by the employee but she did not have the opportunity to comment and the first panel had believed the witnesses and the employee, at our grievance was able to demonstrate a challenge that could be upheld to that information. I can have a think about how I consider we should do it but I want us to say close to SHSCT processes.

If we do need to adjourn, we will agree what with XX on 30 July 2020 and need to be in a position to say how that will work.

Happy to chat at any time, Zoe, re processes, etc.

Apologies for all of this but these are issue that come to mind as Chair and Aisling will want to be assured that I have asked for this clarity. I will speak to you again if, after Aisling and I meet this Thursday, there are any other pre-hearing issues. You appreciate that there is a lot to go through and today has only allowed me to go through all of his submission in detail and make notes for Aisling and me, begin to structure the grievance hearing and highlight the queries above.

Many thanks

Best wishes

Shirley

SHIRLEY YOUNG
Personal Information redacted by USI

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

Montgomery, Ruth

From: Haynes, Mark
Sent: 31 March 2019 10:52
To: OKane, Maria
Subject: RE: Urology
Attachments: Return to Work Action Plan February 2017 FINAL..docx.docx; FW: Urology ECR; FW: Urology; FW: REFS FOR TRIAGE

Morning.

Triage in Urology (and I think most other surgical specialities) is done by the on-call surgeon ('surgeon of the week'). The AOB return to work action plan (attached) concern 1 relates to this;

CONCERN 1

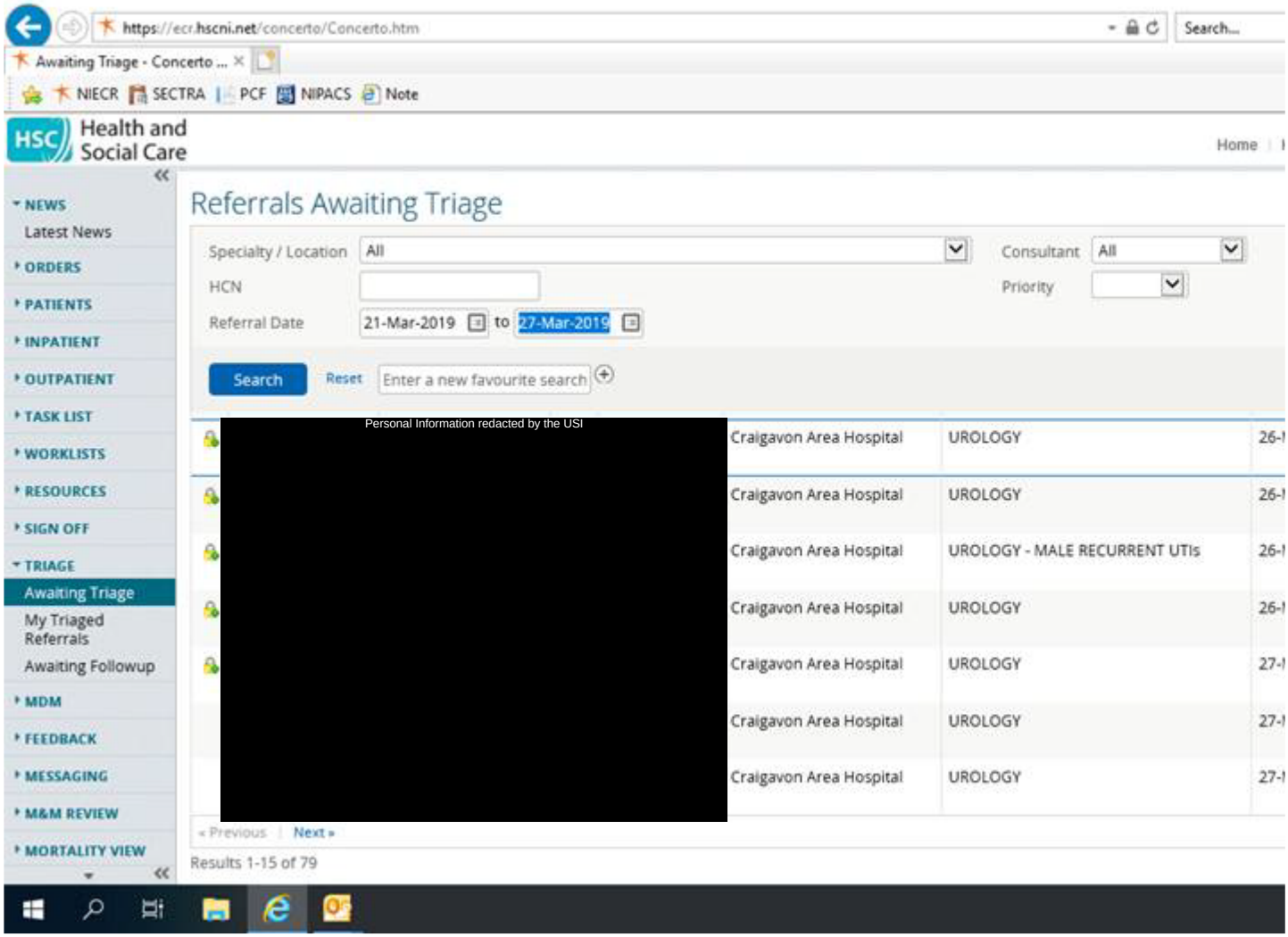
- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters it must be ensured that the secretary will record receipt of these on PAS and then all letters must be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.
Red Flag referrals must be completed daily.
All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

