

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 NICA to consider taking on the role of Lead Clinician of NICA'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 NICA'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 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 increasingly 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.

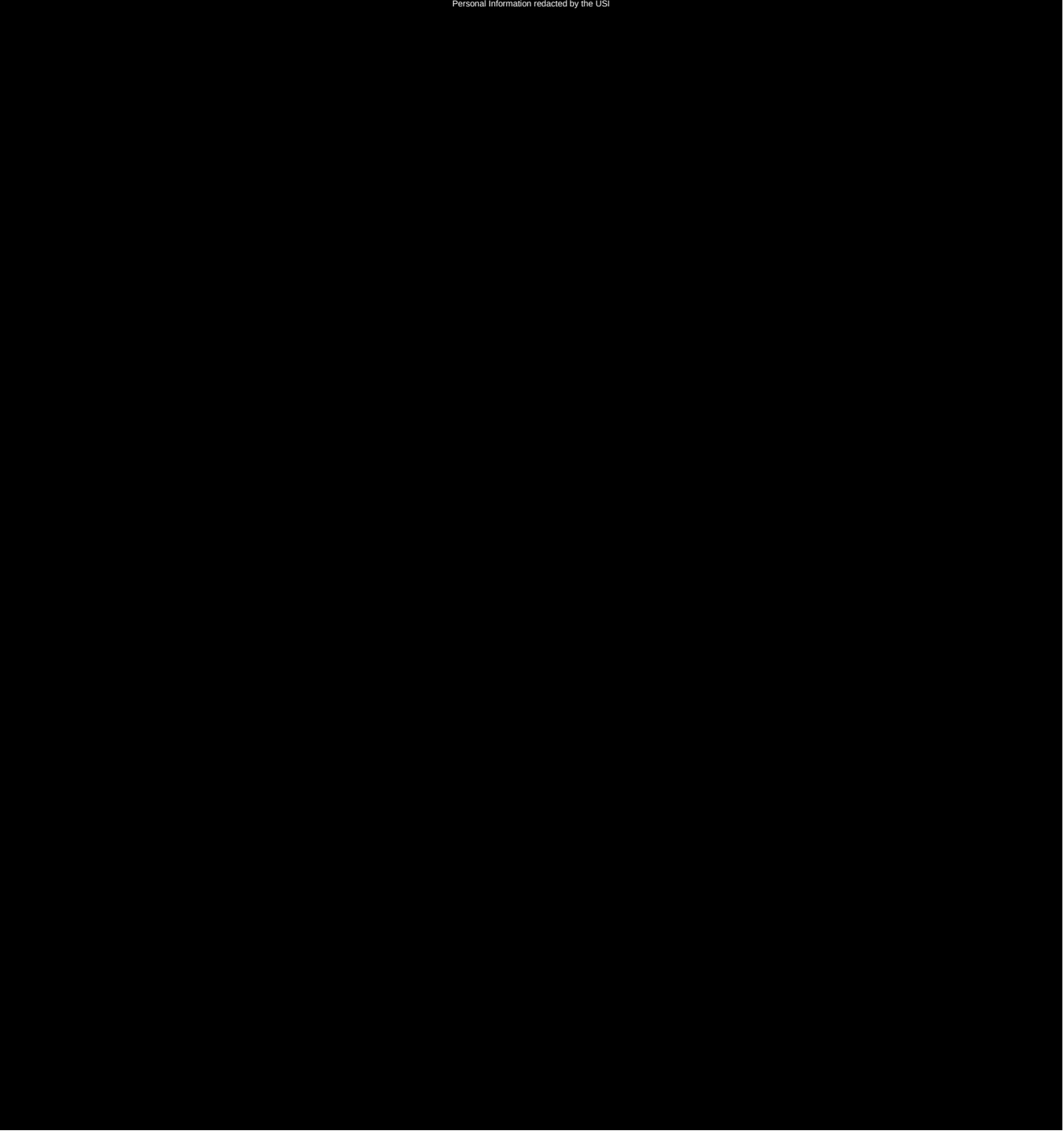
In Section 6, the Report states that a large number of un-triaged referrals were subsequently located in an office drawer in Mr. O'Brien's office, by Mrs. Corrigan. In his review of those un-triaged referrals later upgrade to Red Flag status, Dr. Julian Johnston had been advised that the large number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

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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 untrue. 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 Personal Information redacted by the USI 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 patient 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.

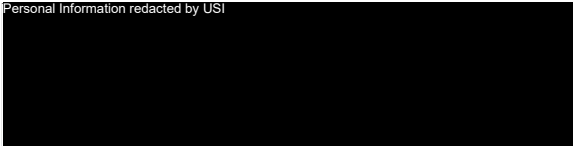
5. The Role of Management

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.

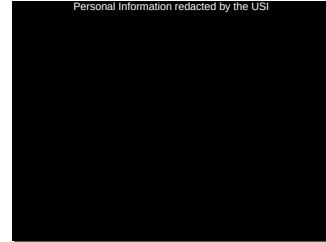
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Aidan O'Brien
10th July 2018

**MHPS RESPONSE
APPENDIX 1**

STRICTLY PRIVATE & CONFIDENTIAL



17 January 2017.

Dr. Richard Wright,
Medical Director,
Southern Health & Social Care Trust,
Southern Trust Headquarters,
Craigavon Area Hospital,
68 Lurgan Road,
Portadown,
BT63 5QQ.

Dear Dr. Wright,

I write to you in relation to my immediate exclusion and the formal investigation of which I was advised when I met with you and Ms. Hailey on Friday 30 December 2016, when I was accompanied by my wife, and of which you formally notified me in your letter of 6th January 2016 (sic) and which I received on 11 January 2017.

Your letter formally notified me of my immediate exclusion, pursuant to Maintaining High Professional Standards in the Modern HPSS (MHPS) and the associated Southern Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (Trust Guidelines), and which was effective from 30th December 2016 when we met with you and Ms. Hailey.

I write to you at this time as I have become increasingly concerned regarding the procedural conduct of the investigation to date.

When we met with you and Ms. Hailey, you advised that a non-executive member of the Southern Health & Social Care Trust Board (the Board) would be appointed and that I would be advised of the identity of this person. I note that the appointment of a non-executive member of the Board is a requirement of MHPS (Section 1: Paragraphs 8 and 28) and of the Trust Guidelines (Paragraph 2.10 and Appendix 2). Both MHPS and the Trust Guidelines stipulate that the role of the non-executive member is to oversee the case to ensure that momentum is maintained, to ensure that the investigation is completed in a fair and transparent way, and to consider any representations from the practitioner about his or her exclusion, or any representations about the investigation.

To date, I have received no written notification of the name of the non-executive member of the Board, or of his or her contact details. Your letter of formal notification did not include any reference to the appointment of a non-executive member. It is for this reason that I am left with the only option of writing to you directly to address my concerns. In this regard, I should be grateful if you would advise me, as a matter of urgency, of the identity of the non-executive member, the date of appointment or designation, and the member's contact details.

Secondly, I have yet to receive the minutes of the meeting of the 30th December 2016. Pursuant to Section 1: Paragraph 24 of MPHS and pursuant to Appendices 2 and 5 of the Trust Guidelines, I should be grateful if you would provide me with a copy of all minutes, records and documentation relating to the meeting of Friday 30 December 2016.

Thirdly, I have become increasingly concerned with regard to the slow pace of proceedings. Despite the distress of our meeting with you and Ms. Hainey, I did take some comfort from your reassurance that you hoped that all would be completed within two or three weeks. I note from Appendix 2 of the Trust Guidelines that the investigation **must** be completed within four weeks.

In particular, I have been concerned not to have received any communication from the Case Investigator, or notification of a meeting with the Case Investigator, to provide me with the opportunity to state my case and to propose alternatives to exclusion, pursuant to Section 1: Paragraph 23 of MHPS and Appendix 5 of the Trust Guidelines, within the four weeks allowed.

For this reason, I took the initiative of contacting Mr. Weir, the Case Investigator, by telephone last evening to enquire of the date of a meeting, and with the expectation that the meeting would be scheduled for later this week. I was reassured that Mr. Weir was cognisant of the significance of my having a meeting with him within the four week period, but alarmed to learn that a meeting has been scheduled for him to meet the HR representative on Thursday 26 January 2017, and that no meeting with me has been scheduled to take place until after that meeting. I therefore should be grateful if you can provide me with details of when I can be provided with the opportunity to meet with the Case Investigator and with the HR representative.

You will be aware that it is the clear guidance from both the MPHS (Section 2: Paragraph 4 – 6) and the Trust Guidelines (Appendix 5) that exclusion is only to be used in the most exceptional circumstances. In advance of the meeting to discuss alternatives to exclusion, I believe that I should be informed in more detail of the reasons and justifications for exclusion, so that I may be able to adequately respond to them, and to consider proposals for alternatives. I note that this is a requirement of Section 1: Paragraph 22 of MHPS.

Whilst I will strenuously and robustly address the concerns enumerated in your letter of formal notification, when provided with the opportunity to do so, I must make clear at this stage that I do not accept, as stated in your letter, that the Trust attempted to address the issues regarding administrative practices, informally or at all. I was invited to meet with Mr. Eamon Mackle and with Mrs. Martina Corrigan on, or after, 23 March 2016 when I was advised of the Trust's concerns, and provided with the letter dated 23 March 2016. There was no enquiry made as to the causes of the concerns. There was no offer of a discussion of how the concerns could be resolved, or of any assistance in doing so. When I asked what I should do to address and resolve the concerns, my request was met with silence and a shrug of the shoulders. There was no follow up to the meeting, or to the letter of 23rd March 2016.

I am anxious to return to work. I am particularly concerned for the welfare of those patients awaiting excessively long periods for admission for surgery, and whose outcomes are being further jeopardised by further delay, and for those patients whose review has been further delayed during this period of exclusion.

You will appreciate that this whole process has been profoundly traumatic, stressful and distressing for me and for my family. The fact that the only communication that I have received from the Trust to date has been your letter of formal notification, has only further exacerbated that stress. It is also inevitable that this is causing me reputational and financial loss and damage, particularly as you advised me to desist from private practice whilst the investigation is conducted. Moreover, the welfare of patients is causing me further concern. Accordingly, I trust that you will address the issues raised in this letter as a matter of urgency.

Yours sincerely,

Aidan O'Brien.

**MHPS RESPONSE
APPENDIX 2**

Concerns Regarding the Investigation Process

7th February 2017

1. A letter dated 23rd March 2016 was provided to Mr O'Brien at a meeting on or around that date by Mr Mackle and Ms Corrigan. The letter raises a number of issues which are now the subject of a formal investigation. There are a number of concerns arising from this letter.

- It does not constitute a formal or informal process under MHPS or any other Trust Guidelines. It included no local action plan to resolve the problems or any suggestions regarding a plan.
- It was provided by Mr Mackle, an individual in respect of whom Mr O'Brien has extant though stayed formal grievance. Mr O'Brien had previously been provided an assurance by both Dr. Gillian Rankin and Mr Mackle that Mr Mackle would have no further meetings with him.
- At the meeting Mr O'Brien asked what he should do to resolve the matter. The only response received was a shrug and silence from Mr Mackle.

The letter of 23rd March 2016, gives rise to a number of questions:

- What was the nature of the complaint that led to this letter being issued?
- What investigation occurred prior to the letter being completed?
- Who completed this investigation?
- How have the suggested numbers of untriaged patients and the review backlogs been arrived at?
- Was there a decision taken by a Clinical Manager that the concerns should be approached by the issue of the letter of 23rd March 2016 or by any other individual? In any case, who took this decision?
- Was this decision taken with reference to MHPS?
- Was this decision taken in consultation with the Medical Director, the Director of Human Resources or any other individual?

2. The origin of this current investigation remains unclear. It has been suggested that this investigation arises out of an ongoing Serious Adverse Incident (SAI) investigation. The following concerns arise

- The issues of concern have been reported before the completion of the report of Serious Adverse Incident Investigation and before Mr O'Brien had even been afforded the opportunity to comment on the SAI. It is therefore concerning that it is premature to commence a formal investigation.
- Insofar as the SAI relates to Mr O'Brien's practice, it is only with reference to triaging referrals whilst urologist of the week. The other issues regarding administrative practices are entirely unrelated. It is therefore unclear how the other concerns became a part of the investigation.
- It is concerning that the initial correspondence regarding the investigation from Dr Wright refers to the letter of 23rd March 2016 as an informal attempt to resolve the issues under investigation when the letter of 23rd March 2016 did not constitute any such process. It seems likely that the erroneous presumption that an informal attempt had been made to resolve the issues and that this attempt had failed has had an effect on the decision to commence a formal investigation.

Therefore, the following questions arise out of the decision to commence a formal investigation.

- Who made the complaint to the Trust that gave rise to this investigation?
- To whom was the complaint made?
- When was the complaint made?
- In what form was the complaint made?
- What was the nature of the concerns brought to the attention of the Trust?

- What investigation had been completed prior to the 30th December 2016, which resulted in the data that was presented at that meeting relating to untriaged referrals and a backlog in dictation?
- Who completed the above investigation?
- What consideration was given to handling this matter through an informal approach?
- If consideration was given to proceeding with an informal approach, why was this deemed inappropriate?
- What effect, if any, did the letter of 23rd March 2016 have on the decision to proceed with a formal investigation?
- What was the rationale for the immediate exclusion? What alternatives were considered?
- As the SAI, insofar as it concerns Mr O'Brien, only relates to triage, why was the investigation launched into the entirety of the administrative practices?

3. The conduct of the investigation is also concerning.

- The Trust Guidelines mandate that an investigation must be completed within four weeks. We are now in the sixth week of this investigation. This is a breach of contract and this was acknowledged by the HR representative at the meeting of 24th January 2017.
- It has been stated that all of these investigations take longer than the four weeks required and therefore there has been no justification offered as to why this investigation must take longer than four weeks.
- At this point, there is no end date in sight for this investigation whatsoever.
- The Non-Executive Director was not appointed until at least two weeks had passed in the investigation, half of the permitted time for completion of the investigation.
- At the meeting of the 24th January 2017, Mr O'Brien was advised that there is a team of investigators attached to this investigation. It is

concerning that any chance of confidentiality being maintained within the investigation is now lost as an unknown number of unidentified people are involved.

- The investigation has now expanded beyond administrative practices and encompasses an alleged issue that private patients have been receiving preferential treatment in having their procedures completed more quickly than NHS patients. It is unclear how this issue can arise out of an investigation into administrative practices.

The following questions arise.

- How long is the investigation expected to take?
- What justification is there for the investigation continuing in breach of the contractual term contained in the guidelines that an investigation must be completed within 4 weeks?
- How many people are now involved in the investigation and what are the identities of the investigators?
- How does the Trust propose to ensure confidentiality and the rights to privacy given the number of professionals involved in this investigation?
- What has given rise to the addition of Mr O'Brien's private practice becoming the subject of investigation?

**MHPS RESPONSE
APPENDIX 3**



Southern Health
and Social Care Trust

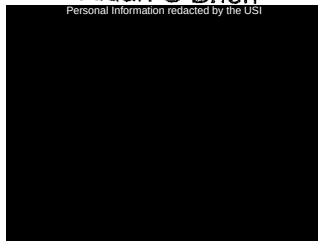
Quality Care - for you, with you

24 February 2017

STRICTLY PRIVATE & CONFIDENTIAL

BY E-MAIL ONLY

Mr Aidan O'Brien



Dear Mr O'Brien

Re: Formal investigation under Maintaining High Professional Standards Framework (MHPS)

Mr John Wilkinson Non-Executive Director has shared with me details of representations you have recently made to him at a meeting on 7 February 2017 about the formal investigation under the Maintaining High Professional Standards (MHPS) Framework.

Following due consideration of the issues you have raised, I wish to respond to you on these matters.

1. The letter of 23 March 2016

I have considered the representations you have made in respect of the letter of 23 March 2016. It is important that I state at the outset, that I was not involved in the conversations or discussions that took place at that time. I understand that concerns were identified by managers within the Acute Services Directorate and the purpose of the March 23rd letter was to set out to you those concerns on an informal basis in order to enable you to put in place measures to rectify the concerns. The issues of concern did not result from a specific complaint.

The letter was not set out to you in the context of an informal process under the Maintaining High Professional Standards Framework but rather was an informal attempt at local resolution of the issues, sent to you through normal line management channels. It was expected that as an experienced and senior Consultant, this notification of concern to you was sufficient to ensure you took all necessary steps to address the concerns and to rectify the identified problems.

You state in your submission to Mr Wilkinson that an agreement was in place that formal contact or meetings would not take place between you and Mr Mackle due to a prior grievance process. I am not aware of this background or the agreement referred to. I understand the Medical Director, Dr Wright is also unaware of this matter. As you will be aware, Dr Gillian Rankin has retired from the Trust. I feel this is a matter best dealt with via the formal investigation process and I would ask that you raise this with the Case Investigator to fully explore the background and history of what preceded the management of the concerns under the MHPS Framework as is relevant to the current investigation.

2. Formal Investigation

You have raised the matter of the circumstances which led to the decision to manage the concerns under the formal process of the MHPS Framework. As you know, there were concerns raised with you in March 2016 about your administrative practices and the impact on patient management and care.

Management follow up is not clear to me at present. It is not my role to investigate the detail of this and I believe this is again a relevant matter for the formal investigation process. I am however aware that Mr Colin Weir was in post as Clinical Director in the period following March 2016 and given your representations to Mr Wilkinson, I feel it is likely Mr Weir may be required to provide information to the investigation on this issue. Therefore I have asked Mr Weir to step down from his role as Case Investigator and I have asked Dr Neta Chada, Associate Medical Director to undertake the role of Case Investigator. Dr Chada will be in contact with you in due course.

The SAI process you refer to in your submission, alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by you as was required. The issue was one of the same issues alerted to you informally in March 2016. You have noted that a decision was made to immediately exclude you from work prior to the finalised report on the SAI. The reason for this decision was due to the very serious nature of the concern. The Trust must ensure patient safety is properly safeguarded and when matters of serious concern arise, consideration is given to any necessary action to immediately ensure the safety of patients. It is for this reason, a decision was made to exclude you and to move to a formal investigation of the concerns.

You suggest the formal investigation has resulted because of an erroneous presumption that an informal attempt at resolution of the issues had failed. The Trust does not always manage issues of concern through an informal process, the seriousness of issues will always be considered. However an informal attempt to address concerns with you in March 2016 was made.

When a very serious issue of concern came to the attention of the Trust, i.e. the harm of a patient, it was necessary for the Trust to take action deemed necessary and proportionate to manage such a concern. This is the current formal investigation process.

A decision was initially taken to exclude you, this decision has since been reviewed taking into consideration the representations you made for alternatives to exclusion and you have returned to work with effect from 20 February pending conclusion of the formal investigation.

As discussed at our meeting on 9 February, you will be returning to work with a clear management plan for supervision and monitoring of key aspects of your work. An immediate priority is to ensure your job plan is reviewed and agreed to ensure a manageable and comparable workload with your other Consultant colleagues. I have asked for this to be completed as a matter of urgency.

3. Timescales of Investigation

The matter of the timescales for the investigation has also been raised by you with Mr Wilkinson and I understand this was also raised by you at a meeting with Colin Weir and Siobhan Hynds on 24 January.

The timescale for a formal investigation as set out in the MHPS Framework states: *'The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days.'*

Given the vast scale of the concerns, the numbers of patients involved, the time period over which the concerns stretch, the records which need to be reviewed and the scale of facts to be gathered, a 4 week turnaround time is not practicable in these circumstances. These are exceptional circumstances.

I can assure you that the investigation process will be concluded as expeditiously as possible ensuring that it is fully and properly completed. I will ensure you are kept informed on an on-going basis as to the status of the investigation and the likely timescale for completion.

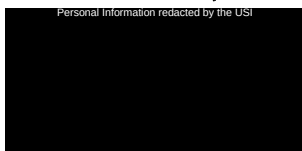
Your understanding that there is a team of case investigators looking at this case is not correct. The case investigator assigned to your case is Dr Chada, who will be assisted by Siobhan Hynds. However a review of the un-triaged patients must be completed to consider what, if any, impact there has been on patient care. A similar review must also be undertaken in respect of the undictated clinics. This can only be done from within the service directorate by individuals with the requisite expertise. This work will inform the case investigator's investigation.

I wish to assure you that all matters pertaining to these concerns will be kept strictly confidential and any individuals involved are wholly bound by their obligations of confidentiality in line with Trust Policy and contract of employment.

I trust this address the issues you have raised and provides assurance to you of my commitment to ensuring the investigation process is concluded as quickly, thoroughly and robustly as possible.

I have shared a copy of this letter with Mr Wilkinson for his information.

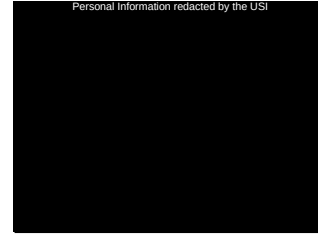
Yours sincerely

Personal Information redacted by the USt


Dr Ahmed Khan
Associate Medical Director &
Case Manager

Copy to: Mr John Wilkinson

**MHPS RESPONSE
APPENDIX 4**



14 February 2017.

Dr. Richard Wright,
Medical Director,
Southern Health & Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
68 Lurgan Road,
Portadown,
BT63 5QQ.

Dear Dr. Wright,

Re: Note of Meeting with Mr. Aidan O'Brien on 30 December 2016.

Thank you for your letter of 18th January 2017, enclosing a Note of the Meeting of 30th December 2016. I wish to take this opportunity to advise of a number of factual errors and omissions:

1. In the first paragraph, the Note states that 'Dr. Wright noted that some of these concerns had been raised with Mr. O'Brien previously and attempts had been made to resolve the matters informally, with no success'.

This statement is incorrect and should have read 'Dr. Wright noted that these issues had been highlighted with Mr. O'Brien in March'.

2. Again, in the third paragraph, the Note states that 'Dr. Wright advised that nevertheless concerns had been raised with him in relation to Mr. O'Brien's administrative practices and because of the seriousness of these, and the fact that informal steps had been unable to resolve the issues previously, a decision had been taken to investigate the matter formally in accordance with the Maintaining High Professional Standards Framework and associated local guidance'.

This statement is incorrect, as Dr. Wright did not make reference to informal steps having been unable to resolve the issues previously.

3. In the sixth paragraph, the Note states that Mr. O'Brien, referring to the inequity of waiting lists, advised that 'he had previously asked through his Clinical Director that this situation be addressed'.

This statement is incorrect, and should have read that 'he had previously asked that this situation be addressed.'

4. The Note records that 'both Mr. and Mrs. O'Brien stated that the job plan was OK'.

This statement is incorrect as, while Mrs. O'Brien may have been of the view that the job plan was OK, I certainly did not state that the job plan was OK.

5. The Note records that Mrs. O'Brien stated that she and her children had sacrificed their family life for her husband's job and 'this is how we are repaid' referring to the discussion taking place.

This statement is incorrect as Mrs. O'Brien did not make any reference to being 'repaid'.

With regard to omissions:

- The Note did not include any record of my being advised of immediate exclusion. The only reference to exclusion is in the second last paragraph when 'Mr. O'Brien was made aware of the paragraphs in the MHPS documentation relating to exclusion', and the query regarding private practice.
- The Note did not include any record of Mrs. O'Brien's concerns regarding one of the signatories of the letter of 23rd March 2016 having caused problems previously.

I would be grateful if you would have the Note amended and a copy of the amended Note returned to me.

Yours Sincerely,

Aidan O'Brien.

**MHPS RESPONSE
APPENDIX 5**

Questions to be Asked

In Paragraph 1.5 of the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance (23 September 2010), it states that, whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

Question 1:

How was it possible to ascertain what had happened and why it had happened without speaking with and enquiring of Mr. O'Brien?

Question 2:

Who made the decision not to speak to or enquire of Mr. O'Brien?

Question 3:

When was that decision made?

In Paragraph 2.2 of the Trust Guidelines, it states that concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director.

Question 4:

Who was the Clinical Manager with whom concerns were raised?

Question 5:

When were concerns raised with that Clinical Manager?

Question 6:

Who raised the concerns with the Clinical Manager at that time?

In Paragraph 2.2 of the Trust Guidelines, it states that, if the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager.

The Medical Director advised at the meeting of 30 December 2016 that the concerns had been brought to his attention during the course of an investigation into a Serious Adverse Incident.

Question 7: Who brought these concerns to his attention?

Question 8: When were these concerns brought to his attention?

Question 9: Did he refer the matter to the relevant Clinical Manager?

Question 10: If so, who was that Clinical Manager?

Question 11: When did he refer the matter to the Clinical Manager?

Question 12: If not, why not?

In Paragraph 2.4 of the Trust Guidelines, it states that the Clinical Manager will immediately undertake an initial verification of the issues raised.

Question 13: Did a Clinical Manager undertake an initial verification of the issues raised?

Question 14: If so, who was that Clinical Manager?

Question 15: If so, when did the Clinical Manager undertake the initial verification?

Question 16: If so, what methods or means was used to verify the issues?

Question 17: If so, did other persons assist in the verification process?

Question 18: If so, who were those persons?

Question 19: If so, why did the verification process not include a consultation with Mr. O'Brien?

Question 20: If an initial verification was not undertaken, why not?

Question 21: If an initial verification was not undertaken, who made the decision not to do so?

Question 22: If an initial verification was not undertaken, when was the decision made not to do so?

In Paragraph 2.6 of the Trust Guidelines, it states that the Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response.

Question 23: Did a Clinical Manager and a nominated HR Case Manager investigate the concerns raised?

Question 24: If so, who was that Clinical Manager?

Question 25: If so, who was that nominated HR Case Manager?

Question 26: If so, when did the investigation begin?

Question 27: If so, when did the investigation end?

Question 28: If so, what methods or means were used to conduct the investigation?

Question 29: If so, did other persons assist in the investigation?

Question 30: If so, who were the other persons?

Question 31: If so, why did the investigation not include a consultation with Mr. O'Brien?

Question 32: If a Clinical Manager and nominated HR Case Manager did not conduct an investigation, why not?

Question 33: Who made the decision not to conduct an investigation?

Question 34: When was that decision made?

Question 35: Why was that decision made?

In Paragraph 2.6 of the Trust Guidelines, it states that the Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised.

Question 36: Did the Clinical Manager or the HR Case Manager take advice from NCAS in determining their assessment of action to be taken in response to the concerns raised?

Question 37: If so, who sought the advice from NCAS?

Question 38: If so, what information was given to NCAS?

Question 39: If so, who provided that information?

Question 40: If so, what advice was given by NCAS?

Question 41: Why was advice not sought from the Occupational Health Department in determining the assessment of action to be taken in response to the concerns raised, particularly as Mr. O'Brien was on sick leave following surgery?

Question 42: Who made the decision not to seek advice from the Occupational Health Department?

Question 43: When was that decision made?

In Paragraph 2.7 of the Trust Guidelines, it states that where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager.

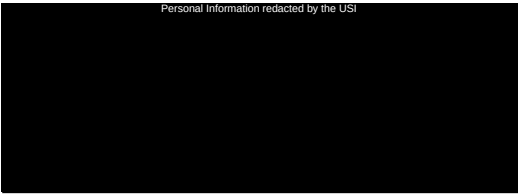
Question 44: Why was a local action plan not agreed with Mr. O'Brien?

Question 45: Why was Mr. O'Brien not consulted in determining whether a local action plan and resolution were possible and appropriate?

Question 46: Who made the decision not to consult with Mr. O'Brien or agree an action plan with Mr. O'Brien?

In accordance with the Trust Guidelines, all of the above constituent parts of the process of Handling Concerns should have been conducted prior to the decision of formal investigation and immediate exclusion. The constituent parts are screening, verification, investigation and an informal action plan with the objective of resolution if possible and appropriate. It is my concern that some of these constituent parts have not been conducted properly and fully, if at all. I have concerns regarding the accuracy of the evidence provided to date, and I would possibly have concerns regarding the sources of that evidence. Above all, I have found it remarkable and unjust that I was not consulted at any stage of the above process when I should have been.

Personal Information redacted by the USI



Aidan O'Brien

06 March 2017.

**MHPS RESPONSE
APPENDIX 6**



Southern Health
and Social Care Trust

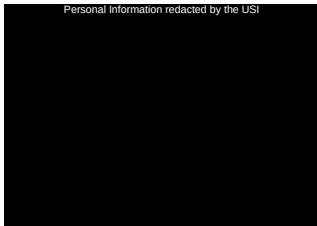
Quality Care - for you, with you

30 March 2017

STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien

Personal Information redacted by the USI



Dear Mr O'Brien

RE: Correspondence dated 6 March 2017 to Mr John Wilkinson

Mr John Wilkinson has passed a copy of a document to me containing a number of questions to which you have requested a response. It is appropriate that I, as Medical Director, respond to these questions.

I can confirm that I was verbally made aware of an ongoing SAI in late December 2016, and that this SAI has raised concerns in relation to a Urology patient who may have had a poor clinical outcome due to the lengthy period of time taken by you to undertake the triage of the GP referral. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. I was also aware that at this stage you had been on a period of sick leave and that you were due to return to work on 2 January 2017.

You will know that I was aware that you had been met with previously by senior management in March 2016 regarding your administration practices relating to un-triaged referral letters, review backlogs, patient centre letters /recorded outcomes and patient notes being retained at home. These concerns were still present at the point you commenced sick leave. Given the indications provided to me from the ongoing SAI in December 2016, as Medical Director, I could not let these concerns go on any further unaddressed.

Prior to Christmas 2016, I had been advised by Acute Services, that there were 318 un-triaged cases, there was a backlog of over 60 undictated clinics, with over 600 patients, going back over 18 months, and that patient notes were not available in the hospital with the view that these notes were located in your home. This information was collated initially as a result of the concerns emanating from the ongoing SAI.

