Southern Health and Social Care Trust

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Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr A[redacted] K[redacted], Case Manager

1.0 Case Manager Determination following Formal Investigation under the Maintaining High Professional Standards Framework in respect of Mr A[redacted] O'B[redacted], Consultant Urologist

Following conclusion of the formal investigation, the Case Investigator's report has been shared with Mr O'B[redacted] for comment on the factual accuracy of the report. I am in receipt of Mr O'B[redacted]'s comments and therefore the full and final documentation in respect of the investigation.

2.0 Responsibility of the Case Manager

In line with Section 1 Paragraph 38 of the MHPS Framework, as Case Manager I am responsible for making a decision on whether:

1. No further action is needed
2. Restrictions on practice or exclusion from work should be considered
3. There is a case of misconduct that should be put to a conduct panel
4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer
5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (re-named as Practitioner Performance Advice)
6. There are serious concerns that fall into the criteria for referral to the GMC or GDC
7. There are intractable problems and the matter should be put before a clinical performance panel.

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

1. (a) To determine if there have been any patient referrals to Mr A O'B[redacted] which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

   (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

2. (a) To determine if all patient notes for Mr O'B[redacted]'s patients are tracked and stored within the Trust.

   (b) To determine if any patient notes have been stored at home by Mr O'B[redacted] for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

   (c) To determine if any patient notes tracked to Mr O'B[redacted] are missing.

3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'B[redacted] in 2015 or 2016.

   (b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'B[redacted] in dictating outpatient clinics.

   (c) To determine if there have been delays in clinical management plans for these patients as a result.

4. To determine if Mr O'B[redacted] has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

5. To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

4.0 Investigation Findings

In answering each of the terms of reference of the investigation, the Case Investigator concluded:

1. (a) It was found that Mr O'B[redacted] did not undertake non-red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged by Mr O'B[redacted]. Mr O'B[redacted] accepts this fact.

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'B[redacted] returned 307 sets of patient notes which had been stored at his home. Mr O'B[redacted] accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'B[redacted] returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'B[redacted].

3. (a) It was found that there were 66 undictated clinics by Mr O'B[redacted] during the period 2015 and 2016. Mr O'B[redacted] accepts this.

   (b) It was accepted by Mr O'B[redacted] that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC are that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'B[redacted] scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

7. Concerns about Mr O'B[redacted]'s practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'B[redacted] regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'B[redacted]'s practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'B[redacted] provided a detailed context to the history of the Urology service and the workload pressures he faced. Mr O'B[redacted] noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'B[redacted] noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'B[redacted] accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'B[redacted] did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'B[redacted]. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'B[redacted].

3. Mr Y[redacted] is the most appropriate comparator for Mr O'B[redacted] as both have historical long review lists which the newer Consultants do not have. Mr Y[redacted] managed triage alongside his other commitments. Mr Y[redacted] undertook Mr O'B[redacted]'s triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'B[redacted] from his home.

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

Undictated clinics

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

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

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

5.0 Case Manager Determination

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

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

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

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

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

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

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

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

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

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

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

Advice Sought

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

My determination:

1. No further action is needed

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

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

There are 2 elements of this option to be considered:

a. A restriction on practice

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

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

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

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

b. An exclusion from work

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

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

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

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

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

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

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

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

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

- Knowingly advantaging his private patients over HSC patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

6.0 Final Conclusions / Recommendations

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

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

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

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

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

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]
Attachments: [redacted]

[redacted]

-----Original Message-----
From: O'Brien, Aidan <[redacted]
To: Aidanpobrien[redacted]
Sent: Tue, 12 Nov 2019 13:45
Subject: FW: Meeting this Friday 8 November 2019

From: Corrigan, Martina
Sent: 06 November 2019 14:06
To: O'Brien, Aidan
Cc: McNaboe, Ted
Subject: RE: Meeting this Friday 8 November 2019

Thank you Aidan,

ave discussed this with Ted and we are both free between 1pm-2pm on this Friday, this meeting should not take too g (10-15 mins) so if you had anytime at all between patients we are happy to call to see you in Thorndale if it was more nvenient for you?

The deviations are listed below and attached and Ted would also like to take the opportunity to organise a another meeting with more time for you and him to sit and discuss your job plan:

CONCERN 1 (Triage) – after your week of oncall on Monday 16 September, there were still 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals outstanding triage, escalation emails were sent to you during your week oncall.

CONCERN 3 (dictation) – As per Marie Evan's email dated 4/11/19 attached there are undictated clinics going back to 23 September and I have attached the detail of these.

I have also received a datix for Patient 112, H&C [redacted] the datix advises that the patient was discussed at MDM on 27 June 2019 and at the MDM on 3 October it was stated that 'it would appear outcomes from previous Uro-Oncology MDM (27/06/2019) have not been actioned), as part of my investigations to close off this datix I noted that you had seen the patient at clinic on 16 August 2019 and only dictated the letter on 4 October 2019 a day after the MDM, therefore this has also been a deviation from your return to work plan.

Regards

Martina

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

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

From: O'Brien, Aidan
Sent: 05 November 2019 19:58
To: Corrigan, Martina
Subject: RE: Meeting this Friday 8 November 2019

Martina.

I do not know whether I will have time to meet with you as I work through lunch doing flexible cystoscopies for patients attending for urodynamic studies as well as reviewing cancer patients.
I am happy to make time to meet, though risking patients waiting etc.

I would be grateful if you would advise in advance of the nature of the deviation,

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 05 November 2019 13:29
To: O'Brien, Aidan
Cc: McNaboe, Ted
Subject: Meeting this Friday 8 November 2019
Importance: High

Dear Aidan,

Ted and I have been asked to meet with you to discuss a deviation from your return to work action plan when you were called in September.

We are both available this Friday at 1pm. The meeting will take place in Ted's office on 3 South.

Can you confirm if this will suit please?

Thanks

Martina

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

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

Southern Health & Social Care Trust IT Department [redacted]

Dear All,

Please find attached Backlog Report for October 2019.

If you have any queries please don't hesitate to contact me.

[redacted]

Kind Regards

Marie Evans
Service Administrator (SEC)
Ground Floor
Ramone Building

T: [redacted]
E: [redacted]

Personal Information redacted by the USI

Mrs Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital,
Craigavon.
BT63 5QQ

07 November 2019.

Dear Martina,

I write in response to your request that I meet with you and Mr. McNaboe tomorrow, Friday 08 November 2019, to discuss deviations from a Return to Work Plan. I am happy to meet with both of you to discuss any issues, though I do find it inappropriate and stressful to do so in the midst of a Cancer Review Clinic.

When I met with the Investigation Case Manager on 09 February 2017, I was advised, in writing, of 'the action plan for Mr. O'Brien's return to work pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework'. The Case Manager concluded the investigation with his Determination of 28 September 2018, and which he presented to me on 01 October 2018. In his Determination, the Case Manager wrote that the 'purpose of this plan was to ensue risks to patients were mitigated during the course of the formal investigation process'.

In the Determination, the Case Manager also recommended that a further 'action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr. O'Brien for a period of time agreed by the parties'. It was recommended that this 'action plan must address any issues with regard to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme'. The Trust has failed to implement this recommendation to date.

It is evident that the issues that you wish to discuss, cannot be considered deviations from a Return to Work Plan which expired in September 2018.

Yours sincerely,

Personal Information redacted by USI

Aidan O'Brien

From: Joanne Donnelly [redacted]
Sent: 12 November 2019 12:53
To: OKane, Maria
Cc: Support TeamELS; Gibson, Simon; Parks, Zoe
Subject: SHSCT - Dr O'Brien GMC - 1394911

Importance: High

Dear Maria,

We need some further information from you (further to the information you provided at our ELA/RO meeting on 7.10.19 that Dr O'Brien has recently, Sept. 19, deviated from his agreed action plan) which will be relevant to our decision as to whether to whether a GMC investigation is necessary:

1. *Can you advise whether there is have any evidence to demonstrate that Dr O'Brien was complying with his agreed local action plan (up to September 19 when the recent deviation occurred)?*

2. *Has Dr O'Brien made any comments to the Trust in response to the recent deviation from his agreed action plan in September 19?*

3. *Regarding the recent incident in September 19, can you provide an update on what actians the Trust plon to take against Dr O'Brien? Specifically, are any measures being put in place to support Dr O'Brien and help him to address his current deficiencies?*

We would be grateful if you would provide this information just as soon as you can – and by Tues 19 Nov 19 at the latest - if that timescale is unworkable for you, or if you need to discuss any aspect of this, please do not hesitate to give me a call.

Kind regards
Joanne

[redacted] – ftp -other – SHSCT - Dr O'Brien GMC – 1394911- GMC request for further information (12.11.19)

Joanne Donnelly
GMC ELA for Northern Ireland

[redacted]

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Southern Health and Social Care Trust

Medical Directorate

Our Ref:

Date:

Joanne Donnelly
ELC Liaison Officer
GMC

Dear Joanne

RE: SHSCT - Dr O'Brien GMC - 1394911

I am writing in response to your e-mail dated 12th November regarding the above, within which you asked three questions. My response to these questions is as below:

Can you advise whether there is have any evidence to demonstrate that Dr O'Brien was complying with his agreed local action plan (up to September 19 when the recent deviation occurred)?

The February 2017 action plan was put in place following Mr O'Brien's return to work following an immediate exclusion process in January 2017. The action plan was shared with Mr O'Brien at a meeting on 9 February 2017 and was to be monitored on-going with any deviation from the action plan to be immediately escalated to the MHPS Case Manager. See attached action plan for information.

A summary e-mail was sent weekly by the service manager to the Case Manager (an example is attached). There were occasions when the backlog reports identified small deviations but given the complex nature of the monitoring process, we could not be confident that these were true deviations but actually resulted from delays in transcription of clinic letters by administrative staff and so continued to assess compliance. These small deviations were not showing consistently from one month to the next. In or around November 2018, the Case Manager sought only to be advised on significant deviations from the action plan as he determined that Dr O'Brien was reasonably compliant.

In terms of evidence of compliance with the action plan the following monitoring arrangements were, and remain, in place. The details of the monitoring arrangements are as follows:

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

Action Plan Monitoring Element	Details
Triage of Referrals	Compliance regarding triage of referrals is monitored via two mechanisms; • The service manager reviews electronic referrals received via NIECR to ensure appropriate triage management • The Trust Referral and Booking Centre Team monitor hardcopy referrals received, and if not returned within the agreed timescale, escalate this to the service manager. In respect of Red flag triage, the action plan initially set out that triage should be completed by 4pm on the Friday following being Mr O'Brien Urologist of the Week. It was amended slightly through monitoring to an understanding that Mr O'Brien would complete all Red Flag triage referrals from his week on call by the end of the working day on the Thursday and the rest by the following Monday morning after he finished the week (handover is Thursday morning). Mr O'Brien had been meeting this expectation however in August and September the completion dates have extended to Tuesday or Wednesday of the following week that he has finished his triage. As the waiting times to first appointments for urology are significant (recently was 67 days), this has not impacted on patient pathways, and so this minor deviation was not considered material.
Clinical Dictation	Completed dictations from each clinic are monitored by the service manager by random checks on NIECR of outpatient sessions and checking if letters have been done. In addition the secretarial staff report backlog data to the admin team and a report is generated monthly. This details any outstanding dictation from outpatient clinics. Escalation occurred at the end August 19 when it appeared that dictations were not done and awaiting transcription. Following further investigation this matter was resolved and no action was

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	necessary.
Keeping Patient Notes at Home	The process whereby Mr O'Brien is expected to transport patient notes on behalf of the Trust to outpatients clinics in South West Acute Hospital (SWAH) remains the same as previous. No patient notes have been tracked out to Mr O'Brien's home and no reports of notes being unavailable at the location they have been tracked to (e.g. Mr O'Brien's secretaries office), or instances of notes being unavailable as not found following a consultation with Mr O'Brien have been noted. Notes are present at Mr O'Brien's home overnight on any Monday that he conducts an outpatient clinic in SWAH. This is for logistical reasons as Mr O'Brien lives in Personal Information redacted by the USI and would not return to Craigavon Area Hospital until Tuesday morning.
Private Practice	Mr O'Brien complies with the trust private practice policy regarding transfer from private care to NHS care and there have been no identified occasions where patients transferring from private care had their treatment expedited more patients of the same urgency from NHS clinics.

Has Dr O'Brien made any comments to the Trust in response to the recent deviation from his agreed action plan in September 19?

Mr O'Brien has made comments to the Trust (letter attached)

Regarding the recent incident in September 19, can you provide an update on what actions the Trust plan to take against Dr O'Brien? Specifically, are any measures being put in place to support Dr O'Brien and help him to address his current deficiencies?

The Trust has offered a meeting with Mr O'Brien on 12th December for further discussions on his job plan, which will include measures to support him in his working practices. As this meeting has not yet taken place, we have not yet had the opportunity to discuss the issues raised in his letter to clarify expectations, agree an action plan and consequence of continued non-compliance. Once an action plan has been agreed, it will be monitored and non-compliance will lead to the implementation of appropriate Trust disciplinary processes.

I hope the above is useful.

Yours sincerely,

Personal Information redacted by USI

Dr Maria O'Kane
Medical Director

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

I think I write in agreement with some of my colleagues in saying that the endoscopy session was not to be configured as a fixed daily session. How on earth can SOW function with the juniors if we are tied up doing a morning endoscopy list? SOW work and seeing patients comes first. Unless it is reflected in job plans. I am not aware that any of us have had that negotiation. I don't mind if ward work has finished then we can utilize the session.

I will not be doing PEG PEG replacement or Colonoscopy.

There is widespread concern regarding ward reconfiguration This is another example of how things are not negotiated anymore. We all have concerns how this will work. When did we have a detailed discussion about it? When did we talk through the implications of it? How are we going to do a ward round when everyone including urology are in attendance? Tell me what the benefits are to quality of care and how you see this working in the real world? Maybe I have missed those discussions too and I am sorry I have.

Maybe Im out on a limb here but our team of nurses are not happy and neither am I.

Anyone else??

Colin Weir FRCS(Ed), FRCS
Consultant General and Vascular Surgeon
Craigavon Area Hospital
Personal Information redacted by the USI
)secretary direct Personal Information redacted by the USI

Mackle, MR E

From: Mackle, MR E
Sent: 02 June 2009 13:10
To: 'Simon.Gibson [redacted] Youart, Joy; O'Brien, Aidan
Subject: Request for leave to clear administration

Simon

Thanks for discussing with me Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork.

I have several serious concerns regarding the request:

1. I think approximately 2 years ago the trust funded a similar exercise to allow Aidan to catchup. It was agreed then that this was a one off and it was his responsibility (as per consultant contract) to prevent such a baglog developing again.

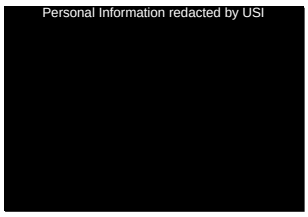
2. There are already 3.87 PAs of admin time in his current job plan. This is way in excess of any other consultant in the trust and is excessive when compared to eg Mr AKhtar (Cons Urologist) who has 1.12 PAs in his job plan for admin.

3. To expect the trust to fund the shortfall in clinical activity in light of Aidan's baglog (despite an over generous allowance of PAs in his job plan) would thus be unreasonable. If his colleagues feel that the request from urology is reasonable then I would expect the sessions to be covered at no additional cost from within the speciality.

4. If as you state Aidan feels there is now a clinical risk because he has allowed the backlog to develop then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may also need to consult with the Medical Director regarding the performance issues raised.

Eamon

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust



12 June 2009.

Mr. Eamon Mackle,
Associate Medical Director,
Surgery and Elective Care,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Eamon,

Two days ago, I opened and read the copy of the email that you sent to Simon Gibson and to Joy Youart on 02 June 2009, and the accompanying cover slip from you, addressed to me. I did so only then as I had mistakenly gathered from you that it had something to do with the arrangements for ward configuration in July. I was shocked beyond words, appalled and flabbergasted on reading both.

In your email addressed to Simon (and sent to Joy), you thank Simon for discussing with you 'Aidan's request to cancel all clinical work during July to allow him to clear the backlog of paperwork'. I certainly did not make or submit to anyone any request to do so.