Attached are a number of escalation emails pertaining to this from Vicki Graham. I would assume that this has been shared with the director of acute services and appropriately escalated to the MHPS case manager? Anecdotally certainly the e-triage is not completed by 4pm on the Friday of his on-call week, indeed looking now there are 79 referrals on e-triage, received between 21st March and 27th March (Mr O'Biren's recent on-call week) that have yet to be triaged, including 16 red flag referrals dating from 25/3 to 27/3 (see screenshot below).

I am not aware of the reporting and escalation that may have occurred of this following the return to work.

Mark



From: OKane, Maria
Sent: 31 March 2019 00:18
To: Haynes, Mark
Subject: RE: Urology

Has this happened in this way before?

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 30 March 2019 06:55
To: OKane, Maria

Subject: FW: Urology
Importance: High

This relates to one of the AOB issues. He has been on call since 22/3/19 and should have been doing the triage.
Mark

From: Graham, Vicki
Sent: 29 March 2019 16:09
To: O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark; Young, Michael; Glackin, Anthony; Tyson, Matthew
Subject: FW: Urology
Importance: High

Hi

The red flag team have advised that there are x 24 referrals on ECR to be triaged, dating back to 22.03.19. Would it be possible to get these triaged please?

Thank you

Vicki
Cancer Services Co-ordinator
Office 2
Level 2
MEC

From: rf.appointment
Sent: 29 March 2019 15:57
To: Graham, Vicki
Subject: Urology

Hey Vicki,

There are 24 referrals from 22/03/19 needing triage for Urology on ECR.
Can you escalate this please.

Best

Sinéad Catherine Joanne Lee
Higher Clerical Officer

✉ **Southern Health & Social Care Trust**
Red Flag Appointments Office
Ramone Buliding Ward 1, Ground floor
Craigavon Area Hospital
Lurgan Road, Portadown

☎ **Ext.** Personal Information redacted by the USI *(Red Flag Team Ext.* Personal Information redacted by the USI *)*

Corrigan, Martina

From: Young, Michael
Sent: 27 May 2015 21:36
To: Haynes, Mark; Corrigan, Martina
Subject: RE: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15

Internal email for those on this circulation only

Point taken
Agree
Play a straight honest game.
We are best placed defining our lists but at risk if above comments not taken on board.
Management not playing straight either by resetting patients clock.

But this is not the approach I want for the Dept

Few issues not prepared to put on paper about process = so discuss later.
Discussion required.

Mark's points very valid – I fully appreciate the questions raised

MY
Lead

From: Haynes, Mark
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Dear Michael / Martina

I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patient listed for an Urgent TURP, the majority of whom will have catheters insitu. They have been waiting up to 92 weeks.

