HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1	Description of Department of Urology and its teams	2017
2	Formal Investigation and Exclusion	2017
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

Mr OBrien is a member of the Urology MDM which meets every Thursday afternoon – radiologist, pathologist, oncologist, palliative care nurse and link in with Belfast.

2017 was very difficult for Mr OBrien as he was excluded as he was the subject of a formal investigation. This issues around him are still ongoing.

Actions Agreed

Mr OBrien will continue to participate in and chair urology MDMs on a weekly basis. The ongoing investigation is having a detrimental effect on his health and well being. It remains a difficult concern for Mr OBrien.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Department of Urology

The Department of urology at Craigavon Area Hospital has grown significantly since I was appointed as a single-handed consultant, assisted by half a Registrar, and with an allocation of four inpatient beds, in July 1992. I provided an unbroken, acute urological service until the appointment of a second consultant in 1996. The Department has had a compliment of six consultant urologists since 2013.

During the 25 years since 1992, there have been a number of developments which have expanded the complexity of the service provided, and the multidisciplinary team which provides the service. CURE (Craigavon Urological Research and Education) was founded in 1994, enabling the funding of research fellowships leading to higher degrees, the appointment of a lecturer in urological nursing at Ulster University, the establishment of academically accredited modules in urological nursing and the launch of the International Journal of Urological Nursing. I remain a Director of CURE.

Northern Ireland's only on-site ESWL (extracorporeal shock wave lithotripsy) service was launched at Craigavon Area Hospital in 1998. The Department established its own purpose built, one-stop, outpatient diagnostic service, the Thorndale Unit, in 2007. The Southern Trust Urological MDT was launched in April 2010. I was appointed its Lead Clinician in April 2012, and I remain a chair of the Urology MDM. Our Department was allocated responsibility for the provision of urological services to the population of County Fermanagh since January 2013.

The Department contains several teams, of consultant urologists as well as consultants in other specialties, particularly anaesthesia, radiology and oncology. I work with all of these in the furtherance of patient management. A team of clinical nurse specialists largely work in the Thorndale Unit, but supplemented by nurse specialists in palliative care and in the community. I work with the teams of junior doctors and nurses caring for inpatients at ward level, and particularly the Elective Admissions Ward and Ward 3 South. I work with the teams of anaesthetists, nurses, radiographers and orderlies to provide optimal operative care in theatre, and postoperatively in Recovery Ward, and in the High Dependency and Intensive Care Units when required.

I conduct a monthly clinic at Armagh Community Hospital, and similarly at South West Acute Hospital in Enniskillen. I particularly enjoy the latter, as it is particularly gratifying to be able to bring an outpatient consultation service to that part of Northern Ireland most distant from urological access, and where that distance is such a significant factor that some patients would not be able to access such a service otherwise.

Aidan O'Brien

Formal Investigation & Exclusion

In my last appraisal for the year 2016, I included the letter of the 23 March 2016 that had been given to me by Mr. Eamon Mackle, Associate Medical Director, and accompanied by Mrs. Martina Corrigan, Head of Service for ENT and Urology, who represented Mrs. Heather Trouton, Assistant Director, detailing their concerns regarding referrals which had not been triaged, outpatient review backlog, an allegation that there had been no record of consultations in patients' notes or on Patient Centre, and my having patients' notes at home. The letter requested that I respond with a commitment and immediately plan to address the concerns. I immediately asked what I should do. I was answered with a shrug of the shoulders.

I left that brief meeting wholly despondent, knowing that I would receive no support or assistance in addressing the concerns. I still remained Lead Clinician of Urology MDT, having responsibility for endeavouring to ensure that urological cancer diagnostic and therapeutic services were delivered to patients within the required timelines. In addition, I was daily conscious of the morbidity suffered by so many patients on our waiting lists, morbidity which was often acute and life threatening, requiring acute readmission to hospital with urosepsis as a consequence of the delay in elective admission for definitive surgical management. For that reason, I used every available operating session, undertaking 22 additional operating sessions during 2016 to endeavour to mitigate the risk to patients. I similarly conducted an additional 10 oncology review clinics for similar reasons.

During all of this time, I [redacted] in order to provide continued support to one of my consultant colleagues while he was urologist of the week. When he advised me that he had taken up an appointment in England, commencing in November 2016, I [redacted] I had also received the agreement of Mrs. Corrigan, Head of Service, to use my time of recovery at home to process and have patients' charts returned from my home. I did so by contacting all patients by telephone to update their clinical status, dictating letters to GPs and to the patients themselves. In doing so, I had scheduled all inpatient and day case operating for January 2017, and had my secretary schedule review appointments for the more clinically significant patients at clinics in January and February 2017. In doing so, I had processed two thirds of all the remaining patients.

I then received a call on 28 December 2016 to advise that the Medical Director wished to meet with me on Tuesday 03 January 2017. I advised that I would be unable to do so at the stipulated time at I would be operating. I offered to speak with him by telephone. However, I was advised that he required to meet me in person. I enquired whether he appreciated that I was still on sick leave. I was advised that he did. I offered to meet with

him on Friday 30 December 2016 instead. That offer was accepted. As I then wondered what the meeting could be about, I requested an agenda. On receipt of the agenda, and which included the advice that I could be accompanied for support, I became greatly concerned.