These past three months have been the most stressful and distressing that I (and everyone else caring for urological patients) have had to endure since I was appointed 17 years ago. Not only have we had to cope with the imposed loss of our ward, and the fragmentation of inpatient urological services posing a potential existential threat to care, we have also had to cope with the reality of the deliberate lack of information and consultation with those most directly and intimately involved in the delivery of the care. Worse still, we additionally had to cope with the reportage that we had not only been informed and consulted, but were in agreement with the plans. Not only have I endeavoured to seek compromise, I have gone to every length to restore some degree of confidence in the credibility of management, when that was at an unprecedented low.

Then I read your email!

I do believe that it would be reasonable to request and expect an acknowledgement, in writing, that I did not make or submit the request recorded in your email,

Yours Sincerely,

Aidan O'Brien.

From: Trouton, Heather [redacted]
Sent: 11 January 2011 11:21
To: O'Brien, Aidan; McCorry, Monica
Cc: Corrigan, Martina; Glenny, Sharon
Subject: Waiting Times

Mr O'Brien

I appreciate that there are important clinical considerations to be made when deciding who to schedule to your inpatient list on a weekly basis. However I have to stress that you currently have 34 patients who will be waiting greater than 36 weeks by the end of March who currently have no date for surgery. The longest waiter at the minute with no date is currently waiting 54 weeks.

Your list for tomorrow has 3 patients waiting 2 weeks , one waiting 14 weeks , one waiting 17 weeks and 1 waiting 19 weeks.

Can I please ask if you would look at these 34 patients and either list them or if they do not require surgery take them off the waiting list particularly as some of these patients are actually categorised as urgent.

Urology has got special dispensation to go out from 13 weeks to 36 weeks as there is a recognition that we do have a capacity gap, however we cannot justify some patients being treated within 2 weeks while others wait 54 weeks.

I appreciate that you have offered to do additional Saturday lists which is great, however as you know this is proving difficult to secure with theatre nursing staff and we really do need to use the core lists we have to treat these long waiters at least until we see what additionality, if any, we can secure.

Can I ask that this gets your urgent attention and Sharon and Martina will be very happy to work with you to identify the patients needing listed before the end of March

Thanks
Heather

Heather Trouton
Acting Assistant Director of Acute Services Telephone ext [redacted] Mobile [redacted]

Corrigan, Martina

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

Heather,

As discussed

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

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

Mr Mackle/ Martina,

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

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

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

Regards

Malcolm

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

Tel: [redacted]

McCorry, Monica

From: Mackle, Eamon
Sent: 05 December 2011 16:47
To: O'Brien, Aidan; McCorry, Monica
Cc: Trouton, Heather; Rankin, Gillian; Corrigan, Martina; Clegg, Malcolm
Subject: Post Facilitation

Dear Aidan

As you are aware in the letter post your job plan facilitation it was stated: "This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this."

I as a result, organised a meeting to discuss same. I note however, that you cancelled said meeting. I am therefore concerned that we haven't met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without need for Trust support then you obviously do not need to contact me to organise a meeting.

Kind Regards

Yours Sincerely

Eamon Mackle

Aimee Crilly

From: Michael Young [redacted] Personal Information redacted by USI
Sent: 04 March 2012 22:09
To: Dignam, Paulette
Cc: O'Brien, Aidan
Attachments: Dear Dr Rankin.docx

Paulette

I would be grateful if you could forward this email to Dr Rankin and to Robin Brown first thing on monday morning as an urgent message - could you also ring Emma and Mr Brown's secretary to ensure they read it. (I do not have the email addresses at home)

Dear Dr Rankin

Please see enclosed letter in reference to the new urology posts. I have kept a close distribution on this letter, parts of which you might want to send on to HR for ammendment.

MY

4TH March 2012

Dear Dr Rankin

I write with reference to the proposed imminent advertisement for three Consultant Urological Surgeons. I write this from both the principles involved, as well as, the practicality of the situation.

In principle, it is found to be very unusual practice to advertise potential jobs within a department, without involving or even showing the job specification to the Lead Clinician of the Unit. I understand this would have been sent to press on Tuesday 6TH March, unseen by myself, even though my name would have been used as the reference point. Would this have been tolerated in any other department?

The principle of advertising three urology posts for the same interview date is observed to be curious, especially as this has the potential to more than double the size of our unit. External factors, over which we have no influence, currently exist within the field of Urology in Northern Ireland. These must be taken into account.

We believe the proposed job specifications are too prescriptive, in terms of their exact job titles. Being so restrictive may narrow our choice of candidates. We feel this ill-advised.

Regarding the practicality of this advertisement, despite the obvious difficultly of disregarding prior advise and at this 'eleventh hour', I would suggest that:

a/ the job title of post 4 should read as 'Consultant Urologist'

(inferring in the job specification of Post 4 states a session for prostate biopsies meaning oncology but not with specific reference to same, thus allowing for a wider number of candidates)

b/ the job title of Post 5 should read Consultant Urologist with a sub-specialty interest such as andrology / female urology / stone management, which would complement the unit.

c/ The job title of Post 3 is satisfactory and should remain.

I believe a new definition for the job descriptions will allow a wider number of candidates to apply, ultimately resulting in an enhanced unit.

I would appreciate a definition of the terms 'OPD teaching / service development', 'prostate biopsy teaching' and 'flexible cystoscopy teaching'. These are defined as SPA activity in the job specification. I am at a loss as to their definitions.

Further points to raise with the Human Resources team in reference to the job specification are:

1/ Post 4: Friday morning theatre session needs to be outlined as Day Surgery (also of note is the fact that travel is not within SPA time).

2/ Post 5: Monday afternoon activity should read as Speciality clinic instead of STC clinic.

3/ Point 3 in the desirable criteria (page 14) should read : additional skills should match the appropriate subspecialty interest.

In conclusion, there are several other erroneous points within most of the job descriptions, not least for instance, the 'one-stop clinic approach' to the prostate diagnostic service, which is currently available. This appears to have been abandoned.

Yours sincerely

M Young MD FRCS (Urol)

Lead Clinician Urology

From: Corrigan, Martina [redacted]
Sent: 06 March 2012 17:03
To: O'Brien, Aidan; [redacted]
Cc: McCorry, Monica
Subject: Copy of PTL REPORTS AS AT 05032012 AOB.xls
Attachments: Copy of PTL REPORTS AS AT 05032012 AOB.xls

Importance: High

Hi Aidan,

Please see attached PTL of patients that need to be seen before end of March. Can you please advise how many of these that can be fitted in as I have to give an update to the Board on Friday.

I note that there are 26 patients left on the INPT PTL. I have advised the Board that we most likely will breach inpatients by 40 weeks MAXIMUM as I have assured the Board that we have been booking in chronological order.

There is 1 D/C also on this:
[redacted]

We need dates for all of the above as well as we cannot breach 36 weeks for daycases.

The Board meeting is this Friday so I would be grateful if you could come back to me by Thursday at the latest.

Many thanks and I am happy to discuss this with you.

Kind regards

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

[redacted]
Personal Information redacted by USI

[redacted]							
05/03/2011	N		AOB	4	N	M43.4	INTRATRIGONAL INJECTION BOTULINUM TOXIN/ADMIT 310312 PER AOB	52
22/04/2011	N	02/03/2012	AOB	2	N	M65.3	TURP CHANGED TO URGENT PER MR O'BRIEN 06/05/11 (FIT 01/03/12 LN)	45
09/05/2011	N		AOB	4	N	N06.3	BILATERAL ORCHIECTOMY AND TESTICULAR PROSTHESES	43
10/05/2011	N		AOB	2	N	Z94.2	RIGHT HYDROCOELECTOMY HOLD(18.07.11)CD/FMCC	43
10/05/2011	N		AOB	2	N	H46.2	HYDROSTATIC DILATATION	43
17/05/2011	N		AOB	4	N	M49.8	INSERTION OF SUPRAPUBIC CATHETER	42
17/05/2011	N		AOB	2	N	M45.9	flexible cystoscopy	42
24/05/2011	N		AOB	2	N	M45.9	CYSTOSCOPY ? URETHROTOMY - (FIT 14/02/12 EM)	41
07/06/2011	N		AOB	4	N	M34.3	RIGHT EPIDIDYMAL CYSTECTOMY HOLD(05.10.11)CD/EMCI I.C.D. IN SITU	39
07/06/2011	N		AOB	4	N	M65.3	TURP FIT(21.10.11)CD	39
10/06/2011	N		AOB	4	N	M65.3	TURP	38
14/06/2011	N		AOB	2	N	M45.9	FLEXIBLE CYSTOSCOPY - SUPRAPUBIC CATHETERISATION	38
14/06/2011	N		AOB	4	N	N10.1	INSERTION OF LEFT TESTICULAR PROSTHESIS	38
25/06/2011	N		AOB	4	N	M43.2	HYDROSTATIC DILATATION (FIT 25.07.11/UPDATED 04/02/12 LN)	36
25/06/2011	N		AOB	4	N	M65.3	TURP FIT(28.09.11)CD/EMCI BMI35.4	36
25/06/2011	N		AOB	4	N		TURP (HOLD 24/02/12 EM)	36
25/06/2011	N		AOB	4	N	M65.3	BLADDER NECK INCISION/TURP	36
28/06/2011	N		AOB	4	N	N19.1	REDO LIGATION LEFT VARICOCELE	36
28/06/2011	N		AOB	2	N		DIVISION OF PREPUTIAL ADHESIONS FIT(PER TEL REV 27.01.12)	36
04/07/2011	N		AOB	2	N	M45.9	CYSTOSCOPY AND TURP	35
08/07/2011	N		AOB	4	N		INTRADETRUSOR INJECTION BOTULINUM TOXIN (FIT 25.07.11)UPDATED 23.02.'	34
11/07/2011	N		AOB	4	N	M45.9	CYSOSCCOPY ? URETHROTOMY FIT(03.08.11)	34
13/07/2011	N		AOB	2	N		ENDOSCOPIC ?OPEN REMOVAL OF SUTURE/MESH FROM BLADDER (HOLD 10/0	34
19/07/2011	N		AOB	2	N	M30.1	LEFT RETROGRADE URETEROGRAPHY & URETEROSCOPY ON PLAVIX H/O CAE	33
19/07/2011	N		AOB	2	N		INTRATRIGONAL INJECTION BOTULINUM TOXIN FIT(17.08.11)CD	33

From: Corrigan, Martina [redacted]
Sent: 13 March 2012 10:47
To: O'Brien, Aidan; [redacted]
Cc: McCorry, Monica
Subject: Copy of Urodynamics 9 wk ptl as at 08032012 AOB.xls
Attachments: Copy of Urodynamics 9 wk ptl as at 08032012 AOB.xls

Dear Aidan,

I have attached an updated PTL for urodynamics. I know we had a conversation regarding this previously and you had advised me that with some scheduling that we would be meeting 32 weeks at end of March. I note that there are 3 patients to be seen in order to meet this target and I was wondering if you had plans to see these patients before the end of March?

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

Casenote	Forenames	Surname	Priority	Referral Date Only	9 Week Target Date	Date Booked (Y/N)	Appt Date	Non Clinical Comments	Weeks Waiting
[redacted]	Personal Information redacted by USI		ROUTINE	04/07/2011	05/09/2011	N		SC PER AOB	35
			ROUTINE	19/07/2011	20/09/2011	N		MMCC	33
			ROUTINE	22/07/2011	23/09/2011	N		MMCC	33
			ROUTINE	16/08/2011	18/10/2011	N		MMCC	29
			URGENT	30/08/2011	01/11/2011	N		MMCC	27
			ROUTINE	12/09/2011	14/11/2011	N		URODYNAMICS	25
			ROUTINE	13/09/2011	15/11/2011	N		SC 230911	25
			ROUTINE	13/09/2011	15/11/2011	N		MMCC	25
			ROUTINE	22/09/2011	24/11/2011	N		URODYNAMICS AS PER MA CLINIC 22092011	24
			ROUTINE	26/09/2011	28/11/2011	N		URODYNAMICS	23
			ROUTINE	30/09/2011	02/12/2011	N		URODYNAMICS AS PER FLEXI 30092011	23
			ROUTINE	01/10/2011	03/12/2011	N		URODYNAMICS JANUARY 2012 PER MR O'BRIEN	23
			ROUTINE	03/10/2011	05/12/2011	N		URODYNAMICS	22
			URGENT	04/10/2011	06/12/2011	N		PLA OPD 041011 URODYNAMICS - ASAP PER REG	22
			URGENT	04/10/2011	06/12/2011	N		PLA PER 041011 CLINIC URODYNAMICS - PRIORITY PER REG	22
			ROUTINE	04/10/2011	06/12/2011	N		MMCC	22
			ROUTINE	18/10/2011	20/12/2011	N		MMCC	20

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ROUTINE	18/10/2011	20/12/2011	N		MMCC	20
ROUTINE	22/10/2011	24/12/2011	N		URODYNAMICS	20
ROUTINE	29/10/2011	31/12/2011	N		URODYNAMICS AS PER MA CLINIC 29102011	19
ROUTINE	31/10/2011	02/01/2012	N		URODYNAMICS	18
ROUTINE	10/09/2010	03/01/2012	N		PD - PER MR YOUNG RE: REF CONT SERVICE/uta 18/07/11 sfa	18
ROUTINE	04/11/2011	06/01/2012	N		URODYNAMICS	18
ROUTINE	04/11/2011	06/01/2012	N		URODYNAMICS	18
ROUTINE	05/11/2011	07/01/2012	N		URODYNAMICS	18
ROUTINE	05/11/2011	07/01/2012	N		URODYNAMICS	18
ROUTINE	07/11/2011	09/01/2012	N		MMCC	17
ROUTINE	07/11/2011	09/01/2012	N		URODYNAMICS AS PER MA CLINIC	17
ROUTINE	12/11/2011	14/01/2012	N		URODYNAMICS AS PER MA CLINIC 12112011	17
URGENT	14/11/2011	16/01/2012	N		PD - PER MR YOUNG 14.11.11	16
ROUTINE	15/11/2011	17/01/2012	N		MMCC	16
ROUTINE	15/11/2011	17/01/2012	N		URODYNAMIC STUDIES AS PER CDSU	16
ROUTINE	16/11/2011	18/01/2012	N		PD - PER MR YOUNG RE: NEW LTR GP 30/09/11	16
ROUTINE	20/11/2011	22/01/2012	N		URODYNAMICS	16
ROUTINE	22/11/2011	24/01/2012	N		MMCC	15
ROUTINE	22/11/2011	24/01/2012	N		MMCC	15
ROUTINE	22/11/2011	24/01/2012	N		MMCC	15

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	ROUTINE	22/11/2011	24/01/2012	N		MMCC	15
	ROUTINE	18/04/2011	24/01/2012	N		URODYNAMICS	15
	ROUTINE	10/05/2011	25/01/2012	N		URODYNAMICS SEPTEMBER PER PT	15
	ROUTINE	28/02/2011	25/01/2012	N		URODYNAMICS PER FLEXI	15
	ROUTINE	03/03/2011	26/01/2012	N		PER CLINIC 030311 URODYNAMICS AS PER MA	15
	ROUTINE	25/11/2011	27/01/2012	N		PD - PER MR YOUNG AT CLINIC 25.11.11	15
	ROUTINE	04/04/2011	28/01/2012	N		URODYNAMICS	15
	ROUTINE	14/03/2011	28/01/2012	N		URODYNAMICS DNA X1 SFA AS PER MA	15
	ROUTINE	26/11/2011	28/01/2012	N		PD - PER MR YOUNG AT BACKLOG CLINIC 26.11.11	15
	ROUTINE	28/11/2011	30/01/2012	N		MMCC	14
	ROUTINE	28/11/2011	30/01/2012	N		URODYNAMICS	14
	ROUTINE	29/11/2011	31/01/2012	N		PER AOB (MY PT) @ DSU 29.11.11	14
	URGENT	29/11/2011	31/01/2012	N		PLA PER 29/11/11 CLINIC URODYNAMICS-SOON	14
	ROUTINE	29/11/2011	31/01/2012	N		PLA PER 291111 CLINIC URODYNAMICS	14
	ROUTINE	29/11/2011	31/01/2012	N		PD - PER MR YOUNG RE: REFERRAL CONTINENCE SERVICE	14
	ROUTINE	30/11/2011	01/02/2012	N		URODYNAMICS	14
	ROUTINE	24/05/2011	02/02/2012	N		SC 250511	14
	ROUTINE	06/12/2011	07/02/2012	N		MMCC	13
	ROUTINE	06/12/2011	07/02/2012	N		MMCC	13
	ROUTINE	07/12/2011	08/02/2012	N		MM URODYNAMICS - LET IN BF	13