Question 1:

Given the likely scale of the patients / notes involved as outlined above, it was necessary to fully understand the extent of the issues and ensure that there was a management plan in place to review the status of each patient, as there was a strong possibility from the information available at that stage that patients may have come to harm. It was necessary for further scoping information to be collated to verify the numbers of patients / notes involved, and this had to be undertaken by the Acute Services management team, including Mr Ronan Carroll and Mrs Martina Corrigan using the necessary clinical systems. It was necessary to collate this information before speaking with you.

Question 2:

There was never a decision made that you would not be spoken with. The decision was made to place you on immediate exclusion to protect you from any further concerns being raised, to protect the interests of patients and to enable the scoping of information to be gathered as part of the investigative process. During the period of immediate exclusion you were met with by Mr Colin Weir, Clinical Director and Mrs Siobhan Hynds, Head of Employee Relations, in compliance with Maintaining High Professional Standards.

Question 3:

See above.

Questions 4, 5 & 6:

I, as the Medical Director, had been advised in relation to the concerns raised as a result of the ongoing SAI. Mr Colin Weir as Clinical Director is the Clinical Manager. Mr Weir had been on Personal Information redacted by the USI leave in December Personal Information redacted by the USI. I advised Mr Weir by telephone on 28 December 2016 of the concerns, and advised him that I would require him to act as Case Investigator.

Question 7:

Mrs Esther Gishkori, Director of Acute Services

Question 8:

Week commencing 19th December 2016

Questions 9, 10, 11, 12:

See response to Questions 4, 5 & 6

Question 13:

This was not necessary as Mr Ronan Carroll and Mrs Martina Hogan were collating the information from the patient systems to confirm the extent of the concerns and patients affected, as outlined in response to Question 1.

Questions 14 – 18:

See response to Question 1

Questions 19 - 22

Prior to you being placed on immediate exclusion it was clear from initial checks made by Mr Carroll and Mrs Corrigan that there were at least 318 un-triaged cases, a backlog of over 60 undictated clinics, with over 600 patients, going back over 18 months, and that patient notes were not available in the hospital with the view that these notes were located in your home. During the period of immediate exclusion further scoping was undertaken to determine the full extent, and you were met with during the 4 week period of immediate exclusion.

Questions 23 – 35

During the initial 4 week period following your immediate exclusion, 30 December 2016 to 27 January 2017, Mr Weir and Mrs Hynds through discussions with Mr Ronan Carroll and Mrs Martina Corrigan established the extent of the concerns. The further scoping exercise identified that there were 783 un-triaged referrals and not 318 as initially identified. Scoping of the concern relating to notes being kept at your home identified initially 27 sets of notes tracked out to you were missing, further investigation of this matter led to a final number of 13 sets of notes missing. Mr Weir

and Mrs Hynds sought your response to each of the 13 sets of notes during this period to determine if any further sets of notes could be found.

The 4 week period also allowed for further scoping of the number of patients who did not have a dictated outcome from a clinic. This was determined to be 668 patients in total. It was also established that there were at least 9 TURP patients who had been seen privately by you, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order. The screening process established that further investigation of this matter was required.

On establishing the extent of the concerns, Mr Weir and Mrs Hynds met with you on 24 January 2017, during the initial 4 week immediate exclusion period, to update you on the extent of the concerns, to seek your initial response to the concerns and to discuss with you your proposals for alternatives to formal exclusion. A case conference meeting was then held in line with MHPS Framework to determine if continued exclusion was required and for the a decision to be made with regards to the need for further formal investigation of the matters of concern.

Question 36 – 40

NCAS advice was sought on 28 December 2016 by myself, in the absence of Mr Weir.

I notified NCAS of my concerns in respect of a consultant urologist and increasing performance concerns. I notified NCAS of my concerns about poor record keeping, slowness of triaging referrals and arranging reviews, removal of a very substantial number of charts from the Trust without returning them despite request to do so and patients who were seen by you where there were no notes available.

I also notified NCAS of the SAI which caused concern that there is potential for patients to have been harmed due to your practices and I explained that I believed the Trust needed to undertake an investigation into the concerns. Furthermore I advised that consideration was being given to your exclusion from work.

I was advised by NCAS with regards to the need to follow a robust investigation process in line with the MHPS Framework, our obligations to appoint the necessary persons under that process and some general advice on Data Protection. I was advised of the option of immediate exclusion for a 4 week period to allow for further information to be collated and to take account of your comments before deciding on the need for formal exclusion.

I was advised to encourage you to contact your defence organisation or BMA for help and advice and also of the Trust's staff care services.

Question 41-43

My initial consideration, given the serious nature of the concerns known to me in December 2016, was regarding investigation and possible exclusion to enable an assessment of the issues to be completed. Given the serious nature of the initial concern/s in particular the SAI process, consideration of a local action plan in these circumstances was not appropriate. Therefore seeking advice from Occupational Health to determine the assessment of action to be taken was not required at that point.

You were referred to Occupational Health by Mrs Martina Corrigan, Head of Service and were assessed by Dr Alan Black on 9 February 2017. By this time a decision had been made not to proceed with formal exclusion. The advice from Occupational Health was followed in respect of your fitness to return to work at that time.

Question 44

It was determined by Dr Khan that there was a case to answer and that the formal investigation should proceed as the most appropriate course of action given the extent of the concerns. A local action plan was agreed in respect of your return to work following the lifting of the immediate exclusion. You received a copy of this from Dr Khan on 9 February 2017.

Questions 45, 46 & 47:

It is the decision of the Case Manager to determine the course of action in accordance with MHPS page 15 Section II para 10. Dr Khan made this decision on 26 January 2017.

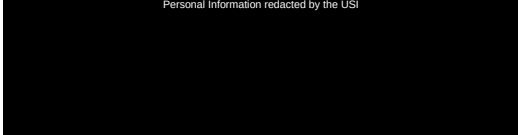
It is noted that you feel all constituent parts of the MHPS Framework should have been conducted prior to the decision to investigate and exclude. Your contention is that this also should have included an informal action plan. Given the very serious nature of the concerns identified and the potential that a patient has come to harm as a result of those concerns, it is my firm belief that formal investigation is the most appropriate action. This belief, following initial screening and verification of the scale of the concerns was also held by Mr Khan, Case Manager.

If you have concern regarding the accuracy of the evidence or the source of the concerns you will have a full opportunity to address these matters as part of the formal investigation and have these considered.

The investigation process is currently underway and you will be kept advised of its progress periodically.

Yours sincerely

Personal Information redacted by the USI

A large black rectangular redaction box covering the signature area.

DR RICHARD WRIGHT
Medical Director

**MHPS RESPONSE
APPENDIX 7**



Southern Health
and Social Care Trust

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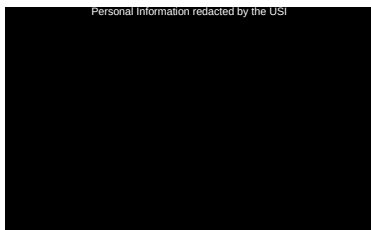
14 June 2017

STRICTLY PRIVATE & CONFIDENTIAL

BY E-MAIL ONLY

Mr Aidan O'Brien

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Dear Mr O'Brien

Re: Formal investigation under Maintaining High Professional Standards Framework (MHPS)

I refer to the on-going investigation under the Maintaining High Professional Standards Framework.

You will have received the witness list from me at an earlier date in the investigation and I can advise that I have now met with all witnesses I feel are appropriate to the investigation. If you feel there are any other relevant witnesses please let me know to ensure I can consider if I need to speak with them.

The next step of the investigation is to meet with you and therefore I would like to meet with you on Wednesday 28 June 2017 at 9.30am in the HR Meeting Room, Ground Floor, Hill Building, St Luke's Hospital site, Armagh.

I am sending you this as early notice of the meeting to enable you to arrange accompaniment should you wish to do so. You are entitled to be accompanied to this meeting as per Section 1 paragraph 30 of the Maintaining High Professional Standards Framework.

I would be grateful if you could confirm your attendance at this meeting as soon as possible via e-mail with Siobhan.Hynds Personal Information redacted by the USI

Prior to our meeting I will send you details of the matters I wish to discuss with you to enable you to prepare for our meeting. You should expect to receive this information from Siobhan Hynds at the beginning of week commencing 19 June 2017.

Yours sincerely

Dr Neta CHada
Associate Medical Director &
Case Investigator

Copy to: Dr A Khan, Case Manager

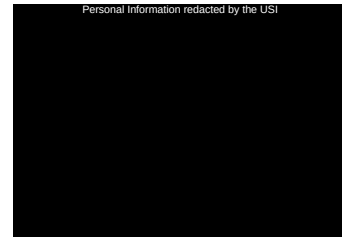
**MHPS RESPONSE
APPENDIX 8**

DATE	CLINIC	CLINIC CODE
24/11/2014	SWAH	EUROAOB
22/12/2014	SWAH	EUROAOB
12/01/2015	SWAH	EUROAOB
23/02/2015	SWAH	EUROAOB
09/03/2015	SWAH	EUROAOB
13/04/2015	SWAH	EUROAOB
11/05/2015	SWAH	EUROAOB
22/06/2015	SWAH	EUROAOB
06/07/2015	SWAH	EUROAOB
28/09/2015	SWAH	EUROAOB
19/10/2015	SWAH	EUROAOB
02/11/2015	ARMAGH CLINIC	AAOBU1
06/11/2015	URODYNAMICS CLINIC	CAOBUDS
24/11/2015	NEW CLINIC	CAOBTDU
30/11/2015	SWAH	EUROAOB
04/12/2015	URODYNAMICS CLINIC	CAOBUDS
07/12/2015	ARMAGH CLINIC	AAOBU1
22/12/2015	NEW CLINIC	CAOBTDU
08/01/2016	UROONCOLOGY CLINIC	CAOBUO
11/01/2016	SWAH	EUROAOB
15/01/2016	UROONCOLOGY CLINIC	CAOBUO
08/02/2016	SWAH	EUROAOB
07/03/2016	SWAH	EUROAOB
21/03/2016	ARMAGH CLINIC	AAOBU1
01/04/2016	UROONCOLOGY CLINIC	CAOBUO
04/04/2016	REVIEW CLINIC - CAH	CAOBT DUR
08/04/2016	UROONCOLOGY CLINIC	CAOBUO
15/04/2016	UROONCOLOGY CLINIC	CAOBUO
18/04/2016	ARMAGH CLINIC	AAOBU1
19/04/2016	NEW CLINIC	CAOBT DU
22/04/2016	UROONCOLOGY CLINIC	CAOBUO
22/04/2016	URODYNAMICS CLINIC	CAOBUDS
29/04/2016	UROONCOLOGY CLINIC	CAOBUO
29/04/2016	URODYNAMICS CLINIC	CAOBUDS
03/05/2016	REVIEW CLINIC - CAH	CAOBT DUR
06/05/2016	URODYNAMICS CLINIC	CAOBUDS
23/05/2016	REVIEW CLINIC - CAH	CAOBT DUR
27/05/2016	UROONCOLOGY CLINIC	CAOBUO
27/05/2016	URODYNAMICS CLINIC	CAOBUDS
03/06/2016	URODYNAMICS CLINIC	CAOBUDS
10/06/2016	UROONCOLOGY CLINIC	CAOBUO
13/06/2016	ARMAGH CLINIC	AAOBU1
20/06/2016	SWAH	EUROAOB
04/07/2016	REVIEW CLINIC - CAH	CAOBT DUR
22/07/2016	UROONCOLOGY CLINIC	CAOBUO
26/07/2016	NEW CLINIC	CAOBT DU
09/08/2016	NEW CLINIC	CAOBT DU
12/08/2016	UROONCOLOGY CLINIC	CAOBUO
19/08/2016	UROONCOLOGY CLINIC	CAOBUO

Appendix 3

DATE	CLINIC	CLINIC CODE
19/08/2016	URODYNAMICS CLINIC	CAOBUDS
22/08/2016	SWAH	EUROAOB
19/09/2016	SWAH	EUROAOB
07/10/2016	URODYNAMICS CLINIC	CAOBUDS
11/10/2016	NEW CLINIC	CAOBTDU
14/10/2016	URODYNAMICS CLINIC	CABOUDS
14/10/2016	UROONCOLOGY CLINIC	CAOBUO
21/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	URODYNAMICS CLINIC	CAOBUDS
28/10/2016	UROONCOLOGY CLINIC	CAOBUO
04/11/2016	URODYNAMICS CLINIC	CAOBUDS
04/11/2016	UROONCOLOGY CLINIC	CAOBUO

**MHPS RESPONSE
APPENDIX 9**



30 July 2017.

Dr. Ahmed Khan,
Associate Medical Director,
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Khan,

Re: Formal Investigation.

As you may know, I have been invited to interview by Dr. Chada, the Case Investigator, on Thursday 03 August 2017. I therefore wish to take this opportunity to register the cumulative concerns which I have had regarding the above investigation, the events leading to it and its conduct to date.

First amongst these is the relationship between 'Maintaining High Professional Standards in the Modern HPSS' issued by the Department of Health, Social Services & Public Safety (DHSSPS) in November 2005 and the 'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' issued by the Southern Health and Social Care Trust (SHSCT) in September 2010. 'Maintaining High Professional Standards in the Modern HPSS' (MHPS) is a framework for the handling of concerns about doctors and dentists in the HPSS. In Paragraph 3 of the Framework, the DHSSPS obliges HPSS organisations to notify the Department of the action they have taken to comply with the framework. In response to that obligation, the SHSCT formulated and issued its Guidelines in September 2010.

Paragraph 1.5 of the Trust Guidelines states that the 'guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists,

to minimise potential risk for patients, practitioners, clinical teams and the organisation'. Therefore, I believe that it is evident that the procedure by the SHSCT handles concerns about its doctors and dentists should be by and in accordance with its Guidelines, as obliged by the DHSSPS. Yet, this investigation has and continues to be conducted under MHPS, rather than under the Trust Guidelines.

In its Introduction, MHPS states that numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures. Paragraph 1.2 of the Trust Guidelines states that the document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patients harmed.

In your letter of 24 February 2017 to me, you advised that the letter of 23 March 2016 given to me was not in the context of an informal process under the MHPS Framework but rather an informal attempt at local resolution of the issues, sent to me through normal line management channels. Apart from the fact that it was given to me rather than sent to me, it should not have been in the context of the MHPS Framework in any case. Instead, SHSCT management should have discussed with me and taken remedial and supportive action to resolve the issues of concern, in accordance with the Trust Guidelines.

In your letter, you stated that it was your understanding that concerns were identified by managers within the Acute Services Directorate and that the purpose of the March 23rd letter was to set out to me those concerns on an informal basis in order to enable me to put in place measures to rectify the concerns. Your understanding would infer that I had not been aware of those concerns prior to being given the letter. I had been burdened with the same concerns prior to being given the letter, and still am. I fail to understand how receipt of a letter outlining concerns of which I had long been aware, was itself enabling, without the remedial and supportive assistance obliged of those who wrote and gave the letter. Instead, it was expected that the letter was sufficient to ensure that I took all necessary steps to address the concerns and to rectify the identified problems.

Without the support which should have been given, it would have required the displacement of other work, and particularly operative activity. The numbers of patients severely suffering while awaiting surgery, at risk of suffering poorer clinical outcomes and actually doing so, remained my greatest clinical priority before and after receipt of the letter of 23 March 2016. During the months after March 2016, I deferred my own surgery which I should have had earlier, and did not take any leave on operating days or on the operating days vacated by colleagues, in order to maximise operating capacity, so as to minimise the poor outcomes suffered by scores of patients. To have attempted to address and rectify the concerns, on my own without support, would certainly have displaced all of the additional operating carried out during the remainder of 2016.

There were 280 patients awaiting admission for surgery in November 2016, excluding those awaiting admission to the Day Surgical Unit. Patients were waiting as far back as February 2014. That number included some thirty patients requiring admission as soon as was possible. The numbers suffering due to delay in admission, at risk of poor clinical outcomes and actually suffering poor clinical outcomes, have been and remain my greatest clinical concern. So far as I am aware, these outnumber many times over, those identified by the investigation as at risk of suffering poor clinical outcomes. When I advised Mr. Weir and Mrs. Hynds of this greatest clinical concern at my meeting with them on 24 January 2017, I was asked whether I had raised this issue with management previously. In addition to advising that I had done so numerous times with all tiers of management, I also asserted that I was doing so again, there and then, and that I predicted that my doing so would not appear in any record of the meeting. It did not! On 27 March 2017, I included this omission in a written request for the Note of the meeting to be amended, and returned to me. Four months later, I still await receipt of the amended Note.

I believe that I, and the patients about whom management claimed to have been concerned, were failed by management's failure to discuss the concerns which they had and which I shared, with a view to agreeing a remedial and supportive course of action over a period of time in order to rectify the problems, as obliged by Trust Guidelines. I would have so welcomed that support. Instead, when I asked what they wanted me to do, there was no advice or support offered.

I believe that the deliverance of a letter to me on 23 March 2016 by members of Trust management, identifying concerns which they expected me to address and rectify, on my own, without remedial action and support, in breach of Trust Guidelines, is untenable, particularly when those same concerns were deemed to be so grave as to merit a Formal Investigation and Immediate Exclusion nine months later.

In your letter of 24 February 2017, you related how the SAI investigation had alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by me as was required. I had indeed previously raised my concern that a decision had been made to proceed with a formal investigation and immediate exclusion, prior to even a draft final report of the investigating panel having been compiled. I was provided with that draft final report on 13 January 2017. I returned my comments upon the report on 25 January 2017. In doing so, I concluded that the terms of reference for the SAI investigation were prejudicial in that the investigation concerned itself with the period of time beginning with CT scanning on 24 June 2014 and ending with the patient's first urological consultation on 06 January 2016. The SAI investigation therefore failed to include that the renal lesion of concern could have been identified on CT scanning as early as December 2012. Most importantly, the patient did not come to any harm as a consequence of the delay in urological consultation. I believe that it was improper and prejudicial to have concluded that harm had been suffered by a patient before the investigation of the case had even reported. I believe that it was even more improper and prejudicial to have used that presumption of harm, which did not exist, to justify Formal Investigation and Immediate Exclusion, as you asserted.

It is also noteworthy that you made reference to my not having 'properly' triaged the letter of referral. I do believe that there is indeed a distinct difference between triage and proper triage. I believe that most, if not all, clinicians would agree that 'triage' is a process to allocate 'red flag', 'urgent' or 'routine' status to any referral in accordance with the information provided in the letter of referral. As I reported in my response to the draft final report of the SAI investigation, the patient had been a routine referral for assessment of a large, simple, right renal cyst, associated with right renal angle pain. Based upon this information, I asserted that I would have retained the routine referral status. The waiting time then for a routine urological outpatient consultation was then 66 weeks. At present, I believe it to be some 84 weeks.

I believe that 'proper' triage would have resulted in the referral status having been amended to 'Red Flag'. This would have required a review of the patient's entire history by access to NIECR. However, crucially, it would also have required a review of the digitalised imaging on NIPACS. I believe that it is a modest proposal that this would have taken some 15 to 20 minutes to undertake. We receive 120 to 160 referrals per week. Even if the mean time required to 'properly' triage were ten minutes each, that would require 20 to 27 hours during a week when one is responsible for all inpatient care of all urological patients, including emergency and urgent surgery, and all emergency and urgent referrals from elsewhere in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital. Indeed, as reported in my comments upon the draft final report of the SAI investigation, on the day upon which the referral of the case was delivered for triage, I had additionally spent three hours previewing the cases for MDM discussion that afternoon when I spent a further three hours chairing MDM, followed by further time that evening proof reading and signing letters emanating from MDM, addressed to GPs. The following day, I reviewed ten oncology patients in addition to the continued responsibilities of being urologist of the week. It was precisely for this reason that I had previously advised that I had found it impossible to conduct triage on urgent and routine referrals, as there simply was inadequate time to do so. Indeed, in March 2015, as lead clinician of MDT, I had been unable to secure the commitment of my colleagues to conduct such triage on 'Red Flag' referrals alone, as they found it too time consuming and that there was not enough time as urologist of the week to do so, as documented in the minutes of the Urology MDT Business Meeting of 02 April 2015, and even though Red Flag referrals constitute only 15% to 20% of all referrals.

Also, in relation to triage, you referred in your letter to my having failed to properly triage *as was required*. I have twice requested a copy of, or a link to, the Trust's Policy and Procedure regarding triage, and to which reference has been made. I still await a reply, a copy or a link. Moreover, the ultimate reason why any patient had to wait 66 weeks for a routine consultation following referral is because the Trust provides such an inadequate service. It is worthy of note that the SAI investigation panel did not include that inadequacy at all as a factor in the patient's delay in diagnosis. Lastly, in relation to that SAI investigation, I have yet to receive a copy of the final report of the investigating panel. I have written to the Director of Acute Services requesting a copy.

Finally, in relation to triage, one of my colleagues luckily discovered during April 2017 that a decision had been made by some person(s) in management not to place patients on a waiting lists for outpatient consultations at all, if investigations had been requested during triage, until it had been determined whether appointments were required, following receipt of the results or reports of the investigations. This had been decided without any consultation with clinicians, never mind their agreement. Following protest, this practice has since been abandoned. So much for the 'agreed / established procedure' so often referred to, during the course of this investigation!

During 2016, I had deferred my own surgery for as long as possible, in order to operate on as many patients as I possibly could, so as to minimise the numbers suffering while awaiting admission, and suffering poor clinical outcomes, as already related. During 2016 alone, I carried out an additional 22 operating sessions, and an additional 17 Urodynamics and Oncology Review sessions. I continued to do so until my symptoms, and particularly pain, rendered it increasingly difficult to travel, to conduct clinics and to operate. In addition, I deferred my own surgery until after the departure from the Trust of a colleague who required support following concerns regarding his competence when urologist of the week.

As indicated previously, prior to my taking sick leave, I had identified thirty patients awaiting admission, and whom I believed required to be admitted as soon as was possible. On 07 November 2016, I advised the Head of Service and my four colleagues of the ten of those patients waiting the longest periods of time, requesting that they be admitted during my sick leave. I had Personal information redacted by the USI

Personal Information redacted by the USI r 2016. During the subsequent weeks following discharge, I had arranged operating lists and clinic sessions to be undertaken by me during January 2017. By mid-December 2016, I had become so increasingly concerned

Personal Information redacted by the USI I contacted the surgeon who arranged for me to be readmitted on 24 December 2016 for Personal Information redacted by the USI

Personal Information redacted by the USI. This proved to be so effective that there was no need for readmission, though it was equally evident that I needed to remain on Personal Information redacted by the USI for a protracted period of time. I felt well enough to have my secretary notify patients of their planned admissions and reviews in January 2017. I felt all the more compelled to do so as only two of the above ten patients had been admitted, by 31 December 2016.

Perhaps, the one aspect of this investigative process which I have found most incomprehensible was the decision to proceed to Formal Investigation and Immediate Exclusion without having consulted with me in the first instance. If I had been Medical Director and received such information, I would have certainly wanted to assess its veracity, accuracy and reliability, not only with those who had provided and delivered the information, but also with the clinician involved. I would certainly have wanted to explore with the clinician involved the reasons for the concerns raised. It would have been for me a matter of common sense, of courtesy and of natural justice. When requested to provide an explanation for this failure, the Medical Director, in his written reply of 30 March 2017, advised that it was not necessary as the required information was being collated by the Assistant Director of Acute Services and by the Head of Service. Instead, I was presented on 30 December 2017 with the fait accompli of Formal Investigation and Immediate Exclusion. Both were inflicted by a Medical Director, on behalf of an Oversight Group, upon a colleague recovering from surgery, even though he claimed to be unaware of the nature of the surgery or of the pathology for which it was performed. The consequences of both upon my health have been the most severe I have suffered in my lifetime, some permanently, and without enquiry since.

When I met with the Medical Director and Ms. Hainey on 30 December 2017, it did appear that the greatest issue of concern was that of 'missing' hospital charts at my home. I did advise that I had never mislaid a patient's chart and that the only patients' charts that I had ever known to have been mislaid, were mislaid by the Trust. Nevertheless, all charts were returned from my home, as directed, on 03 January 2017, so that the Medical Director could advise the Chief Medical Officer of the status of 'missing' charts. I was subsequently presented with a list of 13 patients' charts, tracked out to me, and which were still missing. These included one who had never been my patient, two who never had clinical episodes at Craigavon Area Hospital and who did not even have a Health & Care numbers, one discharged following his birth in 1993 and who had had no episodes since then and who did not have a Health & Care Number, and one who last attended in 1988, four years before my appointment. It also included a patient whose chart had been returned to Medical Records, but which remained tracked out to me, but who is currently an inpatient with her chart intact, provided by Medical records, of course!

It was reported that there were over 600 patients who had attended as outpatients at over 60 clinics, and whose outcomes were unclear. I have yet to be advised of the source of this information, though there has been a belief

that it may have been an extrapolation of an audit of seven outpatient attendances conducted in October 2016. In fact, 349 of 560 patients (62%) who had attended 51 clinics, had already had outcomes dictated and implemented because of their clinical priority. There were 211 patients whose outpatient consultations had neither been dictated or outcomes returned. At the meeting of 30 December 2016, as I had been advised that I would not be able to return to work as intended, I requested a period of two weeks to process these remaining patients, explaining that I would review all of these patients by telephone, to ensure that their current clinical status was up to date. That would have ensured that all of these patients would have been effectively reviewed, relevant correspondence dictated, charts and clinical outcomes returned and implemented, during January 2017. Instead, I was advised that the Oversight Group had directed that the utmost priority was to have the charts returned, by 03 January 2017, so that the Medical Director could see them and report to the Chief Medical Officer of the status of the 'missing' charts.

The Medical Director advised me in his letter of 06 January 2017 that he understood that the charts had been returned as directed, and that their return would be recorded, and their location tracked on PAS, back to filing, to my office or to my secretary's office, in line with Trust procedures. However, charts were not returned to my office or to my secretary's office. Having attended a meeting in the Associate Medical Directors' office on 09 March 2017, I was concerned to find the charts still there. Nevertheless, I had consoled myself that I had been able to document all of the clinical outcomes intended for each patient before returning the charts on 03 January 2017. All of these outcomes were returned, upon request, on Monday 09 January 2017. However, I was advised in June 2017, five months later, that the outcomes had not yet been registered on PAS, never mind implemented. I find it remarkable and contradictory that a Trust purporting to be so concerned about patient safety, harm and potential harm, could have considered it appropriate to insist that 'missing' charts be imminently returned so that they could be declared 'unmissing', having been advised by me that doing so would prevent the processing of those patients in the manner which I have described, and yet allow a further five months to elapse before the returned outcomes were implemented.

Even though it is clearly stated in the Trust Guidelines that the investigation must be completed within four weeks, I still had not received any communication from the appointed Case Investigator, by 16 January 2017,

never mind any notification of a meeting with the appointed Case Investigator, to provide me with an opportunity to state my case and to propose alternatives to exclusion, as required by the same Trust Guidelines, within the four week period permitted. I had to resort to contacting the Case Investigator myself, on 16 January 2017, to be advised that he had a meeting scheduled to take place on Thursday 26 January 2016, the penultimate day of the four week period, with Mrs. Hynds, the Human Resources person appointed to assist him in the investigation, and that no meeting with me had been scheduled to take place at all, within the four week period.

In addition, I had not been provided with the Terms of Reference for the investigation on the day on which it was initiated, in breach of NCAS guidelines. I had not been provided with a copy of correspondence or communication with NCAS. I had not been provided with the minutes of the meeting of the Oversight Group. I had not been provided with a Record of the meeting of 30 December 2016. I had not been advised of the identity of the non-executive Board member appointed to ensure momentum was maintained, to ensure that the investigation was completed in a fair and transparent way, and to consider any representations regarding exclusion or any other aspect of the investigation.

I had to write to the Medical Director on 17 January 2017 requesting to be advised of the identity of the non-executive Board member and requesting all minutes, records and documentation pertaining to the meeting of 30 December 2017. I expressed my concern that a date had not been set for me to meet with the Case Investigator within the four week period, as required by the Trust Guidelines. I also requested the Medical Director to inform me in more detail of the reasons and justifications for immediate exclusion, so that I may be able to adequately respond to them, and to consider proposals for alternatives.

The Medical Director wrote to me on 18 January 2017, enclosing a Note of Meeting of 30 December 2016. In a later letter of 23 January 2017, the Medical Director advised that he had approved the Note of the Meeting on 18 January 2017. I wrote to the Medical Director on 14 February 2017, detailing factual errors and omissions in the Note of the Meeting. I found it most egregious that the Note included a statement, in parenthesis, attributed to my wife who had accompanied me to the meeting, and which she did not make. I received an email from Mrs. Hynds on 01 March 2017, acknowledging receipt of my letter of 14 February 2017 to the Medical Director, and undertaking to arrange for an

amended Note to be sent to me, taking consideration of my comments. I sent a further email to Mrs. Hynds on 19 April 2017, advising her that I still awaited receipt of an amended Note of the meeting of 30 December 2016. I have yet to receive a reply, or an amended Note.