However, on the ward this week is a man (Personal Information redacted by the USI) who went into retention on 16th March 2015, Failed a TROC on 31st March 2015. He was seen in a private clinic on Saturday 18th April and admission arranged for 25th May with a view to Surgery 27th May. The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters insitu for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

Southern Health and Social Care Trust

Quality Care - for you, with you

Urology Cancer MDT Operational Policy - Agreement Cover Sheet

This MDT Operational Policy has been agreed by:

Position	Director of Acute Services
Name	Mrs Esther Gishkori
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal Information redacted by USI

Position	Clinical Director Cancer Services
Name	Dr Rory Convery
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal Information redacted by USI

Position	MDT Lead Clinician (on behalf of MDT members)
Name	Mr Anthony Glackin
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal Information redacted by USI

The MDT members agreed this Operational Policy on:

Date Agreed	**1st September 2017**
Operational Policy Review Date	**1st September 2018**

Angela Kerr

From: Mitchell, Darren <[redacted]>
Sent: 20 November 2014 13:35
To: O'Brien, Aidan
Subject: [redacted]

Aidan –could I ask you to have a look at this case which was passed to me as the regional MDT chair.

Looks like young man with high grade organ confined disease from 2012. From my prospective he would have been considered for neo-adjuvant hormones for 3-6months followed by EBRT in early 2013. He may have been suitable for combined EBRT + BT (pending LUTS assessment). His high grade disease would have encouraged us to offer him 2-3years of adjuvant hormonal therapy after EBRT depending on 2008 or 2014 NICE guidelines and pt tolerance.

I'm not aware of any of his co-morbidities or performance status.

As hormonal therapy in this case we would use LHRHa or occasionally Bicalutamide 150mg OD monotherapy.

I'm told he has only just been referred for radiotherapy at 2 years after initial MDT presentation.

I'm not aware of supportive research for 24months of neo-adjuvant hormones prior to EBRT but the trans-tasmin group 0 vs 3 vs 6 and the Canadian 3 vs 8 are already quoted in our radiotherapy protocol and based on those studies we typically think of 6 months neo-adjuvantly in this kind of case.

6 months of LHRHa prior to EBRT is also recommended in the STAMPEDE protocol for men with high risk non-metastatic disease who are for radical radiotherapy.

I'm also told that he was on Bicalutamide 50mg OD for the first year of his management.

The NICAN hormone protocol (in process) would be useful in standardising our therapy across the region but Bicalutamide 50mg is not licenced for mono-therapy use and will not be recommended in the protocol other than within the licenced context for the management of flare with LHRHa.

The MRHA site provides information on 'off-label' prescribing and our responsibilities within that.

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087990

Happy to discuss this further.

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☒ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.3. Phase of care: Review of Diagnostics (where relevant)

- **Were diagnostic tests or investigations reviewed in a timely manner with appropriate further actions taken?**
- **Were any required actions adequately communicated to patient / primary care / MDT teams?**
- **Please list medication if known and relevant, and comment on medication monitoring where appropriate**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided
Please also include any other information that you think is important or relevant.

There is no evidence that the patients condition was discussed in MDT, the patient was started on suboptimal and unlicenced dose of Bicalutamide of 50mg rather than complete Androgen deprivation.

This treatment dose gave the patient no clinical benefit but only the side effects of AntiAndrogens.

There was a very long delay in referring the patient to the oncology team for consideration of Radiotherapy

Angela Kerr

From: O'Brien, Aidan [redacted]
Sent: 17 March 2015 21:03
To: Mitchell, Darren
Subject: Regional MDM

Dear Darren,

A somewhat sensitive issue.
Last Thursday, two cases had been listed for MDM discussion in which the input of radiologists would have been desirable, if not essential.
Whilst radiologists had been present for the local MDM in Belfast, they left as we linked up for discussion of our cases.
We find this recurring behaviour very frustrating.
I do fully appreciate how difficult it can be to have everyone attend for all of the meeting, as we have had and continue to have our local difficulties in that regard.
In any case, our members felt so strongly with regard to our inability to have a discussion last week that the same two cases have been listed again for Thursday 19 march 2015.
Will it be possible to have radiologists remain for the discussion of our cases?