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ROUTINE	09/12/2011	10/02/2012	N		PLA PER DIS 091211 URODYNAMICS	13
ROUTINE	10/12/2011	11/02/2012	N		URODYNAMICS	13
ROUTINE	12/12/2011	13/02/2012	N		MMCC	12
ROUTINE	12/12/2011	13/02/2012	N		PT WISHS TO HAVE PROCEDURE IN APRIL 2012	12
ROUTINE	12/12/2011	13/02/2012	N		URODYNAMICS PER MA CLINIC	12
ROUTINE	27/01/2011	14/02/2012	N		PD - PER MY AT BACKLOG CLINIC 270111/UTA 161211 BEREAVE	12
ROUTINE	13/12/2011	14/02/2012	N		MMCC	12
ROUTINE	14/12/2011	15/02/2012	N		MMCC	12
ROUTINE	15/12/2011	16/02/2012	N		MMCC	12
ROUTINE	16/12/2011	17/02/2012	N		PD - PER MR YOUNG AT CLINIC 16.12.11	12
ROUTINE	16/12/2011	17/02/2012	N			12
ROUTINE	16/12/2011	17/02/2012	N			12
ROUTINE	16/05/2011	17/02/2012	N		PD - PER MY AT BBPC 16.05.11/UTA 060112 ON HOLS SFA FEB	12
URGENT	20/12/2011	21/02/2012	N		PLA PER 201211 CLINIC URODYNAMICS	11
ROUTINE	20/12/2011	21/02/2012	N		PLA PER 201211 CLINIC URODYNAMICS	11
ROUTINE	22/09/2011	21/02/2012	N		AC-PER MY @ BACKLOG CL 22.09.11	11
ROUTINE	22/12/2011	23/02/2012	N		AC/PER KJ @ BACKLOG CL 22.12.11	11
ROUTINE	23/12/2011	24/02/2012	N		AC/PER MY @ OPD CL 23.12.11	11
ROUTINE	29/12/2011	01/03/2012	N		AC/PER KJ 29.12.11 @ HAEMATURIA CLINIC	10
ROUTINE	30/12/2011	02/03/2012	N		AC/PER MY @ OPD CLINIC 30.12.11	10

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	ROUTINE	02/01/2012	05/03/2012	N		URODYNAMICS	9
	ROUTINE	03/01/2012	06/03/2012	N		PLA PER 030112 CLINIC URODYNAMICS	9
	ROUTINE	03/01/2012	06/03/2012	N			9
	ROUTINE	03/01/2012	06/03/2012	N		MMCC	9
	ROUTINE	06/01/2012	09/03/2012	N		AC/PER MY @ OPD CL 6.1.12	9
	ROUTINE	06/01/2012	09/03/2012	N		AC/PER KJ @ BACKLOG CL 6.1.12	9
	ROUTINE	06/01/2012	09/03/2012	N		AC/PER KJ @ BACKLOG CL 6.1.12	9
	ROUTINE	06/01/2012	09/03/2012	N		PLA PER DISCHARGE 060112 URODYNAMICS	9
	ROUTINE	06/01/2012	09/03/2012	N		SC 090212	9
	ROUTINE	07/01/2012	10/03/2012	N		URODYNAMICS	9
	ROUTINE	05/10/2011	13/03/2012	N		AC-PER KJ 05.10.11 @ DSU	8
	ROUTINE	13/01/2012	16/03/2012	N		AC/PER MY @ BACKLOG CL 13.1.12	8
	URGENT	13/01/2012	16/03/2012	N		PD - PER DR ROGERS AT CLINIC 13.01.12	8
	URGENT	13/01/2012	16/03/2012	N		PD - PER DR ROGERS AT CLINIC 13.01.12	8
	ROUTINE	13/01/2012	16/03/2012	N		PD - PER DR ROGERS AT CLINIC 13.01.12	8
	ROUTINE	14/01/2012	17/03/2012	N		URODYNAMICS	8
	ROUTINE	16/01/2012	19/03/2012	N		AC/PER MY @ BBPC 16.1.12	7
	ROUTINE	16/01/2012	19/03/2012	N		AC/PER MY @ BBPC 16.1.12	7
	ROUTINE	17/01/2012	20/03/2012	N		AC/PER KJ @ BACKLOG CL 17.1.12	7
	URGENT	17/01/2012	20/03/2012	N		SC 160212	7

Personal Information redacted by USI

	ROUTINE	17/01/2012	20/03/2012	N		URODYNAMICS	7
	ROUTINE	17/01/2012	20/03/2012	N		PLA PER 170112 CLINIC URODYNAMICS	7
	ROUTINE	17/01/2012	20/03/2012	N		SC 210212	7
	ROUTINE	18/01/2012	21/03/2012	N		PD - PER MY RE: RESULTS 18/01/12	7
	ROUTINE	19/01/2012	22/03/2012	N		MMCC	7
	ROUTINE	20/01/2012	23/03/2012	N		PD - PER WARD DISCHRGE 20.01.12 (EMAIL FROM JILL)	7
	ROUTINE	20/01/2012	23/03/2012	N		MMCC	7
	ROUTINE	23/01/2012	26/03/2012	N		PLA PER MR O'BRIEN 230112 URODYNAMICS	6
	ROUTINE	24/01/2012	27/03/2012	N		SC 150212	6
	ROUTINE	24/01/2012	27/03/2012	N		MMCC	6
	ROUTINE	24/01/2012	27/03/2012	N		URODYNAMICS	6
	ROUTINE	25/01/2012	28/03/2012	N		PD - PER WARD DISCHARGE 25.01.12	6
	ROUTINE	04/07/2011	28/03/2012	N		MMCC	6
	ROUTINE	26/01/2012	29/03/2012	N		PD - PER SANI RE: REFERRAL ORTHOPAEDICS	6
	ROUTINE	27/01/2012	30/03/2012	N		PD - PER DR ROGERS AT CLINIC 27.01.12	6
	ROUTINE	17/08/2011	30/03/2012	N		URODYNAMICS	6
	ROUTINE	27/01/2012	30/03/2012	N		MMCC	6
Regional Specialty Total: 114							

From: McCorry, Monica < [redacted] >
Sent: 15 March 2012 15:34
To: [redacted] O'Brien, Aidan
Subject: FW: Surgical M&M: Approved January Minutes
Attachments: (1) January Minutes, approved by Mr Lewis.doc; MM ground rules March 12.doc

From: QUINN, Anne M
Sent: 15 March 2012 14:32
To: Akhtar, Mehmood; Aly, Sherif; Arava, Shiva; Blake, Geoffrey; Briggs, Gavin; Brown, Jeffrey; Brown, Robin; Bunn, Jonathon; Bunting, Helen; Carlisle, Robin; Carson, Anne; Clarke, Chris; Conlan, Enda; Cranley, Brian; Cullen, Nicola; Dignam, Paulette; Donnelly, Brian; Epanomeritakis, Manos; Farnon, Cathy; Fawzy, Mohamed; Ferguson, Andrew; Gibson, Niall; Gilpin, David; Gracey, David; Gribben, Laura; Gupta, Nidhi; Haffey, Raymond; Hall, Stephen; Hamill, Marion; Hannon, Robert; Heslip, Jennifer; Hewitt, Gareth; Hughes, Paul; Hussain, Syed; Johnston, Dr Linda; Lennon, Pauline; Lewis, Alastair; Lichnovsky, Erik; Lowry, Darrell; Lynn Wilson; Mackle, Eamon; Magowan, Hannah; Maguire, Peter; Marmion, Catherine; Marshall, Jacqueline; Marshall, Margaret; MAXWELL, Sharon; McAllister, Charlie; McCann, Michael; McCaughey, Liam; McClure, Mark; McConaghy, Paul; McConville, Richard; McCorry, Monica; McCrory, Colin; McCullough, Pat; McKee, Raymond; McKeown, Ronan; Mockford, Brian; Morrow, Michael; Murnaghan, Mark; Murugan, Shanmugam; OBrien, Joanne; OConnor, Kieran; OHare, Bronagh; OReilly, Janice; Orr, Des; O'Toole, Conor; Parks, Lorraine; Patton, Sean; Rafferty, Lauri; Rainey, Gary; Rea, Margaret; Renney, Cathy; Rice, Paul; Richardson, Shirley; Rutherford-Jones, Neville; Scally, Nora; Scullion, Damian; Simpson, John; Slaine, Delma; Sloan, Samantha; Sobocinski, Dr Jacek; Streahorn, David; Tariq, S; Tate, Michelle; Troughton, Elizabeth; Weir, Colin; Williams, Marc; Wright, J; Young, Michael; Yousaf, Muhammad
Subject: Surgical M&M: Approved January Minutes

Dear All

Please see attached the Surgical M&M approved minutes for January and a copy of the M&M Ground Rules.

Apologies for the delay in sending these out.

Many thanks
Laura on behalf of Anne

Anne Quinn
Effectiveness & Evaluation Manager
Tel: [redacted]
Email: [redacted]

Buckley, LauraC

From: Corrigan, Martina
Sent: 28 September 2019 05:34
To: Hynds, Siobhan
Cc: Buckley, LauraC
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Regards

Martina

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

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

From: Trouton, Heather [redacted]
Sent: 04 December 2013 18:40
To: Young, Michael; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Michael

I certainly didn't expect it to be sorted within a few days , and to be honest was surprised to be advised that triage was being taken over as I agree it is not fair to ask the other three surgeons to bear this workload. Robin and I had discussed just yesterday and were planning to meet with Aidan next week to fully discuss this issue. I'm sorry that I was given not totally correct information.

Thankyou for helping with the backlog. Happy to discuss further next week to try to come up with a sustainable solution.

Heather

From: Young, Michael
Sent: 03 December 2013 18:57
To: Trouton, Heather; Brown, Robin
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Not sure if the messages have transposed well
Also not sure 'if it is unlikely that Aidan will change' is correct. I do agree however with the chart issue.
I have offered to help out to get the backlog sorted. This should not have been interpreted as a complete take over of the triage. I do not think it acceptable to ask the other consultants to take up this task – this has not been talked about / discussed etc, yet decisions are being made. I do not find this acceptable. You have expected this issue to have been completely sorted within a matter of a few days. I said I would help sort this out and am doing so.

MY

Angela Kerr

From:
Sent:
To:

-----Original Message-----
From: Aidan O'Brien <[redacted: Aidan O'Brien's email address]>
To: [redacted: Mark Fordham's email address]
Sent: Mon, 26 May 2014 19:57
Subject: Draft Narrative Report of Stock-take of Regional Review of Adult Urological Services in Northern Ireland

Dear Mark,

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

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

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

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

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

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

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

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

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

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

- Lastly, I am particularly appreciative of your drawing attention of the inadequacy of time within job plans for administration generally, and for leadership roles in particular, Results will not be achieved with goodwill and a shoe string alone,

Aidan O'Brien

Corrigan, Martina

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

Martina et al,

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

Firstly, I believe that we should firstly wholly appreciate the potential significance of our Department / Service being given this opportunity to advise / influence / perhaps even dictate how it could / should be!
I believe that I am correct in asserting that this is the first time since 1992 that this has happened.
Whilst I acknowledge that there were times when development was facilitated, notably by the Trust, equally well I have vivid memories when our advice, requests and pleas were undermined by Clinical Director, Medical Director, Director of Acute Services, Chief Executive, Director of Public Health and Board.
For 22 years, it has been most difficult to impress upon authority the notion that those who provide the service may also be those best equipped to know what is required, and how it should or could be provided.
On this occasion, we have not only been provided with that opportunity, but additionally with the possibility that we have been granted the power to manage demand.
I still personally believe that this is the most important aspect of this new opportunity.

I believe that we have been given a responsibility to design a service which will ensure that urological pathology and morbidity can be managed in future in an effective, safe and efficient manner, achieving outcomes which are better all around than they are today.
I also believe that it is crucial that we appreciate that we are being requested to design such a service which will be provided by both primary and secondary care.
My only criticism of the thought processes that we collectively may have had to date, is that we have been more occupied by the configuration of the service that we in secondary care will provide, rather than the universality of care.

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

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

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

I believe that we should wholly engage with the IT people to have our dictations disseminated to primary care via their advice pages.
But crucially, I believe that it is imperative that we do not avail of the lack of availability of an electronic referral system to defer or dilute demand management.
For example, we can write to every GP, dictating to them how to investigate and manage each clinical presentation, morbidity or pathology, including the criteria for referral, and how that should be done.
I have no doubt that this can be achieved, and I can see no reason why we can not be fully implementing Demand Management from 01 January 2015 onwards.

I hope that I am correct in my understanding that the basis of the concept of the 'New Clinic' is that such a clinic would enable us to process a legitimate referral in a manner perceived to be the most efficient way of arriving at an effective and safe conclusion with regard to the patient's further requirements.
Whilst I entirely agree that the first face-to-face consultation that we have with the patient should be as definitive as is possible, I do suspect that successful Demand Management may reduce the proportion of such first consultations that will turn out to be the only consultation.
I also strongly believe that we should avoid the temptation of allowing the New Clinic to obviate careful, advanced triage.
I am concerned that the concept of the New Clinic being a one stop clinic will mean that, having established that a referral has legitimately risen above the referral threshold, the next move will be to 'see' that patient at the New Clinic whereupon the clinician will determine what would have been obvious in most cases had proper triage have been conducted, that the patient requires both flexible cystoscopy and urodynamics studies.
If a GP or other referrer has done all that we have dictated to be done, yet it is obvious on triage that this 82 year old patient in a Nursing Home in Enniskillen would next need a Renal CT or MRI done to make consultation worthwhile, then one should be on the telephone to enquire after the logistical feasibilities, requesting the further scans etc.
In fact, I believe that triage probably should involve initial contact with the patient (+/- referrer) by telephone to advise of the next steps.
In other words, if we allow the one-stop concept of the New Clinic the excuse to conduct proper triage, we will have integrated inefficiency into the New Clinic.
Optimal triage will dictate that the patient requires flexible cystoscopy plus consultation rather than the other way about, or urodynamic studies plus consultation rather than the other way around.

I believe that advanced triage will be the essential bridge between successful demand management and the successful, effective, safe and efficient delivery of outpatient consultation and procedural assessment / investigation, such as flexible cystoscopy, biopsies and urodynamic studies.
I also believe that if we are capable of determining pathways for assessment and management in primary care, we should be equally capable of designing pathways for effective, safe and efficient triage, so that the bulk ? all of triage could be conducted by Nurse Specialists, rather than consultants, one of the latter always available whilst urologist of the week to advise.
As a consequence, I believe that, having successfully implemented Demand Management and Advanced Triage, the New Clinic concept will be required for only a minority of referrals.
The rest will be managed in the way urodynamic studies have been managed to date - studies followed by consultation - except that in future the urodynamic studies will not have been preceded by another outpatient consultation conducted nine months previously.
I hope I have made myself clear: demand management and advanced triage will have ensured that all that can be done as an outpatient prior to arrival at our Department will already have been done (such as imaging, IPSS, etc) so that the actual procedural requirements at the New Clinic can be predicted, scheduled and performed, preferably prior to final consultation, which itself may not always require the involvement of a consultant.

I am passionately of the view that we have not yet grasped the potential impact of demand management, advanced triage and then single visit assessment could have on our Department.
I do believe that it could certainly stall and hopefully reverse the migration of consultant time being increasingly consumed in outpatient services, rather than operating, and which has occurred progressively over the past twenty years.
As a single-handed consultant with one registrar 20 years ago, I conducted one clinic per week (later to become two with the addition of Armagh and Banbridge) and had a minimum of 4 inpatient operating sessions, usually 5, and sometimes 6 (depending upon time of year) as well as a flexible cystoscopy session per week.
Now I cannot safely assume that I will have 2 or 2.5 inpatient operating sessions per week, in addition to 0.5 DSU sessions, whilst I am doing 4 clinic sessions per week.
Now we spend more time at the shop front, inviting more people in, and having less time to operate on them in the back room.
I believe that the Health Care Pathway, as Michael has so aptly described it, and as I have outlined above, will free up more consultant time to operate, and which is just as important component of a future sustainable service as is freeing up theatres to operate in.