As a consequence of my contacting the Case Investigator on 16 January 2017, and of my letter to the Medical Director on 17 January 2017, I was advised by the Case Investigator, by telephone on 19 January 2017, that a meeting was arranged with him and with Mrs. Hynds on 24 January 2017. I was advised that the purpose of the meeting was to discuss alternatives to exclusion. I was then advised by the Case Investigator, in writing on 20 January 2017, that the purpose of the meeting was two-fold, an opportunity to state my case and to propose alternatives to formal exclusion, even though I had not yet been provided an opportunity to discuss alternatives to immediate exclusion. On 23 January 2017, the Medical Director confirmed in writing that a date for the meeting had been proposed. The Medical Director did not advise me of any specific reasons or justifications for immediate exclusion as requested. He did however avail of the opportunity to opine that the Trust Guidelines created an expectation that investigations are completed in four weeks, even though the Guidelines explicitly assert that investigations must be completed within four weeks. That the investigation was in breach of Trust Guidelines was acknowledged at the meeting with the Case Investigator and with Mrs. Hynds on 24 January 2017. That acknowledgement was not included in the Note of the Meeting.

At that meeting, I asked for specific reasons for my immediate exclusion. None could be given. I asked for specific reasons why exclusion should be continued. None could be given. That none could be given was not included in the Note of the Meeting.

It was at that meeting that it was claimed that a fourth issue of concern was identified during the initial scoping exercise and relating to nine patients who had private outpatient consultations, and who then had prostatic resections performed as NHS patients, after waiting times significantly less than for other patients. However, it was not possible for this fourth concern to be identified during scoping of triage of NHS referrals, NHS outpatient consultations and NHS charts retained at my home. I requested how this concern had been raised or who had raised it. I was advised that I would be advised of the source. Six months later, I have still not been advised. I requested the identity of the nine patients concerned. I still have not been advised of their identity. I asked

whether patients who had had private consultations and who still awaited prostatic resection had been identified, or whether NHS patients who had prostatic resections performed after a similarly short waiting time would be included in a comparative manner in such an investigation. Indeed, in a further communication from the Medical Director, dated 30 March 2017, he advised that all nine patients were classified as routine. I do not know how he could have come to such a conclusion, or who did so, on his behalf. Now, six months later and four days before interview by the Case Investigator, I have still not been advised of any further developments in the investigation of this fourth concern.

On 06 February 2017, I received from Mrs. Hynds a Note of the Meeting of 24 January 2017, inviting me to advise her of any amendments required to the factual accuracy of the Note. On 28 March 2017, I submitted to Mrs. Hynds amendments to be made as a consequence of factual errors and omissions. I still have not received an amended Note.

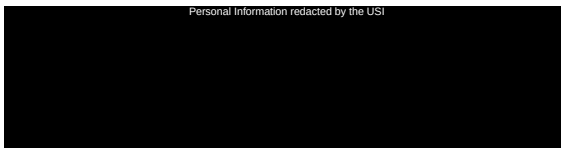
I was provided with the Terms of Reference for the investigation on 16 March 2017, though NCAS guidelines stipulate that the terms of reference be provided to the practitioner when advised of the formal investigation. On the same date, I was provided with a list of seven witnesses. Dr. Chada advised in her letter of 14 June 2017 that I will have received a witness list from her at an earlier date. I have not received any such list from Dr. Chada. I have not been provided with the testimonies of any witnesses. I have not yet been provided an opportunity to see all relevant correspondence, as obliged by Trust Guidelines.

I had considered deferring this record of my concerns until after interview by Dr. Chada. However, I have decided to do so at this time after a recent experience. I had taken annual leave the week commencing Monday 10 July 2017, but had agreed upon request to be on call on Saturday 15 July and Sunday 16 July 2017. On Friday 14 July 2017, I received calls from colleagues advising me of patients acutely admitted for surgery over the weekend. There were a total of eight patients requiring urgent surgery but I was only able to operate on four due to lack of theatre capacity. Some days later, I was approached by a member of staff whom I presume has not known of this investigation but was concerned enough to advise me that an investigation was being conducted into the cases upon whom I had operated, as it had been reported that I had arranged for one or more of these patients to be admitted electively. I was shocked by this revelation. I reported this experience when I

met with the Assistant Director of Acute Services, the Clinical Director and the Head of Service on Tuesday 25 July 2017. It was evident that this investigation was known to one or more of them, if not instigated by one or more of them. I find this a matter of grave concern.

I have very much appreciated the flexibility demonstrated by Dr. Chada in facilitating her interviewing me on a date which did not further compromise patient management and outcomes. I approach that interview with integrity, sincerity, accountability and with some apprehension. However, I do so convinced that there was a safer and less traumatic way of dealing with the concerns identified by management in March 2016, and which I had shared before and since. I should have been offered and provided with remedial action and support to address and resolve those concerns at that time. I believe that I was failed by management, as were the patients I care for. In December 2016, I should then have been offered remedial action and support to address those same concerns. An investigation of untriaged referrals could have been conducted by my colleagues, without my involvement, as I provided all of those referrals in chronological order, upon request. All of the undictated outcomes could have been completed, with updated reviews, by mid-January 2017, as described above. All of the 'missing' charts would have been returned by then. I do believe that there was no need whatsoever for immediate exclusion to be imposed in December 2016, no more than was considered necessary to be continued in January 2017, thereby avoiding the consequences upon my health suffered since, and which have been further exacerbated by the administrative conduct of an investigation into my administrative practices.

Yours Sincerely,

Personal Information redacted by the USI


Aidan O'Brien.

**MHPS RESPONSE
APPENDIX 10**

From: Aidan O'Brien [Personal Information redacted by the USI]

To: Siobhan.Hynds [Personal Information redacted by the USI]

Subject: Formal Investigation

Date: Mon, 31 Jul 2017 10:06

Siobhan,

In preparation for the interview on 03 August 2017, I would be grateful if you would provide me with the following:

- A copy of the minutes of the meeting in December 2016 of the Oversight Group
- A copy of correspondence and / or 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)
- A list of the Witnesses and their statements

Thank you,

Aidan O'Brien

From: Aidan O'Brien [Personal Information redacted by the USI]

To: Siobhan.Hynds [Personal Information redacted by the USI]

Subject: Re: FORMAL INVESTIGATION

Date: Mon, 31 Jul 2017 13:16

Siobhan

In addition to my earlier request, could you please add the details of the 9 Private Patients included in the investigation and the name or names of those who identified them.

Aidan O'Brien.

**MHPS RESPONSE
APPENDIX 11**

Inpatient Operating 2013 - 2016

2013:	Job Plan	70 sessions
	Actual done	113
2014:	Job Plan	70 sessions
	Actual done	101.25
2015:	Job Plan	70
	Actual done	95.5
2016:	Job Plan	61
	Actual done	83.25

All of this additional operating was directed to those patients in most need.

All of this additional operating resulted in scores of patients having less poor outcomes than they would have had otherwise.

There remain 30 patients on my waiting list at risk of suffering poorer clinical outcomes as a consequence of their delayed admissions.

Elective Inpatient Operating 2013

			Sessions
Wednesday	02 January	9 am – 5pm	2.0
Wednesday	09 January	9 am – 7pm	2.5
Wednesday	16 January	9 am – 1pm	1.0
Friday	18 January	9 am – 5pm	2.0
Saturday	19 January	9 am – 5pm	2.0
Wednesday	23 January	9 am – 7pm	2.5
Wednesday	30 January	1 pm – 7pm	1.5
Wednesday	06 February	9 am – 7pm	2.5
Wednesday	13 February	9 am – 7pm	2.5
Saturday	16 February	9 am – 5pm	2.0
Wednesday	27 February	1 pm – 7pm	1.5
Wednesday	06 March	9 am – 7pm	2.5
Saturday	09 March	9 am – 5pm	2.0
Wednesday	13 March	Professional Leave: Interviews	
Wednesday	20 March	9 am – 1pm (Audit in afternoon)	1.0
Saturday	23 March	9 am – 1pm	1.0
Wednesday	27 March	9 am – 7pm	2.5
Wednesday	03 April	9 am – 7pm	2.5
Saturday	06 April	9 am – 5pm	2.0
Wednesday	10 April	9 am – 7pm	2.5
Wednesday	17 April	1 pm – 7pm	1.5
Wednesday	01 May	9 am – 7pm	2.5
Wednesday	08 May	9 am – 7pm	2.5
Saturday	11 May	9 am – 5pm	2.0
Wednesday	15 May	1 pm – 7pm	1.5
Wednesday	22 May	1 pm – 7pm	1.5
Wednesday	29 May	9 am – 7pm	2.5
Saturday	01 June	9 am – 5pm	2.0
Wednesday	05 June	1 pm – 7pm	1.5
Wednesday	12 June	9 am – 7pm	2.5
Wednesday	26 June	9 am – 7pm	2.5
Wednesday	03 July	9 am – 7pm	2.5

Wednesday	10 July	1 pm – 7pm	1.5
Wednesday	17 July	9 am – 7pm	2.5
Wednesday	24 July	9 am – 7pm	2.5
Wednesday	31 July	9 am – 7pm	2.5
Wednesday	28 August	9 am – 7pm	2.5
Wednesday	04 September	9 am – 7pm	2.5
Friday	13 September	1 pm – 5pm	1.0
Wednesday	18 September	9 am – 7pm	2.5
Wednesday	02 October	9 am – 7pm	2.5
Friday	04 October	1 pm – 5pm	1.0
Wednesday	09 October	9 am – 7pm	2.5
Wednesday	16 October	1 pm – 7pm (Audit in morning)	1.5
Wednesday	23 October	1 pm – 7pm	1.5
Wednesday	30 October	9 am – 7pm	2.5
Friday	01 November	1pm – 5pm	1.0
Saturday	02 November	9 am – 5pm	2.0
Wednesday	06 November	9 am – 7pm	2.5
Wednesday	13 November	9 am – 7pm	2.5
Friday	22 November	1 pm – 5pm	1.0
Wednesday	27 November	9 am – 7pm	2.5
Wednesday	04 December	9 am – 7pm	2.5
Saturday	07 December	9 am – 5pm	2.0
Wednesday	11 December	9 am – 7pm	2.5
Wednesday	18 December	9 am – 7pm	2.5

Total = 113 sessions

Plus 1.5 hours of perioperative patient care on each date = 82.5 hours

Total = 20.625 sessions

Plus 1 hour of administration time per session = 113 hours

Total = 28.25 sessions

Total = 161.875 sessions

Elective Inpatient Operating 2014

			Sessions
Friday	03 January	1 pm – 5 pm	1.0
Monday	06 January	1 pm – 5 pm	1.0
Wednesday	08 January	9 am – 7 pm	2.5
Wednesday	15 January	9 am – 7 pm	2.5
Wednesday	29 January	9 am – 7 pm	2.5
Saturday	01 February	9 am – 5 pm	2.0
Wednesday	05 February	9 am – 7 pm	2.5
Wednesday	12 February	9 am – 7 pm	2.5
Saturday	15 February	9 am – 5 pm	2.0
Wednesday	19 February	9 am – 1 pm (Audit in afternoon)	1.0
Wednesday	26 February	1 pm – 7 pm	1.5
Wednesday	05 March	9 am – 7 pm	2.5
Wednesday	19 March	9 am – 7 pm	2.5
Saturday	22 March	9 am – 5 pm	2.0
Wednesday	26 March	9 am – 7 pm	2.5
Wednesday	02 April	9 am – 7 pm	2.5
Wednesday	09 April	9 am – 7 pm	2.5
Saturday	12 April	9 am – 5 pm	2.0
Wednesday	16 April	9 am – 1 pm (Audit in afternoon)	1.0
Wednesday	23 April	9 am – 7 pm	2.5
Wednesday	07 May	9 am – 7 pm	2.5
Wednesday	14 May	9 am – 7 pm	2.5
Wednesday	28 May	9 am – 7 pm	2.5
Wednesday	04 June	9 am – 7 pm	2.5
Wednesday	11 June	Chairing NICA N Urology	
Wednesday	18 June	9 am – 7 pm	2.5
Wednesday	25 June	9 am – 7 pm	2.5
Tuesday	01 July	9 am – 1 pm	1.0
Wednesday	02 July	9 am – 7 pm	2.5
Wednesday	09 July	9 am – 7 pm	2.5

Wednesday 16 July	M&M / Audit in afternoon	
Wednesday 23 July	9 am – 7 pm	2.5
Wednesday 30 July	9 am – 7 pm	2.5
Wednesday 06 August	9 am – 7 pm	2.5
Wednesday 13 August	9 am – 7 pm	2.5
Wednesday 27 August	9 am – 7 pm	2.5
Wednesday 03 September	9 am – 7 pm	2.5
Wednesday 10 September	9 am – 7 pm	2.5
Wednesday 17 September	9 am – 1 pm	1.0
Wednesday 01 October	9 am – 7 pm	2.5
Wednesday 08 October	1 pm – 5 pm	1.0
Wednesday 15 October	1 pm – 8 pm	1.75
Monday 20 October	9 am – 1 pm	1.0
Wednesday 22 October	8 am – 8 pm	3.0
Wednesday 12 November	9 am – 7 pm	2.5
Wednesday 19 November	1 pm – 7 pm	1.5
Wednesday 26 November	1 pm – 7 pm	1.5
Wednesday 03 December	12 noon – 8 pm	2.0
Wednesday 17 December	12 noon – 8 pm	2.0
Wednesday 31 December	9 am – 5 pm	2.0

Total = 101.25 session

Plus 1.5 hours of perioperative care on each date = 72 hours

Total = 18 sessions

Plus 1 hour administrative time per session = 101.25 hours

Total = 25.31 sessions

Total = 144.56 sessions

Elective Inpatient Operating 2015

			Sessions
Wednesday	07 January	12 noon – 8 pm	2.0
Wednesday	14 January	12 noon – 8 pm	2.0
Wednesday	28 January	12 noon – 8 pm	2.0
Wednesday	11 February	12 noon – 8 pm	2.0
Wednesday	18 February	12 noon – 8 pm	2.0
Wednesday	25 February	12 noon – 8 pm	2.0
Wednesday	04 March	8 am – 8 pm	3.0
Wednesday	11 March	12 noon – 8 pm	2.0
Saturday	14 March	9 am – 1 pm	1.0
Wednesday	18 March	5 pm – 8 pm	0.75
Wednesday	25 March	8 am – 8 pm	3.0
Tuesday	31 March	8 am – 12 noon	1.0
Wednesday	01 April	12 noon – 8 pm	2.0
Wednesday	15 April	12 noon – 8 pm	2.0
Wednesday	29 April	12 noon – 8 pm	2.0
Wednesday	06 May	8 am – 8 pm	3.0
Friday	22 May	1.30 pm – 5.30 pm	1.0
Wednesday	27 May	9 am – 5 pm	2.0
Wednesday	03 June	9 am – 5 pm	2.0
Tuesday	09 June	12 noon – 8 pm	2.0
Wednesday	10 June	12 noon – 8 pm	2.0
Wednesday	24 June	9 am – 7 pm	2.5
Wednesday	08 July	9 am – 8 pm	2.75
Wednesday	15 July	9 am – 5 pm	2.0
Wednesday	22 July	12 noon – 8 pm	2.0
Wednesday	29 July	9 am – 7 pm	2.5
Wednesday	19 August	9 am – 1 pm	1.0
Friday	21 August	9 am – 5 pm	2.0
Wednesday	26 August	2 pm – 8 pm	1.5

Wednesday	09 September	9 am – 7 pm	2.5
Monday	14 September	9 am – 8 pm	2.75
Wednesday	16 September	12 noon – 8 pm	2.0
Wednesday	23 September	12 noon – 8 pm	2.0
Wednesday	30 September	12 noon – 8 pm	2.0
Wednesday	14 October	9 am – 7 pm	2.5
Wednesday	21 October	12 noon – 8 pm	2.0
Tuesday	27 October	8 am – 1 pm	1.25
Wednesday	28 October	12 noon – 8 pm	2.0
Wednesday	04 November	12 noon – 8 pm	2.0
Wednesday	11 November	8 am – 8 pm	3.0
Wednesday	25 November	9 am – 8 pm	2.75
Wednesday	02 December	12 noon – 8 pm	2.0
Wednesday	09 December	12 noon – 8 pm	2.0
Wednesday	16 December	12 noon – 8 pm	2.0
Wednesday	23 December	12 noon – 8 pm	2.0
Wednesday	30 December	9 am – 8 pm	2.75

Total = 94.5 sessions

Plus 1.5 hours of perioperative patient care on each date = 69 hours

Total = 17.25 sessions

Plus 1 hour of administration time per session = 94.5 hours

Total = 23.625 sessions

Total = 135.375 sessions

Elective Inpatient Operating 2016

			Sessions
Wednesday	06 January	Urologist of the Week	
Wednesday	13 January	9 am – 8 pm	2.75
Wednesday	20 January	12 noon – 8 pm	2.0
Wednesday	27 January	12 noon – 8 pm	2.0
Wednesday	03 February	12 noon – 8 pm	2.0
Wednesday	10 February	12 noon – 8 pm	2.0
Wednesday	17 February	Urologist of the Week	
Wednesday	24 February	9 am – 8 pm	2.75
Friday	26 February	1.30 am – 5.30 pm	1.0
Saturday	27 February	9 am to 1 pm	1.0
Wednesday	02 March	Professional Leave: expert witness	
Wednesday	09 March	12 noon – 8 pm	2.0
Saturday	12 March	9 am – 1 pm	1.0
Wednesday	16 March	9 am – 8 pm	2.75
Wednesday	23 March	12 noon – 8 pm	2.0
Wednesday	30 March	Urologist of the Week	
Wednesday	06 April	12 noon – 8 pm	2.0
Wednesday	13 April	9 am – 8 pm	2.75
Wednesday	20 April	Audit	
Wednesday	27 April	12 noon – 8 pm	2.0
Wednesday	04 May	12 noon – 8pm	2.0
Wednesday	11 May	Urologist of the Week	
Wednesday	18 May	12 noon – 8 pm	2.0
Wednesday	25 May	12 noon – 8 pm	2.0
Wednesday	01 June	12 noon – 8 pm	2.0
Wednesday	08 June	Urologist of the Week	
Wednesday	15 June	12 noon – 8 pm	2.0
Wednesday	22 June	Professional Leave: expert witness	
Wednesday	29 June	9 am – 8 pm	2.75

Wednesday	06 July	9 am – 8 pm	2.75
Wednesday	13 July	9 am – 8 pm	2.75
Monday	18 July	1.30 pm – 5.30 pm	1.0
Wednesday	20 July	9 am – 1 pm	1.0
Wednesday	27 July	9 am – 8 pm	2.75
Wednesday	03 August	Urologist of the Week	
Wednesday	10 August	9 am – 8 pm	2.75
Wednesday	17 August	12 noon – 8 pm	2.0
Wednesday	24 August	9 am – 8 pm	2.75
Friday	26 August	9 am – 5 pm	2.0
Saturday	27 August	9 am – 1 pm	1.0
Wednesday	31 August	9 am – 8 pm	2.75
Wednesday	07 September	12 noon – 8 pm	2.0
Wednesday	14 September	Urologist of the Week	
Wednesday	21 September	9 am – 8 pm	2.75
Wednesday	28 September	9 am – 8 pm	2.75
Wednesday	05 October	12 noon – 8 pm	2.0
Wednesday	12 October	12 noon – 8 pm	2.0
Wednesday	19 October	Audit	
Wednesday	26 October	Urologist of the Week	
Wednesday	02 November	9 am – 8 pm	2.75
Wednesday	09 November	9 am – 8 pm	2.75

Total = 83.25 sessions

Plus 1.5 hours of perioperative patient care for each date: 58.5 hours

= 14.625 sessions

Plus 1 hour of administration time per session: 83.25 hours

= 20.8125 sessions

Total = 118.6875 sessions

Number of elective inpatient sessions contracted at per Job Plan = 58

Elective Day Case Surgery 2012 – 2016

The obligation defined in my Job Plan has been to undertake two Elective Day Surgical Sessions per calendar month, with the expectation that four cases would be admitted per session.

Performance

2012:	Job Plan	42 weeks 19.38 elective day case sessions
	Actual	25 sessions
2013:	Job Plan	42 weeks 19.38 elective day case sessions
	Actual	20 sessions
2014:	(Urologist of the Week introduced in September 2014)	
	Job Plan	39.5 weeks 18.23 elective day case sessions
	Actual	23 sessions
2015:	Job Plan	35 weeks 16.15 elective day case sessions
	Actual	20 sessions
2016	(Until commencement of Sick Leave on 16 November 2016)	
	Job Plan	30.5 weeks 14.07 elective day case sessions
	Actual	17 sessions

Job Planned Sessions:	87.21 elective day case sessions
Actual Sessions:	105 sessions

Additional sessions = 17.79

Job Planned Patients:	349 patients
Actual Patients:	482 patients

Additional patients = 133

Additionality

Each additional session is 4 hours of operating:	71.16 hours
Each additional session required one hour to arrange:	17.79 hours
Each additional session preceded by 0.5 hours to consent:	08.90 hours

Total additional time allocated to elective day case operating 2012 – 16:

= 97.85 hours

Mean additional time allocated to elective day case operating per week:

= 0.52 hours

Elective Day Case Surgery 2012

Tuesday	24 January	x 5 patients
Tuesday	31 January	x 5 patients
Tuesday	14 February	x 5 patients
Tuesday	21 February	x 5 patients
Tuesday	13 March	x 5 patients
Tuesday	27 March	x 4 patients
Tuesday	03 April	x 5 patients
Tuesday	24 April	x 4 patients
Tuesday	01 May	x 4 patients
Tuesday	08 May	x 4 patients
Tuesday	29 May	x 5 patients
Tuesday	19 June	x 5 patients
Tuesday	26 June	x 5 patients
Tuesday	24 July	x 3 patients
Tuesday	07 August	x 4 patients
Tuesday	14 August	x 5 patients
Tuesday	29 August	x 3 patients
Tuesday	04 September	x 5 patients
Tuesday	11 September	x 5 patients
Tuesday	02 October	x 5 patients
Tuesday	09 October	x 5 patients
Tuesday	30 October	x 4 patients
Tuesday	06 November	x 5 patients
Tuesday	13 November	x 5 patients
Tuesday	04 December	x 5 patients

Total sessions = 25

Total patients = 115

Elective Day Case Surgery 2013

Tuesday	22 January	x 4 patients
Tuesday	05 February	x 5 patients
Tuesday	12 February	x 5 patients
Tuesday	12 March	x 5 patients
Tuesday	09 April	x 5 patients
Tuesday	16 April	x 5 patients
Tuesday	14 May	x 4 patients
Tuesday	04 June	x 5 patients
Tuesday	11 June	x 5 patients
Tuesday	02 July	x 4 patients
Tuesday	09 July	x 5 patients
Tuesday	27 August	x 5 patients
Tuesday	03 September	x 5 patients
Tuesday	10 September	x 5 patients
Tuesday	15 October	x 5 patients
Tuesday	22 October	x 5 patients
Tuesday	12 November	x 4 patients
Tuesday	26 November	x 5 patients
Tuesday	03 December	x 5 patients
Tuesday	10 December	x 5 patients

Total sessions = 20

Total patients = 96

Elective Day Case Surgery 2014

Tuesday	14 January	x 5 patients
Tuesday	28 January	x 5 patients
Tuesday	11 February	x 4 patients
Tuesday	25 February	x 3 patients
Tuesday	18 March	x 5 patients
Tuesday	25 March	x 4 patients
Tuesday	08 April	x 5 patients
Tuesday	15 April	x 5 patients
Tuesday	06 May	x 4 patients
Tuesday	27 May	x 6 patients
Tuesday	03 June	x 6 patients
Tuesday	08 July	x 5 patients
Tuesday	22 July	x 5 patients
Tuesday	29 July	x 5 patients
Tuesday	05 August	x 5 patients
Tuesday	26 August	x 5 patients
Tuesday	02 September	x 5 patients
Tuesday	16 September	x 5 patients
Tuesday	07 October	x 5 patients
Tuesday	21 October	x 5 patients
Tuesday	18 November	x 5 patients
Tuesday	16 December	x 4 patients
Tuesday	30 December	x 4 patients

Total sessions = 23

Total patients = 110

Elective Day Case Surgery 2015

Tuesday	06 January	x 4 patients
Tuesday	27 January	x 5 patients
Tuesday	10 February	x 4 patients
Tuesday	17 February	x 4 patients
Tuesday	10 March	x 4 patients
Tuesday	24 March	x 4 patients
Tuesday	28 April	x 4 patients
Tuesday	12 May	x 4 patients
Tuesday	26 May	x 4 patients
Tuesday	09 June	x 3 patients
Tuesday	23 June	x 5 patients
Tuesday	28 July	x 4 patients
Tuesday	25 August	x 4 patients
Tuesday	08 September	x 4 patients
Tuesday	22 September	x 4 patients
Tuesday	13 October	x 4 patients
Tuesday	03 November	x 5 patients
Tuesday	24 November	x 5 patients
Tuesday	08 December	x 4 patients
Tuesday	22 December	x 5 patients

Total sessions = 20

Total patients = 84 patients

Elective Day Case Surgery 2016

Tuesday	19 January	x 5 patients
Tuesday	02 February	x 4 patients
Tuesday	23 February	x 4 patients
Tuesday	15 March	x 4 patients
Tuesday	22 March	x 5 patients
Tuesday	05 April	x 5 patients
Tuesday	19 April	x 4 patients
Tuesday	03 May	x 5 patients
Tuesday	31 May	x 5 patients
Tuesday	28 June	x 5 patients
Tuesday	19 July	x 5 patients
Tuesday	26 July	x 5 patients
Tuesday	09 August	x 4 patients
Tuesday	06 September	x 4 patients
Tuesday	20 September	x 4 patients
Tuesday	11 October	x 4 patients
Tuesday	01 November	x 5 patients

Total sessions = 17 sessions Total patients = 77

Lead Clinician of MDT & Chair of MDM

I was appointed Lead Clinician of Urology MDT and Chair of Urology MDM on 01 April 2012.

I held the post of Lead Clinician of Urology MDT until 31 December 2016.

I chaired every MDM from April 2012 until the introduction of a three person rotation for chairing MDM in September 2014.

The numbers of cases discussed at each MDM was limited to 40.

Chairing MDM requires the Chairperson to preview all cases for discussion.

This task was made all the more taxing due to failure of clinicians to provide clinical summaries of all cases, as is required.

Previewing each MDM required 3 to 4 hours of time depending upon the numbers discussed.

MDM was followed by proof reading outcomes prior to them being sent to GPs.

**Additional Time spent previewing and proof reading MDMs chaired:
(allocating a mean total of 4 hours per MDM)**

2012: 31.5 weeks: MDM x 25 = 100 hours = **3.17 hours per week**

2013: 42 weeks: MDM x 44 = 176 hours = **4.19 hours per week**

2014: 39.5 weeks: MDM x 35 = 140 hours = **3.54 hours per week**

2015: 35 weeks MDM x 17 = 68 hours = **1.94 hours per week**

2016: 30.5 weeks MDM x 16 = 64 hours = **2.09 hours per week**

In addition as Lead Clinician, I brought the SHSCT Urology MDT from one which did not meet any National Cancer Plan target in 2012 to one that did not have a single case outside target timelines in 2015 when Peer Reviewed.

During the years as Lead Clinician, I established and secured agreement for all urological cancer referral and clinical management pathways.

I wrote and secured agreement for the MDT Operational Policy by having Business Meetings on alternate months.

I lead the SHSCT Urology MDT through National Peer Review in June 2015 and through the Peer Review update in September 2016.

All of these duties of Lead Clinicianship required a minimum of 1 additional hour of time allocated every week from April 2012 to September 2016.

The mean additional time allocated to MDT and MDM from 2012 to 2016 per week = 3.9 hours.

**MHPS RESPONSE
APPENDIX 12**

DATE	CLINIC	CLINIC CODE	PATIENTS	COMPLETED	UNDONE
24/11/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2014	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
12/01/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
23/02/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
09/03/2015	SWAH	EUROAOB	RETURNED BEFORE 30TH DECEMBER 2016		
13/04/2015	SWAH	EUROAOB	15	8	7
11/05/2015	SWAH	EUROAOB	17	10	7
22/06/2015	SWAH	EUROAOB	16	7	9
06/07/2015	SWAH	EUROAOB	15	5	10
28/09/2015	SWAH	EUROAOB	15	6	9
19/10/2015	SWAH	EUROAOB	15	8	7
02/11/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
06/11/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
24/11/2015	NEW CLINIC	CAOBTDU	RETURNED BEFORE 30TH DECEMBER 2016		
30/11/2015	SWAH	EUROAOB	16	9	7
04/12/2015	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
06/12/2015	ARMAGH CLINIC	AAOBU1	RETURNED BEFORE 30TH DECEMBER 2016		
22/12/2015	NEW CLINIC	CAOBTDU	7	4	3
08/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
11/01/2016	SWAH	EUROAOB	17	10	7
15/01/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
08/02/2016	SWAH	EUROAOB	18	10	8
07/03/2016	SWAH	EUROAOB	16	5	11
21/03/2016	ARMAGH CLINIC	AAOBU1	16	13	3
01/04/2016	UROONCOLOGY CLINIC	CAOBUO	9	8	1
04/04/2016	REVIEW CLINIC - CAH	CAOBT DUR	13	7	6
08/04/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
15/04/2016	UROONCOLOGY CLINIC	CAOBUO	7	5	2
18/04/2016	ARMAGH CLINIC	AAOBU1	13	8	5
19/04/2016	NEW CLINIC	CAOBT DU	6	3	3
22/04/2016	UROONCOLOGY CLINIC	CAOBUO	5	4	1
27/04/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
27/04/2016	UROONCOLOGY CLINIC	CAOBUO	9	3	6
29/04/2016	URODYNAMICS CLINIC	CAOBUDS	3	1	2
03/05/2016	REVIEW CLINIC - CAH	CAOBT DUR	RETURNED BEFORE 30TH DECEMBER 2016		
06/05/2016	HOT CLINIC		2	0	2
23/05/2016	REVIEW CLINIC - CAH	CAOBT DUR	16	12	4
27/05/2016	UROONCOLOGY CLINIC	CAOBUO	10	8	2
27/05/2016	URODYNAMICS CLINIC	CAOBUDS	5	4	1
03/06/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
10/06/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
13/06/2016	ARMAGH CLINIC	AAOBU1	15	7	8
20/06/2016	SWAH	EUROAOB	21	13	8
04/07/2016	REVIEW CLINIC - CAH	CAOBT DUR	17	10	7
22/07/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
26/07/2016	NEW CLINIC	CAOBT DU	7	4	3
09/08/2016	NEW CLINIC	CAOBT DU	10	6	4
12/08/2016	UROONCOLOGY CLINIC	CAOBUO	9	7	2
19/08/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1

19/08/2016	UROONCOLOGY CLINIC	EUROAOB	5	4	1
22/08/2016	SWAH	EUROAOB	16	4	12
19/09/2016	SWAH	EUROAOB	18	7	11
07/10/2016	URODYNAMICS CLINIC	CAOBUDS	3	2	1
11/10/2016	NEW CLINIC	CAOBTDU	9	8	1
14/10/2016	URODYNAMICS CLINIC	CABOUDS	3	2	1
14/10/2016	UROONCOLOGY CLINIC	CAOBUO	5	3	2
21/10/2016	URODYNAMICS CLINIC	CAOBUDS	4	2	2
28/10/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
28/10/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
04/11/2016	UROONCOLOGY CLINIC	CAOBUO	RETURNED BEFORE 30TH DECEMBER 2016		
			PATIENTS	COMPLETED	NOT PROCESSED
	TOTAL OF 41 CLINICS		450	261	189

BREAKDOWN OF UNPROCESSED	REVIEW	DISCHARGES	DNA	THORNDALE	DAY SURG	INPATIENT W/L
189	110	35	10	13	7	14

**MHPS RESPONSE
APPENDIX 13**

From: aidanpobrien

Personal Information
redacted by the USI

To: Siobhan.Hynds

Personal Information redacted by the USI

CC: neta.chada

Personal Information redacted by the USI

Subject: Investigation

Date: Mon, 2 Apr 2018 21:14

Attachments: Comments relating to the Respondent Statement of Thursday 03 August 2017.docx (41K),
Comments concerning the Respondent Statement of the Meeting of 06 November 2017.docx (65K),
Comments concerning Witness Statements.docx (72K)

Siobhan,

Thank you for your email of 04 March 2018.