Aidan.

There is a nodule in the lung fields, which may represent a metastasis. This must be discussed at a specialist MDT (Belfast) to consider the timing of adjuvant treatment.

My only observation is that the reasonable change of plan should have been discussed in the MDT in a timely fashion. I don't think the patient suffered any harm as a consequence of this omission. I don't think this amount to a SAI.

As an aside, I would be very interested in the histology of the kidney tumour. The combination of papillary thyroid cancer, renal neoplasia and follicular lymphoma points towards a genetic cause.

KR, Hugh

From: Kingsnorth, Patricia Personal Information redacted by USI
Sent: 03 December 2020 14:23
To: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST) Personal Information redacted by USI
Subject: ENCRYPTION

Dear Hugh
I have been asked if you could assist me some independent view regarding screening for this case. He will not be part of the SAI group but may need to have an SAI separately if required.
I apologise that I am adding to your busy workload and will understand if this is not appropriate to ask the question. Just delete the email if that is the case.

This is a gentleman has a renal carcinoma. He was also attending haematology with lymphoma and preparing for chemotherapy when a CT scan showed a renal lesion which required biopsy.
MDM made a recommendation to biopsy the kidney. This did not happen as the consultant (in his letter dated 16 August 2019) explained why this didn't happen in view of the patient currently undergoing chemo therapy and with his factor V111 condition. This was not fed back to MDM.
The question is given what appears to be a reasonable reason for the delay to action MDM outcome and not feedback to the MDM does that make this an SAI? However I will point out the letter was not written until October 2019.

There does not appear to be a proper process for feeding back to MDM and this will be one of the learning from SAI. Can you advise if this was a reasonable approach for this gentleman particularly if it had been with any other practitioner?

Kind regards
Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital
Personal Information redacted by USI

Southern Health and Social Care Trust

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE [redacted]
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE [redacted]	**4.** DATE OF INCIDENT/EVENT **5.** 09 May 2018
6. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: NO ***Please select as appropriate***	**7.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
8. DATE OF SEA MEETING / INCIDENT DEBRIEF	

9. SUMMARY OF EVENT:

[redacted] was admitted to Craigavon Area Hospital (CAH) on 09 May 2018 for elective urology surgery (cystoscopy, replacement of ureteric stents and bilateral ureterolysis). Following the procedure on 09 May 2018 [redacted] condition deteriorated and he was admitted to the Intensive Care Unit (ICU) critically ill. [redacted] suffered a cardiac arrest which was managed as per Adult Life Support (ALS) guidelines. Following discussion with [redacted]'s wife cardiopulmonary resuscitation (CPR) was stopped and [redacted] died on [redacted]. [redacted] was discussed with the coroner and a post mortem was requested.

The review team have drafted this report on the information available to them, the review team are aware that some of the clinical notes may not be available to them.

Causative Factor

The review team concluded [redacted] had an unrecognised haemorrhage post operatively.

The review team note [redacted]'s post mortem report. [redacted] death was discussed with the Coroner who recommended a post mortem.
The Cause of death was reported after post mortem as 1(a) Intra-abdominal and retroperitoneal haemorrhage following cystoscopy, insertion of ureteric stents and ureterolysis. 11 Cardiomegaly
The post mortem reported noted *'Death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen……..The post-mortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. Such enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses place upon the body by the effects of the blood loss. Indeed the severity of his heart disease was such that it could have caused his death at any time. Therefore as his pre-existing heart disease would have made him more susceptible to the effects of haemorrhage it would be best regarded as a contributory factor in his death'.*

I will need assistance when replying to this email.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

From: aidanpobrien Personal Information [mailto: Personal Information redacted by the USI]
Sent: 25 August 2011 15:37
To: Corrigan, Martina
Subject: Re: Results and Reports of Investigations

Martina,

I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:

- Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?
- Are all results or reports to be reviewed, irrespective of their normality or abnormality?
- Are they results or reports to be presented to the reviewer in paper or digital form?
- Who is responsible for presentation of results and reports for review?
- Will reports and results be presented with patients' charts for review?
- How much time will the exercise of presentation take?
- Are there other resource implications to presentation of results and reports for review?
- Is the consultant to report / communicate / inform following review of results and reports?
- What actions are to be taken in cases of abnormality?
- How much time will review take?
- Are there legal implications to this proposed action?