I believe that the most important point raised by Michael relates to the 'Hot Clinic'.

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

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

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

Aidan.

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

Sent: Sun, 17 Aug 2014 15:33
Subject: RE: 'Capacity'

Dear Martina and All

Writing in response to the 'capacity' email sent a few days ago.

You should all be congratulated on this substantial amount of information gathering and processing. Mark has done a great job. This is exactly the information needed.

I believe I have been misinterpreted about how we present data. We have always been led by the DoH in what we were to do ie the SBA. The information now collated is ours, detailed, accurate and as such can stand over. I feel it is most important now to have the various strands of how each component part fully thought through before declaring it to the Board. Sorting out the whole service for the 1st Sept, is in my opinion, not a good idea to be presented. We need some breathing space to think through the consequences of our actions (- Mr Sullivan did say we will be committed to our agreement). In saying this, there will be work completed in detail for presentation that we certainly want them to hear loud and clearly.

My understanding of Mr Sullivan's meeting was that he was looking for fresh ideas to improve urology delivery on a timely basis. This we have interpreted as 'New' ways and being more efficient. The Trusts experience of this already in orthopaedics, is I understand, is as above but also now to go off and do the Sums. Are we in Urology trying to do all this for a presentation in a fortnight?

Mr Sullivan said there was no new money. I'm not entirely sure this is fully the case. We clearly have to first present our new processes and efficiency measures in detail and in an extremely positive fashion so that the Board buys into our ideas completely before we emphasis the short falls. This will be difficult and is why I see this presentation best put across in a set a presentations (a game of two halves!)

Having such a major topic discussed over the summer months has not been ideal. We have all not been present at our meetings. I've only made the initial two and due to leave and doing two haem flex lists, have missed the rest. Others have not made any. It is commendable for those who have been present to accomplish so much. However it is a shame we have not had the opportunity to all discuss what is to be presented to the Chief Executive tomorrow, but as noted before it not a good time of year to be sorting out such issues, which makes it all the more important to get correct.

I would like to make some comments on the capacity document. This is a great bit of work. There appears to be a fairly consistent monthly referral rate of about 400 +- 50 cases. I appreciate comments on year on year increases in referrals but I am not too sure about the inclusion (or the maths) on working on the assumption of demand reduction of 20% (is this speculation?). Why not present the data as it is and record that the New process will provide what we say it will. Then stress to the Board that it is hoped that the new ECR process has a great opportunity to reduce demand (but if it does not do so then we are not penalized)

The A/E and other referral rate is surprising higher than I expected (not sure if others had felt that way?) - its about 2:1 - is this mainly A/E or is there a fair split between this and other consultants? (referral from other Consultants can be more complex).

Collecting the information on monthly referrals is timely enough as there should be enough time allowance for the routine referrals to be given a date for consultation. Not sure that this is the same for the Red Flag referrals - Do we have or can we get such information from the Cancer Services on a weekly basis? This was an especially productive exercise when trying to define the existing haematuria service.

I'm not clear about all the types of clinics to be offered to new referrals. We were putting across the New one stop clinic, (which I think should be renamed as a Urology outpatient investigative clinic or something similar) - is this to look after absolutely everything ie routine ,urgent, Red Flags, stones, urodynamics or will there be the specialist clinics for direct referral., ie STC, urodynamics , oncology clinics. Will the oncology clinics only be for follow-up and post mdt?

On the subject of general clinics, I believe the current review numbers are probably considerably better than the 1:1.5 expected or indeed our past experience. Like the rest of you, our outpatient outcome sheets from recent clinics should be used to define how many reviews are actually being logged. I am discharging or converting most patients from my general clinic. I think it would be particularly productive to know our departments review ratios for the various clinics in time for the main meeting with the DoH. I would hope that this would show the DoH that the review backlog is historical and not a continuing ongoing issue. This was one of their main issues with us. Let's not let them castigate this one back at us (and it is in fact something we should know anyway)

The HOT clinic label gives a sense of urgency to it. I'm wondering if it should be called the 'UrGE' clinic after our previous discussions which concluded that it was a portal for Urology advanced triage of Gp letters (even with ECR) and GP contact point combined with Emergency outpatient consults. Unfortunately I disagree that the HOT clinic will be able to see 8 patients per session. This will nearly fill the session and we have to be mindful of what else was planned for the morning's activities. If on the other hand the HOT clinic was in the afternoon then that would be a different equation.

Where does the SWAH and DHH (and Banbridge + Armagh) fit in? only reviews?, some news?, our new urology outpatient manger to define who goes where pending location / age? Discussion required.

I also believe our New clinic should have three planned consultants in attendance. This can have an SpR in attendance when available ie taking into account their training needs and holiday leave. Consultant leave also needs to be factored in. If the design was two consultants, then with leave the potential that it may be down to only one consultant doing such a clinic. The only other way is as per theatre and backfill. Consistently backfilling is not ideal for our job contracts and especially when the working week is so full now in terms of clinical sessions and consultants, that it may not be as easy to arrange backfill as previously.

Very good work on the theatre times. It appears that the theatre times per procedure are a little long, but there you are, these are the facts. (not sure what 41 weeks means?) but 51 hours equating to 13 sessions is clear as to the requirements to cover the time needed to treat patients logged for surgery each week. In theory we have 8 main theatre sessions + one weekly tuesday CAH DSU + 1/2 weekly Wednesday GA DSU CAH + 1/2 weekly STH DSU GA lists, adding up to 10 sessions. This clearly shows one full day main theatre and a day list (?DHH) is needed. This is certainly attainable. Is it enough?

What exactly are we presenting to the DoH as our innovative Ideas?

John is the only one who has not had the opportunity to have his say. It will be great for all to get round the table again as we all need to be kept in the loop on what is going on. For instance, the electronic Referral process work is being looked at but I'm not too sure where exactly this is presently.

We are probably the Team in the best position to make headway in this current arena. Our experience in setting up an Icats service ahead of a DoH request (ie the process of arranging) and the provision of our Thorndale unit, provides us with a particularly good platform, which others do not have. Yes, let's cease the opportunity but ensure the sums are what we can and will deliver, combined with a series of innovative ideas (some small, some big) that collectively are looking at the complete patient and healthcare provider journey.

MY

Ps: where and when tomorrow?

Southern Health & Social Care Trust IT Department [redacted]

From: Farrell, Roisin [redacted]
Sent: 10 September 2012 13:13
To: Corrigan, Martina; Young, Michael; O'Brien, Aidan; Matier, Pauline
Cc: Reid, Trudy; Burke, Mary; Wright, Elaine; Stinson, Emma M
Subject: Trust Response - [redacted]
Attachments: [redacted].pdf

For your information

Regards
Roisin

Roisin Farrell
Personal Secretary/
Governance Administrator
Acute Services
Office 3, Level 2, MEC
Craigavon Area Hospital
Tel: [redacted]

Southern Health and Social Care Trust

6 September 2012 **Our Ref:** Personal Information redacted by the USI **Your Ref:**

Private & Confidential

Patient 131
Personal Information redacted by the USI

Dear Patient 131,

I refer to your complaint in respect of the treatment and care provided to you firstly at the Emergency Department of Craigavon Area Hospital and in general the service provided to you by Urologists.

At the outset I would like to apologise that you feel your treatment in the Emergency Department did not meet your expectations and I fully appreciate your concerns over the conflicting information given. I also regret the length of time it has taken to respond to your complaint.

In relation to your comment that "They did an x-ray and told me the stent hadn't moved", I sincerely regret that you were given conflicting information whilst in the Emergency Department. I have asked Dr Personal Information redacted by the USI to make a comparison of the two most recent x-rays available to him and sincerely regret any misunderstanding which has arisen. At the stage Dr Personal Information redacted by the USI provided you with information I understand he had already spoken to the Urology on-call team who had accepted your care. I believe the only reason he told you this piece of information was to keep you up to speed with your progress through the Emergency Department and to ensure you did not feel forgotten about. I apologise that this has led to distress for you.

With regard to your comments that "The A+E doctor's attitude towards you was hardly professional as he stated "you can stay if you want, but you probably won't be treated until Tuesday". Our investigation has confirmed that this was not Dr Personal Information redacted by USI Nonetheless it was unacceptable for the doctor who said this to do so and I sincerely apologise for how it made you feel.

Moving on to your complaint in respect to the waiting time for your procedure in Urology, I have asked Mrs Martina Corrigan, Head of Urology to investigate this delay. I can confirm that you were admitted under Mr O'Brien, Consultant Urologist on 8 January 2012 and that you were discharged with an appointment arranged for you to attend the Stone Treatment Centre on 8 February 2012 under Mr Young's care. You attended this and a further appointment in the Stone Treatment Centre on 30 April 2012. As you state in your correspondence you were advised that you had been placed on the waiting list for further treatment. Mrs Corrigan advises that you have since been admitted under Mr O'Brien's

Clinical and Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone: Personal Information redacted by USI

care on 13 June and that you have had your procedure completed and that you are scheduled to be reviewed again in one year.

I apologise that you have had to wait longer than you had expected for your procedure and for the pain and discomfort you experienced during this wait. There has been an increase in the demand for Urology within the Southern Health and Social Care Trust. The Commissioners are working with the Trust and Consultant Urologists to address this increase.

I hope that you are keeping well since your surgery and that this correspondence answers the issues that you have highlighted to us.

If however you remain unhappy please do not hesitate to contact a member of the Clinical and Social Care Governance Team on Personal Information redacted by USI who will discuss the options available to you.

Yours sincerely

Personal Information redacted by USI

DR GILLIAN RANKIN
Director of Acute Services

for Mairead McAlinden, Chief Executive

From: Corrigan, Martina [redacted]
Sent: 01 October 2015 14:39
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: Datix Incident Report Number [redacted]

Good afternoon

Ciara submitted this IR1 yesterday.

Any comments?

Martina

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

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

-----Original Message-----
From: datix [redacted]
Sent: 30 September 2015 11:03
To: Corrigan, Martina
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

Over the past few weeks it has been an area of concern that Discharge Letters are not being completed on day of discharge.

Informed by the ward clerk today that currently there are 13 discharge letters not done and when she approached the FY1 she was informed that they were to busy and didnt have time to do them.

This is cause for concern for missed reviews appointments and Gp follow ups.

FY1's have expressed concern that they are under pressure and are unable to complete all their duties and it is usually the discharging that suffers.

Please go to http [redacted] to view and approve it.

From: Haynes, Mark [redacted]
Sent: 01 October 2015 17:36
To: Corrigan, Martina; Glackin, Anthony; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: RE: Datix Incident Report Number [redacted]

I do.

Our single FY1 this week is split across two wards at present resulting in significant inefficiency and difficulty in working. There is no CST supporting them in this work. At the same time I understand that there have been times when there are strikingly different levels of FY1 / jnr dr staffing levels on other wards (eg 4N). Indeed I do not recall seeing fewer than 2 FY1s on 4N at any point. I believe on occasion this week there have been 3. Because they are ward based the FY1s are doing the jobs on their ward and not any other. Thus while our FY1 is struggling on their own, staying late every night and working across two locations, their colleagues are leaving on time. Added to this, it is my view based upon experience of working elsewhere that our FY1s are performing duties (eg first dose IV Abx) which are not considered the duties of a doctor in any other hospital / trust that I have worked in.

The result of this is that our FY1 this week is becoming increasingly disillusioned with her job and career. Her pat on the back is an IR1 form (this may not be intended to be critical of the FY1 but I am sure that is how the FY1 will interpret it).

Something has to give. Either the FY1 staffing levels across all surgical wards need to be reviewed daily so that the 3 on one ward and 1 on another (that is split to two places) situation does not arise or we need to agree what the FY1 should be prioritising (should it be the bloods, the imaging, the IV access, empting their bladder, the incomplete drug kardexs, the patient that needs reviewing, the consultant ward round, their lunch etc) and what can be left to the bottom of the priority list. If nothing can be left then we need to ensure that 'the shit flows uphill', our Registrars need to start helping out with FY1 duties and we start doing the Registrar duties, inevitably something wouldn't get done though.

Long term I think the duties expected of an FY1 need to be looked at here (CAH / NI) and brought into line with the rest of the NHS (along with support nursing / auxiliary staff) as this is the only way we will have FY1s being trained and not being disillusioned by their urology experience (how many of our FY1s are finishing thinking they've experienced urology in some way and are keen to explore it as a career?). The problem is across the FY1 grade in CAH, I hear the medical FY1s dare not allowed on the medical ward round and simply get given a list of jobs by the team.

Mark

-----Original Message-----
From: Corrigan, Martina
Sent: 01 October 2015 14:39
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: Datix Incident Report Number [redacted]

Good afternoon

Ciara submitted this IR1 yesterday.

Any comments?

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

-----Original Message-----
From: datix Irrelevant information redacted by the USI
Sent: 30 September 2015 11:03
To: Corrigan, Martina
Subject: Datix Incident Report Number Personal Information redacted by the USI

An incident report has been submitted via the DATIX web form.

The details are:

Form number: Personal Information redacted by the USI

Description:

Over the past few weeks it has been an area of concern that Discharge Letters are not being completed on day of discharge.

Informed by the ward clerk today that currently there are 13 discharge letters not done and when she approached the FY1 she was informed that they were to busy and didnt have time to do them.

This is cause for concern for missed reviews appointments and Gp follow ups.

FY1's have expressed concern that they are under pressure and are unable to complete all their duties and it is usually the discharging that suffers.

Please go to http: Irrelevant information redacted by the USI to view and approve it.

From: Haynes, Mark [redacted] Personal Information redacted by the USI
Sent: 26 February 2016 16:29
To: Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP
Subject: FY1

Importance: High

Dear All

I have been copied into the correspondence below. It is clear that our current FY1s are experiencing difficulties with workload and conscientiously staying beyond their shift times to complete work. Sadly this is starting to effect the wellbeing of our current FY1. This problem is not unique to our current FY1s and my understanding is that the previous FY1 hours monitoring came out as non compliant with new deal requirements. Our FY1 is supposed to finish at 5pm on a day shift and it is frequent that FY1s stay beyond 7pm-8pm to complete daytime jobs.

I discussed patterns of work with our FY1 today. It is clear that while throughput and sheer bulk of workload is an issue there are patterns of senior medical practice that can add to this burden. An additional component is a lack of a formalised handover process for the FY1s and I have raised this with Colin Weir so we can institute a process ASAP. It was identified that workload becomes more manageable when;

Ward round starts at 9am (or earlier).
Ward round is consultant led throughout.
Evening ward rounds start at 4pm and are performed as 'board' reviews of results with bedside review of sick patients only.

Practices which worsen workload issues are;

Late start to ward rounds.
Ward rounds starting as SPR with consultant joining later and re-reviewing the patients already seen.
Multiple days ward rounds performed by SPR alone.
Full evening ward rounds (bedside reviews of all patients) continuing beyond 5pm and generating multiple jobs.

As a team, as previously agreed, can we ensure that we ensure our work patterns are as was discussed at inception of the current urologist of the week work pattern, ie;

Consultant led daily (Mon-Fri) ward rounds starting no later than 9am.
Senior afternoon 'board' round and review of results at 4pm to be completed by 4.30pm.

Thanks

Mark

-----Original Message-----
From: John, Alexander
Sent: 25 February 2016 16:08
To: Weir, Colin; Nelson, Amie
Cc: Haynes, Mark; Yousaf, Muhammad
Subject: FW: Meeting
Importance: High

Hi Colin,
See mail below from Noleen.
I met with her yesterday itself..