Thank you for the draft Respondent Statement relating to the meeting of 06 November 2017.

I have attached comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2018.

I have also attached comments relating to the Statements of Witnesses.

I also take this opportunity to remind you that I had written to Dr. Wright on 14 February 2017 with details of factual errors and omissions in the Note of the Meeting I had with him and Ms. Hainey on 30 December 2016.

You had written to me on 01 March 2017, advising that you would arrange an amended Note to be sent to me, taking consideration of my comments.

I still have not received an amended Note.

You had also provided me on 06 February 2017 with a Note of the Meeting of 24 January 2017 with Mr. Weir and with yourself.

I submitted proposed amendments to that Note on 28 March 2017.

I still await an amended Note.

I particularly would be grateful if you would clarify whether it is intended to provide amended Notes, and if so, when I might expect to receive them.

Thank you,

Aidan.

Comments relating to the Respondent Statement of Thursday 03 August 2017

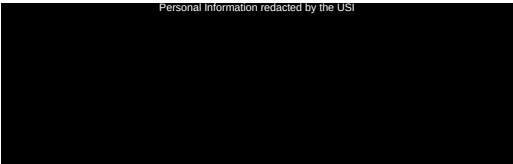
The following is a list of comments relating to the interview conducted by Dr. Chada on Thursday 03 August 2017:

- The statement did not include my enquiry relating to my failure to receive amended Notes of previous meetings following my submission of those proposed amendments. (This related to the Note of the meeting with Dr. Wright and Ms. Hainey on 30 December 2016 and to the Note of the meeting with Mr. Weir and Ms. Hynds on 24 January 2017.)
- Paragraph 3 relates that I have been asked to provide this statement in respect of an investigation in response to concerns about my conduct / clinical practice being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework. Paragraph 3 is incorrect as I was not asked to provide this statement in accordance with either the Trust Guidelines or the Framework, nor could I have possibly been asked to do so, for the reasons as detailed in my letter of 30 July 2017, addressed to Dr. Khan. Succinctly, the Trust formulated its Guidelines in September 2010 in response to its obligation to do so, in order to implement the Framework. Therefore, such an investigation can only be conducted by the Trust in accordance with its Guidelines, and as the investigation was not completed by 30 January 2017, its continuation since then cannot have been, and has not been, in accordance with its Guidelines.
- Paragraph 7 should read: 'Of the non-personalised referrals allocated to me, i.e., those allocated to me as Consultant Urologist of the week, I triaged all red flag referrals during 2015 and 2016, but did not triage the remaining referrals during 2015 and 2016.'
- Even though later paragraphs elaborate further, Paragraph 8 requires some amendment by way of clarification. The practice of allocating referrals to be triaged by the Consultant Urologist of the week, whilst being Consultant Urologist of the week, was introduced concurrent with the introduction of the Consultant Urologist of the week model in 2014. Whilst I did agree with it being so, I soon found it impossible to do, and I did advise by early 2015 that I had found it impossible to do. The possibility or otherwise of doing so was not assisted by the complete lack of any clarity or agreement regarding the detail of the triaging process.
- Paragraph 9 referred to the number of referrals which I had not triaged during 2015 and 2016. I have been provided with the details of 319 referrals which I had not triaged during that time, and agree that that number is factually correct.
- The second sentence in Paragraph 13 should read: 'The *quantity* of referrals is such that you cannot properly triage them'.
- Paragraph 14 is very important. Did I ever say that I was no longer doing this. I believe that I did by advising that I had found it impossible to do. I did not use the words 'I am no longer

doing this' as I did not appreciate that those words were required in addition to advising that I had found it impossible to do, but nevertheless, I do regret not additionally doing so.

- The second sentence of Paragraph 16 should read 'I had endeavoured to get colleagues to do *advanced* red flag triage'.
- Paragraph 20 should also have included my assertion that I am aware that inpatient care has been compromised by Consultants of the week conducting triage while being Consultant Urologist of the week, and patients have suffered as a consequence.
- The first sentence of Paragraph 29 should read 'It was noted that I had returned 288 sets of notes from home, *on 03 January 2017*, on request from the Medical Director in *December 2016*'.
- The first three sentences of Paragraph 31 should read 'I returned a total of 288 charts from my home. These included 77 Trust charts of patients who had attended privately and 211 Trust charts of NHS patients, the latter consisting of 22 patients who had been discharged, and 189 patients who had attended clinics, without dictation.
- Paragraph 34 should read 'I shared a copy of the outcome sheets I returned to Martina Corrigan in January 2017. I accepted that there were *41 clinics for which dictated outcomes had not been done for all patients who had attended those clinics. A total of 450 patients had attended those clinics. Following their clinical prioritisation, 261 (58%) patients had clinical outcomes dictated and implemented, 189 patients had not.*'
- The first sentence of Paragraph 41 should read 'I accepted that outcome sheets for the 41 clinics were not returned on time'.
- The third sentence of paragraph 43 should read '*There are 189 of the patients with less clinical priority, some of whom are waiting long periods of time to be reviewed.*'

Personal Information redacted by the USI



Aidan O'Brien
30 March 2018

Comments concerning the Respondent Statement of the Meeting of 06 November 2017

The following are comments regarding the draft Respondent Statement of 06 November 2017, received upon request on 04 March 2018:

- e The draft Respondent Statement did not include any reference to a lengthy discussion concerning the difficulty in responding to allegations made of witnesses in their statements without being provided with documentary evidence of those allegations. One such allegation was used to exemplify this difficulty. It has been alleged that I had been allocated more administrative time in my job plan than my colleagues had. Not only was I unaware of having been so, I am unable to clarify whether the allegation is true as I do not have any knowledge of the job plans of my colleagues. It would therefore have been useful to be provided with that clarification in order to be able to make an informed comment upon the allegation.e
- e Paragraph 5 requires amendment. I was first made aware of a concern having been raised regarding patients who had attended privately and who had subsequently been admitted for TURP after a waiting time that was significantly less than for other patients, when I met with Mr. Weir and with Ms. Hynds on Tuesday 24 January 2017. I was informed in writing that there were nine such patients. The concern had been added to the initial three concerns as Issue Four. It, and the number of patients concerned, were reiterated in the Note of that meeting. Both were again repeated in writing in the Return to Work meeting with Dr. Khan on 09 February 2017. When Dr. Wright wrote to me on 30 March 2017, he claimed that it had been established that there were at least 9 TURP patients who had been seen privately, who were routine in terms of clinical priority, but appeared to have had their NHS procedure done in non-chronological order. Lastly, in his witness statement of 06 April 2017, Mr Carroll reported that he and Martina Corrigan had looked to see if there was a trend for TURP patients to be 'seen out of sequence and there were (sic) a number identified'. He did not specify the number.e
- e As indicated by the draft Respondent Statement, I had been provided, on 03 August 2017, with a list of 11 patients who had procedures performed, having previously had a private consultation. The list included the details of the date upon which each patient had been entered on the waiting list and the date of the procedure performed. It also included a judgement provided by a senior clinician as to whether there had been a clinical reason why each patient had waited such a short period of time. As indicated, I provided copies of a synopsis of each case, including the clinical reasons and circumstances pertaining to the management of each case.e
- e In doing so, I clarified that the date on which each case had been placed on the waiting list had been correct in only two cases. It did appear that the patients may have been placed on a waiting list on the date upon which their GP was being advised of their admission, with no relation to the date upon which they had had a private consultation. As a consequence, it did appear that one patient was admitted for surgery 54 days after entry on a waiting list rather than 428 days after the consultation when it was agreed to proceed with surgery. However, I also pointed out that another patient had been entered on the waiting list 12 days before he had had any consultation.e

- e In the course of doing so, and as inadequately indicated in the draft Respondent Statement, I drew attention to the inadequacy of having waiting lists with only two categories of urgency (urgent and routine), instead of four, as had been the case previously. I advised that there is no separate category for red flag patients. Instead, they are added to the urgent waiting list which is almost four years long. I advised that patients awaiting TURP provide an example of the inadequacy of the current categorisation. For example, it could not be justified to have patients with indwelling catheters following acute urinary retention, often complicated by acute renal injury or urosepsis or both, waiting four years for admission for TURP.e
- e Also, in the course of doing so, I expressed concern that another clinician could have arrived at a judgement regarding the clinical justification for admission after any period of time, on the basis of a letter alone. I was particularly concerned that it had not been considered reasonable to have an 82 year old woman admitted for ureteroscopic laser lithotripsy to a 1.2 cm stone obstructing her left ureter, and doing so after a period of 25 days.e
- e As inferred by the Respondent Statement, I was asked by Dr. Chada whether there were any further comments I had to make concerning the list provided. I advised that the most striking feature of the list was that it was not a list of nine, or more, patients who had been admitted for TURP after a prior private consultation at all. It did in fact include three patients who had been admitted for TURP after an apparently short period of time following a private consultation, though one of those had been the patient admitted 428 days following that consultation, rather than 54 days.e
- e At the meeting with Dr. Chada on 03 August 2017, I requested to be advised of the manner in which that conclusion had been reached. I was advised by Ms. Hynds on 28 September 2017 that it had been so by having a report run on all of the surgery performed by me in 2016. I advised Dr. Chada and Ms. Hynds at the meeting of 06 November 2017 that I had since reviewed all of the surgery performed by me during that same period. I reported that a total of 46 patients had prostatic resection (TURP) during 2016, and that indeed nine previously had an private outpatient consultation with me. I advised that the mean time from the consultation when it was decided to proceed to TURP for those nine patients (whether that consultation was the earlier private consultation or an intervening NHSE review consultation) was 202 days. The mean waiting period for the remaining 37 patients was 219 days. Also, five (56%) of the nine patients who had had a private consultation had waited more than 100 days, in contrast to fourteen (38%) of the remaining 37 patients. I provided Dr. Chada with these figures, asserting my belief that they do not reflect a preference given to those with whom I had had a private consultation previously.e
- e The draft Respondent Statement does not include my expressed concerns regarding the above. It does not include my expressed concern regarding the failure to have undertaken a comparative analysis of the periods of time awaited by those admitted for TURP, having had a previous outpatient consultation and those who had not. Since this issue was first raised on 24 January 2017, I had enquired whether such a comparative analysis had been undertaken. In fairness, I had been advised that it had not. Instead, and according to the

Witness Statement from Mr. Carroll, following receipt of one email received from Mr. Haynes, he and Mrs. Corrigan had had a look to see if any such patients were 'seen out of sequence' and that 'there were (*sic*) a number identified'. I expressed my concern that, on the basis of this 'look', a non-comparative conclusion may have been made without any reference to the clinical circumstances. I further expressed my concern that Dr. Wright had then been advised of that conclusion. Indeed, Dr. Wright had additionally stipulated that all nine TURP patients had been categorised as routine! I expressed my concern that the Oversight Group would also have been similarly informed by the time it had met on 26 January 2017 to consider my exclusion.

- Lastly, the draft Respondent Statement does not include my expressed request that this matter be investigated, and that I be advised of its outcome.

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Aidan O'Brien
31 March 2018.

Comments concerning Witness Statements

In commenting upon the statements of witnesses, I have endeavoured to restrict them to those which I have considered pertinent to the substantive issues of concern, while avoiding repetition unless relevant to do so. Lack of comment on all said does not infer acceptance.

Comments concerning the Witness Statement of Ms. Katherine Robinson

- Paragraph 5 relates that Mr. O'Brien's triage was raised every Tuesday morning at Dr. Rankin's meeting, as she would have tabled the issue, and that triage was always discussed every Tuesday morning. I find it remarkable that management would have discussed an issue every week during the tenure of Dr. Rankin, and failed to have discussed that issue with me as frequently as it was discussed about and without me.
- In Paragraph 8, Ms. Robinson relates that copies of referrals to Mr. O'Brien were kept in case they were not triaged, and so that they could go to other consultants. This is a new revelation for me. I have not been aware of this having been done. I would have thought that I would have been advised of such by my colleagues if it had been the case, or have read reference to it in their Witness Statements.

Comments concerning the Witness Statement of Mrs. Heather Trouton

- I am alarmed to read in Paragraph 5 that Mrs. Trouton asserted that she was aware that I did not agree with triage, and that I made it clear that I did not agree with the three categories of referral, that red flags were important but that the others were not. This is of course completely untrue. I have never disagreed with triage. On the contrary, I believe that triage is most important, and so important that it requires time to do properly. Ironically, the triaging of red flag referrals is less important and less time consuming by the very nature of their clinical urgency which will dictate that they will be assessed in an appropriately, timely manner. It is the remaining majority of referrals that are even more important and time consuming, particularly in the context of an urgent referral having to wait over 80 weeks for an outpatient consultation, and a routine referral having to wait over 100 weeks for a similar consultation. It requires time to request investigations, give advice, initiate treatment and review reports, so that such patients may have some progress made in their investigation and management during those periods of time.
- On the contrary. I do believe that Mrs. Trouton was absolutely correct when she asserted that I did not agree with the system in place, and for all of the reasons which I have alluded to above and previously.
- I am pleased to note in Paragraph 9 that Mrs. Trouton related that I had possibly said that I was not doing triage. At least one person has been able to equate my reporting that I had found it impossible to do, with not doing so. In relating that it was never agreed that he could not do it, I assume that she may have meant to say that it was never agreed that I was permitted not to do so. It is indeed true that I did not receive a permission not to do

so, but I was advised of the implementation of the default process of reverting to the category of referral stated in the letter of referral, for that very reason.

- Mrs. Trouton is mistaken in paragraph 11 in asserting that most referrals are red flag referrals, which have always and still do comprise a minority of the total of referrals
- I was surprised to learn in Paragraph 13 that a meeting had been held with Dr. Wright on 11 January 2016 regarding the issues raised in the letter given to me on 23 March 2016. I was surprised particularly as I had had a meeting with Dr. Wright on Friday 01 April 2016 concerning unrelated matters. I would have considered that concerns of such import would have been raised with me at that time.
- Mrs. Trouton is mistaken in relating in Paragraph 14 that a complaint had been received from me, accusing Mr. Mackle of bullying. I did not submit any complaint of bullying on the part of Mr. Mackle. Instead, I had submitted on 30 January 2012 a formal written grievance concerning deductions that Mr. Mackle had unilaterally made to payments owed to me for extra-contractual work undertaken by me. The grievance was upheld. As Mr. Mackle's Personal Information
Personal Information redacted by the USI, I suspended further proceedings, reserving the right to resume doing so, if the need arose.
- In Paragraph 20, Mrs. Trouton asserted that nothing was recorded in patients' charts concerning consultations. This I would entirely dispute. I have never in my career not entered a legible, hand-written note in a patient's chart concerning their consultation, in sharp contrast to many who have written nothing.

Comments concerning the Witness Statement of Mr. Colin Weir

- I have found it remarkable, if not alarming, to read in Paragraphs 6 -9 that discussions were being regularly held between so many people regarding the issues contained in the letter of 23 March 2016, and over a period of months thereafter, and including Dr. Mc Allister, Mr. Weir, Mr. Haynes, Mr Young, Mrs. Corrigan and Mr. Carroll, and that during all of that time, no one had managed to discuss the issues with me, with a view to arriving at a supported plan to assist in addressing and resolving the issues.
- I certainly have found it alarming to read in Paragraph 10 that Mr. Weir was told at a point not to meet with me concerning the issues. As I have previously asserted, there has been a complete failure of management to provide support to me after 23 March 2016 to address and resolve the issues. To learn that the Clinical Director was directed not to do so, is a more serious matter altogether.
- In paragraph 15, Mr. Weir related that Dr. Mc Allister felt that the correspondence of 23 March 2016 had not addressed the problem. I agree.

Comments concerning the Witness Statement of Mr. Eamon Mackle

- In Paragraph 10, Mr. Mackle relates that he had to deal with the appropriateness of Mr. O'Brien's use of antibiotics. In fact, this issue related to the practice of both Mr. Young and I electively readmitting patients, who regularly suffered from recurring urosepsis, for intravenous hydration and antibiotic therapy, in order to minimise the frequency and severity of infection. This practice was disapproved by the Trust. However, our experience was subsequently published, having proven to be successful in its purpose, and without emerging antibiotic resistance.
- In Paragraph 10, Mr. Mackle relates that they had been alerted by nursing staff that Mr. O'Brien had removed notes from a patient's chart and dumped them in a bin in the ward. In fact, I had removed fluid balance charts of years previously from the chart of Personal Information redacted by the USI as there was not enough space in her chart to file continuation sheets on which I had written clinical notes while the patient was an inpatient. I had formed the judgement that the fluid balance charts of years previously were not likely ever to be required, while the current clinical notes were pertinent. I did place them in the confidential waste bin in the ward. My doing so was reported by a ward clerk, not by nursing staff.
- It is worthy of note that, in Paragraphs 11 and 12, Mr. Mackle relates that I had complained that he was bullying / harassing him, while omitting to report that the single complaint that I had formally submitted related to the deduction of payments and the resulting breach of contract referred to above.
- In paragraph 14, Mr. Mackle relates that I had stopped seeing new patients to clear a backlog and that 18 months previously, I had asked for another month free to similarly do so. Again, this is untrue.
- Most importantly of all, Mr. Mackle certainly did not set out to me the actions I needed to take when he gave me the letter of 23 March 2016, and as he claims to have done in Paragraph 21. He has been correct in his statement that no supports to address the issues were discussed.

Comments concerning the Witness statement of Mrs. Martina Corrigan

- Mrs. Corrigan relates in Paragraph 12 that the issues of concern had been verbally addressed with me by Dr. Patrick Loughran and by Dr. John Simpson. I only had one meeting with Dr. Loughran during his tenure as Medical Director, and that was in the company of Mr. Young and in relation to the elective readmission of patients for intravenous hydration and antibiotic therapy. The only occasions when in the company of Dr. John Simpson was on interview panels. I have never had a meeting with Dr. Simpson. Neither spoke to me at any time regarding these issues. Even though I had had a meeting

with Dr. Wright on Friday 01 April 2016, these issues were not raised by him. The first time he raised these issues with me was on 30 December 2016.

- In Paragraph 14, Mrs. Corrigan relates that I was offered help. Mr. Young did indeed carry out triage for me from February 2014 to June 2014, and which I very much appreciated at that time as I had to spend so much time on preparing the Trust for Peer review of Urological Cancer Services. I gain the impression that other help was offered. None was.
- In Paragraph 14, Mrs. Corrigan asserts that I would always have said that I was determined to give a Rolls Royce service to his patients. This assertion is just patently untrue. I have never used the metaphor and have never considered that the service which I have provided, has been to some unnecessary standard of luxury or perfection. This is a good example of a perception of me being attributed to me.
- Mrs. Corrigan incorrectly states in Paragraph 15 that I needed 30 minutes consultation with each patient. The only patient cohort for which I claimed to need 30 minutes of consultation time was cancer patients, whether new or review. The BAUS guidelines 2016 state that 20 minutes be provided for the new, generic patient and 10 – 15 minutes for the review generic patient. For new patients attending a specialist clinic, the BAUS guidelines recommended 30 – 45 minutes per patient and 15 – 45 minutes for the review patient.
- In Paragraph 15, Mrs. Corrigan states that I 'see' on average 10 patients where others will have 14 – 16 patients booked to their clinics. However, it is my understanding that 9 new patients attend each New Clinic per consultant, and that 12 patients attend each general review clinic per consultant. At oncology review clinics, I review 7 or 8 patients in addition to 2 or 3 patients for urodynamic studies, with or without flexible cystoscopy. I believe that this is in accordance with BAUS guidelines. If I have been 'seeing' less patients than my colleagues, then perhaps it is my colleagues who may not be practising in accordance with BAUS guidelines.
- In Paragraph 16, Mrs. Corrigan asserts that it was preference to operate rather than do outpatient clinics, and that I would sometimes agree and do a 9 am to 8 pm list (always my choice). Indeed, I always agreed to do a 9 am to 8 pm operating session if available, and without remuneration, foregoing annual leave on those days, only due to having 280 patients awaiting surgery for up to four years.
- In Paragraph 17, Mrs. Corrigan states that I have been allocated additional administration sessions because of my attention to detail. As stated previously, I have been unaware of having additional time allocated to administration.
- In Paragraph 17, Mrs. Corrigan relates that I spent large amounts of time preparing for the chairing of Urology MDM and that others considered was unnecessary. I believe that it was necessary, and I have never been advised by others that it was unnecessary.
- In Paragraph 19, Mrs. Corrigan refers to 365 charts returned to my office from my home in January 2017. For the sake of accuracy, 288 were returned from my home, the remainder having been on shelves in my office.

- In Paragraph 22, Mrs. Corrigan relates that 668 patients did not have letters dictated. I do not recognise this figure, and I have not been provided with documentary evidence in support of it.
- In Paragraph 25, Mrs. Corrigan repeats the assertion that there were 66 clinics not dictated. As I have submitted in detail, there were only 189 patients for whom letters had not been dictated from 41 clinics

Comments concerning the Witness Statement of Mr. Ronan Carroll

- In Paragraph 6, Mr. Carroll states that at one time, in 2007, I told him that I did not agree with the cancer standards, and that I would continue to practise as I had always done. For the sake of clarification, I only reservation I had in relation to cancer standards was the complete lack of any standards relating to the rest of urological pathology. If I had not agreed with the cancer standards per se, I would not have dedicated so much of my time over a period of four years being Lead Clinician and Chair of the NICaU Urology Clinical Reference Group, and Lead Clinician of the Southern Trust urology MDT and Chair of its MDM.
- In Paragraphs 7 and 8, Mr. Carroll states that either Mr. Haynes or Mr. Glackin felt that the patient, Personal Information should have been upgraded to red flag based on the symptoms. As detailed in my response to the SAI relating to this patient, the symptom of pain could not have been considered a reason to upgrade to red flag status a patient reported to have a simple renal cyst.
- In Paragraph 18, Mr. Carroll states that Mr. O'Brien never said that he was not doing triage. I find Mr. Carroll's omniscience remarkable.
- In Paragraph 26, Mr. Carroll states that my colleagues follow the two categories of urgency allocated to patients on waiting lists. I certainly hope that they are not doing so!

Comments concerning the Witness Statement of Mr. Mark Haynes

- I do agree with Mr. Haynes' assertion in Paragraph 10 that triage should by definition be conducted and categorised by the referrer, rather than by the secondary care clinician to ensure that the referrer has done so properly. However, I do not anticipate that allocating the proper category of referral to the referrer will gain much traction. Nevertheless, I do believe that it should be possible to raise the threshold for referral, as much more investigation and management could, and should, be carried out in primary care, particularly in the light of long waiting times for a first outpatient consultation.
- Also in Paragraph 10, Mr. Haynes correctly asserts that triage takes up an inordinate amount of consultant time. We receive approximately 176 referrals per week. If five minutes were spent on each referral, that would require almost 15 hours, almost two working days. Though I have referred to this matter previously, undertaking triage while

being Urologist of the week, has resulted in triage being conducted instead of patient management. Patients have been acutely admitted and discharged without ever having been seen by the Consultant, have had unsupervised surgery performed by the registrar with suboptimal outcomes, have been discharged without surgery which could have been done. It has appeared to me that triage has assumed a primacy whilst being urologist of the week, because of its associated standards, whilst the management of inpatients has lost that primacy, because it does not have standards related to it.

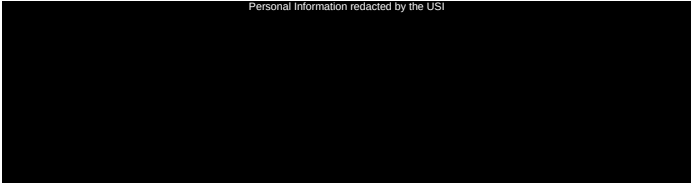
Comments concerning the Witness Statement of Mr. Anthony Glackin

- In Paragraph 17, Mr. Glackin refers to the referral which gave rise to the SAI. I believe that this Paragraph is of central importance to the issue of triage. I do agree that it had been entirely reasonable for the GP to have referred this patient routinely. I do still contend that it can only be logical that the referral would have been triaged as routine, if triage is confined to the information contained in the referral. I then find it most interesting that Mr. Glackin asserts that we had agreed as a team to arrange investigations before attendance at clinics, and if this had been done, it would have been appreciated that there were other aspects to the case which would have resulted in upgrading to red flag status. I have already submitted documentary evidence that I had been unable to obtain a commitment from my colleagues to do so for red flag referrals which constitute a minority of referrals. In Paragraph 14 of her Witness Statement, Mrs. Corrigan stated that I had wanted to conduct advanced triage, but that advanced triage had not been agreed. This lack of agreement to a standard of triage in every case, and the complete failure of Trust management to address this issue, persists. I do believe that the waiting times relating to urgent and routine referrals should mandate that proper, complete, advanced triage be conducted on each case. I believe that the time required to do so, whilst Urologist of the week, has been and remains untenable and unsafe. It was for that reason that I advised that I had found it impossible to do.
- In Paragraph 18, Mr. Glackin relates that my written response to the SAI was very lengthy and written in an adversarial and legal manner. I agree that it was very lengthy indeed, and was so because it was forensic, and being so led to conclusions which I reached, and which have been highlighted once again in the Comment above.
- In Paragraph 35, Mr. Glackin relates that I had requested administration time on the Tuesday morning which followed the monthly Monday clinic at SWAH, and that this caused dissent among other members of the team. I have not appreciated that doing so could have caused dissent. I still do not understand how it is that not undertaking either of the twice monthly, day case surgical operating list on the morning after the SWAH clinic could have done so.
- In Paragraph 36, Mr. Glackin asserts that productivity at the SWAH clinic has been poor. It has been my understanding that it was agreed that Mr. Young and I would have 16 patients attend our clinics in SWAH. I have had no appreciation that the numbers attending my SWAH clinic has been lower than those attending Mr. Young's clinic, and have been provided with evidence to that effect.

Comments concerning the Witness Statement of Mr. Michael Young

- In Paragraph 9, Mr. Young relates that we had introduced advanced triage, and that all consultants bought into the change. As indicated above, this has certainly not been the case, and still does require resolution. Of course, his referring to advanced triage not being a necessity, has proven to be the let out clause in the vast majority of referrals.
- In Paragraph 32, Mr. Young may have given the impression that I had been allocated the Tuesday morning after the monthly Monday SWAH clinic instead of undertaking a day surgical operating list. I believe that it has since been clarified that is not so.
- In Paragraph 36, Mr. Young relates that the vast number of the charts reviewed by him and his colleagues had no dictated letter relating to the patient's outpatient consultation. I would have understood that none would have had, as all of the charts being reviewed were only those for whom no outpatient letter had been dictated.
- In Paragraph 41, Mr. Young states that managers had not discussed the issues of concern with him. I believe that this assertion is at variance with those of other witnesses.
- In Paragraph 42, Mr. Young relates that I had never indicated that I was not doing all my triage, even though I had previously advised, in his presence, to him and to others, that I had found it impossible to do. Perhaps it had been expected that I would do it anyway, even though I had advised that I had found it impossible.