I believe that all of these issues need to be addressed,

Aidan.

-----Original Message-----
From: Corrigan, Martina < Personal Information redacted by USI >
To: Aidanpobrien Personal Information redacted by the USI ; my Personal Information redacted by USI >; Akhtar, Mehmood Personal Information redacted by USI >; O'Brien, Aidan < Personal Information redacted by USI >; Young, Michael < Personal Information redacted by USI >
CC: Dignam, Paulette < Personal Information redacted by USI >; Hanvey, Leanne < Personal Information redacted by USI >; McCorry, Monica < Personal Information redacted by USI >; Troughton, Elizabeth Personal Information redacted by USI >
Sent: Wed, 27 Jul 2011 5:30
Subject: FW: Results
Dear all

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 16 November 2011 13:53
To: Trouton, Heather
Subject: RE: Amended 2011/12 Job Plan

Heather,

As discussed

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Clegg, Malcolm
Sent: 16 November 2011 13:04
To: Mackle, Eamon; Corrigan, Martina
Subject: FW: Amended 2011/12 Job Plan

Mr Mackle/ Martina,

Please see response from Mr O'Brien to his job plan offer following Facilitation.

I have responded to Mr O'Brien today to inform him that arrangements have been made with salaries and wages to implement the 12.75 PA job plan from 1st October 2011. I also advised him that I would be notifying you both of the comments he had made as you might need to discuss these issues further with him.

We have decided to proceed with implementation of the 12.75 PA job plan from 1st October 2011 as Mr O'Brien never formally requested an appeal despite now indicating his disagreement with the job plan. I do feel however that we cannot ignore Mr O'Brien's comments. Mr O'Brien was informed in his notification letter following Facilitation that the new job plan will require him to change his working practices and administration methods and that the Trust will provide any advice and support it can to assist him with this. It is important therefore in view of the comments made by Mr O'Brien that we follow through with this.

Regards

Malcolm

Malcolm Clegg
Medical Staffing Department
Southern Health and Social Care Trust
Craigavon Area Hospital
BT63 5QQ

Tel: [redacted]

Corrigan, Martina

From: Young, Michael
Sent: 15 September 2015 10:47
To: O'Brien, Aidan; Suresh, Ram; Haynes, Mark; Glenny, Sharon; Glackin, Anthony; ODonoghue, JohnP
Cc: Corrigan, Martina; Graham, Vicki
Subject: RE: Urology Triaging