As you know I had written to you about my meeting her on 16th Feb... initial impression was that there were issues with distribution of work...
I think the heavy work load & constant overstay till 8PM is wearing her down. She was tearful with me & tells me that her parents are concerned about her health.
She is a very hard working & conscientious FY1 & feels she has to complete all tasks before leaving & is unable to leave before 8pm daily...
It appears to be getting to her & she expressed concerns about her wellbeing to me yesterday.
She tells me that she has mentioned it on several occasions to the consultants on the ward, who all empathise with her but have not resolved the problem..
As per email below, she is contemplating contacting NIMDTA. Considering her wellbeing, I have referred her to Occupational health.
I think that extra MAs in the ward & also a system of handing over tasks at a reasonable time in the evening should be considered.
Best Wishes
Alex

-----Original Message-----
From: Noleen Osborne [redacted]
Sent: 24 February 2016 15:27
To: John, Alexander
Subject: Meeting

Dear Dr John,

I am unsure if my email from today went through as it isn't appearing in my sent box, apologies if I am emailing you twice. I was looking to have a quick meeting about my current situation. I don't feel like things are improving from my end of things. I was going to contact NIMDTA but thought best to go through yourself first. I feel if things don't improve soon I may need to take some time off as I am struggling massively.

Sorry to bother you again,

Noleen

alternatively allow the patient to wait 1.5 years for an urgent consultation, or some combination of both, and which I believe and have argued is unsafe on both counts. In any case, we were not allocated any predictable time at all in our job plans for triage while urologists of the week, and the Southern Trust does not have a Policy and Procedure on Triage, even though it claimed in writing in 2017 that it did do so, and that I was not compliant with it.

It is the Trust's actions since the beginning of 2016 that are the subject of my grievance.

2.3.1: <u>The Letter dated 23rd March 2016</u>

The Trust only raised the concerns with me once and this was in March 2016. This was in a letter dated 23rd March 2016 signed by Eamon Mackle, Associate Medical Director, and Heather Trouton, Assistant Director, which is attached in the schedule of documents at Tab 8.

The origin of this letter appears to be a meeting held by Heather Trouton and Dr Richard Wright, Medical Director on 11th January 2016 at 10am. I do have any Minutes or other record of this meeting. However, Heather Trouton has provided a witness statement which is attached in the schedule of documents at Tab 9. At Paragraph 13 of her statement, she asserts she addressed the concerns with Dr Wright as he was a newly appointed Medical Director and that at that meeting on 11th January 2018, she outlined the concerns to him and that she "*took his advice so we formally addressed the issues via a letter*".

I attended at a short meeting on or around the 23rd March 2016 with Eamon Mackle and Martina Corrigan, Head of Service. They handed me the letter dated 23rd March 2016 at the meeting. The letter makes reference to four areas of concern;

a) Untriaged outpatient referral letters – it was stated there were 253 untriaged letters dating back to December 2014;

b) Current Review Backlog – it was stated there was a review backlog of 679 patients in addition to a cancer review waiting list of 286 patients;

c) Patient Centre Letters – the Letter stated that there was a concern about frustration that there was no record of consultations / discharges on Patient Centre; and

d) Patient Notes at home – the letter asked for notes kept in my home to be brought back to the hospital.

The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*". The Trust was indeed fully aware of my workload and was aware that the problems of backlogs could not be related to any lack of effort on my part. I did not have the time to do all that was expected of me to do.

At the meeting, I read the letter and this reminded me of the workload pressures that I knew all too well. I asked Mr Mackle and Ms Corrigan, "*what am I supposed to do?*" **The only response I was given was by Mr Mackle who simply shrugged his shoulders.** Accordingly, I was, yet again, left to deal with the problems alone, and without any input, assistance, intervention, monitoring or supervision by line management or by the Trust. As Dr. Wright said at the meeting of 30 December 2016, "*We left it with you*".

The Trust Guidelines describe how concerns about a Practitioner should be handled. Paragraph 1.5 provides that:

> 1.5 This Guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk to patients, practitioners, clinical teams and the organisation. 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 the underlying problem

Therefore, the Trust Guidelines are designed to provide an overarching and clear process for addressing concerns such as those raised at the meeting of 11th January 2016 and outlined in the letter of 23rd March 2016. At Page 4 of the Trust Guidelines it is stated at Note 1:

> Examples of Concerns may include:- when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored**.

Firstly, Paragraph 2.2 states, "*Concerns should be raised with the practitioner's Clinical Manager*." My Clinical Manager at that time was Mr Sam Hall or Mr Robin Browne. To my knowledge, the Concerns were not raised with either of those two individuals. I am certain that no Concern/s were ever raised with me by either Mr Hall or Mr Browne.

The Concerns were instead raised with the Medical Director, Dr Wright. Paragraph 2.2 further provides that, "*if the initial report/ concern is made directly to the Medical Director, 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. Such concerns will then be subject to the normal process as stated in the remainder of this document*." Again, my Clinical Manager was not informed of these concerns, to the best of my knowledge.

Part 2 and Appendix 1 of the Trust Guidelines describes the process for screening Concerns. The Clinical Manager is to undertake this process. Clearly, that did not happen. It is not at all clear what did happen in the 10 weeks between 10th January 2016 and 23rd March 2016. However, there appears to have been some screening done by some individual or individuals at the direction of the Medical Director who identified the number of patients waiting in a

review backlog and cancer review backlog and the number of untriaged referral letters, since these details are included in the letter of 23rd March 2016.

Had the Trust Guidelines been followed, the process may have lead to an informal local action plan that would likely have resolved all of the issues. I believe that such a plan would have resolved all of the issues because I have been the subject of a return to work action plan since February 2017 and it has been confirmed that these issues are no longer of concern. Paragraph 2.7 provides guidance on a local action plan. It states "*MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action".*

Even if the Medical Director had not followed the letter of the Trust Guidelines, the "*General Mutual Obligations*" of my contract of employment ought to have led the Medical Director to seek a collaborative approach. The Trust did not provide any assistance for me whatsoever. No supports were identified, no plan was drawn up.

In failing to follow the Trust Guidelines, the Trust has committed a breach of contract.

2.3.2 Attempts by Clinical Managers

As stated above, there was no follow up with me by the Trust to the letter of 23rd March 2016. Personally, I had been addressing the review backlog issue by taking on *additional* cancer clinics and I was also using any available theatre time to ease the operating waiting lists. My personal initiative was known to Trust management. I did make some headway with the Review Backlog and this was not raised as one of the concerns in December 2016. I have detailed this fully in my response at Tab 5.

Whilst no one spoke to me about the issues, it is clear that Management was considering the issue throughout the summer and autumn of 2016. By around April 2016, Mr Hall had retired and my new Clinical Director was Mr Colin Weir. I was reluctant to speak to any of the individuals who have given statements during the investigation whilst the investigation was ongoing. However, since the investigation has concluded, I have spoken to Mr Weir about a matter raised in his witness statement – which is attached to the schedule of documents at Tab 10.

Mr Weir describes activity in August and September 2016 after he was made aware of the concerns by Dr Charlie McAllister, Associate Medical Director for the Urology Service at that time. Mr Weir has confirmed to me that the concerns had been discussed at least once at the weekly meetings that he had with fellow clinical directors and Associate Medical Director. Both he and Dr McAllister were strongly of the opinion they should address these concerns with me in a constructive and supportive manner in order to see them resolved, *a fortiori* since they had given some thought as to how the backlogs could be addressed.

Mr Weir further described at Paragraph 7 of his statement that he met with Martina Corrigan, the Head of Service around the end of September 2016 and got further information about charts tracked to me, about being behind in triage of GP referrals, and the backlog that needed to be addressed. He was intent on dealing with the matter informally.

Angela Kerr

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

Martina,

I find this situation to be quite unacceptable.
I spent almost all of last Thursday rigorously reviewing all 275 patients on my inpatient waiting list, as of 28 April 2016, allocating categories of five categories of urgency to them, as opposed to the inadequate two categories formally allocated.
In doing so, I equated Red Flags patients, those cancer patients who have no Red Flag status, those with indwelling stents for up to two years, those with indwelling catheters for over two years whilst trying to accommodate in some equitable fashion those who have been pleading through various channels, including your own, to have their admissions expedited.

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

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

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

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

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

Aidan.

From: Corrigan, Martina
Sent: 27 June 2016 14:36
To: (Marian Korda's email address); (Peter Leyden's email address); McCaul, David; David McCaul (David McCaul's email address); Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; Mr Reddy; Reddy, Ekambar; Ted McNaboe (Ted McNaboe's email address); Turlough Farnan (Turlough Farnan's email address); (Aidan O'Brien's email address); (Michael Young's email address); Glackin, Anthony; Haynes, Mark; Mark (Mark Haynes's email address); Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; (John P O'Donoghue's email address); Ram Suresh (Ram Suresh's email address); Suresh, Ram; Tony Glackin (Anthony Glackin's email address); Tyson, Matthew; Matthew Tyson (Matthew Tyson's email address)
Cc: McClenaghan, Nichola; McGeough, Mary; Clayton, Wendy; Scott, Jane M; Cunningham, Andrea; Sharpe, Dorothy; Henry, Gillian; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth; Burke, Catherine; Cooke, Elaine; Cowan, Anne; Hall, Pamela; Mulholland, Angela; Wortley, Heather; Sheridan, Patrick; Carroll, Ronan
Subject: RE: ** Urgent ** CAH Main Theatre Lists Tuesday 28th June until Friday 1 July 2016
Importance: High

Dear all

As per my email last week, we have discussed the rest of this week's theatre lists at the bed meeting this afternoon and because the bed pressures have not eased the decision is for the lists that are planned for CAH Main Theatres for the rest of this week, that is, Tuesday 28th, Wednesday 29th, Thursday 30th June and Friday 1 July **are to be red-flag patients only**. I would be grateful if you could review your lists and cancel anyone who is not a red-flag this will unfortunately include any non-red flag patients that had been cancelled previously.

Paediatrics can go ahead but please co-ordinate how many are on each list.

Any issues please advise.

Regards

Martina

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

Telephone: (Personal Information redacted by the USI)
Mobile: (Personal Information redacted by the USI)
Email: (Personal Information redacted by the USI)

From: Corrigan, Martina
Sent: 21 June 2016 15:53
To: (Marian Korda's email address); (Peter Leyden's email address); David McCaul (David McCaul's email address); David McCaul (David McCaul's email address); Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; 'Mr Reddy'; Reddy, Ekambar; Ted McNaboe (Ted McNaboe's email address); Turlough Farnan (Turlough Farnan's email address); (Aidan O'Brien's email address); (Michael Young's email address); Glackin, Anthony (Anthony Glackin's email address); Haynes, Mark; Mark (Mark Haynes's email address); (Michael Young's email address); O'Brien, Aidan; ODonoghue, JohnP; (John P O'Donoghue's email address); Ram Suresh (Ram Suresh's email address); Suresh, Ram; Tony Glackin (Anthony Glackin's email address)
Cc: McClenaghan, Nichola; McGeough, Mary; Clayton, Wendy; Scott, Jane M; Cunningham, Andrea; Sharpe, Dorothy; Henry, Gillian; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth; Burke, Catherine; Cooke, Elaine; Cowan, Anne; Hall, Pamela; Mulholland, Angela; Wortley, Heather

Subject: FW: ** Urgent ** CAH Main Theatre Lists Thurs 23rd to Mon 27th June
Importance: High

Dear All,

As you will be aware we are experiencing significant bed pressures which are impacting on the running our elective lists. I've already been in touch with those of you operating tomorrow, however a decision has also been taken for lists planned to take place in CAH Main Theatres on Thursday, Friday and Monday – **only red-flag patients are to be operated on.** I would be grateful if you could review your lists and cancel anyone who is not a red-flag.

For lists scheduled for Tuesday 28th June onwards a decision will be taken and communicated later this week.

Any issues please let me know.

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training | Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
.....and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI Mobile Personal Information redacted by USI
Personal Information redacted by USI

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther Personal Information redacted by USI wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.

Happy to discuss any time and I will of course brief the oversight committee of any progress we make.

Many thanks
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
<image001.png> **Office** Personal Information redacted by the USI **Mobile** Personal Information redacted by the USI
<image002.png> Esther.Gishkori Personal Information redacted by the USI

<image003.png><image004.png><image005.png>

Southern Health & Social Care Trust

Case Conference
26th January 2017

Present:
Vivienne Toal, Director of HROD, (Chair)
Dr Richard Wright, Medical Director
Anne McVey, Assistant Director of Acute Services (on behalf of Esther Gishkori)

Apologies
Esther Gishkori, Director of Acute Services

In attendance:
Dr Ahmed Khan, Case Manager
Simon Gibson, Assistant Director, Medical Director's Office
Colin Weir, Case Investigator
Siobhan Hynds, Head of Employee Relations

Dr A O'Brien

Context
Vivienne Toal outlined the purpose of the meeting, which was to consider the preliminary investigation into issues identified with Mr O'Brien and obtain agreement on next steps following his period of immediate exclusion, which concludes on 27th January.

Preliminary investigation
As Case Investigator, Colin Weir summarised the investigation to date, including updating the Case Manager and Oversight Committee on the meeting held with Mr O'Brien on 24th January, and comments made by Mr O'Brien in relation to issues raised.

Firstly, it was noted that 783 GP referrals had not been triaged by Mr O'Brien in line with the agreed / known process for such referrals. This backlog was currently being triaged by the Urology team, and was anticipated to be completed by the end of January. There would appear to be a number of patients who have had their referral upgraded. Mr Weir reported that at the meeting on 24th January, Mr O'Brien stated that as Urologist of the Week he didn't have the time to undertake triage as the workload was too heavy to undertake this duty in combination with other duties.

Secondly, it was noted that there were 668 patients who have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months. A review

of this backlog is still on-going. Mr Weir reported that Mr O'Brien indicated that he often waited until the full outcome of the patient's whole outpatient journey to communicate to GPs. Mr Weir noted this was not a satisfactory explanation. Members of the Case Conference agreed, that this would not be in line with GMCs guidance on Good Medical Practice, which highlighted the need for timely communication and contemporaneous note keeping.

Thirdly, there were 307 sets of patients notes returned from Mr O'Briens home, and 13 sets of notes tracked out to Mr O'Brien were still missing. Mr Weir reported that the 13 sets of notes have been documented to Mr O'Brien for comment on the whereabouts of the notes. Mr Weir reported that Mr O'Brien was sure that he no longer had these notes; all patients had been discharged from his care, therefore he felt he had no reason to keep these notes. Mr Weir felt that there was a potential of failure to record when notes were being tracked back into health records, although it was noted that an extensive search of the health records library had failed to locate these 13 charts. Members of the Case Conference agreed further searches were required taking into consideration Mr O'Brien's comments.

Historical attempts to address issues of concern.
It was noted that Mr O'Brien had been written to on 23rd March 2016 in relation to these issues, but that no written response had been received. There had been a subsequent meeting with the AMD for Surgery and Head of Service for Urology to address this issue. Mr Weir noted that Mr O'Brien had advised that at this meeting, Mr O'Brien asked Mr Mackle what actions he wanted him to undertake. Mr O'Brien stated Mr Mackle made no comment and rolled his eyes, and no action was proposed.

It was noted that Mr O'Brien had successfully revalidated in May 2014, and that he had also completed satisfactory annual appraisals. Dr Khan reflected a concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal.

Discussion
In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon.

At the meeting on 24th January, Mr O'Brien expressed a strong desire to return to work. Mr O'Brien accepted that he had let a number of his administrative processes drift, but gave an assurance that this would not happen again if he returned to work. Mr O'Brien gave an assurance to the Investigating Team that he would be open to monitoring of his activities, he would not impede or hinder any investigation and he would willingly work within any framework established by the Trust.

Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this.

Decision
As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers.

This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required.
Action: Mr Weir

Formal investigation
There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

- Protecting patients
- Protecting the integrity of the investigation
- Protecting Mr O'Brien

Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

The members discussed whether Mr O'Brien could be brought back with either restrictive duties or robust monitoring arrangements which could provide satisfactory safeguards. Mr Weir outlined that he was of the view that Mr O'Brien could come back and be closely monitored, with supporting mechanisms, doing the full range of duties. The members considered what would this monitoring would look like, to ensure the protection of the patient.

The case conference members noted the detail of what this monitoring would look like was not available for the meeting, but this would be needed. It was agreed that the operational team would provide this detail to the case investigator, case manager and members of the Oversight Committee.
Action: Esther Gishkori / Ronan Carroll

It was agreed that, should the monitoring processes identify any further concerns, then an Oversight Committee would be convened to consider formal exclusion.