Personal Information redacted by the USI



Aidan O'Brien
01 April 2018

**MHPS RESPONSE
APPENDIX 14**

From: aidanpobrier [Personal Information redacted by the USI]
To: Siobhan.Hynds [Personal Information redacted by the USI]
CC: neta [Personal Information redacted by the USI], Ahmed.Khan [Personal Information redacted by the USI], John.Wilkinson [Personal Information redacted by the USI]
BCC: johnwilkinson [Personal Information redacted by the USI]
Subject: Investigation
Date: Sun, 10 Jun 2018 17:07

Attachments: Comments relating to the Respondent Statement of Thursday 03 August 2017.docx (41K),
Comments concerning the Respondent Statement of the Meeting of 06 November 2017.docx (65K),
Comments concerning Witness Statements.docx (72K)

Siobhan,

I refer to my email of 02 April 2018, attached below.
I have not yet received a reply, acknowledging its receipt.
I would appreciate if you would provide an acknowledgement as soon as possible.
I would also be grateful if you could provide me with a time frame in which I will receive a substantive response to the points raised in the Comments attached.
I would also appreciate if you would provide me with the amended minutes of meetings as requested, and promised, over one year ago.

Finally, 17 months have elapsed since this investigation was initiated, and 16 months in breach of Trust Guidelines.
I would be grateful if you could provide an update on when the report on the investigation is likely to be completed and when I am likely to receive it.

Aidan.

-----Original Message-----

From: Aidan O'Brien [Personal Information redacted by the USI]
To: Siobhan.Hynds [Personal Information redacted by the USI]
CC: neta.chada [Personal Information redacted by the USI]
Sent: Mon, 2 Apr 2018 21:14
Subject: Investigation

Siobhan,

Thank you for your email of 04 March 2018.
Thank you for the draft Respondent Statement relating to the meeting of 06 November 2017.

I have attached comments concerning the proposed Respondent Statements of 03 August 2017 and of 06 November 2018.

I have also attached comments relating to the Statements of Witnesses.

I also take this opportunity to remind you that I had written to Dr. Wright on 14 February 2017 with details of factual errors and omissions in the Note of the Meeting I had with him and Ms. Hainey on 30 December 2016.
You had written to me on 01 March 2017, advising that you would arrange an amended Note to be sent to me, taking consideration of my comments.
I still have not received an amended Note.

You had also provided me on 06 February 2017 with a Note of the Meeting of 24 January 2017 with Mr. Weir and with yourself.

I submitted proposed amendments to that Note on 28 March 2017.
I still await an amended Note.

I particularly would be grateful if you would clarify whether it is intended to provide amended Notes, and if so, when I might expect to receive them.

Thank you,

Aidan.

Report of a Root Cause Analysis of SAI

Personal
Information
redacted by the USI

Comments regarding Factual Accuracy

Patient 16 was 68 years old when he developed colonic obstruction due to an adenocarcinoma of his sigmoid colon necessitating sigmoid colectomy and a Hartmann's end colostomy in July 2012. He subsequently declined adjuvant chemotherapy. He required a small bowel resection in August 2014 for small bowel obstruction due to metastatic colonic adenocarcinoma. On CT scanning on 11 March 2015, it was evident that he had metastatic disease progression in the form of a left pulmonary nodule which had increased in size, and of a left pelvic mass causing left upper urinary tract obstruction. Following discussion at the Lower GI MDM on 12 March 2015, his primary colorectal surgeon (ConsSurg9) wrote to Consultant Urologist 11 (ConsUrol11) with a view to considering left ureteric stenting. Even though referred to ConsUrol11, he attended a clinic of Consultant Urologist 15 (ConsUrol15) on Thursday 26 March 2015, when his Specialist Trainee wrote in her letter to Patient 16's family doctor that they had arranged his elective admission on 31 March 2015 for insertion of a left ureteric stent.

The report then states that Patient 16 was admitted to Craigavon Area Hospital on 31 March 2015 under the care of Consultant Urologist 13 (ConsUrol13). Having reviewed the record of his admission both on NIECR and PAS, it is evident that I am Consultant Urologist 13. However, the record is untrue. I had undertaken to conduct an additional operating session on the morning of Tuesday 31 March 2015. As I have retained records of all admissions arranged by me, currently back to and including 2010, I can confirm that I arranged the admissions of four patients for surgery that morning. Patient 16 was not one of them. I have cross checked with my secretary who has provided a copy (attached) of the operating list entered on the Theatre Management System. Patient 16 is not included on the list. It is a matter of concern that the Review Team have been prepared to rely upon the record of NIECR and PAS without checking its veracity.

However, even though I do arrange admissions with the agreement and commitment of the patients involved, one of those four patients was unable to be admitted that morning. Though entirely speculative on my part now, I suspect that it is most probably the case that I had time as a consequence to supervise the procedure undergone by Patient 16 in another theatre that morning, particularly as the same Specialist Trainee was not rostered to my operating session that morning.

As a consequence, as detailed in the Report, I agreed to have Patient 16 placed on my waiting list on 02 April 2015 for Removal of Left Ureteric Stent, Ureteroscopy and ? Restenting, with an indicative date for his readmission being October 2015, though the intent was that the stent would not be removed or replaced until the patient had completed chemotherapy.

Serious Adverse Incident Review

Organisation's Unique Case Identifier: ID

Personal
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Patient Patient 10

Introduction

In considering the comments which I had regarding the final draft of the report of the Review Panel investigating the above serious adverse incident, I concluded that there were a number of factual errors, omissions and inferences in their report, and to the extent that I considered it necessary to relate Patient 10's clinical history below.

Clinical History

Patient 10 was 59 years old when acutely admitted to Craigavon Area Hospital on 5th January 2010, under the care of Dr 1, having had abdominal pain and nausea during the previous ten days. On CT scanning of her abdomen and pelvis on 6th January 2010, she was reported to have significant sigmoid colonic diverticular disease with an extraluminal collection which was considered to have probably resulted from perforation of a diverticulum. She was managed conservatively and successfully, enabling her discharge on 13th January 2010.

The CT scan of 6th January 2010 was also reported to have demonstrated the presence of multiple, simple, right renal cysts, the largest coming from the upper pole, and measuring 5.6 cm. The left kidney was reported to be unremarkable.

Patient 10 had a barium enema performed as an outpatient on 17th February 2010 when she was reported to have a long shouldered stricture of the proximal sigmoid colon in keeping with a primary malignancy. From subsequent documentation available on NIECR, it would appear that she underwent a sigmoid colectomy on 9th March 2010 and that pathological examination of the resection specimen confirmed the presence of a pT4b N1 M0 colonic adenocarcinoma, for which she subsequently had adjuvant chemotherapy.

During her postoperative recovery period, she had a CT scan of her chest, abdomen and pelvis performed on 22nd March 2010. The report of 25th March 2010 included that multiple renal cysts were present, the largest located at the upper pole of the right kidney and measuring 6.3 cm in diameter.

The first annual CT scan of the patient's chest, abdomen and pelvis was requested by an oncologist, was performed on 18th November 2010 and reported on 03rd December 2010. Apart from the reported lack of evidence of metastatic disease, she was reported to have a 'simple renal cyst particular in right. No solid renal mass'.

This CT scan is also the earliest for which digitalised images have been archived and available for review. On review, it is evident that there were three, exophytic, cystic lesions

arising from the right kidney. The largest lesion arose from the upper pole and had a mean density of 23 Hu (deviation 30 Hu). The smallest arose from the lower pole and had a mean density of 20 Hu (deviation 27). The third lesion, the index lesion of later concern, had a mean density of 28 Hu (deviation 31) and a diameter of 28.5 mm. All three had the appearances of simple renal cysts.

The next CT scan was requested by Dr 1, was performed on 22nd December 2011 and reported on 24th December 2011. The report included reference to 'simple cysts noted in the right kidney. No renal mass of significance'. Review of the archived images would agree with the report that all three lesions had the appearances of simple cysts, with the index lesion having a mean density of 24 Hu (deviation 30).

The next CT scan was again requested by Dr 1, was performed on 21st December 2012 and reported by Dr 10 on 13th January 2013. The only reference to the right renal lesions was of a 'Bosniak type 1 cyst present right kidney'. However, review of the archived images found a subtle but definite change in the appearance of the index lesion compared to previously, in that it appeared to be denser, with an increase in its mean density to 32 Hu (deviation 47), and particularly in its medial portion where the mean density was 51 Hu (deviation 39). No appreciation of this change was reported.

Patient 10 then had a lobulated carcinoma of her right breast managed by wide local excision and sentinel node biopsy in October 2013, followed by radiotherapy and hormonal therapy. She had also contacted the Out of Hours service on three occasions on 28th February 2014 and 1st March 2014, following her return from holiday where she had dysuria and increased frequency of micturition for a period of one week, but had developed fever, flank pain and visible haematuria since her return. She was prescribed Amoxicillin for presumed urinary infection which was confirmed on urinary culture on 03rd March 2014 and on 12th March 2014 when the infecting organism was found to be resistant to Amoxicillin. Urinary microscopy and culture were both normal on 07th May 2014.

The next CT scan was again requested by Dr 1 as before, was performed on 24th June 2014 and reported by Dr 7 on 7th July 2014. Multiple and bilateral simple renal cysts were reported. The index lesion was reported as a 'cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its (sic) medial aspect which was probably present previously. The cyst appears minimally larger'. In the conclusion, it was reported that the appearances may have represented a haemorrhagic or proteinaceous cyst, but a localised ultrasound was recommended to ensure that there was no soft tissue component. Review of the archived images would indicate that the mean densities of the entire lesion and of its medial region had remained unchanged since December 2012, but that the density deviations had reduced significantly to 20 and 13, respectively, indicating that the subtle changes of December 2012 had been consolidated in the interim.

Dr 1 wrote to Patient 10 on 10th July 2014 advising that there was a 'cyst in your right kidney which is almost certainly a water-filled cyst with no consequence and has been noted before but the radiologist has suggested confirming this with an ultrasound'. Dr 1 advised that he

would arrange the ultrasound scan and that he would review Patient 10 in or around September 2014.

Dr 1 requested the ultrasound scan on 10th July 2014. It was performed on 24th July 2014 and reported by Dr 2 on 30th July 2014. The report was the first enumerated description by a radiologist of all three right renal lesions. The index lesion was described as a complex lower pole cyst noted anteriorly, 3.7 cm in diameter, containing echogenic, well defined material posteriorly, possibly solid. Dr 2 advised renal MRI scanning with IV contrast to determine if the solid component enhanced.

Renal MRI scanning was requested by, or on behalf of, Dr 1 on 08th September 2014. It was performed on 26th September 2014 and reported by Dr 2 on 29th September 2014. The report read 'Comparison to previous ultrasound dated 24th July 2014 and CT dated 24th June 2014. There is a large, well-defined, ovoid, cystic mass arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. The lesion is T2 hyperintense, T1 hypointense and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. There was no description of the other two right renal lesions.

In the interim, Patient 10 was reviewed by Dr 3 at the Breast Clinic on 23rd September 2014 when Patient 10 reported that she had had pain on the right side during the previous two weeks, initially on inspiration, by then if she moved suddenly. She reported that the pain had improved since taking Ibuprofen. She was found to have some tenderness in the lateral right breast, particularly around her scar. Dr 3 noted that Patient 10 was awaiting MRI scanning following CT and ultrasound scanning for a right renal lesion. Dr 3 advised that she had organised a CT scan of the patient's chest. A CT scan of chest and abdomen was in fact requested.

The CT scan was performed on 29th October 2014 and reported by Dr 4 on 1st November 2014. The report referred to a '3.6 cm, exophytic, complex cyst seen in the lower pole of the left (sic) kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion'. Then in conclusion, Dr 4 referred to a 'complex cyst right kidney (previously investigations noted).

Dr 5, a GP, referred Patient 10 as a routine referral on 29th October 2014. The reason for referral was 'Large renal cyst 8.7 cm x 5.3 cm' and with the comment that 'this 64 year old lady with a h/o bowel cancer and more recently breast cancer had an MRI scan done in Sept'14 for persistent R renal angle pain. She is otherwise well but has some nocturia. MRI scan showed a well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm. The lesion is T2 hyperintense, T1 hypointense and demonstrates no abnormal enhancement. MR appearances are consistent with a cyst. I would be grateful for your assessment and advice.'

Dr 3 wrote to Patient 10 on 7th November 2014 advising that the CT scan of 29th October 2014 had 'shown no worrying abnormality. The cyst on your right kidney, as previous investigations had noted, was remarked upon again.' Patient 10 was further reviewed at the Breast Clinic by another doctor on 4th March 2015 when no reference was made to the index right renal lesion. Moreover, Patient 10 had been reviewed by her breast oncologist on 7th October 2014 and on 14th April 2015, without reference to the index right renal lesion.

The routine referral by Dr 5 resulted in Patient 10 having a urological outpatient consultation with Dr 8 on 6th January 2016 when the significance of the index right renal lesion was appreciated, and which was explained to Patient 10 and to her husband who accompanied her. Dr 8 requested a further CT scan of chest, abdomen and pelvis, and provisionally arranged a date for renal surgery on 25th January 2016.

CT scanning was performed on 8th January 2016. The index right renal lesion was reported to be a complex cyst and to have increased in size to 3.8 cm (from 2.85 cm in November 2010 and from 3.6 cm in October 2014). Its density characteristics had not changed significantly since 2014. The CT scan was also reported to have demonstrated partially healed fractures of the right sixth and seventh ribs, and most importantly, the presence of an enlarged, left axillary lymph node measuring 2.2 cm in diameter.

Patient 10 was advised of these findings at further review by Dr 8 on 11th January 2016 when she was advised that she would be reviewed at the Breast Clinic on 12th January 2016, and that it had been possible to bring forward her admission for renal surgery to 16th January 2016.

Patient 10 was reviewed by Dr 3 at the Breast Clinic on 12th January 2016 when a core biopsy was taken from the left axillary lymph node mass. Histopathological examination was reported on 14th January 2016, confirming that the axillary lymphadenopathy was due to metastatic lobular breast carcinoma. At further review on 15th January 2016, it was agreed that the management of the metastatic breast carcinoma should take precedence. She proceeded to have left axillary lymphadenectomy in February 2016, followed by systemic chemotherapy and radiotherapy.

Following completion of treatment of metastatic breast carcinoma, Patient 10 was admitted electively on 31st October 2016 for laparoscopic right partial nephrectomy which was performed by Dr 8 that day. She was discharged on 5th November 2016. Histopathological examination of the resection specimen confirmed that the lesion was a Fuhrman grade III, papillary, renal cell carcinoma which was predominantly encapsulated but with a nodular infiltration of renal parenchyma to within 0.2 mm of the inked resection margin.

Dr 8 has since advised Patient 10 that the tumour had been completely removed, and that hopefully surgery will have been curative.

Comments

In compiling Patient 10's clinical history, I did so prospectively from January 2010. Whilst not a radiologist, I was able to appreciate that there had been a change in the appearance of the index right renal lesion on CT scanning performed on 21st December 2012 and reported by Dr 10 on 13th January 2013. This change was later referred to by Dr 7 in his report of the appearance of the index lesion on CT scanning performed in June 2014 as subtle layering with high density in its medial aspect, and which was probably present previously. Retrospective measurement of densities confirms that the change was definitely present previously in December 2012. It is regrettable that an appreciation had not been included in

the report of January 2013. Had it been so, the further assessment and management of the lesion may have proceeded during 2013, rather than two to three years later.

Patient 10 developed a coliform urinary infection while on holiday [Personal Information redacted by the USI] during the last week of February 2014. She contacted the Out of Hours service on three occasions during 28th February 2014 and 1st March 2014 as she had developed worsening and systemic symptoms, including visible haematuria. Even though the infecting organism was resistant to the antibiotic initially prescribed, there is no documentary evidence of recurrence of visible haematuria. Therefore, there was no indication for referral of Patient 10 to the urological service, in accordance with referral guidelines which pertained then or revised since.

I believe that it is understandable that Dr 7 did not bring his appreciation of the change in the appearance of the index lesion to the attention of the urological service in July 2014, as he considered that the significance of the change was equivocal, and for which reason he advised further assessment by ultrasound scanning. However, had he done so, the management of the lesion would have been progressed in the months thereafter.

Dr 1 was regrettably premature in his letter of reassurance to Patient 10 on 10th July 2014 when ultrasound scanning was requested. Dr 1 may not have appreciated the potential significance of the changed appearances of the index lesion as reported by Dr 7.

The report of the ultrasound scan of the 24th July 2014 by Dr 2 was characteristic of his detailed, scrupulous reportage in that it was the first report to describe all three right renal lesions. He advised MRI scanning with intravenous contrast to determine whether the possibly solid material, within the cyst, enhanced. It is regrettable that Dr 2 did not refer the patient to Urology MDM at this time, particularly in light of his reasonably significant index of concern regarding the lesion, and the fact that the incremental assessment of the lesion was not known to the urological service. Dr 2 would have frequently brought such cases to the attention of MDM in such circumstances, and was facilitated to do. Another opportunity to bring the patient and her lesion to the attention of the urological service was missed.

There is no record on PAS or on NIECR of Patient 10 having been reviewed by Dr 1 in September 2014, or subsequently. As I presume that she underwent colonic resection in March 2010 in a non-NHS institution, I presume that Dr 1 may have reviewed Patient 10 privately in September 2014 when renal MRI scanning was requested. However, the lack of documentation resulting from subsequent review by Dr 1 deprives one of assessing the response of Dr 1 to the report of the MRI scan of 26th September 2014.

The MRI scan was performed on 26th September 2014 and reported on 29th September 2014 by Dr 2 who had advised it be done in the first instance. In the first sentence of his report, he had compared the findings to those of the previous ultrasound and CT scans. It has been my impression that the report as presented was probably the first paragraph of a report in which the large upper pole cyst was described in that first paragraph, and that the other two right renal lesions would be described in subsequent paragraphs, as would have been expected of Dr 2. Had he been interrupted? Could further paragraphs or portions of the report been lost or deleted by some technical glitch? In any case, I believe that this was the most significant, missed opportunity to bring Patient 10 to the attention of the urological service.

Patient 10 was then reviewed, with respect to her breast cancer, on 23rd September 2014, by Dr 3, and not by Dr 2 as reported by the Review Panel in their final draft report. Dr 3 documented that Patient 10 had right breast and chest wall pain and tenderness, and not right renal angle or flank pain. By way of reassurance, Dr 3 requested a CT scan of chest and abdomen, performed on 29th October 2014 and reported by Dr 4 on 1st November 2014, and in which he reported that there was an exophytic complex cyst seen in the lower pole of the left kidney anteriorly containing solid and cystic components, then reported that the left kidney showed no focal lesion and concluded by reporting that there was a complex cyst of the right kidney. Again, this represented a further missed opportunity to bring Patient 10 to the attention of the urological service, by whatever means.

Dr 3 then wrote to Patient 10 on 7th November 2014 that the CT scan of 29th October 2014 had shown no worrying abnormality and that the cyst on her right kidney, as previous investigations had noted, was remarked upon again. However, the cyst to which Dr 3 referred was the complex cyst described on CT scanning, and not to be confused with the large, simple cyst described on MRI scanning.

One can only conclude that Dr 3 did not appreciate the potential significance of a complex cyst. As a consequence, no referral to urology was made.

By then, Dr 5, a GP in the practice in which Patient 10 was registered as a patient, had referred Patient 10 as a routine referral, on 29th October 2014, requesting assessment and advice regarding Patient 10 whom Dr 5 related had had an MRI scan performed in September 2014 for persistent right renal angle pain, and that the MRI scan had shown a large, simple cyst arising from the upper pole of her right kidney. Dr 5 was mistaken in asserting that the MRI scan had been performed in the investigation of pain of any kind. Whilst I have not met Patient 10 I doubt whether she ever did have any right renal angle pain. As documented above, the pain was related to her right breast and chest. Moreover, the Review Panel were mistaken in their report that Dr 5 had requested assessment and advice in relation to the MRI findings regarding a large renal cyst and recent breast cancer. The referral sought assessment and advice regarding the finding of a large, simple, right renal cyst in a 64 year old lady, with a history of bowel cancer and more recently breast cancer, and which Dr 5 believed may have been causing right renal angle pain. The referral letter was not triaged by Dr 6.

Patient 10 was reviewed by her oncologist on 7th October 2014 and again on 14th April 2015, without reference to the right renal lesion. She was again reviewed by another doctor at the Breast Clinic on 04th March 2015. Even though this was the service that requested the CT scan of 29th October 2014, there was no reference to the complex renal cystic lesion reported, and no referral made to the urological service by any means.

As a consequence of failure of triage, the default triage management process resulted in Patient 10 having to wait 64 weeks from the time of GP referral until the appointment with Dr 8 on 06th January 2016 when the significance of the index right renal lesion was appreciated by the urological service for the first time since its existence in December 2012. Somewhat reassuringly, it had only increased in diameter from 2.85 cm to 3.8 cm in that time. Laparoscopic right partial nephrectomy was deferred until 30 October 2016 following

completion of management of the metastatic breast carcinoma detected on further staging CT scanning performed in January 2016.

I agree with Dr 8 in his reassurance to Patient 10 in November 2016 that surgery has probably been curative. It probably would have been even more reassuring if there had been a wider normal resection margin, though I believe that the evidence for that is scant. There is the additional concern regarding the high Fuhrman grade and whether it would have been lower had the lesion been resected at an earlier date. Nevertheless, the overwhelming probability is that surgery will have been curative, and that the delay in surgery will not have resulted in a negative outcome.

Comments regarding Triage

In replying with comments regarding the final draft report, I have attempted to do so comprehensively, fairly and honestly. With regard to the referral letter of 29th October 2014, if I had triaged the letter on or after 30th October 2014, I would have retained its routine status. If I were to triage it afresh today, I do believe that I would do likewise. Why?

This was a referral which was graded as routine by Dr 5. I do agree with Dr 8 in his letter of 6th January 2016 that it was entirely reasonable that the referral was routine, even though the patient had a history of bowel and breast carcinoma, and even though Dr 5 believed, probably mistakenly, that the cyst may have been causative of persistent, right renal angle pain. Such referrals are not uncommon. In a minority of cases, larger simple cysts do cause discomfort or pain. The impression that I would have had from the referral letter would have been that her pain had been comprehensively investigated, including by MRI scanning, and that the cyst potentially causative of pain was unequivocally proven to be large and simple. Therefore, I would certainly not have considered upgrading it to Red Flag status. I also do not believe that I would have upgraded it to Urgent status, as the likelihood of a large simple cyst being the cause of persistent pain would have been minimal.

The Review Panel have not offered any explanation as to why the status of the referral should have been upgraded, and to which status. I do not know whether it was because of the history of bowel and breast cancer, or whether the Panel were of the view that the report of the MRI scan, and by inference, of any other scans should have been reviewed on NIECR or NIPACS, or indeed whether the images should have been reviewed in addition. If this were the case, then the content of all letters of referral would be ignored, and a complete review conducted on line. As a consequence, it would never be considered defensible to triage a referral on the contents of the letter alone, and as a consequence, considerable cumulative time would be required to do so.

I have believed, and have expressed the view, that the inclusion of the triage of all letters of referral in the duties and responsibilities of the urologist of the week was inappropriate. The introduction of the 'urologist of the week' was borne out of a realisation that the increasing numbers of inpatients and the complexities of their morbid and comorbid status were such that they would be better served by a 'urologist of the week' than by the previous 'urologist on call'. This reality has been acknowledged and implemented by many other specialties.

The purpose and priorities of the 'urologist of the week' are for the consultant to deliver hands-on clinical and operative management of all urological inpatients, all other inpatients in the hospital whose assessment and management was sought, all patients in the Emergency Department whose assessment and management was sought, and importantly, all such patients in other hospitals in our area of responsibility, and particularly, Daisy Hill and South West Acute Hospitals. Optimising the outcomes of all of these patients requires time and commitment. It should not be inappropriately delegated to junior doctors. It requires every attempt be made to carry out definitive surgical management if possible. It should not be compromised by triage of non-red flag referrals. In consideration of their inferred clinical priority, I have always agreed that red flag referrals be triaged by the urologist of the week, and which I have always done, even if I had not always managed to completely do so by the end of the week in question.

I have previously tried to conduct detailed triage of the non-red flag referrals whilst being urologist of the week. I would have reviewed all details on NIECR and reviewed all images, if any, on NIPACS, irrespective of the content of the letters. However, I was not prepared to compromise inpatient management by doing so. I was not prepared to spend time triaging non-red flag referrals rather than operating on patients if at all possible. With around 280 patients on an three year, inpatient waiting list, I could not justify discharging acutely admitted inpatients to that waiting list.

I also found it impossible to have the time to do so when not 'urologist of the week' because of additional work load, due to the continued pressure to minimise the incidence of poor clinical outcomes of patients awaiting long periods of time for admission and readmission for surgery. In 2014, I had arranged and undertaken 22.25 additional, elective, inpatient operating sessions 4 additional, elective, day surgical sessions, and some 19 additional, specialty clinic sessions. I had also previewed, chaired and reviewed all cases discussed at MDM each week, from April 2012, until the introduction of a rota in September 2014.

I do not have any means of knowing how many inpatients I was responsible for from 29th October 2014 to 31st October 2014, or how many emergency operations I performed during that time. I do know that I previewed all of the cases for the Urology MDM of Thursday 30th October 2014. This would have typically taken some three hours during the evening or night of 29th October 2014, in addition to chairing the MDM on 30th October 2014, and spending typically one hour with the cancer tracker that evening reviewing and signing off the outcomes of MDM. I also reviewed ten cancer patients on the morning of Friday 31st October 2014.

I do believe that the inclusion of triage of all non-Red Flag referral letters in the duties of a consultant urologist when urologist of the week has been inappropriate and regrettable. I do believe that it has, on occasion, compromised inpatient care and has, on occasion, resulted in deferment of definitive management of inpatients. It was for all of these reasons that I had advised personnel from the Appointments Office, when we met them to discuss the issue, that I had found it impossible to triage non-Red Flag referrals, whilst urologist of the week, and that another system or method or time was needed for them to be done, if by a consultant at all, and which I believed and advised was not in itself necessary.

Conclusion

Patient 10 had a complex right renal cystic lesion since December 2012. During the next two years, its potential significance had either not been appreciated, or had been appreciated but not reported by at least two radiologists, and not reported to the urological service. Similarly, the potential significance of the lesion had not been appreciated by at least two clinicians who had requested further imaging which had been advised by radiologists in the investigation of the lesion from June 2014 to March 2015, and had similarly failed to refer Patient 10 to the urological service. I believe that the Review Panel may have failed to appreciate the significance of the cyst having changed between 2011 and 2012.

Even though there were failures on the part of clinicians and radiologists who had assessed and investigated Patient 10 and the index right renal lesion, I found the Review Panel's emphasis on the lack of triage of the letter of routine referral as the main cause of delay in Patient 10 having a urological appointment, as remarkably asymmetric. I do believe that it would have been reasonable and defensible to have relied upon the information contained in the letter of referral, and to have maintained the referral as routine. Therefore, lack of triage did not impact upon the time to consultation.

I also do believe that the triage on non-red flag referrals should be revisited, with a commitment to accommodate all views, to discuss who, when and how this challenge can be satisfactorily resolved.

Aidan O'Brien.

25 January 2017

Comments concerning the RCA Report on Review of SAI

Personal Information
redacted by the USI

In submitting this commentary regarding the RCA Report of SAI Personal Information redacted by the USI I have reviewed all retained correspondence relating to the issue of triage, all retained documentation relating to other issues impacting upon triage and all retained documentation relating to other issues referred to by others interviewed during the course of the Root Cause Analysis. Having done so, I believe that the Recommendations outlined in the Report are its most important component, though I believe that at least one additional recommendation is required to ensure that the others could be effectively implemented. I have endeavoured to be concise.

Having been interviewed by Dr. Johnston and having read the above Report, I do believe that the singular and significant flaw of the Review has been to investigate the failure to triage urgent and routine referrals in isolation of other pressures and clinical priorities which I believe are evidently more important. As a clinician and a clinical department, I believe that these greater clinical priorities cannot be compromised for the sake of triage, as they have been and continue to be.

Urologist / Consultant of the Week

While agreeing that triage is indeed a serious issue and very important, I was concerned to being expected to agree that triage of referrals has 'number one ranking in the overall scheme of things'. I believe that it is vitally important to fully appreciate the significance of this claim, especially as triage has been aligned with the duties of the Urologist of the Week (UOW). If, as has been my experience during my last week as UOW, one does a ward round from 09.00 am to 11.30 am, prior to going to theatre to undertake seven emergency / urgent operations, is triage the most important concern that day, or the day after, if it is similar?

I most earnestly urge the Review Team to review the wording of Recommendation 6, urging the Trust to re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. I believe that it is important to appreciate that the Trust has never examined or assured itself in the first place, never mind do so again. I believe that it is crucially important that the duties and priorities of the CoW and the expectations of the Trust of the CoW in the conduct of those duties and priorities, be clearly agreed and expressed in a written Memorandum of Understanding, or similar. I do so as there has been an ambiguity since its inception as to those duties and priorities.

Following a long period of gestational discussion, the UOW came into existence in late 2014. The major reason for the length of that gestational discussion was the belief, particularly on the part of our Lead Clinician, that the duties of the UOW could not possibly take up a whole day. This belief was borne out of his perception that the UOW would essentially be on call. When subsequently persuaded and convinced that it would be a good for inpatient management that the UOW would conduct an ward round each morning, it was then proposed that we could then undertake a clinic in the afternoon each day, as the duties of UOW could be confined to the morning, as one would rarely be called to theatre in an emergency. When successfully disabused of that proposal which would have necessitated the disorderly cancellation of outpatient attendances, the proposal of

being able to undertake triage of all referrals while UOW was born, as it could be undertaken at any flexible time.

There is no doubt that the clinical and operative demands upon the UOW have evolved and increased during the past five years. Nevertheless, there persists a lack of clarity as to its very purpose, and I have no doubt that there persists a dichotomy of Urologist on Call and Urologist of the Week. It had been my understanding ab initio that its *raison d'être* was to provide hands-on, clinical management of all inpatients within our department, whether acutely or electively admitted, to provide advice and management to patients attending and referred from other Departments at Craigavon Area, Daisy Hill and South West Acute Hospitals, and to undertake emergency and urgent surgical intervention so far as is possible. To do so effectively in pursuit of optimal clinical outcomes requires knowing patients, often with complex comorbidities, in detail, and that requires time. However, this has not always been the case.