1/ A lot of this stems from GPs not completing their referrals adequately.
2/ We have said before that there should be a minimum dataset – ie to have the u/e done (or at least say on the form that it has been done).
3/ I agree with most of Aidan's points (except the last)
4/ I thought all this was fairly straight forward but some are making it complicated and some are not listening (sorry to say)
5/ The New triage box (and that means what is written in it) notes on the left hand side to which clinic the patient is to be booked. This should remain unaltered especially the Red Flag patient – the GP and patient are expecting this outcome. This should make it clear to the Booking Office. I think we set out a time line for the urgent patients as well (not sure if this has slipped a bit though). Where a scan etc has been ordered in advance this should not impinge on the Booking Office arranging an appointment at the New Clinic. 'All well and good' if the scan results are available – I thought this is what we agreed. We felt that waiting for some scans was holding up the overall care pathway (and indeed this does not make it a one stop clinic but we don't like that phrase anyway)
6/ if someone wants to pre-arrange a test then this is written outside of the box. If the patient is deemed in the Red Flag category then they should have been given an appointment anyway and therefore there should not be any time left to re-triage. (unfortunately the Booking Office have DAROed a lot of patients where they have seen that test have been pre-booked. I feel this is a complete mistake and certainly should not have been applied to RF patients).
7/ Pre-arranged tests for the urgent and routine patients are indeed fair enough for a variety reasons. These patients also should not be DAROed. It is likely their tests will be done within our clinic time-frames. It was agreed that these patients test results were the responsibility of the triaging Consultant up to when they were seen in the clinic. Ie if an action was required urgently. A further point on this relates to subsequent ownership of the patient. Pre-clinic time relates to the triaging Consultant but once seen at the Clinic then this switches to that particular Consultant (no matter who pre-ordered the tests) This particular point needs to be ironed out for the haematuria Clinic (discuss later).
8/ Inside the Triage Box on the right hand side is to indicate, in advance, of what is likely / potentially to be needed 'on the day'. This is for use by the Booking Office to have a spread of activities. (ie not all TRUSes or an xs of flex C/Us). It is also for the Nursing staff before the clinic starts that day to plan the patient flow of activities. If none of the boxes are ticked then it is not anticipated that the patient will need any such tests (this however may change when the patient is actually seen however)
9/ I appreciate the comments about pre-arrangements. Such things as GP lack of inclusion of results, patients not picking up the phone, patients not attending for urgently arranged blood or indeed their xrays. This all takes up valuable time on our behalf when we have so much to do. So I suggest keeping it all simple as there are so many involved in the pathways. I do not think anyone should be DAROed as our timelines already fit and indeed due consideration should be given to the minimum dataset on letters for red flag referrals – there is indeed certain expectation for us to see patients on time and I think it is more than reasonable for us to expect GP to supply us with adequate information.

See you all at Audit in the Ulster ?

MY

From: O'Brien, Aidan
Sent: 14 September 2015 18:04

Gibson, Simon

From: Gibson, Simon
Sent: 24 January 2020 12:57
To: OKane, Maria; Weir, Lauren
Cc: Carroll, Ronan; Haynes, Mark; Corrigan, Martina; Hynds, Siobhan; McNaboe, Ted; Khan, Ahmed; Carroll, Anita; McClements, Melanie; Toal, Vivienne
Subject: FW: For Response - Meeting Request - AOB

Dear Maria

As requested below, I co-ordinated and chaired this meeting. The purpose of the meeting was agreed as consideration of the below points laid out in your e-mail of 17th November, specifically:

1. describe in detail the management plan around the backlog report ,
2. the expectation re compliance
3. and the escalation

to assist a meeting with Mr O'Brien to discuss his deviation from the action plan

Present at the meeting were:

- Simon Gibson
- Ronan Carroll
- Martina Corrigan
- Mark Haynes
- Ahmed Khan

The Backlog Report

The Backlog Report was commenced in approximately 2016, (it existed before though detail and format may have been different) to quantify workload between secretarial and audio-typist staff and allow movement of work where necessary. Information was gathered by completion of a template by secretaries themselves on a monthly basis, when they were asked to quantify the level of work awaiting to be done either by their consultant or themselves.

This information was compiled into a report and circulated to consultant staff, and copied to relevant Heads of Service and Assistant Directors. It was not forwarded to medical staff acting in their capacity as CD or AMD. There appears to be variable consideration of this report by specialties within either patient safety meetings or specialty meetings. It should be noted that one of the reasons this report did not receive regular consideration was that there was some scepticism of the accuracy of this data, as it did not reconcile with individuals own recollection of behaviour or workload of colleagues. In essence, it was felt that there may have been inaccuracies in the data provided by staff. This data was never independently verified, and there was no electronic method of collecting this data. It was never raised in the Patient Safety meetings in Urology, and was not regularly discussed at the Urology specialty meeting.

Expectation re compliance

None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standard set externally by Royal Colleges or other organisations. Therefore, on the occasions when this data was considered, there was no agreed standard to use as a gauge against reported performance.

Escalation

As there was some cynicism in relation to the validity of the data, combined with a lack of standards to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report.