It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.
Action: Esther Gishkori/Ronan Carroll

Following consideration of the discussions summarised above, as Case Manager Dr Khan decided that Mr O'Brien should be allowed to return to work.

This decision was agreed by the Medical Director, Director of HR and deputy for Director of Acute Services.

It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

Action: Dr Khan

It was noted that Mr O'Brien was still off sick, and that an Occupational Health appointment was scheduled for 9th February, following which an occupational health report would be provided. This may affect the timetable of Dr O'Brien's return to work.

It was agreed to update NCAS in relation to this case.
Action: Dr Wright

MR O'BRIEN: For the trust.

COLIN WEIR: I suppose --

SIOBHAN HYNDS: The concerns for the Trust will always be -- the overriding concern will always be about patient safety and that will always about.

MICHAEL O'BRIEN: I understand that in a global sense.

MR O'BRIEN: That's (inaudible).

MR O'BRIEN: But I am wondering about the particulars of that (inaudible).

COLIN WEIR: I suppose the Trust has to say, right, if somebody is looking at the Trust and they say you have got this consultant who's been very bad, not this specifically but whatever, and they haven't engaged with the investigation properly, then the Trust is remiss obviously, but whether -- I suppose it depends on the nature of the problem and then of the scale of the problem. I think what we are setting out here and what we got out of this was the scale of the problem, but then you've, if you like in mitigation, you have said some things already. You have said the 13 charts you have given a very detailed response. The private thing. It is not to me, I am on the fence ~~(inaudible)~~ to be honest with you. I have said that all along when I saw this. And so we are down to this numbers game and whether I suppose patients -- I suppose the Trust would say if your practice caused harm in terms of patient outcome and I think that's --

SIOBHAN HYNDS: The Trust will also look at not ~~that~~ just actual harm but the potential for harm as well by way of your practices. So it won't be, okay, everything maybe wasn't as it should be but there was no actual harm. It will also have to look at whether or not by -- as a consequence of your practices was there the potential for harm to patients.

MR O'BRIEN: Can I also ask the question? Will the Trust actually be considering as well by virtue of my practice and what I have done in recent years, whether harm was avoided and good was done? I am not meaning in a sort of general altruistic manner. I mean, I could keep a committee going with SAIs. I have not never completed an SAI in my life. I mean, there are people suffering severely because of delays.

I mean, in the data that I will submit to you, I haven't missed an operating session availability during 2016. Even if I took a couple of days off, I never took off on a Wednesday. I refused to even go to court on behalf of the Trust or be available as an expert witness in defence of cases if it interfered with operating on a Wednesday. I have used every available opportunity and I have actually prevented poor definite clinical outcomes in scores of patients. And even in spite of all of that overperformance, I still haven't succeeded because I know of poor clinical outcomes of patients that are -- have occurred and one of which has occurred since I took off. I know about that.

I mean, this is -- this is the enormous elephant in the room that is not being addressed at all. And you are asking me, Colin and Siobhan, in a sense, who have you raised this with before and I am raising it now. It will never appear on this A4 sheet of paper.

MICHAEL O'BRIEN: You have your formal meetings (inaudible) your meeting's on Thursday.

MR O'BRIEN: Yes, we have departmental meetings. And occasionally what we have done is say, wonder if you take ten or 20 patients from Michael's list and my list and give to the others and then that's done for another six months.

COLIN WEIR: (Inaudible) explore that. You have ~~a~~ department meetings every Thursday (inaudible). So you have a degree of governance and oversight on the team. The team are kind of -- you are discussing cases and you have conferences (inaudible).

MR O'BRIEN: We are discussing -- well, I chair, and this is another issue that will be used in my defence or mitigation. I took over as lead clinician and chair of MDM in April 2012. I chaired every MDM that occurred each week until I had the idea of having a rotation for chairing in September/October -- September 2014.

So, you know, I would do my operating. I would finish at 8 o'clock in the evening operating. Sometimes 7.30. Sometimes I would overrun. I would always do my administration. I was very particular about that with regard to outcomes of patients following surgery and I'd do it by email to my secretary, or whatever. And then I would leave the hospital at 9 o'clock and I'd go home and get something to eat. And then I would sit down for three to four hours, you know, until 2/3 o'clock in the morning previewing 35, 40, 45 cases. It's like doing an enormous cancer clinic. Most of the patients you don't know. Reviewing all the digitalised images and so forth and getting, if you are lucky, two or three hours of sleep and coming in the following day. I did all that.

MICAHEL~~R~~ O'BRIEN: But what I was saying there was about the fact that you have your meetings with your colleagues, is it not every Thursday that you have a meeting?

MR O'BRIEN: Yes, but anyhow, Michael, we would have like a rolling agenda. It could be, you know, the use of glycine in theatre this week and you know it may not.

SIOBHAN HYNDS: I may not come every --

MR O'BRIEN: It wouldn't come up every at all. And one of those is a scheduling one for the calendar month later and so forth.

MICHAEL O'BRIEN: (Inaudible) response that you did to a patient complaint about delay.

MR O'BRIEN: That's one poor clinical outcome.

MICHAEL~~R~~ O'BRIEN: (Inaudible) response to that. A written response that you provided which detailed a lot of the issues (inaudible).

Meeting with Mr O'Brien, Mr Weir, Mrs Corrigan
11:30am – 9th March 2017 – AMD Office – Admin Floor

Purpose of the meeting was as a follow on from Mr O'Brien's return to work meeting that took place with Mr O'Brien and Mr Weir on Friday 24 February 2017. (Mrs Corrigan was on Annual Leave).

Following topics was discussed:

1. **Enniskillen Clinics**

Mr O'Brien reiterated his wish to go to the clinics in South West Acute Hospital (SWAH) on a monthly basis as he felt that it wasn't fair that patients had to travel. Mr Weir advised that it wasn't that we would be stopping him from doing these clinics altogether but this was to facilitate his return to work after surgery and that we planned to reinstate them after a few months. However, Mr O'Brien advised that he was feeling much better since his surgery and that the journey would no longer be an issue for him and again this was needed to accommodate the Fermanagh patients and prevent them having to travel.

It was agreed therefore that he could start back as soon as possible and that Mrs Corrigan would look to see when the next suitable date would be.
Follow-up note: Mrs Corrigan has checked and there are no suitable Monday's available in April:
3rd – Review Clinic booked for CAH
10th – Mr O'Brien is Urologist of the Week
17th – Easter Monday
24th – Mr Young has a clinic
Mrs Corrigan has advised Mr O'Brien of this by email and that the next clinic would be held on Monday 8th May 2017.

Mrs Corrigan also to check is it possible to for Mr O'Brien to use his laptop in SWAH and do his digital dictation from there.
Follow-up note: Mr Young is going to SWAH on Monday 13th March and has agreed to trial this on his laptop and report back, if this doesn't work then Mrs Corrigan to contact IT in SWAH to see is there any way that we can link their digital dictation to our systems.

It was agreed that Mr O'Brien would see 16 patients (8 x AM and 8 x PM) on these clinics and that he would get one hour to dictate at the end of the clinic. Mr O'Brien agreed to this and that he would not leave SWAH until all the charts had been dictated on.

Mr Weir asked Mr O'Brien was this fair and to which Mr O'Brien replied '*nothing about job plans was fair*'.

One point that hasn't been agreed from this meeting and needs followed up is in respect to returning the notes after the clinic – Mrs Corrigan to action.

2. Admin since return to work

Mrs Corrigan asked on clarification on the backlog that Mr O'Brien's secretary had reported that she was doing and Mr O'Brien advised since his return to work he had been doing any outstanding Admin/Results etc. that had not been done whilst he had been off and this included patient follow-up from his diaries. Mrs Corrigan said that there should be no information kept in diaries and that it all needed to be recorded on PAS. Mr O'Brien assured Mrs Corrigan and Mr Weir that it was all also on PAS.

3. New Outpatient Clinics

Mr O'Brien advised Mr Weir and Mrs Corrigan that he no longer felt it was fair that he would continue to see New Outpatients. Mrs Corrigan advised that this was not feasible as all Consultants needed to see New Outpatients. Mr O'Brien clarified that the reason he felt this was because he had the most patients waiting to be operated on with the longest waiting times and that it wasn't fair for him to continue to see new patients and adding to his waiting list as he couldn't deal with them.

Mrs Corrigan clarified that Mr O'Brien didn't have the most nor the longest waiting times for In and Day patients:

Mr Young	-	228 patients (162 weeks)
Mr Suresh	-	267 patients (93 weeks)
Mr O'Brien	-	257 patients (152 weeks)
Mr Haynes	-	191 patients (143 weeks)
Mr Glackin	-	146 patients (62 weeks)
Mr O'Donoghue	-	134 patients (101 weeks)

Mrs Corrigan gave further detail on Mr O'Brien's total waiting with their longest waiting times:

Daycases:	37 Urgent (longest waiting 110 weeks)
	25 Routine (longest waiting 137 weeks)
Inpatients	124 Urgent (longest waiting 148 weeks)
	71 Routine (longest waiting 152 weeks)

Mr O'Brien advised that he didn't agree with classifications of an *Urgent* or of a daycase and that whilst these were the numbers waiting they should be classified differently.

Follow-up note – Mrs Corrigan to work with Mr O'Brien to get these validated and classified accordingly.

4. **Annual Leave**

Mr O'Brien had previously requested Mrs Corrigan to provide him with how many annual leave days he had taken to date. This was emailed through to Mr O'Brien on 7th March 2017:

Dear Aidan

As discussed your annual leave year commences on 1 July each year. I have recorded that up until today you have taken 18 annual leave days leaving you with 16 days to take before 30 June 2017.

I have also noted that you hope to take a further 4 days in April (14th, 19-21st) and I have noted this on the Annual Leave sheet.

Mrs Corrigan asked Mr O'Brien if this was ok to which he advised he hadn't had a chance to look at this but that there was also 12 July 2016 that Mrs Corrigan hadn't added in when he came in and operated all-day on a patient of his and of note he wasn't oncall.

Follow-up, Mrs Corrigan to clarify if this should be added in as it wasn't an oncall day-in-lieu.

Mr O'Brien also asked for clarity on how many days he was entitled to and Mrs Corrigan advised him that he was entitled to 34 annual leave and 10 Bank Holidays. He asked for clarity if this was worked out as per his job plan which is how it is worked out in England and Mr Weir advised that for our Trust we followed a regional policy and that it was 32 days up until 7 years and then 34 days thereafter.

Mr O'Brien then advised that he was holding the last week in March for a court case (Mrs Corrigan was not aware of these dates), and that he had got word to say he was no longer needed to appear in Court but that he still wanted to take the Monday 27th and Tuesday 28th March off as Annual Leave, Mrs Corrigan advised that there was a New outpatient clinic set up for Mr O'Brien but as no patients had been booked she would cancel same and noted the annual leave dates.

5. **Review Backlogs**

Mrs Corrigan asked for clarification on the review oncology patients that Mr O'Brien had been booking to his clinics and that he kept referring to in conversations.

Mr O'Brien advised that for all of his Oncology patients he kept this information in a diary, i.e. he took a patient detail label and stuck it in the diary with notes for when they were due a review and anything that needed to be done with the patient. Mrs Corrigan and Mr Weir advised that this was causing them a lot of concern because although Mr O'Brien knew no-one else knew and if something happened to him this information would be lost. But he assured Mr Weir and Mrs Corrigan that these were on PAS.

Mrs Corrigan shared Mr O'Brien's Review Urgent Outpatient backlogs:

CAOBUO (oncology reviews) -	2014 = 89
	2015 = 77
	2016 = 46
	End of March 2017 =32
	Total = 244
EUROU = Enniskillen Urgent	2014 = 1
	2015 = 1
	2016 = 25
	End of March 2017 = 32
	Total = 63

Mr O'Brien asked for clarity on how the patients were identified for the Enniskillen Urgent Review list and Mrs Corrigan advised him that if not specified then the patient if seen originally as an urgent patient then they will remain as urgent unless otherwise directed.

Mr O'Brien also advised that the patients whilst on the oncology review clinical code (CAOBUO) they were not all oncology as the list was a combination of urgent and oncology. Mrs Corrigan asked would it be possible to validate this list and separate out the oncology patients as again this is very concerning that we do not have a handle on what is Oncology and what is Urgent.

Follow-up: Mrs Corrigan to provide patient detail on the CAOBUO review backlog and can work through getting the urgent patients moved to a different code:

NOTE: after the meeting Mr O'Brien and Mrs Corrigan walked together to the Urology Departmental meeting and discussed the reviews. Mr O'Brien advised that he actually contacted a lot of patients by phone and discussed their follow-up and that there was no recognition of this. Mrs Corrigan advised him that it was imperative that he dictated on these patients as not only was it away of capturing this activity but it was a record of the decisions that had

been made on the patient because again the Trust didn't have any record of this.

6. MDT

Mr O'Brien raised about the Urology Oncology MDT and advised Mr Weir and Mrs Corrigan that he was no longer prepared to operate on a Wednesday until 8pm then go home and preview for the next day's MDT as he had done in the past. He advised Mr Weir and Mrs Corrigan that he hadn't quite made up his mind if he was going to continue with chairing this MDT group but if he did continue then he wouldn't be coming into work on a Thursday morning but the time would be spent previewing for the MDT. Mr O'Brien advised that he spends considerable time preparing for the meeting if he is going to Chair and that he went through all patients in great detail including all their images. He also advised that in the past he had spent considerable time after the MDT correcting the outcomes i.e. grammar etc. He advised that he prided himself on having one of the best-prepared and well-run MDT's.

Mrs Corrigan advised that as Mr Glackin was now the Lead for MDT that he should speak with him to determine his views on this.

Follow-up note: Mrs Corrigan spoke with Mr Young who felt that it Mr O'Brien wants to continue to Chair then he should drop his theatre session once per month and give it to the Locum Consultant and this would allow him to do the preparation for the MDT.

7. Investigation

Mr O'Brien raised the Investigation and the worry it was causing him. He said that he wasn't sleeping and that it was more now the mental stress that this was causing him rather than the physical. He advised that he was suffering from [redacted] and needed to go to bed early (he also advised that he was on [redacted]). He told Mr Weir and Mrs Corrigan that he had a pain [redacted] and that he needed new glasses. Mrs Corrigan asked him did he want to be referred back to Occupational Health? He replied that his wife had mentioned the same but he wasn't sure. Mr Weir discussed with him that he should attend his own GP as it sounded like he was suffering from [redacted]. Mr O'Brien said he knew his GP – Dr [redacted] well, but of note Mr O'Brien didn't agree to go and see Dr [redacted]

Follow-up: Mrs Corrigan to check with Mr O'Brien on his health and again ask does he want to be referred to Occupational Health.

Mr O'Brien told Mr Weir and Mrs Corrigan that whilst he had had an indication that the Investigation would be complete by mid-April he had no indication on when he would be called for interview. He requested that when this would happen that he would have no clinical activity before or on the day of the

interview. Mrs Corrigan advised that she would speak with Mrs Hynds and see if the Investigation Team had any approximate timescale for Mr O'Brien's interview and that she would ensure that his clinical activity for that day would be cancelled.

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

1.0 Introduction

1.1 **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 This 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 patient's harmed.

1.3 The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.4 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.5 This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. 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.

1.6 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.7 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.8 This guidance should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns[1] should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. 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. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

[1] Examples of Concerns may include: - when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 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. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

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. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 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. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following

informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.

2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
An informal process. This can lead to resolution or move to:

Appendix 2
A formal process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.

3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Appendix 1

Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding compliance.