I have experienced a patient being unnecessarily and inappropriately discharged when it would have been entirely possible for them to have had surgical intervention while inpatients, only to be acutely readmitted, sicker than previously and for another UOW to manage. I have witnessed patients undergoing surgery by Registrars (while the UOW triaged referrals) with outcomes inferior to those I believe would have been achieved had the UOW been operating, or at least attending in supervision. I have been requested by Nursing Staff to assess inpatients who had never been seen by a UOW. Indeed, the most frequently occurring practice which persists is that of the UOW not coming to the hospital at all, particularly over weekends, unless 'called' of course, or not undertaking ward rounds even if present in the hospital.

And while it has been and continues to be easier to undertake triage while being 'on call', I have also no doubt whatsoever that the expectation to undertake triage of all referrals lends itself to being Urologist on Call rather than UOW. Indeed, a senior executive manager of the Trust has written that UOW was introduced to facilitate triage! If that is one understanding, there certainly needs to be a discussion and an agreement in the first instance of the duties of the UOW.

In 2018, following discussion amongst our colleagues, it was agreed that we would set aside a whole day, Monday 24 September 2018, to meet with senior management to discuss this very issue, among others. We were requested to submit those issues which we wanted to have discussed (I have separately attached my submission). No clinical commitments were arranged for that day. The meeting was cancelled, with loss of all clinical activity that could have been scheduled. The meeting was rescheduled for Monday 03 December 2018, again with no clinical commitments scheduled. No senior management personnel could attend. I therefore have no confidence whatsoever that Recommendation 6 will be addressed.

Triage and Waiting Times

I also do contend that it is not possible to deal adequately with the very important issue of triage without consideration of waiting times, and how this could or should affect the nature of the triage conducted. Dr Johnston was of the view that the Red Flag referrals were not an issue as they 'go straight into the system'. However, the recent waiting time for a first consultation for a patient suspected of having prostatic carcinoma is 107 days. We have recently been circulated with the details of twelve patients referred as, or upgraded to, Red Flags as they were suspected of having

prostatic carcinoma. They were triaged, without any consideration of any form of preliminary investigation being requested. It would have taken less than one minute to ascertain their Red Flag status, and 'they go straight into the system', and wait almost four months for a first consultation. The further ignominy is that, on attending almost four months later, some have waited all of that time just to have a serum PSA repeated, before deciding whether to proceed with Investigative imaging, such as MRI scanning, prior to prostatic biopsies. Lest there be any doubt, the reason for the conduct of triage in such a manner is the lack of time to do otherwise, coupled with a determination that triage will be completed on completion of the period of UOW. As indicated above, I have witnessed such minimalist triage being conducted instead of undertaking ward rounds.

In March 2015, I endeavoured as Lead Clinician of Urology MDT to have my colleagues agree to advanced / enhanced triage of Red Flag patients alone. The purpose of doing so was to facilitate patients progressing along the diagnostic and therapeutic pathway in the timeliest manner possible. I did not succeed, as they declined to commit to doing so, and the reason given then was the lack of adequate time while being UOW. I have retained a written record which can be provided if requested. As a persistent consequent, a patient recently referred with a renal tumour detected on ultrasound scanning, waited for a first consultation before having staging CT scanning performed, and which could have been requested if time had been taken or available to do so, to request the scan, informing the patient (and referrer) that it had been requested.

The issue of the referrals which are actually triaged as urgent and routine is even more pressing. It is worth asserting that a referral triaged as urgent may be as life threatening, except that it is presumed that it will not be threatened by a malignancy. However, as has been a recent experience, last year's pyelonephritis was actually a renal cell carcinoma, and she was not even referred, never mind triaged. The recent waiting time for a first consultation for an urgent appointment was 85 weeks. For a routine consultation, it is over three years! Scrotal swellings considered benign by the referrer are routinely triaged by most as routine, without any imaging requested. Yet, seven of 77 such referrals (9%) have been found in a recent audit to have testicular tumours.

Apart from the lack of adequate time to conduct optimal triage while UOW, an additional disincentive is that the UOW will be responsible for the receipt of any investigations requested, and without any additional administrative time allocated to do so. During my last period as UOW, I requested 47 scans. I did so, mainly in the days following completion of the period as UOW. Today, I have received the result of a CT Urogram indicating that the patient probably has pancreatic carcinoma with hepatic secondaries. I will arrange an outpatient consultation for this patient in coming days.

Yet, despite repeated claims to the contrary, the Trust does not have a policy regarding urological triage, and particularly in the context of such waiting times, and with respect to an ongoing expectation that triage will be conducted by the UOW while being the UOW. It remains the case that the Trust is happy with and prefers that the referral is triaged as quickly as possible, so that they are in the system, without investigation and irrespective of the periods of time waiting for a first consultation. It is now almost three years since I recommended in my report concerning the index case Patient 10 that the Trust should meet with us to discuss and agree who should undertake triage, when it should be conducted, and the nature of the triage to be conducted. There has been

no response to date. Two attempts to arrange meetings with senior Trust management in late 2018 did not materialise. I have come to the view that the Trust is only interested in the avoidance of any shared responsibility for these issues, preferring instead that they will be the sole responsibility of the clinician, without provision of the time to do so.

To conclude this section, the Report implies that, irrespective of the difficulties and pressures which my colleagues did have in conducting triage while UOW, they did so, and that there were no negative consequences in there doing so. Inpatient care or the quality of triage suffered to varying degrees, and particularly in the context of long waiting times. I have personally experienced a number of cases of delayed diagnoses of cancer following triage by my colleagues since 2017.

Number One Ranking in the Overall Scheme of Things

Number one ranking in the overall scheme of things for any urological department should be the provision of acute care to those most urgently in need of it; hence, the concept of the UOW. Of course, triage is a method of selecting those patients who may next most urgently need such care. Meanwhile, patients languish on ever increasingly long lists awaiting elective admission, some 600 awaiting urgent elective admission for surgery, some now waiting over five years.

We collectively have over 640 patients awaiting admission for prostatic resection. At least 10% of these patients will be found to have prostatic carcinoma. A recent review has reported an incidence of 13.4% in men aged less than 65 years, and of 28.7% of men older than 65 years. One third of the younger patients required curative or palliative treatment. So, we have a situation where at least 64 patients are waiting for years to have a diagnosis of prostatic carcinoma found. Such a figure contrasts profoundly with the five cases found due to the failure to upgrade to Red Flag status, the subject of the Report. Yet, these patients have been assessed by our Department, placed on waiting lists, with a significant risk of having a cancer diagnosis, some requiring treatment with either curative or palliative intent. Which guidelines, goals, objectives, root cause analyses, SAls apply to these patients? None, but for our concern for them.

Factual Inaccuracies

AMD1 reported that referrals were not triaged by me in the early 90s, that referrals were being kept in a ring binder and were not on any waiting list, that I stopped the practice when challenged, and would then slip back etc. This is untrue. I was a single handed urologist from 1992 to 1996. I triaged all referrals, sorting them into urgent, soon and routine. Each category had a ring binder of referrals. I had my secretary allocate appointments for patients from each category, in commensurate numbers, to every clinic. I continued to do so until the appointment of Mr. Michael Young in 1998 when it was more appropriate to have an appointments office make appointments.

I find it difficult to believe that patients were waiting 10 years for a first appointment, as claimed by DAS2. It has been my experience that the current waiting times are the longest we have ever had. Of course there were no serious clinical issues due to the effective triage that had been conducted.

DAS1 claimed that I struggled to adapt to the modernisation and change resulting from the Regional Transformation of Urology Services. This is particularly untrue. I can provide for you on request my written submission to the Regional Review Team in 2009, detailing my concerns regarding the future provision of urological services outside of Belfast, my views concerning the lack of a Urological Department at Antrim Area Hospital, and where radical prostatectomies and radical cystectomies should be undertaken in the future. I was particularly concerned regarding the 'centralisation' of radical cystectomies for bladder cancer to Belfast. Even then, I did not entirely appreciate the negative consequences of that centralisation, in that our Department continues to have patients suffering and dying due to their not having radical cystectomies performed.

I was particularly concerned at interview that HOS1 claimed that she had discovered over 700 untriaged referral letters in my filing cabinet, having gained permission to enter my office. I also found that Dr Johnston appeared to struggle to accept that I had advised HOS1 of the whereabouts of the letters of referral, in the third drawer of the filing cabinet in my office. They were not discovered, or uncovered. Moreover, they were all copies of the originals, as the originals or copies were retained by the Appointments Office for appointment in chronological order in accordance with the Informal Default System (IDS) introduced in 2014.

The Report does acknowledge that I had advised colleagues and management that I had found it impossible to conduct non-Red Flag referrals while UOW, while continuing to triage Red Flag referrals, as detailed in my annual appraisal. It is inconceivable that a IDS was introduced to deal with the lack of triage of non-Red Flag referrals without management being aware that they were not being done, or claiming not to have been informed or aware. The Report implies that it was my sole responsibility, and that Trust management did not bear any responsibility for either their claimed lack of awareness, or its failure to address the issue in a constructive, agreed manner, and which it has still failed to do.

Recommendation 10

The Trust is recommended to set in place a robust system for highlighting and dealing with 'difficult colleagues' and 'difficult issues'. I entirely agree. I believe that it should be included in this Recommendation that any such systems should conform with and be implemented in compliance with national guidelines.

The Report is entirely silent on any Recommendation as to how clinicians, individually or collectively, are to deal with 'difficult management', and particularly management which has repeatedly and consistently failed to address issues of concern for clinicians. The absence of such a Recommendation implies an asymmetry unworthy of the Report.

Recommendations 11 and 12

Recommendation 11 advises that I review my chosen 'advanced' method and degree of triage, to align it more completely with that of my Consultant colleagues. This is itself inconsistent with the claim on Page 18 of the Report that other members of the consultant team were also 'ordering

investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons 1's advanced triage'.

Nevertheless, I believe that this recommendation should be amended. I believe that I should triage in the manner agreed with and expected by the Trust in a written policy for urological referral. That way, there will be no room for variance in how or when triage is conducted, and the trust will bear responsibility for any negative consequences, provided clinicians have conducted triage in accordance with the agreed policy. In doing so, Recommendation 12 will have been complied with.

Conclusions

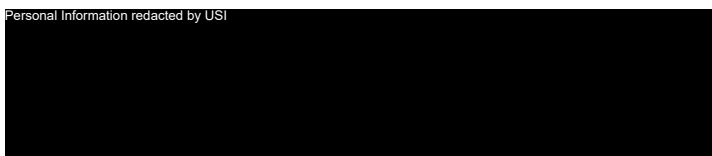
I do agree with the Recommendations contained in the Report, with a number of caveats. I do believe that it is crucially important that Recommendation be amended to ensure that the Trust develop a clear, agreed, written policy of its expectations, duties and performance of the Urologist of the Week, before it consider whether it is feasible to undertake triage while Urologist of the Week. Qualitatively and quantitatively defining and describing its expectations of the complexity of triage without firstly doing so for UOW will lead to a fudged failure.

I believe that no Consultant Urologist should be expected to concern him or herself with reviewing their conduct of triage to align themselves with his or her colleagues, especially when the colleagues claim to be conducting triage in a similar manner. That proposal will be replaced by a clear, agreed, written policy of the Trust concerning the conduction of triage. Then each Consultant only has to comply with the policy, and not with conduct of his or her colleagues, real or imagined.

Lastly, the report should include a Recommendation concerning the establishment of systems enabling clinicians, and particularly clinical departments, deal with difficult or dysfunctional management.

I look forward to receiving a revised report in due course. I have little confidence that it will have been significantly amended. I have less confidence that any of its Recommendations will be implemented.

Personal Information redacted by USI



Aidan O'Brien

11 December 2019

Initial call made to CMO OFFICE (DoH) on 01.08.20 DATE

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name Dr Maria O'Kane Organisation Southern Health and Social Care Trust
Position Medical Director Telephone Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. Urgent regional action
2. Contacting patients/clients about possible harm
3. Press release about harm
4. Regional media interest
5. Police involvement in investigation
6. Events involving children
7. Suspension of staff or breach of statutory duty

Brief summary of event being communicated: *If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
 - There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.
- In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:
- Discussions with the GMC employer liaison service have been conducted
 - This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
 - Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
 - A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) Personal Information redacted by the USI

Mobile (work or home) Telephone (work or home) Personal Information redacted by the USI

Forward pro-forma to the Department at: Personal Information redacted by the USI and the HSC Board at: Personal Information redacted by the USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: Office:

Forwarded for consideration and appropriate action to: Date:

Working for a Healthier People



From: [Craig Sedwell](#) Personal Information redacted by the USI
To: [Aidan O'Brien](#)
Cc: [Andrew Anthony](#)
Subject: GMC Ref: C1-2598136964 - TS-Live.FID694915
Date: 14 May 2021 15:27
Attachments: [Final Overarching SAI Report.pdf](#)
[Patient A - SAI Report.pdf](#)
[Patient C - SAI Report.pdf](#)
[Patient D - SAI Report.pdf](#)
[Patient E - SAI Report.pdf](#)
[Patient F - SAI Report.pdf](#)
[Patient G - SAI Report.pdf](#)
[Patient H - SAI Report.pdf](#)
[Patient I - SAI Report.pdf](#)

Dear Dr O'Brien,

Please find enclosed a copy of the 'Serious Adverse Incident Report' which I have received from the Trust, along with a copy of eight individual patient reports. Unfortunately, I cannot provide you with a copy of Patient B/Service User B's individual report as the family of Patient B are currently reviewing this. However, given our commitment to provide ongoing disclosure, I am happy to disclose the information relating to Patient A and C-I. As soon as Patient B's individual report is available, you will be provided with a copy.

Given the contents of the attached reports, we are in the process of considering the next steps and will write further in due course.

Kind regards,

Craig Sedwell
Investigation Officer

General Medical Council,
3 Hardman Street,
Manchester M3 3AW

Email: Personal Information redacted by the USI
Website: www.gmc-uk.org
Telephone: Personal Information redacted by the USI

11 July 2020

STRICTLY PRIVATE & CONFIDENTIAL

Mr A O'Brien

Personal Information redacted by USI

Via E-Mail only

Personal Information redacted by USI

Dear Mr O'Brien

I am writing to advise you of a number of concerns that have arisen in respect of your practice as a Consultant Urologist.

On 7th June 2020 at 22.25, you sent an email which was copied to me, in which you explained that you had added 10 patients to the Trust's list for urgent admission. On my initial review of the list of patients in my capacity as AMD, I noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy"*.

It appeared to me that these patients had been assessed on the dates given by you, but the outcomes of these assessments did not appear to have been actioned by you as required with the patients being added to the inpatient waiting list on the Trust's Patient Administration System. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that.

Since this has come to light, the Trust has been seeking as a matter of urgency to establish the position in relation to these 2 specific patients and also to clarify whether any other patients are similarly affected. A review of records back to January 2019 has been undertaken.

At this stage, I enclose a summary of the concerns following initial review of patient records dating back to January 2019.



Working together

Excellence

Openness & Honesty

Compassion

Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, PORTADOWN BT63 5QQ



Personal Information redacted by USI

The concerns identified will be managed in line with the '*Maintaining High Professional Standards in the Modern HPSS*' Framework (MHPS). I have enclosed a copy of this document for your information.

We are at the initial enquiry stage of the process and I would like to offer you the opportunity at this point to make any initial representations on the concerns outlined in the attached document.

Once we have concluded our initial enquiries, a determination will be made about the next steps in the process. The possible actions following initial enquiries are set out in detail within the MHPS Framework at Section I Paragraph 15.

The Medical Director has been in contact with NHS Resolution (formerly National Clinical Assessment service (NCAS)) regarding this matter to seek advice on the management of your case. This is a normal part of any MHPS process. I enclose a copy of the letter received from NHS Resolution, for your information, and would draw to your attention, that you can contact them directly to discuss your case confidentially with an advisor.

In line with MHPS Section I paragraph 18, and following advice from NHS Resolution, the Medical Director and I have considered any necessary restrictions. We believe, that given our level of concern at this stage of preliminary enquiries, that it is necessary to put in place the following restrictions with immediate effect:

- 1. That you are no longer to undertake clinical work.**
- 2. That you do not access or process patient information either in person or through others either in hard copy or electronically.**

I would invite you to consider the underlying principle in Section II paragraph 22, and request that you voluntarily undertake to refrain from seeing any private patients at your home or any other setting. I would request confirmation of this undertaking, by return, via email.

I would also request that you notify me via email of any patient / clinical related information, reports and files which you have in your possession at home so that we can make the necessary arrangements to have them returned to assist us with our preliminary enquiries, and ensure any appropriate patient follow up.

I must also advise you that given the existing referral to the GMC in respect of the outstanding MHPS case, the Medical Director has informed the GMC's Employment Liaison Officer regarding these most recent concerns.

In summary, I seek confirmation by email, **by return**, your voluntary undertaking in respect of private patients, and confirmation as to any patient related information and or files in your personal possession.

If you have any representations that you wish to make regarding the concerns highlighted above, I would request these **by no later than 17th July 2020**.

I fully acknowledge that this will undoubtedly be a difficult time for you, and wish to highlight to you that the services of the Trust's Occupational Health Department or the staff counselling service, Carecall are available to you. You can contact Occupational Health on Personal information redacted by the USI or CareCall on Personal information redacted by the USI

Yours sincerely

Personal information redacted by the USI

Mr Mark Haynes
Associate Medical Director
Surgery and Elective Care

Enc. 'Maintaining High Professional Standards in the Modern HPSS' Framework (MHPS)

NHS Resolution - correspondence

Summary of concerns

Subject: Patient 105 Personal Information redacted by the USI
From: O'Brien, Aidan <Personal Information redacted by the USI>
To: Elliott, Noleen <Personal Information redacted by the USI>
Sent: 11/09/2019 12:38:49

Noleen,

This man had incomplete fragmentation of a right ureteric stone and right ureteric stenting yesterday evening.

He may be going home today.

Please place him on CURWL for

Removal / Replacement of Stent and Right Ureteroscopic Laser Lithotripsy

Urgency 2

Date of entry: 11 September 2019

Thank you,

Aidan

with report
27.9.15

AOB-37002

IGN	Forename	Surname	Age	Specialty	Original Date	Waiting List Code	Date Booked Y/N	Consultant Name	Urgency Code	Admission Reason
Personal Information redacted by the USI	Patient 105		74	URO	11/09/2019	CURWL	N	O'Brien A Mr	2	REM/REP OF STENT & RIGHT URETEROSCOPIC LASER LITHOTRIPS
	Personal Information redacted by the USI		67	URO	15/09/2019	CURWL	N	O'Brien A Mr	2	RIGHT URETEROSCOPY AND LASER LITHOTRIPSY

Elliott, Noleen

From: Dawson, Coronette
Sent: 09 December 2019 10:13
To: McCann, Frances; Elliott, Noleen
Cc: Neville, Linda
Subject: Patient 105

Categories: Dealt with

Hi

This patients wife rang today to say he will not be attending for surgery on 11.12.19 as has been admitted to hospital in Enniskillen.

Hospital No :

Personal Information redacted by
USI

Regards
Coronette

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Elliott, Noleen

From: McCann, Frances
Sent: 09 December 2019 14:33
To: O'Brien, Aidan
Cc: Elliott, Noleen; McClenaghan, Nichola; Wethers, Amy; Moran, Julie
Subject: FW: Patient 105
Importance: High
Categories: Dealt with

Please see e-mail below. Patient has been listed for URGENT REM/REP of stent and right ureteroscopic laser lithotripsy and was coming in for procedure on 11/12/19 to 1 WEA @ 11AM under the care of Mr O'Brien. Now an inpatient in SWA and will not be attending. Please advise.

From: Dawson, Coronette
Sent: 09 December 2019 10:13
To: McCann, Frances; Elliott, Noleen
Cc: Neville, Linda
Subject: Patient 105

Hi

This patients wife rang today to say he will not be attending for surgery on 11.12.19

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From: O'Brien, Aidan
Sent: 10 December 2019 13:29
To: Elliott, Noleen
Subject: FW: [REDACTED]

Patient 105

Personal Information
redacted by the USI

Noleen,

I have reviewed the above patient's data on ECR.

I do believe that it is evident that he will not be fit to be transferred for surgery tomorrow.

I have not been able to contact his wife as I had done previously, but will do in due course.

Please return him to CURWL.

I have been able to contact the following patient who is only too willing to come in instead:

Personal Information redacted by USI

73 years 1WEA

TCI at 11.00 am, fasting from 08.00 am, for

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Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone:

Personal Information redacted by USI

E mail:

Personal Information redacted by USI

Secretary:

Mrs N. Elliott

Patient 105

Personal Information redacted by the USI

HCN:

Personal Information redacted by USI

Dear

Patient 105

I was delighted to have the opportunity of speaking with your wife by telephone on Sunday 15th March 2020, learning that you have recovered very well following your severe chest infection in December 2019. You will receive formal notification of your admission to our Department at Craigavon Area Hospital on Wednesday 25th March 2020 for removal of the stent from your right ureter, and with a view to achieving complete fragmentation of any remaining stone in your right kidney. When you receive notification, you will be advised of the expected time of your arrival at the Elective Admissions Ward at Craigavon Area Hospital, as well as the duration of fasting.

I write particularly to ensure that you do not take any Dabigatran, the blood thinning tablet, after Sunday 22nd March 2020.

Kind Regards

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Patient 105

DOB:

Personal Information redacted by the USI

H+C:

Personal Information redacted by the USI



Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Redacted]
E mail: [Redacted]

Secretary: Mrs N. Elliott

[Redacted]

Dear [Redacted]

Re: Patient Name: [Redacted]

D.O.B.: [Redacted]

Address: [Redacted]

Hospital No.: [Redacted]

H&C No: [Redacted]

I write to you regarding this 74 year old man who had been transferred to our Department on the 8th September 2019, from South West Acute Hospital where he had been admitted one week previously due to being generally unwell in addition to vomiting and urinary symptoms indicative of urinary infection. On CT scanning, he was eventually found to have a stone obstructing his right ureter. Following his transfer he had the stone fragmented by ureteroscopic laser lithotripsy, and his right ureter was stented, not least because he still did have a further stone located in his right kidney, and which would have caused recurrence of upper tract obstruction if it had migrated into his right ureter without stenting. He was discharged on the 18th September 2019.

I am aware that [Redacted] was acutely admitted to South West Acute Hospital once again on 9th December 2019, suffering from influenza, and was eventually transferred to Omagh Hospital on 23rd December 2019 for a further period of rehabilitation. He was discharged on 7th January 2020.

I have had the opportunity of speaking with his wife by telephone, she advising me that he has now well recovered following his respiratory infection. He is still troubled by symptoms due to the right ureteric stent remaining in place, and including dysuria and haematuria. In any case, I have arranged for him to be electively re-admitted to our Department on Wednesday 25th March 2020 for removal of the right ureteric stent, and flexible ureteroscopic laser lithotripsy, with the aim of rendering him entirely free of any stones affecting his right upper urinary tract. Hopefully, it may be possible to also leave him without any stent in his ureter as well.

I have advised that [Redacted] not take any Dabigatran after Sunday 22nd March 2020.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 15/03/20

Date Typed: 16/03/20-CN

Patient 105

DOB: [Redacted]

[Redacted]

H+C: [Redacted]

[Redacted]

From: O'Brien, Aidan
Sent: 18 March 2020 23:00
To: Glackin, Anthony
Subject: RE: Urology Theatre Cases 23-27 March 2020

Tony,

The one patient whom I think should be admitted on Wednesday 25 March is Patient 105 who is a comorbid man of very poor performance status who has been awaiting readmission since September 2019, but whose readmission was frustrated by him becoming acutely unwell with Influenza A in December 2019, remaining in hospital until January 2020. He has now optimally recovered, and I would fear him relapsing, preventing his admission.

The one patient whom I would like to accommodate on Friday 27 March

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Elliott, Noleen

From: Poland, Orla
Sent: 24 March 2020 09:32
To: Elliott, Noleen
Subject: FW: Tuesday list (24/3/20)

Categories: Dealt with

From: Hanvey, Leanne
Sent: 23 March 2020 12:41
To: Poland, Orla; Corrigan, Martina; Nelson, Amie; Robinson, Katherine
Cc: Evans, Marie
Subject: RE: Tuesday list (24/3/20)

Hi

Regarding Urology patients

1) (AOB) Patient 105 Personal information redacted by the USI – REMOVAL/REPLACEMENT OF STENT AND RIGHT RIGID & FLEXIBLE URETEROSCOPIC LASER LITHOTRIPSY
NO - Please note patient is on Dabigatran and needs two days notice. Once he was told of the cancellation to his first date he went back on the medication

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O'Brien, Aidan

From: Elliott, Noleen
Sent: 24 March 2020 09:56
To: O'Brien, Aidan
Subject: FW: Tuesday list (24/3/20)

Aidan,

Just to keep you informed:

As per Leanne Hanvey,

Patient 105
[redacted] was unable to come on for this list as he had started taking Dabigatran. He has been replaced
with [redacted] Personal Information redacted by USI
[redacted] Personal Information redacted by USI is coming in.

Regards.

Noleen

From: Poland, Orla
Sent: 23 March 2020 12:01
To: Maxwell, Sharon; Elliott, Noleen; Hanvey, Leanne; Smyth, Kate
Cc: Evans, Marie
Subject: FW: Tuesday list (24/3/20)

Hi Girls,

Please see below, can these patients

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O'Brien, Aidan

From: O'Brien, Aidan
Sent: 24 March 2020 14:44
To: Corrigan, Martina
Cc: Haynes, Mark; Young, Michael; Glackin, Anthony; ODonoghue, JohnP
Subject: RE: URGENT Theatre cases Tuesday/Friday

Martina,

I have spoken to the wife of Patient 105
She will be happy to take her husband to DHH on Friday.
As he will be travelling from Personal
Information
redacted by USI I think that it would be reasonable to ask him to arrive at 10.00 am,
fasting from midnight.
If it could be confirmed that he could be accommodated on Friday, I will be able to speak to her again to advise
that he not take Dabigatran after today.

Aidan.

From: Corrigan, Martina
Sent: 24 March 2020 14:24
To: Glackin, Anthony; Haynes, Mark; O'Brien,

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O'Brien, Aidan

From: O'Brien, Aidan
Sent: 24 March 2020 21:24
To: Corrigan, Martina
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP
Subject: FW: URGENT Theatre cases Friday in DHH

Importance: High

Martina,

I have spoken again to the wife of

Patient 105

They remain keen for admission on Friday.

I have advised that he not take Dabigatran tomorrow and Thursday, and that I will advise whether his admission to DHH on Friday can proceed,

Aidan.

From: Glackin, Anthony
Sent: 24 March 2020 15:37
To: Troughton, Elizabeth
Cc: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: FW: URGENT Theatre cases Friday in DHH
Importance: High

Personal Information redacted by USI

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O'Brien, Aidan

From: O'Brien, Aidan
Sent: 02 April 2020 13:07
To: McLoughlin, Laura; McCann, Frances; Cullen, Aidan
Subject: RE: Personal Information
redacted by the USI Patient 105

Laura et al,

I am aware of all in your email.

On the one hand, I had been keen one week ago to have this man admitted to DHH for surgery, particularly as he had probably optimally recovered from influenza A.

On the other hand, I was equally concerned regarding his Covid 19 vulnerability.

I suspect that he is the kind of patient who would succumb if infected.

As there was no reason to suspect that his indwelling ureteric stent and stone were causing him any problem at present, I decided in conjunction

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**CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ**

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by USI]
E mail: [Personal Information redacted by USI]
Secretary: Mrs N. Elliott

[Personal Information redacted by USI]

Dear [Personal Information redacted by USI]

Re: Patient Name: [Patient 105]
D.O.B.: [Personal Information redacted by the USI]
Address: [Personal Information redacted by the USI]
Hospital No: [Personal Information redacted by the USI] **HCN:** [Personal Information redacted by the USI]

I wrote to you on the 15th of March 2020 advising that I had arranged for [Patient 105] to be electively admitted on Wednesday the 25th of March 2020 for removal or replacement of the right ureteric stent before and possibly after flexible ureteroscopic laser lithotripsy. Unfortunately, due to the restrictions imposed upon elective admission as a consequence of the coronal viral pandemic, [Patient 105]'s arranged admission was cancelled.

I have had the opportunity of speaking with his wife by telephone on Thursday the 23rd of April 2020, and was pleased to hear that [Patient 105] remains well, with no particular problems attributable to the indwelling ureteric stent. However, I write to advise you that we are currently in the process of rendering it possible to have patients electively admitted to coronal viral free hospital zones, including having the patient tested for covid-19 prior to their admission. I would hope to be able to have [Patient 105] admitted during May 2020 under such circumstances.

I note that [Patient 105] has been prescribed both Ferrous Fumarate and Folic Acid for iron deficiency and folate deficiency, both contributing to his recent anaemia. I would be most grateful if you could arrange for a Community Nurse to repeat a full blood count as well as repeating Vitamin B12, Folic and Iron levels, in order to ensure that his condition has been optimised prior to any forthcoming admission.