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

Appendix 2

Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 3a

Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

During the hearing - witnesses:

- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:

- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 4

Appeal Procedures in Clinical Performance Cases

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

↓

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

→

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

↓

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

↓

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

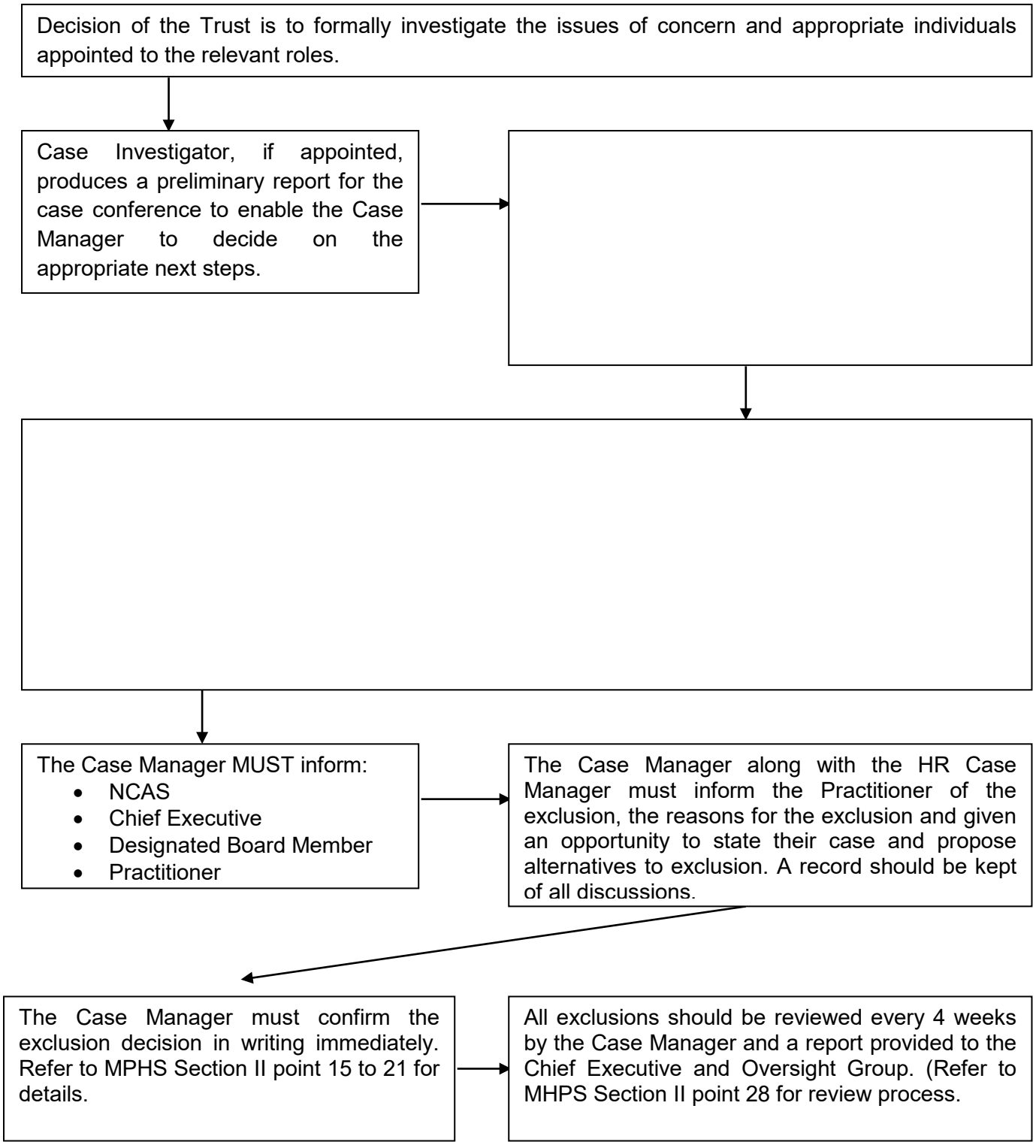
→

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion



Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Mr O'Brien may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016

Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken. Mr O'Brien was accompanied by his wife, Mrs Personal Information redacted by the USI. **(Appendix 2)**

A letter was issued to Mr O'Brien in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Mr O'Brien that Dr Ahmed Khan had been appointed as Case Manager for the case and Mr Colin Weir was identified as the Case Investigator. **(Appendix 3)**

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		
0 .2/2015	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	CAOBTDUR	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	CAOBTDU	6	3	3
22/04/2016	UROONCOLOGY CLINIC	CAOBUO	5	4	1
27/04/2016	URODYNAMICS CLINIC	CAOBUDS	RETURNED BEFORE 30TH DECEMBER 2016		
2 /04/2016	UROONCOLOGY CLINIC	CAOBUO	9	3	6
29/04/2016	URODYNAMICS CLINIC	CAOBUDS	3	1	2
03/05/2016	REVIEW CLINIC - CAH	CAOBTDUR	RETURNED BEFORE 30TH DECEMBER 2016		
06/05/2016	HOT CLINIC		2	0	2
23/05/2016	REVIEW CLINIC - CAH	CAOBTDUR	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	CAOBTDUR	17	10	7
22/07/2016	UROONCOLOGY CLINIC	CAOBUO	12	11	1
26/07/2016	NEW CLINIC	CAOBTDU	7	4	3
09/08/2016	NEW CLINIC	CAOBTDU	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

Most of the patient notes stored in Mr O'Brien's home were notes which had been taken to his SWAH clinics. As no transport is available between Craigavon Area Hospital and SWAH in Enniskillen, both Mr O'Brien and Mr Young who undertake clinics at SWAH undertook the practice of taking the notes from each clinic with them at the end of the clinic to be returned to Craigavon Area Hospital.

Mr O'Brien did not dictate the outcomes / letters from the SWAH clinics at the end of the clinics; instead he took the charts home to dictate them at home at another time. Mr Young dictated the outcomes at the end of each clinic and returned the notes directly to Craigavon Area Hospital the next day.

Alongside the clinic dictation, it is also the agreed practice that each Consultant should complete a clinic outcome sheet which should be returned to their secretary for immediate action of patients on to Trust waiting lists.

In January, when a large number of the patient notes from Mr O'Brien's home were returned, it was found that Mr O'Brien had a significant volume of clinic outcomes and dictation outstanding. In total it was found that dictation had not been completed for patients who had attended 66 clinics dating back to November 2014, affecting 668 patients.

A full review of the charts for each affected patient was undertaken by the remaining Trust Consultant Urologists. This review took approximately 6 months to ensure all patients were reviewed and to provide the Trust with an assurance that all necessary and appropriate actions were in place. This review was done by the Consultant Urologists during additional PA time agreed specifically for this work to be undertaken. **(Appendix 32)**

Examples of findings from the review of the patients are:

1.	Personal Information redacted by the USI [redacted]	Patient seen 6 times and no letters on file for any of the attendances
2.		Letter done when patient was a private patient, no other letters on file
3.		Patient seen 14 times but no letters on file – not on a review list
4.		Patient seen on 19 September 2016, letter dictated on 28 February 2017
5.		According to PAS, patient attended on 19 June 2016 but note in the chart says DNA (discharge to GP) this has not been done.

Southern Health and Social Care Trust

30th December 2016

Dr Aidan O'Brien
Personal Information redacted by the USI

Dear Mr O'Brien

Formal notification of exclusion and investigation under Maintaining High Professional Standards (MHPS)

I am writing to confirm our discussions from our recent meeting and inform you of the Southern Trusts intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practice.

This investigation should be seen in the context of the letter written to you on 23rd March (copy attached as Appendix 4), in which a number of concerns were raised and a plan was sought from you to address these concerns. No plan was provided and similar concerns have been raised again.

The Terms of Reference of this investigation are attached as Appendix 1 and will focus on 4 areas, as detailed below:

Area 1 – Untriaged letters

As of 22nd December, you had 318 untriaged outpatient referral letters, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks. It would appear from an ongoing Serious Adverse Incident (SAI) investigation that a number of patients may have had an adverse clinical outcome caused by this lengthy delay in triaging outpatient referrals.

Area 2 – Patients notes at home

It has been identified that, as at 23rd December, there are 365 notes directly tracked to you on PAS (Appendix 2), and there is continuing concern that a proportion of these notes may be at your home address and may have been there for some time. There is a concern that the urological clinical management plan for these patients is unclear, and may be delayed. There is also concern that when patients have attended other specialties within the Trust for care or treatment, their notes have not been available to assist with their consultation.

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

One immediate action that I confirmed at our meeting is the expectation of the Trust that all hospital notes at your house are returned to Martina Corrigan, Head of Service for Urology, within 72 hours of the date on this letter.

There are to be no exceptions to this.

Once these charts are returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretary's office, in line with Trust procedures.

Issue three – Unreported outcomes from clinics

It has been reported that, as at 15th December, you had a backlog of 61 undictated clinics going back to November 2014 (Appendix 3). This means that a significant number of patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Issue four – Non-compliance of Trust policy in relation to management of private patients being seen within NHS services

A case has been raised which may indicate that you may have offered an advantage to an NHS patient awaiting an inpatient procedure who had previously attended you in a private outpatient capacity, to the disadvantage of other patients awaiting an inpatient procedure, by not listing patients in chronological order.

These issues were considered by the Southern Trusts Oversight Committee on 22nd December. Given the seriousness of these issues, the Oversight Group further considered if exclusion or any restrictions of practice should be placed upon you during the course of the investigation.

It was agreed by the Oversight Committee that there was the potential that your administrative practices may have led to patients coming to harm. If this was the case, should you return to work, the potential that your administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude you for the duration of a formal investigation under the MHPS guidelines. In line with NCAS and DHSSPS guidelines, this decision was discussed and endorsed by NCAS on 23rd December.

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

Southern Health and Social Care Trust

I very much appreciate that investigations can be particularly stressful and I therefore wish to advise you that the services of Carecall (0808 800 0002) are open to you throughout the course of the investigation to provide help and support.

Under MHPS, it is intended that the Investigation Team will conclude their investigation by 31st January; however, you will be kept informed if this is not achievable.

Yours sincerely

Dr Richard Wright
Medical Director

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

Appendix 1

Southern Health & Social Care Trust
Investigation into Dr Aidan O'Brien

TERMS OF REFERENCE

During the completion of a Serious Adverse Incident investigation, a number of concerns were raised with the Medical Director. The Medical Director, under delegated authority from the Chief Executive, authorised a range of preliminary enquiries to seek to verify the substance and accuracy of issues raised by staff.

Following completion of the Trust's preliminary enquiries, information was presented to an Oversight Group consisting of the Medical Director, the Assistant Director of Acute Services, (acting on behalf of the Acute Services Director) and Director of Human Resources and Organisational Development. This preliminary information led the Oversight Group to agree that a formal investigation under Maintaining High Professional Standards was justified to consider the following issues:

1. **To determine whether there has been unreasonable delays in the triaging of outpatient letters by Dr O'Brien, and whether patients may have come to harm as a result of these delays**

2. **To determine whether patients notes have been stored at home by Dr O'Brien, whether these have been at home for significant periods of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties**

3. **To determine whether there has been an unreasonable delay by Dr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients**

4. **To determine whether Dr O'Brien offered an advantage to NHS patients awaiting a procedure who had previously attended him in a private outpatient capacity, to the disadvantage of other patients awaiting a procedure, by not listing patients in chronological order**

Appendix 1

Further to these Terms of Reference, The Oversight Group directed that a Case Manager, Case Investigator and Senior HR advisor should now be appointed, and that Dr O'Brien should be met with to inform him of:

- A formal investigation commencing, and the Terms of Reference
- The membership of the investigating team
- The process of investigation under the Maintaining High Professional Standards Framework
- The initial 4 issues of concern under consideration
- The immediate restrictions being placed upon Dr O'Brien
- A timetable for the progression of the investigation

Southern Health and Social Care Trust

30th December 2016

Dr Michael McBride
Chief Medical Officer
DHSSPS
C5.15 Castle Buildings,
Stormont Estate,
Belfast,
BT4 3SQ

Dear Dr McBride

Notification of immediate exclusion of Mr Aidan O'Brien GMC No: 1394911 Consultant Urological Surgeon, Southern Health & Social Care Trust

I am writing to inform you that, under the terms of Maintaining High Professional Standards (MHPS), the Southern Trust has today excluded the above doctor.

The reason for the exclusion, taken following advice from NCAS, was to allow a four week period to scope out the scale of potential problems in relation to Mr O'Briens administrative practices, which may have led to patients coming to harm, and form the Terms of Reference of a formal investigation.

The scoping exercise will be considering:

1. Potential delays in triaging GP referral letters
2. Potential delays in recording the clinical outcome of outpatient clinics
3. Potential adverse impact of patients notes being kept at home for unreasonable periods of time

The decision was taken by the Southern Trust's Oversight Committee on the basis that, if Mr O'Brien's administrative practices have potentially led to patients coming to harm, should he return to work, the potential that his administrative practices could continue to harm patients would still exist.

In line with MHPS guidance, this scoping exercise will be completed within four weeks, and I will update you upon its conclusion. If the exercise identifies significant concerns during its progress, I will of course alert you earlier.

Yours sincerely

Personal Information redacted by USI

Dr Richard Wright
Medical Director

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

Note of Meeting with Mr Aidan O'Brien, Consultant Urologist – 30th December 2016

Present:

Mr O'Brien (accompanied by his wife, Personal Information redacted by USI
Dr Richard Wright, Medical Director
Ms Lynne Hainey, Employee Relations

Introductions were made and Dr Wright thanked Mr O'Brien for attending the meeting. It was explained that the reason the meeting had been called was to make Mr O'Brien aware that concerns had been raised with Dr Wright on the back of a Serious Adverse Incident (SAI) Investigation. Dr Wright noted that some of these concerns had been raised with Mr O'Brien previously and an attempt had been made to resolve the matters, with no success. Ms Hainey made Mr O'Brien aware of the nature of the concerns that had been raised with Dr Wright ie concerns relating to his administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. In particular:-

1. The lengthy period of time taken to undertake the triage of GP referrals (with currently 318 un-triaged cases).

   Ms Hainey referred to the ongoing SAI investigation relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Mr O'Brien to undertake triage of GP referrals. Mr O'Brien was also informed that the SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

2. That there is a backlog of over 60 undictated clinics going back over 18 months and therefore there is approximately 600 patients who may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients.

3. That some of the patients seen by Mr O'Brien may have had their notes taken back to his home, and are not available within the hospital. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Mr O'Brien advised that he was not aware of the cases in question being investigated under SAI, and that he had no involvement in the SAI process. Dr Wright advised that he would raise this with the SAI Team, stating that the process remains ongoing and they may not have contacted Mr O'Brien yet because he had been on sick leave.

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 previous action had proved unsuccessful in being able to resolve the issues, a decision had been taken to investigate the matter formally in accordance with the Maintaining High Professional Standards Framework and associated local guidance. Ms Hainey provided Mr O'Brien with a copy of both documents for his information, explaining that these outline the process by which an investigation is undertaken and Mr O'Brien's rights in the process.

Dr Wright confirmed that a Case Manager and Case Investigator had been appointed (Mr Ahmed Khan, Case Manager and Mr Colin Weir, Case Investigator). Ms Hainey explained that Mr Weir will be supported in the investigation by a representative from Human Resources (as yet to be appointed). Dr Wright advised that a Non-Executive Director will also be appointed to oversee the investigation process, and the detail of this person to be communicated to Mr O'Brien asap.

Mr O'Brien was informed that as an interim precautionary measure, he was being placed on immediate exclusion with full pay. He was informed that the decision had been taken by the Oversight Committee in the Trust and that NCAS had been informed of this prior to the meeting. It was explained that this would be for no longer than 4 weeks, and that during that time, further preliminary information would be collated to decide the scope of the investigation, and therefore the Terms of Reference for investigation which would be forwarded in due course. Mr O'Brien was informed that a meeting would be arranged to take place with him during the 4 week period, and that he would be kept informed of any progress in relation to the investigation.

Mr O'Brien advised that the concerns needed to be considered in the context of the enormous pressure on him to operate. He stated that clinical outcomes are compromised because of a lack of capacity. He stated that there is an inequity within the department and gave an example that in October, he had a waiting list of 288 for inpatient admission whilst a colleague had a waiting list of 29. He advised that he had previously asked that this situation be addressed. But that because of the waiting list the demand on him was to operate.

Mr O'Brien stated that it was important to appreciate the totality of the work that he does, and as a result he does not have time to triage non red flag referrals. He advised that the referral of these was a historical hangover from the time when it was felt there was not enough to do when on-call. The triage of non-red flag referrals was undertaken to justify on-call time. Mr O'Brien advised however that this time is now spent on operations eg the last week he was in work, he undertook 21 operations whilst on-call.

Dr Wright noted the points made by Mr O'Brien and advised that whenever an investigation is undertaken, there may be criticisms of the Trust, and its systems but that would have to await the outcome of the investigation.

Mrs O'Brien stated that her husband had worked for 25 years as a Consultant in the Trust and that during that time he had worked 70-90 hours per week including week-ends. She advised that when taking someone off the waiting list in chronological order ie those longest on the waiting list, her husband is conscious that so much could have changed for the patient during the intervening period and so he would take the time to ring and speak to the patient to find out how doing etc. Mr O'Brien advised that he had 19 additional theatre sessions and 15 extra oncology sessions, and is under pressure to do all.

Dr Wright advised that he is well aware of the work that Mr O'Brien does for the Trust, but that given the concerns that have been brought to his attention, the matters have to be investigated. Ms Hainey stressed that it is an investigation to establish the facts and that Mr O'Brien would be given every opportunity to respond in full as part of the investigation process.

Mrs O'Brien stated her view that the system needs to change as there is too much work being placed on Consultants. She advised that when she worked as a nurse practitioner 40 years previous, it was her role to triage the referrals. Mr O'Brien reiterated that he had raised two years previous that he did not have capacity to deal with non-red flag triage. He said that it is his view that you need to speak to patients rather than ticking a box, and that to do so takes time.

Dr Wright referred to the need to return any notes as a matter of urgency. Mr O'Brien was requested to return these to Martina Corrigan, Head of Service for Urology by 11.00 am on Tuesday 3rd January 2017. Mr O'Brien stated that he could not return these without processing them. Dr Wright stated that the notes needed to be returned by the above date and time, as he was accountable and needed to deal with the matter. He stated that if there were notes missing, this was a very major problem that would need to be dealt with through Information Governance. Mr O'Brien advised that he has all the notes that are tracked out to him. Both Mr and Mrs O'Brien queried what happens with the patients given that Mr O'Brien has not processed them, and would be the best person to process the cases. Dr Wright advised that he will deal with this. Mr O'Brien asked for a deferment of two weeks to allow him to process the files and Dr Wright advised that no deferment could be granted. Ms Hainey reiterated that in the interests of all parties, and of the investigation process, that the notes needed to be returned as per Dr Wright's management request.

Mr O'Brien said that he was shell-shocked. Mrs O'Brien said that there would be no better person to process the cases. Dr Wright said Mr O'Brien had been asked to return all the information in March 2016 but did not. Mr O'Brien said that the emphasis for him at that time was operating. When the letter of March 2016 was discussed, Mrs O'Brien stated that she would have concerns about one of the signatories as he had caused problems previously. It was made clear that the notes had to be returned as requested and that anything associated with the care of those patients would be reviewed by others. Ms Hainey asked Mr O'Brien to comply with the request and Mrs O'Brien stated that she was concerned about how the cases would be dealt with. Dr Wright advised that he would take responsibility for this. He advised that the matter would have to be reported to the Chief Medical Officer who would be querying where all the notes are, and therefore that it is imperative that Mr O'Brien return the notes as requested.

As it was obvious that both Mr and Mrs O'Brien were upset, Ms Hainey asked if anyone wished a glass of water or cup of tea/coffee. This was declined. Mrs O'Brien stated that there was too much bureaucracy in the Health Service and she felt this was a major issue. She advised that Mr O'Brien's SPA time was spent operating or reviewing cancer patients, and that he took time in December to do his appraisal. Mr O'Brien said that he had been pleading for the past 2-3 years that he should not see any new patients because of the immorality of not being able to do what he had pledged to do. He said that as a consequence of operating, other duties get neglected. He said that there were not enough hours to be faultless, that he had tried in the past without sleeping or without food.

Mr O'Brien stated that he was devastated by what had been communicated to him today. Dr Wright queried if Mr O'Brien's job plan was unrealistic. Both Mr and Mrs O'Brien stated that the job plan is OK but things are allocated to SPA time that are not admin work. Dr Wright stated that if the job plan does not cover all the work have to do, then it is not right. Mrs O'Brien stated that the first job plan was 15.5 when in reality it should have been about 18. She said that now the job plan is 10

sessions. Mrs O'Brien stated that she and her children have sacrificed their family life for her husband's job and stated that she found it most hurtful that it should be reduced to this moment, and that it was grossly unfair.

It was again reiterated that there is an obligation to address concerns when these are raised, and that Dr Wright had been made aware of serious concerns about Mr O'Brien's administrative practices which may have / has the potential to lead to harm for patients.

Mr O'Brien was made aware of the paragraphs in the MHPS documentation relating to exclusion. He queried if he can continue to work with private patients. Dr Wright suggested that he take advice from his union, but said that as RMO, he would discourage this. Dr Wright suggested that Mr O'Brien ask his colleagues to review any private patients that he has.

Mr O'Brien was made aware of support services available through Care-call and OH. He was advised that an OH appointment would be made for him and would be communicated to him. Prior to meeting concluding, Mr O'Brien apologised to Dr Wright.

Southern Health and Social Care Trust

6th January 2016

STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien

Personal Information redacted by the USI

Dear Mr O'Brien

Formal notification of immediate exclusion and investigation under Maintaining High Professional Standards Framework (MHPS)

Thank you for meeting with Ms Lynne Hainey, Acting HR Manager and myself on 30th December 2016, at which you were accompanied by your wife.

The reason for meeting was to inform you of concerns that have been brought to my attention as part of a Serious Adverse Incident (SAI) Investigation. As discussed, these concerns relate to your administrative practices, and the possibility that patients may have come to harm as a result of those administrative practices. You will recall that we had previously attempted to address some of the issues regarding these administrative practices informally, however this has been unsuccessful (the enclosed letter of 23rd March refers).

As discussed, the initial concerns raised are as follows:-

1. The lengthy period of time taken to undertake the triage of GP referrals (with currently 318 un-triaged cases).

   The ongoing SAI investigation is in relation to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by you to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

   You indicated that you have had no involvement in the SAI process and therefore I undertook to raise this with the SAI Team. I am advised that the

SAI commenced in October 2016, and therefore has coincided with your period of sick leave. The SAI is ongoing, and you will be contacted as part of this process.

2. That there is a backlog of over 60 undictated clinics going back over 18 months and therefore there are approximately 600 patients who may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients.

3. That some of the patients seen by you may have had their notes taken back to your home, and are not available within the hospital. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Given the serious nature of the concerns, we met with you to discuss the matter and the process for managing the complaint.

It was confirmed that the concerns identified will be managed in line with the '*Maintaining High Professional Standards in the Modern HPSS*' Framework (MHPS) and the associated *'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* (copies of both documents were provided to you for your information).

In line with the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance, an Oversight Committee within the Trust has been appointed. It has been agreed that given the serious nature of the concerns a formal investigation will be undertaken.

As discussed, Dr Ahmed Khan, AMD (Paediatrics) has been appointed as the Case Manager for this investigation. Mr Colin Weir, Clinical Director is the Case Investigator and will be assisted by a representative from the Trust's HR Department (HR Representative to be confirmed).

It was explained to you at our meeting that, in accordance with MHPS, a decision has been made to immediately exclude you from the workplace effective from 30th December 2016, with full pay. This is a pre-cautionary measure and is to protect you from any further concerns being raised, to protect the interests of patients, and to assist the investigative process. Please note that NCAS had been informed of this, in advance of the meeting.

This exclusion will be up to but no more than 4 weeks and will allow for further preliminary information to be collated to decide the scope of the investigation, and therefore the Terms of Reference for investigation. The Case Manager will make

contact with you as soon as possible in relation to the progression of the formal investigation process, and to provide you with a copy of the Terms of Reference for same. In the meantime, contact will be made with you to arrange a meeting during the 4 week period of immediate exclusion to allow you to state your case, and propose alternatives to exclusion. You are entitled to be accompanied to all meetings during the course of the investigation as per Section 1 Paragraph 30 of the MHPS Framework.

This 4 week exclusion period should allow sufficient time to determine a clear course of action, including the need for formal exclusion. Any decisions made will, of course, be communicated to you. I would refer you to the MHPS Framework document, Section 1, Paragraphs 18 – 27 and Section II, Page 13 – 20 regarding exclusion.

It was made clear to you that you are required to return any case notes / dictation that you have in your possession. You were requested to return these to Martina Corrigan, Head of Service for Urology by 11.00 am on 3rd January 2017, and I understand that you have now done this. Now that these charts have been returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretary's office, in line with Trust procedures. A review will be undertaken by the Trust of any actions required for each patient.

I recognise that this will be a stressful time for you and I would therefore reiterate that the services of the Trust's Occupational Health Department or the staff counselling service, Care-call are available to you. An appointment was arranged for you to attend the Trust's Occupational Health Department on Thursday 5th January 2017, and your manager now awaits the report from Occupational Health. Please note that Care-Call services are also available and they can be contacted on 0808 800 0002.

In the meantime, should you have any queries in relation to the content of this letter, please do not hesitate to contact me.

Yours sincerely

Personal Information redacted by USI

Dr Richard Wright
Medical Director

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

professional standards framework, Mr O'Brien, which refers to a decision and situations like this to exclude a practitioner from the work place for a period of time, as Dr Wright says, to do a preliminary exercise and scope out the terms of reference for the formal investigation. And during that period of time we would hope to be able to meet with you and give you an opportunity to provide any representations that you wish to make to the Trust. But certainly what we will is we will confirm all of this in writing to you after today.

…….. silence ……..

I appreciate it is a lot to take in and certainly we would want to look to provide you with as much support as possible during this time. As Dr Wright says we can certainly link with other occupational health and get an urgent referral for you. We also have what is known as care call. It is a (inaudible) staff to avail of in such circumstances if they felt they needed that additional support.

…….. .silence …….

MR O'BRIEN: So what you are saying is the charts are to be returned by Tuesday morning.

…….silence ……..

And what about all of the things that are organised?

What happens to clinics and the operating list?

DR WRIGHT: We will be discussing that with your clinical lead and your clinical director to follow up with that but it doesn't sound from what you are telling me this morning, even from a physical point of view, that you would necessarily be in a position to action those in any case but we will have to put other arrangements in place for those patients.

~~FEMALE SPEAKER 1~~Ms HAINEY: Just to be clear, any exclusion is obviously on full pay and it is (inaudible) precautionary measure. It is not a sanction in itself. And (inaudible) period.

…….. silence…….

MR O'BRIEN: I'm Shell-shocked. ~~(Pause)~~

…… silence……

DR WRIGHT: I appreciate that *……*

MRS O'BRIEN: I think there is no better person, you know, to process the thing than yourself. Nobody is going to be able to process what you need to do.

DR WRIGHT: And that (inaudible). We will have to see the extent. I am hoping that when we get the notes back this is a much smaller problem than it potentially could be. But currently I have up to 300 notes that are tracked out to you that can't account for. So I -- this could be quite a big problem or it could be a very small problem. I am hoping it

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National Clinical Assessment Service

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www.ncas.nhs.uk
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13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

Relevant regulations/guidance:

- Local procedures;
- General Medical Council Guide to Good Medical Practice;
- Maintaining High Professional Standards in the Modern HPSS (MHPS).

Review date:

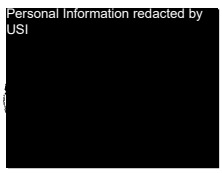
7 October 2016.

As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely



Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

DR WRIGHT: (Inaudible).

MRS O'BRIEN: -- you know, all that concern about the undictated things. You see that 189.

DR WRIGHT: If that's right --

MRS O'BRIEN: Not one of those patients -- there's nothing. There's nothing has happened. Nothing has happened.

DR WRIGHT: That's good. (Inaudible).

MRS O'BRIEN: And the thing about is that in March 2016 -- the exact same concerns were exactly the same in March 16 as they were in December 16. There's no difference. But suddenly it was (inaudible).

DR WRIGHT: I suppose from my perspective I had been probably naively assuming that in the interim period that Aidan and the management team had been working together to resolve a lot those issues. So it was a bit of a surprise when I discovered. And then once I realised they were still (inaudible) I can't know about this and not act. So I would accept it shouldn't have been there in that position. ~~(inaudible).~~ However, anyway, thank you for coming in to speak to me. I am glad we've had this conversation. Sorry I missed you earlier.

~~(Audio ends)~~

To: O'Brien, Aidan
Cc: Connolly, Connie
Subject: RE: SAI Reports
Importance: High

Dear Mr O'Brien

I have forwarded your response to the Corporate Office and I have been advised that [redacted] Patient 16 's report is to be reviewed by the end of today 30 October 2019, as the Trust is committed to having the report with the family in the immediate future.

Can you please review the 2nd report which you received by Wednesday 2nd November 2019.

Regards

Carly

From: O'Brien, Aidan
Sent: 29 October 2019 07:39
To: Connolly, Carly
Subject: RE: SAI Reports

Dear Carly,

I received your email yesterday evening.
I have not had time to read the attached reports in detail.
I have incompletely read one, finding a number of factual inaccuracies and untruths.

The main purpose of replying to you so early this morning is to enquire if you genuinely intended to request a response by tomorrow?
If so, why?

Thank you,

Aidan.

From: Connolly, Carly
Sent: 28 October 2019 15:58
To: O'Brien, Aidan
Cc: Connolly, Connie; Cardwell, David
Subject: SAI Reports
Importance: High

Dear Mr O'Brien

I attach for your attention a copy of the SAI reports into the care of [redacted] Patient 16 , [redacted] Patient 11 , [redacted] Patient 12 , [redacted] Patient 13 , [redacted] Patient 14 and [redacted] Patient 15 . As you were involved in these cases I would be grateful if you could read over the reports and confirm their factual accuracy. If you identify any inaccuracies I would be grateful if you would please report these back to me by Wednesday 30/10/2019.

Can you please confirm receipt of this email.

Many Thanks

From: Connolly, Connie
Sent: 04 November 2019 12:43
To: O'Brien, Aidan
Cc: Connolly, Carly
Subject: FW: SAI Reports
Importance: High
Sensitivity: Confidential

Dear Mr O'Brien
My name is Connie Connolly and I am Carly's line manager. After our weekly Governance with Melanie McClements this morning, I have been asked to contact your comments below in relation to both the Patient 16 and the joint report re: Patient 11, Patient 12, Patient 13, Patient 14 and Patient 15.
As you are aware, checking for factual accuracy is routine after the compilation of each SAI report. Given that you did not receive the reports until Wednesday 30th October 2019, the Trust requests that your comments are returned by 12 noon on Wednesday 13th November 2019. This provides you with sufficient time to peruse the reports. We are anxious to have the reports ready for both the families and the Ombudsman.
Regards
Connie Connolly

Connie Connolly
Acting Clinical Governance Co-ordinator
Office number [redacted]
Mobile Personal Information redacted by USI

From: O'Brien, Aidan
Sent: 30 October 2019 22:34
To: Connolly, Carly
Subject: RE: SAI Reports

Dear Carly,

When you sent me the below email this morning, I was about to complete consenting patients having surgery today.
I have been operating all day.
I left the hospital after 7 pm.
I have had a meal for the first time today, following which I have compiled the list of patients to be notified tomorrow of their admissions to DSU on 08 November 2019.
I have now just read any emails sent to me today, including yours!

I was advised in early 2017 that the management of Patient 16 would be the subject of a SAI investigation.
I respectfully find it most remarkable that, two and half years later, I would be sent a report of the investigation, accompanied with a deadline to respond within two days, and then to learn, after expiry of the deadline. that there is a commitment to share the report with the family of Patient 16 in the immediate future.
The report will require from me a considered response, and which I cannot provide until I have had the time to do so.

I believe any reasonable person would consider the above proposed timeline to be unreasonable.

Aidan.

From: Connolly, Carly
Sent: 30 October 2019 08:32

Comments concerning the RCA Report on Review of SAI [Personal Information redacted by USI]

In submitting this commentary regarding the RCA Report of SAI [Personal Information redacted by 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'etre 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, SAIs 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 consisted 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.

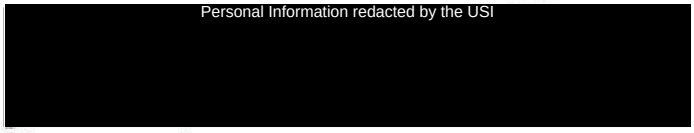
Conclusions

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.



Aidan O'Brien

11 December 2019