Yours sincerely

Dictated but not signed by

**Mr A O'Brien FRCS
Consultant Urological Surgeon**

Date Dictated: 23/04/20	Date Typed: 24/04/20-NE
--------------------------------	--------------------------------

HON	Forename	Surname	Age	Original Date	Current Date	Waiting List Code	Date Booked Y/N	Consultant Name	Urgency Code	Intended Manager	Admission Reason	Intended Primary Procedure	Weeks waiting
Personal Information redacted by USI			68	15/09/2019	15/09/2019	CURWL	N	O'Brien A Mr	2	N	RIGHT URETEROSCOPY AND LASER LITHOTRIPS	M30.9	33
Personal Information redacted by the USI			53	05/11/2019	05/11/2019	CURWL	N	O'Brien A Mr	2	N	OPEN BILATERAL URETEROLYSIS	M30.9	26
Patient 105			75	11/09/2019	11/12/2019	CURWL	N	O'Brien A Mr	2	N	REM/REP OF STENT & RIGHT URETEROSCOPIC L	M09.2	21



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone:

Personal Information redacted by
USI

E mail:

Personal Information redacted by USI

Secretary:

Mrs N. Elliott

Personal Information redacted by USI

Dear

Personal Information redacted
by USI

Re: Patient Name:

Patient 105

D.O.B.:

Personal Information redacted
by the USI

Address:

Personal Information redacted by the USI

Hospital No:

Personal Information redacted by
the USI

HCN:

Personal Information redacted by
the USI

I last wrote to you in April 2020 when I requested that Patient 105 have a full blood count, serum iron, Vitamin B12 and folate levels repeated prior to his readmission for removal or replacement of the indwelling right ureteric stent following flexible ureteroscopic laser lithotripsy. I am pleased to note that his haemoglobin had increased significantly to 116g/L by the 3rd of June 2020, and that serum iron, Vitamin B12 and folate levels were all within the normal range. It was also reassuring to note that his global renal function remains normal.

I have had the opportunity of speaking with Patient 105 and with his wife by telephone once again, when he reported that he had been having some abdominal discomfort that could be attributed to the indwelling ureteric stent. Both Patient 105 and his wife were entirely happy for his admission to our department at Daisy Hill Hospital in Newry to be arranged. I do hope to have Patient 105 admitted during coming weeks, and you will be advised of the outcome in due course.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 04/06/20

Date Typed: 05/06/20-NE

Patient 105

DOB:

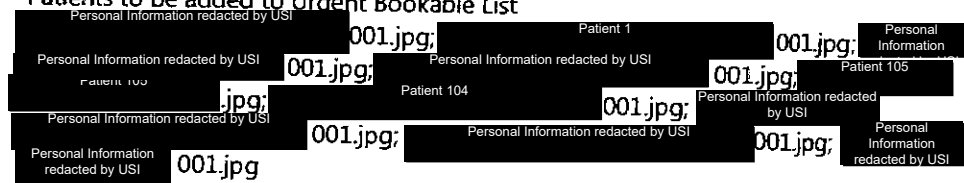
Personal Information
redacted by the USI

H+C

Personal Information
redacted by the USI

O'Brien, Aidan

From: O'Brien, Aidan
Sent: 07 June 2020 22:25
To: Neville, Linda; McIlveen, Jacqueline
Cc: Sector, Independent; Glackin, Anthony; Haynes, Mark; Elliott, Noleen
Subject: Patients to be added to Urgent Bookable List
Attachments:



Dear Linda and Jacqueline,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.

Mark Haynes has already arranged to have the first of those patients, Patient 113 admitted to Kingsbridge Private Hospital on Wednesday 10 June 2020.

I have scanned and attached completed Green Forms for the remaining nine patients.

I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.

Please let me know if I can be of any further assistance.

I hope the above will facilitate their admissions.

Thank you,

Aidan.

Patient Name: [Redacted] Write details
D.O.B: [Redacted]
H&C N: [Redacted]

Date of Clinic / Decision to list: 05 Nov 2019
Consultant: AO'BRIEN
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RETROPERITONEAL FIBROSIS / RETROPERITONEAL SARCOMA
Procedure: BILATERAL URETEROLYSIS & RETROPERITONEAL BIOPSY
Estimated Duration of Surgery: 5 HOURS
Additional Comments / Instructions: FOR ADMISSION TO CRATGAVON AREA HOSP

Urgency
Please tick appropriate box

Red Flag	☒
Urgent	☐
Routine	☐
Planned	☐

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	☐
Local	☐

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
Please tick appropriate box

Day Case	☐
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	CAH
Specific Unit Requirement	AWCA
Specific Consultant	AO'BRIEN

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐
- Clopidogrel or Prasugrel? ☐
- Dabigatran, Rivaroxaban or Apixaban? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature: [Redacted] Print Name: Aidan O'Brien Date: 07.06.20
Countersigned (Consultant): [Redacted] Date: [Redacted]

Patient Name:	Patient 1 details
D.O.B.:	Personal Information redacted by the USI
H&C No.	

Date of Clinic / Decision to list	01 JUNE 20
Consultant	A O'Brien
Specialty	Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	BLADDER OUTLET OBSTRUCTION DUE TO PROSTATE CANCER
Procedure:	ENDOSCOPIC RESECTION OF PROSTATE - TURP
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR ADMISSION TO DH HOSPITAL

Urgency	
Please tick appropriate box	
Red Flag	☒
Urgent	☐
Routine	☐
Planned	☐

Anaesthetic Type	
Please tick appropriate box	
General / Spinal	☒
Sedation	☐
Local	☐

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management	
Please tick appropriate box	
Day Case	☒
Inpatient	☐

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	DH
Specific Unit Requirement	Urology A
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☐ Yes ☒ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Print Name	Date
	A O'Brien	07.06.20
Countersigned (Consultant)		Date

Patient Name	
D.O.B.	
H&C N	

Date of Clinic / Decision to list	04.06.20
Consultant	AO'Brien
Specialty	Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	BILATERAL LIPPER URINARY TRACT OBSTRUCTION
Procedure:	BILATERAL URETEROCERAPHY & URETERIC STENTING
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR ADMISSION TO DHH

Urgency	
Please tick appropriate box	
Red Flag	☒
Urgent	☐
Routine	☐
Planned	☐

Anaesthetic Type	
Please tick appropriate box	
General / Spinal	☒
Sedation	☐
Local	☐

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management	
Please tick appropriate box	
Day Case	☐
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	DHH
Specific Unit Requirement	LEVEL 4
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
- b. Continue to take as normal ☐
- c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- b. Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature

Print Name

Date

Countersigned (Consultant)

Date

Personal Information redacted by USI

Patient Name: [Redacted]
D.O.B: [Redacted]
H&C: [Redacted]

Date of Clinic / Decision to list: 15.09.19
Consultant: AOBRIEN
Specialty: UROLOGY

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER URETERIC & RENAL CALCULI
Procedure: RIGHT RIGID & FLEXIBLE URETEROSCOPIC LITHOTRIPSY
Estimated Duration of Surgery: 2 HOURS
Additional Comments / Instructions: FOR UIC / KINGSBRIDGE / DHH

Urgency
Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
Please tick appropriate box

Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒ ASPIRIN 75 MG
If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature

Print Name

AOBRIEN

Date

07.06.20

Countersigned (Consultant)

Date

Patient Name: [Redacted] Patient 105
Write details
Name: [Redacted] Personal Information redacted by the USI
D.O.B.: [Redacted]
H&C No.: [Redacted]

Date of Clinic / Decision to list: 11.09.19
Consultant: A O'Brien
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER TRACT COLIC
Procedure: REMOVAL OF STONE & RIGHT FLEX. URETER. LITHOTRIPSY
Estimated Duration of Surgery: 2 HOURS
Additional Comments / Instructions: FOR ADMISSION TO D.H. HOSPITAL

Urgency
Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
Please tick appropriate box

Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	DHH
Specific Unit Requirement	Level 4
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☒ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature

Print Name

Date

Countersigned (Consultant)

Date

Personal Information redacted by USI

Patient Name: [Redacted]
D.O.B: [Redacted]
H&C: [Redacted]

Date of Clinic / Decision to list	13.05.20
Consultant	AO'BRIEN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT URETERIC CALCULI
Procedure:	RIGHT URETEROSCOPIC LASER LITHOTRIPSY ? STONING
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR LHC OR KINGSBRIDGE OR DHH

Urgency	
Please tick appropriate box	
Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type	
Please tick appropriate box	
General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management	
Please tick appropriate box	
Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7 days prior to surgery ☐
- b. Continue to take as normal ☐
- c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- b. Patient should discontinue 7 days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is unable to discuss decisions at a suitable point thereafter,

Doctor's Signature	Print Name	Date
[Redacted]	AO'BRIEN	07.06.20
Countersigned (Consultant)		Date

Patient Name:	Personal Information redacted by the USI
D.O.B.:	Personal Information redacted by the USI
H&C No:	Personal Information redacted by the USI

Date of Clinic / Decision to list	11.02.20
Consultant	Aidan O'Brien
Specialty	Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT UPPER URACAL COLIC
Procedure:	REMOVAL OF STENT & FLEX. URETEROSCOPIC LITHOTRIPSY
Estimated Duration of Surgery:	8 HOURS
Additional Comments / Instructions:	UIC OR KINGSBRIDGE OR DHH

Urgency	
Please tick appropriate box	
Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type	
Please tick appropriate box	
General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management	
Please tick appropriate box	
Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
- b. Continue to take as normal ☐
- c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- b. Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Print Name	Date
Countersigned (Con)	A O'Brien	07.06.20

Personal Information redacted by USI

Patient Name: [Redacted]
D.O.B: [Redacted]
H&C: [Redacted]

Date of Clinic / Decision to list: 15.05.20
Consultant: A O'Brien
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT URETERIC AND BLOOD INJURY
Procedure: CYSTOSCOPY, REMOVAL OF STENT, RIGHT URETEROCERGRAPHY & CYSTOGRAM
Estimated Duration of Surgery: 1 HOUR
Additional Comments / Instructions: FOR ADMISSION TO DHH

Urgency
Please tick appropriate box

Red Flag ☐
Urgent ☒
Routine ☐
Planned ☐

Anaesthetic Type
Please tick appropriate box

General / Spinal ☒
Sedation ☐
Local ☐

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management
Please tick appropriate box

Day Case ☐
Inpatient ☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement: DHH
Specific Unit Requirement: Room 4
Specific Consultant:

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒ ENDXAPARIN
If yes, please indicate if patient is on any of the medications below and the action required: 60 MGS ONLY

- Warfarin? ☐
- Aspirin 300mg? ☐
- Clopidogrel or Prasugrel? ☐
- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

a. Reduce to 75mg daily 7 days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7 days prior to surgery ☐

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature: [Redacted] Print Name: Aidan O'Brien Date: 07.06.20
Countersigned (Consultant): [Redacted] Date:

Patient Name: [REDACTED]
D.O.B: [REDACTED]
H&C N: [REDACTED]

Date of Clinic / Decision to list: 14.05.20
Consultant: AO'BRIEN
Specialty: UROLOGY

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER TRACT OBSTRUCTION
Procedure: REMOVAL OF STONE & RIGHT URETEROSCOPIC LITHOTRIPSY
Estimated Duration of Surgery: 1 HOUR
Additional Comments / Instructions: FOR UIC OR KINGSBIDGE OR DHH

Urgency
Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management
Please tick appropriate box

Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

- Clopidogrel or Prasugrel? ☐
- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant [REDACTED] should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Print Name	Date
[REDACTED]	AO'BRIEN	07.06.20
Countersigned (Consultant)		Date
[REDACTED]		

Subject: Patients to be added to Urgent Bookable List

From: O'Brien, Aidan

Personal Information redacted by USI

To: Neville, Linda

Personal Information redacted by USI

, McIlveen, Jacqueline

Personal Information redacted by USI

Cc: Sector, Independent

Personal Information redacted by USI

, Glackin, Anthony

Personal Information redacted by USI

, Haynes, Mark

Personal Information redacted by USI

, Elliott,

Noleen

Personal Information redacted by USI

Sent: 6/7/2020, 10:25:19 PM

Personal Information redacted by USI

001.jpg

Patient 1

Personal Information redacted by the USI

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Personal Information redacted by the USI

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Patient 105

Personal Information redacted by the USI

001.jpg

Patient 104

Personal Information redacted by the USI

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Personal Information redacted by USI

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Personal Information redacted by USI

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Personal Information redacted by USI

001.jpg

Dear Linda and Jacqueline,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.

Mark Haynes has already arranged to have the first of those patients, Patient 113, admitted to Kingsbridge Private Hospital on Wednesday 10 June 2020.

I have scanned and attached completed Green Forms for the remaining nine patients.

I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.

Please let me know if I can be of any further assistance.

I hope the above will facilitate their admissions.

Thank you,

Aidan.

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr MRA Young, Consultant Urologist
SECRETARY: Miss Paulette Dignam
TELEPHONE: Personal Information redacted by the USI

Personal Information redacted by the USI

Dear

Personal Information redacted by the USI

Re: Name:
D.O.B:
Address:
Hospital No:

Patient 105
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI
H&C No: Personal Information redacted by the USI

Date of Admission: 25/06/2020	Method of Admission
Date of Discharge:	WAITING LIST
Procedure: Right Ureterscopy & Lasertripsy	

Patient 105 has been electively admitted to Daisy Hill Hospital with regards to therapy to his right renal and right ureteric stones. Today we found a healthy urethra; there was a high bladder neck and a lot of inflammation around the ureteric orifice where the stent has been. Guide wire was deployed and the stent was then removed. Again, there was great difficulty with the rigid ureterscope; it wouldn't get beyond the pelvic brim. We then proceeded to use the flexible ureterscope and dealt with the renal stone, fragmenting it to dust and on retraction of the flexible scope we were able to define the stone in the mid ureter. It was indeed quite embedded into the wall of the ureter but with manipulation this was moved and lasertripsy performed.

Due to the amount of work performed and fragments I have left a JJ stent on strings. I am making arrangements for its removal via our nurse practitioner in Enniskillen on Tuesday 30th June 2020 and we will subsequently review Mr Patient 105 at our Stone Treatment Centre via a virtual clinic review appointment. We have left a catheter in situ overnight and this will be removed tomorrow before his discharge.

Yours sincerely,

DICTATED BUT NOT
PERSONALLY SIGNED BY:

Mr M RA Young, MD FRCS (Urol)
Consultant Urologist/pd

Patient 105 DOB: Personal Information redacted by the USI H+C: Personal Information redacted by the USI

cc STC meeting

Date Dictated: 25/06/2020

Date Typed: 25/06/2020

AOB-37030Southern Health
and Social Care TrustCraigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ
Tel: 028 3861 3674/2952

ECR Copy

Ward Tel:

Personal Information redacted by USI

Date: 19/09/2019 11:48

Discharge Id: Personal Information

Version: 53

Dear

Personal
Information
redacted by USI**DISCHARGE NOTIFICATION**

The patient was admitted under the care of **MR A O'BRIEN** (specialty: **UROLOGY(C)**) into **3 SOUTH ELECTIVE WARD** Ward at **CRAIGAVON AREA HOSPITAL** on **08/09/2019 16:00:00** and discharged on **18/09/2019**.

Forenames:

Patient 105

Address:

Personal Information redacted by USI

Surname:

D.O.B:

Personal Information
redacted by the USI

Hospital No:

NHS No:

Gender:

Male

Ward:

3 SOUTH ELECTIVE WARD

Presenting Complaint

Transferred from SWAH with bilateral renal calculi.

Patient Receiving Palliative Care? No**Principle Discharge Diagnosis**

Renal stones.

Additional Information for GP**Changes to Medications - Start/Stop**

See discharge prescription below for medication changes.

Clinical Narrative

Underwent right ureteroscopy, lithotripsy and ureteric stenting on the 10th September.

Recovered well on the ward, initially for inpatient rehab in [Personal Information] as [Patient 105] and his wife felt he was off baseline. In the following week they decided he was closer to baseline and would be happier returning home with a package of care.

Medically fit for discharge.

Did the patient receive a blood transfusion?

No

Allergies:

Patient Has Allergies

Details of Allergies:

H/O: drug allergy - Likely Moderate

Allergy

24-Jun-2009 Simvastatin 40mg tablets

Known Reactions to Allergies:

n/a

Additional Information:**Infection Status:****Follow Up Details****Arrangements for Follow Up:**

On waiting list for urgent ureteroscopy and lithotripsy for the remaining stone.

Further Detailed Discharge Letter to Follow:

No

Awaiting Further Results:

No

Awaited Results:**Patient Aware of Diagnosis:**

Yes

Other Management Information For GP

Many thanks for your ongoing care.

Medication History [Personal Information redacted by USI] 09/09/19

<https://ecr.hscni.net/cViewer/process.action?encryptedRequest=59F308309BB049DB134...> 08/07/2020

AOB-37031

CC on ward SB 18/09/19 16:13 - new medicines and episenta supplied on discharge.

Pharmacist Note: Relvar noted as stopped - ignore (error) - continued on discharge.

Discharge Prescription:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP Continue?
Admission drugs (unamended)					
ATORVASTATIN Tablets	80mg	Each Morning	-	Oral	Yes
Dabigatran Capsules	150mg	Twice Daily	-	Oral	Yes
Pregabalin 150mg Capsules	150mg	Each Night	-	Oral	Yes
BUSPIRONE 5 mg Tablets	5mg	Twice Daily	-	Oral	Yes
CLONAZEPAM Tablets	250 micrograms	Each Night	-	Oral	Yes
ZOPICLONE Tablets	7.5mg	Each Night	-	Oral	Yes
SENNA 7.5 mg Tablets	15mg	Each Night	-	Oral	Yes
THIAMINE HYDROCHLORIDE Tablets	100mg	Three Times Daily	-	Oral	Yes
BETAHISTINE DIHYDROCHLORIDE Tablets	16mg	Three Times Daily	-	Oral	Yes
(Additional Info: Patient states he uses BD at home - kindly review) (Change Reason: .)					
CARBOCISTEINE 250 mg in 5mL Syrup	7.5ml	Four Times Daily	-	Oral	Yes
SODIUM VALPROATE (Episenta)	900mg	Twice Daily	-*	Oral	Yes
(Additional Info: supplied on discharge as patients own supply used in SWAH - ward stock sent to pharmacy) (Change Reason: .)					
Xaltan Eye drops 50 micrograms/ml	1-2 drops	Each Night	-	Topical	Yes
(Additional Info: Left Eye)					
INCRUSE ELLIPTA Inhaler	55 microgram (1 Puff)	Each Morning	-	Inhaled	Yes
(Additional Info: 55micrograms/dose) (Change Reason: .)					
OLANZAPINE Tablets	2.5mg	Each Morning	-	Sublingual	Yes
SERTRALINE Tablets	100mg	Each Morning	-	Oral	Yes
LANSOPRAZOLE Capsules	30mg	Each Morning	-	Oral	Yes
RAMIPRIL	2.5mg	Each Morning	-	Oral	Yes
BISOPROLOL Tablets	1.25mg	Each Morning	-	Oral	Yes
DIGOXIN Tablets	125 micrograms	Each Morning	-	Oral	Yes
LEVOTHYROXINE SODIUM Tablets	100 micrograms	Each Morning	-	Oral	Yes
MIRTAZAPINE Tablets	30mg	Each Night	-	Oral	Yes
PARACETAMOL 500 mg Tablets	1g	4-6 Hourly When Req.	-	Oral	Review
(Change Reason: .)					
RELVAR Ellipta 92/22 Inhaler	1 Puff	Each Morning	-	Inhaled	Yes
Salbutamol 100microgram/dose CFC free MDI	1-2 Puffs	When Required	-	Inhaled	Yes
Drugs prescribed since admission					
CO-AMOXICLAV Tablets	625mg	Three Times Daily	1*	Oral	No
(Additional Info: until 18/09/19 nocte - 1 dose needed to complete course) (Change Reason: .)					
LACTULOSE Solution	15mls	Twice Daily	14*	Oral	Review
(Change Reason: .)					
Admission drugs (amended)					

Stopped Medication:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				
RELVAR Ellipta 92/22 Inhaler	T	Each Morning	-	Inhaled
(Change Reason: Duplicate)				
LAXIDO SUGAR-FREE Powder	T	Twice Daily	-	Oral
(Change Reason: Switched to lactulose)				

Authorised Forms

Form

Adult Clinical Details (Emergency-CMPM)

Authorised By

ADAM LONGWELL

Prescribing Clinician:

ADAM LONGWELL

Bleep No:Personal Information
redacted by USI<https://ecr.hscni.net/cViewer/process.action?encryptedRequest=59F308309BB049DB134...> 08/07/2020

cc STC meeting

Date Dictated: 25/06/2020	Date Typed: 25/06/2020
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AOB-37033Southern Health
and Social Care TrustDaisy Hill Hospital, 5 Hospital Road, Newry, County Down, BT35 8DR
Tel: 028 3083 5000

ECR Copy

Ward Tel:

Personal Information redacted by USI

Date: 26/06/2020 10:33

Discharge Id: Personal Information

Version: 33

Deal: Personal Information redacted by USI

DISCHARGE NOTIFICATION

The patient was admitted under the care of MR M YOUNG (specialty: UROLOGY(C)) into MALE SURGICAL Ward at DAISY HILL HOSPITAL on 25/06/2020 07:30:00 and discharged on 26/06/2020.

Forenames: Patient 105
Surname:
D.O.B: Personal Information redacted by the USI
Hospital No:
NHS No:
Gender: Male
Ward: MALE SURGICAL

Address:

Personal Information redacted by USI

Admission Reason

Elective admission for Right Flexible Ureteroscopy Lasertripsy and Stent Exchange

Patient Receiving Palliative Care? No**Principle Discharge Diagnosis**

Right Flexible Ureteroscopy Lasertripsy and Stent Exchange

Operations/Procedures/Radiology

Right Flexible Ureteroscopy Lasertripsy and Stent Exchange

Additional Information for GP**Past Medical/Surgical History**

Personal Information redacted by USI

Changes to Medications - Start/Stop

See discharge prescription below for medication changes

Clinical Information/Comments

Elective admission for Right Flexible Ureteroscopy Lasertripsy and Stent Exchange.

Uncomplicated recovery.

Stent Pull - Tuesday 30th June 2020 - Thorndale Unit - arranged and Pt aware
Virtual Stone Clinic R/V in 4/12.

Now medically fit for discharge. Many thanks for your ongoing care.

Did the patient receive a blood transfusion?

No

Allergies

Patient has allergies

Details of Allergies

Simvastatin

Known Reactions to Allergies

Discharge Date

26/06/2020

Discharge Time

AOB-37034**Arrangements For Follow-Up**

Stent Pull - Tuesday 30th June 2020 - Thorndale Unit - arranged and Pt aware
Virtual Stone Clinic R/V in 4/12

Further Detailed Discharge Letter To Follow: No

Awaiting Further Results: No

Patient Aware Of Diagnosis: Yes

Other Management Information For GP**Discharge Prescription:**

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP Continue?
Admission drugs (unamended)					
Trelegy Ellipta Inhaler	T	Each Morning	*	Inhaled	Yes
FOLIC ACID Tablets	5mg	Each Morning	*	Oral	Yes
FUROSEMIDE Tablets	40mg	Each Morning	*	Oral	Yes
CARBOCISTEINE 250 mg in 5mL Syrup	7.5mls	Four Times Daily	*	Oral	Yes
PARACETAMOL 500 mg Tablets	1g	Four Times Daily	*	Oral	Yes
Episenta M/R (Additional Info: SODIUM VALPROATE - CRITICAL MED) (Change Reason: .)	900mg	Twice Daily	*	Oral	Yes
LATANOPROST 50 micrograms in 1mL Eye Drops	T (left eye)	Each Morning	*	Oral	Yes
OLANZAPINE Tablets	2.5mg	Each Night	*	Oral	Yes
MIRTAZAPINE Tablets	30mg	Each Night	*	Oral	Yes
ATORVASTATIN Tablets	80mg	Each Night	*	Oral	Yes
SERTRALINE Tablets	100mg	Each Morning	*	Oral	Yes
LANSOPRAZOLE Capsules	30mg	Each Morning	*	Oral	Yes
RAMIPRIL	2.5mg	Each Morning	*	Oral	Yes
BISOPROLOL Tablets	1.25mg	Each Morning	*	Oral	Yes
DIGOXIN Tablets	125 micrograms	Each Morning	*	Oral	Yes
LEVOTHYROXINE SODIUM Tablets	100 micrograms	Each Morning	*	Oral	Yes
Pregabalin 150mg Capsules	150mg	Each Morning	*	Oral	Yes
BUSPIRONE 5 mg Tablets	5mg	Twice Daily	*	Oral	Yes
CLONAZEPAM Tablets	250 micrograms	Each Night	*	Oral	Yes
ZOPICLONE Tablets	7.5mg	Each Night	*	Oral	Yes
FERROUS FUMARATE 305 mg Capsules	305mg	Each Morning	*	Oral	Yes
Salbutamol 100microgram/dose breath-actuated inhaler (Easi-breathe)	T-TT	When Required	*	Inhaled	Yes
Dabigatran Capsules (Additional Info: PLEASE RESTART DABIGATRAN ON SATURDAY 27th JUNE 2020)	150mg	Each Morning	*	Oral	Yes
Drugs prescribed since admission					
Admission drugs (amended)					

Stopped Medication:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				

Authorised Forms

Form

Adult Clinical Details (Elective-CMPM)

Authorised By

Patrick Breen

Prescribing Clinician:

Patrick Breen

Bleep No:**Discharged by:**

Patrick Breen

Bleep No:
 Personal
Information
redacted by
USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by USI]

E mail: [Personal Information redacted by USI]

Secretary: Mrs N. Elliott

[Personal Information redacted by USI]

Dear [Personal Information redacted by USI]

Re: Patient Name:

D.O.B.:

Address:

Hospital No:

[Patient 104]

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]

H&C No:

[Personal Information redacted by the USI]

I write to you regarding this 50 year old man recently referred by your colleague, [Personal Information redacted by the USI] for further assessment and management of the recently reported, bilateral renal calculi on ultrasound scanning performed on 13th June 2019. I note that [Patient 104] had a relatively large, left ureteric stone managed by ureteroscopic laser lithotripsy and ureteric stenting in 2014. I also note that he was reported to have a smaller left lower ureteric stone on CT scanning performed in 2016.

I have requested the Department of Radiology at South West Acute Hospital to arrange an appointment for [Patient 104] to attend to have a further CT scan of his urinary tract performed, and I then hope to review him with the report at my clinic at South West Acute Hospital.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS

Consultant Urological Surgeon

Date Dictated: 26/06/19	Date Typed: 01/07/19-CN
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[Patient 104] **DOB:** [Personal Information redacted by the USI] **H+C:** [Personal Information redacted by the USI]

Page 1 of 1



Southern Health
and Social Care Trust

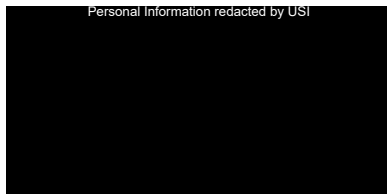
CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN BT63 5QQ

UROLOGY DEPARTMENT

Telephone:

E mail:

Secretary: Mrs N. Elliott



Dear [Redacted]

Re: Patient Name:

D.O.B.:

Address:

Hospital No:

Patient 104

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

HCN:

Personal Information redacted by the USI

Date/Time of Clinic: 23/12/19	Follow Up: W/L
Procedure (if applicable)	

I write to you regarding this 50 year old man referred by your colleague, Dr [Redacted] in July 2019 requesting management of bilateral renal calculi as demonstrated on ultrasound scanning in June 2019. I requested a CT scan of [Redacted] Patient 104's urinary tract, and which was performed on 16th July 2019 when he was reported to have a large stone, measuring 1.8cm in diameter, located at the right renal outlet, remarkably without causing any right renal outlet obstruction. He was reported to have a number of calyceal calculi in the lower pole of the right kidney as well as a number of smaller stones of similar size in the left kidney.

In response to the further request by your colleague, Dr [Redacted] in October 2019, I met [Redacted] Patient 104 for the first time at my clinic at South West Acute Hospital on 23rd December 2019 when he reported that he had been keeping rather well until these passed two months when he has been very dependent upon taking Diclofenac to relieve intermittent right loin pain.

I have arranged for [Redacted] Patient 104 to be electively admitted to our Department on Wednesday 8th January 2020 for right ureteroscopic laser lithotripsy. I have advised him that it may not be possible to gain endoscopic access to the large stone at the right renal outlet, and that it may only be possible to stent his right ureter in the first instance, followed by elective re-admission for ureteroscopic laser lithotripsy at a later date. However, hopefully it will be possible to gain endoscopic access to the right renal calculi, and I have advised him that I would hope to achieve maximum stone fragmentation, and that he will certainly require right ureteric stenting following fragmentation of such a large stone burden.

Patient 104 **DOB:** [Redacted] **H+C:** [Redacted]

You will be advised of the outcome and of any plans for his further management in due course.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 23/12/19	Date Typed: 30/12/19-cn
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Patent 104

DOB:

Personal Information
redacted by the USI

H+C:

Personal Information
redacted by the USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by USI]

E mail: [Personal Information redacted by USI]

Secretary: Mrs N. Elliott

[Personal Information redacted by USI]

Dear [Personal Information redacted by USI]

Re: Patient Name: [Patient 104]

D.O.B.: [Personal Information redacted by the USI]

Address: [Personal Information redacted by the USI]

Hospital No: [Personal Information redacted by the USI]

H&C No: [Personal Information redacted by the USI]

I wrote to you in December 2019, advising that I had arranged for [Patient 104] to be admitted to our Department on Wednesday 8th January 2020 for right ureteroscopic laser lithotripsy. Regrettably his admission was cancelled that day due to the recent industrial action. I write to advise you that I have re-arranged his admission for Tuesday 4th February 2020, when hopefully there will be no hindrance to his admission.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 26/01/20	Date Typed: 27/01/20-CN
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[Patient 104]

DOB:

[Personal Information redacted by the USI]

H+C:

[Personal Information redacted by the USI]



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by USI]

E mail: [Personal Information redacted by USI]

Secretary: Mrs N. Elliott

[Personal Information redacted by USI]

Dear [Personal Information redacted by USI]

Re: Patient Name: [Patient 104]

D.O.B.: [Personal Information redacted by the USI]

Address: [Personal Information redacted by the USI]

Hospital No: [Personal Information redacted by the USI]

HCN: [Personal Information redacted by the USI]

I wrote to you on the 26th of January 2020, advising that it had not been possible to have [Patient 104] admitted as planned on Wednesday the 8th of January 2020 due to planned industrial action that day. I therefore arranged his admission for Tuesday the 4th of February 2020, but most regrettably, it was not possible to have him admitted that day either due to lack of bed availability.

It does concern me somewhat to note that [Patient 104] presented to the Emergency Department at South West Acute Hospital on the 27th of January 2020 following the onset of right loin and flank pain, accompanied by passing only very small quantities of urine. When I spoke with [Patient 104] once again recently, he reported that both of these problems resolved later that day. Knowing that he does have a stone located at the outlet of his right kidney, and knowing that he also does have calculi in his contralateral left kidney, I would be most concerned by the possibility of [Patient 104] developing bilateral upper tract obstruction simultaneously, even though such an event occurs rarely.

I have rearranged his admission to Tuesday the 11th of February 2020 and I do most sincerely hope that he will be admitted that day.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 04/02/20

Date Typed: 05/02/20-NE

[Patient 104]

DOB:

[Personal Information redacted by the USI]

H+C:

[Personal Information redacted by the USI]

Elliott, Noleen

From: Baird, Veronica
Sent: 12 February 2020 13:32
To: Elliott, Noleen
Subject: re admit

Categories: Dealt with

Hi

Mr Patient 104 Personal Information redacted by the USI discharged 11022020 is for re admission in 4-6/52 for URS/Furs/Laszer lithotripsy

Regards

Veronica

Ward Clerk
1 West Elective Admissions
Ext Personal Information redacted by the USI
Tracking code CEAW

This item has been archived by HP Consolidated Archive. [View](#) [Restore](#)

Elliott, Noleen

From: O'Brien, Aidan
Sent: 07 April 2020 22:30
To: Glackin, Anthony
Cc: Young, Michael; Haynes, Mark; ODonoghue, JohnP; Elliott, Noleen
Subject: Admissions to DHH on Monday 13 April 2020

Categories: Dealt with

Tony,

I would be grateful if consideration could be given to having the following two patients admitted to DHH on Monday 13 April 2020:

1. Personal Information redacted by USI 83 years TURBT

Personal Information redacted by USI is prepared to be admitted, but happy to be admitted if I am doing the procedure?!
I have advised him to not take any Clopidogrel after today

2. Patient 104 Personal Information redacted by the USI 50 years

This item has been archived by HP Consolidated Archive. [View](#) [Restore](#)

O'Brien, Aidan

From: O'Brien, Aidan
Sent: 11 April 2020 17:34
To: Haynes, Mark
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; Corrigan, Martina
Subject: Priority Cases for consideration of admission during week commencing Monday 20 April 2020

Mark,

I would be grateful if consideration could be given to the following four patients being electively admitted during week commencing Monday 20 April 2020:

1. Patient 104 Personal Information redacted by the USI 50 years

· Removal / Replacement of Stent & Right Flexible Ureteroscopic Laser Lithotripsy

(Lives in Personal Information redacted by the USI : entirely happy to be admitted to UIC / Kingsbridge / DHH)

2. Personal Information redacted by the USI

This item has been archived by HP Consolidated Archive. [View](#) [Restore](#)

O'Brien, Aidan

From: O'Brien, Aidan
Sent: 30 April 2020 16:29
To: Elliott, Noleen
Subject: Patient 104 Personal Information
redacted by the USI

Noleen,

This man cancelled his admission to DHH on Friday 01 May 2020 due to work commitments.
Please ensure that he remains on CURWL.

Thank you,

Aidan.

HCN	Forename	Surname	Age	Consultant	Expected Admission Date	Expected Method of Adm. Desc	Expected Method of Adm.	Urgency Code	Original Date	Waiting List Code	Intended Management	Admission Reason	Weeks waiting	Total Waiting
Personal Information redacted by the USI	Patient 104			51	AOB	23/04/2020	PLANNED ADMISSION PL	2	11/02/2020	CURWLN		RIGHT FLEXIBLE URETEROSCOPIC LASER LITHOTRIPSY - MARCH 2020	12	1
														708

O'Brien, Aidan

From: O'Brien, Aidan
Sent: 02 June 2020 14:34
To: Glackin, Anthony
Cc: Haynes, Mark; Mills, Debbie
Subject: FW: WC 8 June 2020 theatres

Tony,

I have added five patients to the list below.

As I work through patients whom I deferred previously for varying reasons, I may have more who would be suitable for admission next week.

I would be grateful if I could be advised as to whether more can be accommodated next week.

Thank you,

Aidan.

From: Glackin, Anthony
Sent: 02 June 2020 13:55
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark
Cc: Mills, Debbie
Subject: WC 8 June 2020 theatres

Dear Colleagues

Please add cases to the list and return to me and Debbie.

Thanks

Tony

Name	HCN	DOB	Date on WL	Disease type	Speciality	Procedure
Personal Information redacted by USI		63	16/05/2020		URO	RF CYSTOSCOPY A
		77	26/02/2020		URO	RF TURBT
		66	26/05/2020		URO	RED FLAG TURBT
		69	26/05/2020		URO	RED FLAG TURBT
		59	12/02/2020		URO	GA CYSTOSCOPY+, BLADDERNECKINC
		60			URO	JUNE 2020 CHANG
Patient 113			18/07/2019		URO	Replacement of L
Patient 104			11/02/2020		URO	Removal / Replace Lithotripsy
Personal Information redacted by USI			13/05/2020		URO	Right Ureteroscop
			14/05/2020		URO	Removal / Replace
			01/06/2020		URO	TURP
Patient 1						

O'Brien, Aidan

From: Haynes, Mark
Sent: 02 June 2020 14:35
To: O'Brien, Aidan; Glackin, Anthony
Cc: Mills, Debbie
Subject: RE: WC 8 June 2020 theatres

The lists for DHH and CAH lists WC 8th June are full already (I have to complete by 1 week before the week starts). Any patients identified will be looking to WC 15th June.
 Mark

From: O'Brien, Aidan
Sent: 02 June 2020 14:34
To: Glackin, Anthony
Cc: Haynes, Mark; Mills, Debbie
Subject: FW: WC 8 June 2020 theatres

Tony,

I have added five patients to the list below.

As I work through patients whom I deferred previously for varying reasons, I may have more who would be suitable for admission next week.

I would be grateful if I could be advised as to whether more can be accommodated next week.

Thank you,

Aidan.

From: Glackin, Anthony
Sent: 02 June 2020 13:55
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark
Cc: Mills, Debbie
Subject: WC 8 June 2020 theatres

Dear Colleagues

Please add cases to the list and return to me and Debbie.

Thanks

Tony

Name	HCN	DOB	Date on WL	Disease type	Speciality	Procedure
Personal Information redacted by USI		63	16/05/2020		URO	RF CYSTOSCOPY A
		77	26/02/2020		URO	RF TURBT
		66	26/05/2020		URO	RED FLAG TURBT
		69	26/05/2020		URO	RED FLAG TURBT
		59	12/02/2020		URO	GA CYSTOSCOPY+, BLADDERNECKINC
		60			URO	JUNE 2020 CHANG

Patient 113			18/07/2019		URO	Replacement of
Patient 104			11/02/2020		URO	Removal / Replacement Lithotripsy
Personal Information redacted by USI			13/05/2020		URO	Right Ureteroscopy
Patient 1			14/05/2020		URO	Removal / Replacement
			01/06/2020		URO	TURP

O'Brien, Aidan

From: Haynes, Mark
Sent: 03 June 2020 13:11
To: O'Brien, Aidan; ODonoghue, JohnP
Subject: RE: WC 8 June 2020 theatres

Categories: Red Category

The 3 highlighted would only be able to be done in UIC.

John – you are down for Tuesday 9th in UIC have you filled this list as yet?

Mark

From: O'Brien, Aidan
Sent: 02 June 2020 14:34
To: Glackin, Anthony
Cc: Haynes, Mark; Mills, Debbie
Subject: FW: WC 8 June 2020 theatres

Tony,

I have added five patients to the list below.

As I work through patients whom I deferred previously for varying reasons, I may have more who would be suitable for admission next week.

I would be grateful if I could be advised as to whether more can be accommodated next week.

Thank you,

Aidan.

From: Glackin, Anthony
Sent: 02 June 2020 13:55
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark
Cc: Mills, Debbie
Subject: WC 8 June 2020 theatres

Dear Colleagues

Please add cases to the list and return to me and Debbie.

Thanks

Tony

Name	HCN	DOB	Date on WL	Disease type	Speciality	Procedure
Personal Information redacted by USI		63	16/05/2020		URO	RF CYSTOSCOPY A
		77	26/02/2020		URO	RF TURBT
		66	26/05/2020		URO	RED FLAG TURBT
		69	26/05/2020		URO	RED FLAG TURBT

[illegible]



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Redacted]

E mail: [Redacted]

Secretary: **MRS N. ELLIOTT**

[Redacted]

Dear [Redacted]

Re: Name: [Redacted]

D.O.B: [Redacted]

Address: [Redacted]

Hospital No: [Redacted]

H&C No: [Redacted]

Date of Admission: 11/02/20	Method of Admission
Date of Discharge: 11/02/20	PLANNED ADMISSION
Procedure: Right ureteric stenting performed on the 11 th of February 2020	

Diagnosis: Bilateral renal calculi

I last wrote to you on the 5th of February 2020 when I arranged for [Redacted] to be admitted on the 11th of February 2020 for ureteroscopic management of the large right renal pelvic stone causing right renal outlet obstruction. On attempted ureteroscopy performed under general anaesthesia that day, it was not possible to advance the ureteroscope up to the right renal pelvis. The right ureter was stented, and [Redacted] was fit for discharge later that day.

[Redacted] then presented to the Emergency Department at South West Acute Hospital on the 14th of February 2020 due to increased right loin and flank pain. CT scanning of his urinary tract that day confirmed that the right ureteric stent was in a satisfactory position within his right upper urinary tract, and that the large right renal pelvic stone had migrated into the lower pole of his right kidney. It also served to demonstrate that [Redacted] has additional right renal calculi as well as having left renal calculi.

I then arranged for [Redacted] to be admitted on the 1st of May 2020 for removal or replacement of the right ureteric stent following right flexible ureteroscopic laser lithotripsy. However, [Redacted] was unable to be admitted as he felt that he could not leave his wife to manage his business alone. However, he has since developed increasing discomfort obviously related to the indwelling stent as well as the right renal calculi. He has therefore agreed to be admitted as soon as is possible for further management.

Patient 104

DOB:

[Redacted]

H+C:

[Redacted]

Page 1 of 2

Patient 104 has been advised that he may be admitted to the Ulster Independent Clinic in Belfast, or the Kingsbridge Clinic in Belfast, or to our department at Daisy Hill Hospital in Newry. Patient 104 does not have any particular preference. I have advised him that he should now remain in self-isolation so far as is possible while awaiting admission, and I have advised him that he will have Covid-19 testing arranged to be conducted 2 days prior to the intended date of his admission. He is aware that he will only be admitted if found to be Covid-19 negative on testing.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 02/06/20	Date Typed: 03/06/20-NE
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O'Brien, Aidan

From: O'Brien, Aidan
Sent: 04 June 2020 18:52
To: Glackin, Anthony
Cc: Haynes, Mark; Mills, Debbie; Brady, Una; Elliott, Noleen
Subject: Patients for consideration of admission during week commencing Monday 15 June 2020

Tony,

Please find below a list of my patients (in blue) which I have added to the list of patients for consideration of admission during the week commencing Monday 15 June 2020.

I would appreciate if it would be possible to have Personal Information redacted by the USI admitted to CAH on Monday 15 June 2020 as I would be free to do his operation that day.

Thank you,

Aidan.

From: O'Brien, Aidan
Sent: 02 June 2020 17:53
To: Haynes, Mark
Cc: Mills, Debbie; Glackin, Anthony
Subject: RE: WC 8 June 2020 theatres

Mark,

Will it be possible to have four of the five listed admitted to UIC or Kingsbridge?

Also, has any progress been made in facilitating the admissions of patients who meet the clinical criteria for admission, but who are resident in Nursing Homes?

Aidan.

From: Haynes, Mark
Sent: 02 June 2020 14:35
To: O'Brien, Aidan; Glackin, Anthony
Cc: Mills, Debbie
Subject: RE: WC 8 June 2020 theatres

The lists for DHH and CAH lists WC 8th June are full already (I have to complete by 1 week before the week starts). Any patients identified will be looking to WC 15th June.

Mark

From: O'Brien, Aidan
Sent: 02 June 2020 14:34
To: Glackin, Anthony
Cc: Haynes, Mark; Mills, Debbie
Subject: FW: WC 8 June 2020 theatres

Tony,

I have added five patients to the list below.

As I work through patients whom I deferred previously for varying reasons, I may have more who would be suitable for admission next week.

I would be grateful if I could be advised as to whether more can be accommodated next week.

Thank you,

Aidan.

From: Glackin, Anthony

Sent: 02 June 2020 13:55

To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark

Cc: Mills, Debbie

Subject: WC 8 June 2020 theatres

Dear Colleagues

Please add cases to the list and return to me and Debbie.

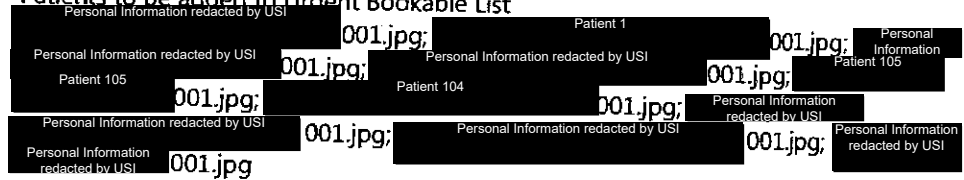
Thanks

Tony

Name	HCN	DOB	Date on WL	Disease type	Speciality	Procedure
Personal Information redacted by USI		63	16/05/2020		URO	RF CYSTOSCOPY A
		77	26/02/2020		URO	RF TURBT
		66	26/05/2020		URO	RED FLAG TURBT
		69	26/05/2020		URO	RED FLAG TURBT
		59	12/02/2020		URO	GA CYSTOSCOPY+ BLADDERNECKING
		60			URO	JUNE 2020 CHANG
Patient 113			18/07/2019	Malignant	URO	Replacement of L
Personal Information redacted by USI			05/11/2019	? Malignant	URO	Bilateral Ureteroh
Patient 1			01/06/2020	Malignant	URO	TURP
Personal Information redacted by USI			04/06/2020	Malignant	URO	Bilateral Ureterogra
			15/09/2019	Benign	URO	Right Rigid & Flexi
Patient 105			11/09/2019	Benign	URO	Removal / Replac Lithotripsy
Patient 104			11/02/2020	Benign	URO	Removal / Replac Lithotripsy
Personal Information redacted by USI			13/05/2020	Benign	URO	Right Ureteroscopy
			14/05/2020	Benign	URO	Removal / Replac
			15/05/2020	Benign	URO	Removal of Bilate

O'Brien, Aidan

From: O'Brien, Aidan
Sent: 07 June 2020 22:25
To: Neville, Linda; MdIveen, Jacqueline
Cc: Sector, Independent; Glackin, Anthony; Haynes, Mark; Elliott, Noleen
Subject: Patients to be added to Urgent Bookable List
Attachments:



Dear Linda and Jacqueline,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.

Mark Haynes has already arranged to have the first of those patients, Patient 113, admitted to Kingsbridge Private Hospital on Wednesday 10 June 2020.

I have scanned and attached completed Green Forms for the remaining nine patients.

I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.

Please let me know if I can be of any further assistance.

I hope the above will facilitate their admissions.

Thank you,

Aidan.

To be completed if a patient is to be added to a Day-Case / Inpatient Waiting List

Patient Name: [Redacted] Write details
D.O.B.: [Redacted]
H&C No: [Redacted]

Date of Clinic / Decision to list: 05 Nov 2019
Consultant: AO'BRIEN
Specialty: UROLOGY

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RETROPERITONEAL FIBROSIS / RETROPERITONEAL SARCOMA
Procedure: BILATERAL URETEROLYSIS & RETROPERITONEAL BIOPSY
Estimated Duration of Surgery: 5 HOURS
Additional Comments / Instructions: FOR ADMISSION TO CRAGGAVON AREA HOSP

Urgency
Please tick appropriate box

Red Flag	☒
Urgent	☐
Routine	☐
Planned	☐

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	☐
Local	☐

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
Please tick appropriate box

Day Case	☐
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	CAH
Specific Unit Requirement	AWCA
Specific Consultant	AO'BRIEN

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature: [Redacted] Print Name: Aidan O'Brien Date: 07.06.20
Countersigned (Consultant): [Redacted] Date: [Redacted]

Patient details

Name: [Redacted]
D.O.B.: [Redacted]
H&C No.: [Redacted]

Date of Clinic / Decision to list: 01 JUNE 20
Consultant: A O'Brien
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: BLADDER OUTLET OBSTRUCTION DUE TO PROSTATIC CANCER
Procedure: ENDOSCOPIC RESECTION OF PROSTATE - TURP
Estimated Duration of Surgery: 1 HOUR
Additional Comments / Instructions: FOR ADMISSION TO DHHOSPITAL

Urgency
Please tick appropriate box

Red Flag	☒
Urgent	☐
Routine	☐
Planned	☐

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	☐
Local	☐

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
Please tick appropriate box

Day Case	☐
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	DHH
Specific Unit Requirement	Urology A
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☐ Yes ☒ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature

Print Name

Date

07.06.20

Countersigned (Consultant)

Date

Personal Information redacted by USI

Patient Name: [REDACTED]
D.O.B.: [REDACTED]
H&C N: [REDACTED]

Date of Clinic / Decision to list: 04.06.20
Consultant: AO'Brien
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: BILATERAL UPPER URINARY TRACT OBSTRUCTION
Procedure: BILATERAL URETEROGRAPHY & URETERIC STENTING
Estimated Duration of Surgery: 1 HOUR
Additional Comments / Instructions: FOR ADMISSION TO DHH

Urgency
Please tick appropriate box

Red Flag ☒
Urgent ☐
Routine ☐
Planned ☐

Anaesthetic Type
Please tick appropriate box

General / Spinal ☒
Sedation ☐
Local ☐

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
Please tick appropriate box

Day Case ☐
Inpatient ☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement: DHH
Specific Unit Requirement: LEVEL 4
Specific Consultant:

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
- b. Continue to take as normal ☐
- c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- b. Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature: [REDACTED] Print Name: Aidan O'Brien Date: 07.06.20
Countersigned (Consultant): [REDACTED] Date:

Patient Name: [Redacted]
 D.O.B.: [Redacted]
 H&CN: [Redacted]

Date of Clinic / Decision to list: 15.09.19
 Consultant: AOBRIEN
 Specialty: UROLOGY

*** FOR URGENT BOOKABLE LIST ***
 Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER URETERIC & RENAL COLIC
 Procedure: RIGHT RIGID & FLEXIBLE URETEROSCOPIC LITHOTRIPSY
 Estimated Duration of Surgery: 2 HOURS
 Additional Comments / Instructions: FOR UIC / KINGSBRIDGE / DHH

Urgency
 Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
 Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management
 Please tick appropriate box

Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒ ASPIRIN 75MG
 If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

- Please advise whether the Patient should either:
- a. Reduce to 75mg daily 7days prior to surgery ☐
 - b. Continue to take as normal ☐
 - c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

- Please advise:
- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
 - b. Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, the decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature

Print Name

Date

AOBRIEN 07.06.20

Countersigned (Cons)

Date

to be completed if a patient is to be added to a Day-Case / Inpatient Waiting List

Patient Name: [Redacted] Patient 105
 D.O.B.: [Redacted]
 H&C No.: [Redacted]

Date of Clinic / Decision to list: 11.09.19
 Consultant: AOBrien
 Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
 Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER TRACT CALCULI
 Procedure: REMOVAL OF STONE & RIGHT FLEX. URETER. LITHOTRIPSY
 Estimated Duration of Surgery: 2 HOURS
 Additional Comments / Instructions: FOR ADMISSION TO D.H. HOSPITAL

Urgency
 Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
 Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management
 Please tick appropriate box

Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	DHH
Specific Unit Requirement	Level A
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- a. Reduce to 75mg daily 7days prior to surgery ☐
- b. Continue to take as normal ☐
- c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- b. Patient should discontinue 7days prior to surgery ☐

Dabigatran, Rivaroxaban or Apixaban? ☒ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge. If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature: [Redacted]
 Countersigned (Consultant): [Redacted]
 Print Name: Aidan O'Brien
 Date: 07.06.20

Patient Name: [Redacted]
D.O.B.: [Redacted]
H&C No: [Redacted]

Date of Clinic / Decision to list: 13.05.20
Consultant: AO'Brien
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT URETERIC CALCULI
Procedure: RIGHT URETEROSCOPIC LASER LITHOTRIPSY ? STENTING
Estimated Duration of Surgery: 1 HOUR
Additional Comments / Instructions: FOR UIC OR KINGSBRIDGE OR DHH

Urgency
Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management
Please tick appropriate box

Day Case	
Inpatient	☒

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature: [Redacted]	Print Name: AO'Brien	Date: 07.06.20
Countersigned (Consultant): [Redacted]		Date:

Patient Name:	Personal Information redacted by the USI
D.O.B.:	
H&C No:	

Date of Clinic / Decision to list	11.02.20
Consultant	Aidan O'Brien
Specialty	Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT UPPER GROOVE COLIC
Procedure:	REMOVAL OF STENT & FLEX. URETEROSCOPIC LITHOTRIPSY
Estimated Duration of Surgery:	3 HOURS
Additional Comments / Instructions:	LIC OR KINGSBRIDGE OR DHH

Urgency	
Please tick appropriate box	
Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type	
Please tick appropriate box	
General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission - please state & give reason

Intended Management	
Please tick appropriate box	
Day Case	
Inpatient	☒

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery - stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Print Name	Date
	A O'Brien	07.06.20
Countersigned (Consultant)		Date

Patient Name:	Personal Information redacted by USI
D.O.B.:	
H&C N.:	

Date of Clinic / Decision to list	15.05.20
Consultant	A O'Brien
Specialty	Urology

*** FOR URGENT BOOKABLE LIST ***
 Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT URETERIC AND BLADDER INJURY
Procedure:	CYSTOSCOPY, REMOVAL OF STONE, RIGHT URETEROGRAPHY & CYSTOGRAM
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR ADMISSION TO DHH

Urgency	
Please tick appropriate box	
Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type	
Please tick appropriate box	
General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management	
Please tick appropriate box	
Day Case	
Inpatient	☒

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	DHH
Specific Unit Requirement	Room 4
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☒ ENOXAPARIN

If yes, please indicate if patient is on any of the medications below and the action required: 60 MGS DAILY

- Warfarin? ☐
 - Aspirin 300mg? ☐
 - Clopidogrel or Prasugrel? ☐
 - Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

Latex Allergy? No ☒ Yes ☐ MRSA? No ☒ Yes ☐
 Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
 If the Consultant is not available, a decision should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Print Name	Date
	Aidan O'Brien	07.06.20
Countersigned (Consultant)		Date

Personal Information redacted by USI

Patient Name: [REDACTED]
D.O.B: [REDACTED]
H&C: [REDACTED]

Date of Clinic / Decision to list: 14.05.20
Consultant: A O'Brien
Specialty: Urology

*** FOR URGENT BOOKABLE LIST ***
Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis: RIGHT UPPER TRACT OBSTRUCTION
Procedure: REMOVAL OF STONE & RIGHT URETEROSCOPIC LITHOTRIPSY
Estimated Duration of Surgery: 1 HOUR
Additional Comments / Instructions: FOR UIC OR KINGSBRIDGE OR DHH

Urgency
Please tick appropriate box

Red Flag	
Urgent	☒
Routine	
Planned	

Anaesthetic Type
Please tick appropriate box

General / Spinal	☒
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason.

Intended Management
Please tick appropriate box

Day Case	
Inpatient	☒

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:

Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☒ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- Warfarin? ☐
- Aspirin 300mg? ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

- Reduce to 75mg daily 7days prior to surgery ☐
- Continue to take as normal ☐
- Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

- Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
- Patient should discontinue 7days prior to surgery ☐

- Dabigatran, Rivaroxaban or Apixaban? ☐ Please refer to Trust Guidance and SPC.

Latex Allergy? No ☒ Yes ☐

MRSA? No ☒ Yes ☐

Diabetic? No ☒ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.

If the Consultant should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Print Name	Date
[REDACTED]	A O'Brien	07.06.20
Countersigned (Consultant)		Date

Subject: Patients to be added to Urgent Bookable List

From: O'Brien, Aidan

Personal Information redacted by USI

To: Neville, Linda

Personal Information redacted by USI

McIlveen, Jacqueline

Personal Information redacted by USI

Cc: Sector, Independent

Personal Information redacted by USI

Glackin, Anthony

Personal Information redacted by USI

, Haynes, Mark

Personal Information redacted by USI

, Elliott,

Noleen

Personal Information redacted by USI

Sent: 6/7/2020, 10:25:19 PM

Personal Information redacted by USI

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Patient 1

001.jpg

Personal Information redacted by USI

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Personal Information redacted by USI

001.jpg

Patient 105

001.jpg

Patient 104

001.jpg

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Personal Information redacted by USI

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Dear Linda and Jacqueline,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.

Mark Haynes has already arranged to have the first of those patients, Patient 113 admitted to Kingsbridge Private Hospital on Wednesday 10 June 2020.

I have scanned and attached completed Green Forms for the remaining nine patients.

I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.

Please let me know if I can be of any further assistance.

I hope the above will facilitate their admissions.

Thank you,

Aidan.



**Southern Health
and Social Care Trust**

**UROLOGY
DISCHARGE LETTER**

Craigavon Area Hospital
68 Lurgan Road
Portadown
Co Armagh
BT63 5QQ

Consultant Urologist: Mr Glackin
Secretary: Elizabeth
Telephone: Personal Information redacted by the USI

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Name:

D.O.B:

Address:

Hospital No:

Patient 104

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

H&C No:

Personal Information redacted by the USI

Date of Admission: 22/06/20	Method of Admission
Date of Discharge: 24/06/20	FROM OTHER HOSPITAL
Procedure: Right semi-rigid ureteroscopy and removal of stent 23 rd June 2020.	

Outcome: Discussion in stone meeting, query shockwave lithotripsy for lower pole stone.

Patient 104 presented acutely to the Urology service with severe stent symptoms. This was his second presentation to unscheduled care. He had a recent flexible ureteroscopy plus laser lithotripsy. A CT scan suggested that some of these fragments might be in his ureter alongside his stent. For this reason operative management was carried out.

Findings at cystoscopy her normal external genitalia, normal anterior urethra, short prostatic urethra, grossly normal bladder with normal UO and stent looking clean. Access to the right renal pelvis was relatively straightforward with a semi-rigid ureteroscope. There was no residual ureteric stone. The lower pole calculi could be seen clearly on x-ray. Alongside a sensory safety wire a 6/7.5 semi-rigid ureteroscope was advanced to the right renal pelvis. Limited retrograde pyelogram was performed for anatomy. His ureteric stent was removed.

Follow up shall be likely shockwave lithotripsy to the residual lower pole stone disease after discussion in the stone meeting. His calcium and uric acid levels are normal.

Patient 104 **DOB:** Personal Information redacted by the USI **H+C:** Personal Information redacted by the USI

Yours sincerely,

Dictated but not signed by

Abhishek Sharma
ST4 in Urology
Mr AJ Glackin, MD FRCSI (Urol)
Consultant Urologist

Cc Stone Meeting - Emailed Teresa 25/06/2020

Date Dictated: 24/06/2020	Date Typed: 25/06/20 - ET
---------------------------	---------------------------

Patient 104

DOB:

Personal Information
redacted by the USI

H+C:

Personal Information redacted
by the USI

Page 2 of 2

**THE
FUTURE DEVELOPMENT
OF
UROLOGICAL SERVICES**

SUMMARY

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

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

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

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

BACKGROUND

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

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

GENERAL DESCRIPTION OF CURRENT SERVICE

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

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

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

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

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

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

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

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

ACTIVITY

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

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

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

DEVELOPMENTS

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

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

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

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

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

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

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

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

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

ISSUES FOR PURCHASERS

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

ISSUES FOR PROVIDERS

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

ISSUES FOR PATIENTS

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

AMBITIONS FOR THE FUTURE

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

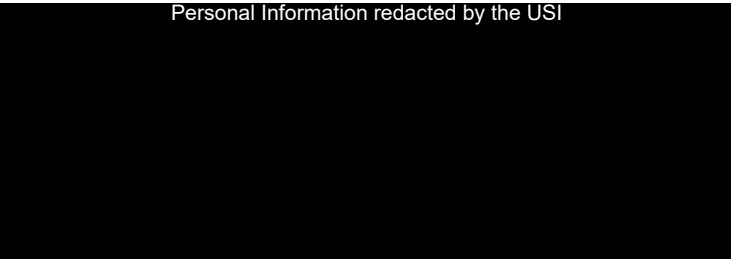
Moreover, the Trust and its Department of Urology are fully aware that increased and improved urological services can only be achieved by paying full attention to aspects of training and education of both urological and nursing staff. Both the Trust and the Department are wholly committed to support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

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

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

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

Personal Information redacted by the USI



MARCH 1997