I attended the meeting, accompanied by my wife, on 30 December 2016 when I was advised that an Oversight Committee had decided that a formal investigation of my administrative practices be held, and that I was to be immediately excluded from the workplace for a period of time, and up to a maximum of four weeks. As I was subsequently to learn from the record of this Oversight Committee, and made available to me only in October 2018 after requests had been ignored since July 2017, this has been just one of the untruths perpetuated during the past two years, as the Oversight Committee had determined on 22 December 2016 that I should be formally excluded for the duration of a formal investigation, which took 18 months to complete, breaching the Trust's own guidelines in doing so.

The month of January 2017 was the most traumatic month for me in my lifetime. In pointing out that the Trust had breached its own Guidelines, a Case Conference was held on 26 January 2017 when it was determined that there was no need for continued exclusion, and that I could return to work, under the terms to be advised by Occupational Health. Whilst I was so pleased to be able to return to work, not least out of concern for patients, I was a difficult process.

Since then, any residuum of confidence which I had in the integrity of a number of senior personnel in the Trust has been completed demolished. Most importantly, any belief that I had in their claim that their conduct, actions and inactions had been guided by concern for the welfare of patients, has been completely eliminated.

This domain of Good Medical Practice has been one in which I have been widely acknowledged to excel in. Not a clinic ends without my having been thanked by patients and relatives for my explanation of their condition, their options of management and the manner in which it has been communicated. I do believe that I have always endeavoured to work collaboratively and respectfully with my colleagues whose support I have enjoyed throughout my career. I have had continuity of patient care a first priority, maintaining with them a partnership in their ongoing care, indefinitely. Most importantly, I have done so with honesty and transparency.

To then be subjected to an investigative process which has been lacking in honesty and transparency, and which has included fabrication, misinformation and prejudice, has been the most traumatic, disillusioning and demoralising experience of my 40 year career in medicine.

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
Resolution of the concerns raised in the letter of 23 March 2016	To cooperate with the Investigation of the concerns raised	I participated fully in the Investigation.
Continued Professional Development	To attend a Urological Conference	I attended the Annual Meeting of the British Association of Urological Surgeons in Liverpool in June 2018.

CLICK HERE **for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click** here.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**
To have a written expectation from the Trust of its expectations of me when urologist of the week	Memorandum of understanding of what is expected from the Trust.	Decemb. 2018
To have an clear, written understanding of the expectation of the Trust of the type of triage to be conducted, and when it should be conducted.	Memorandum. + to adhere to Trust Policy	Decemb 2018
Continued Professional Development	To attend EAU in Barcelona in March 2019	Decemb 2018
Use college template to record CPD	Use college Templ	

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

CURRENT JOB PLAN

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

I have attached the proposed Job Plan which was to come into effect on 01 July 2011, and for a period of one year. This Job Plan provided for a total of 11.25 Programmed Activity sessions. Following facilitation in September 2011, the total number of Programmed Activity sessions was increased to 12.75 until 28 February 2012, reducing to 12 thereafter (letter attached). The current Job Plan (attached) was proposed to come into effect on 01 April 2013, providing for a total of 11.275 Programmed Activity sessions. However, that Job Plan was predicated on 5 Consultant Urologists in post, and which has only variously been the case since 01 April 2013. As a consequence, the initial job plan of 2011/12 remains in effect. However, that job plan has not been reviewed or amended to take account of changes in work patterns which have since developed, such as all day clinic sessions at South West Acute Hospital (rather than a half day) once monthly, extended inpatient operating sessions once weekly, and the additional work required in chairing Urology Multidisciplinary Team meetings.

ADDITIONAL INFORMATION

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

The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is on ongoing cause for concern.

Notes of meeting 20-4-09
PI, AOB,CMcA, ND
Loughran office

Three related topics were addressed

1. Compliance with Trust Antibiotic Guidance, as set out in covering letter (attached).

Mr O B said that his personal experience would support the antibiotic use as he currently followed and he was not persuaded to adopt the Trust advice.
Dr Loughran felt that the Trust had circulated the guidance for comment and was anxious that the Urology team had not joined the consultation.
The evidence base of the guidelines especially as applied to Gentamycin was debated, and all agreed should be discussed separately.
Dr McA said many clinicians were reluctant to take advice in relation to long held beliefs and habits but the adoption of guidance and then measuring outcomes was the best way forward.

It was agreed that Dr D and some or all of the urology team will meet in the immediate future to agree the Guidelines as applied to urology. Dr L asked for the final agreement to be evidence based

2. The Trust has identified a cohort of about 30 patients who are admitted as elective cases for IV antibiotics and IV fluids as a prophylaxis for recurrent UTIs. The evidence base for this was described by AOB, and he described a study of outcome which was being prepared for publication.

3. The third related issue is the letter from Mrs C Hanna MLA to Mr M McGimpsey MLA asking for the above treatment to be made available at the homes of two patients.

Dr L agreed that he would contact the Commissioner (Dr Corrigan).

Note of a phone call M Young 21 4 09 at 4pm
PL explained the 3 issues and meeting 20 th April – views as lead clinician ??

Alternative to IV therapy is to wait till patients get clinical infection - quoted a patient who does very well and family are very keen to get prophylaxis.
"low bacterial count not 10 to the power 5 as required by Dr D etc"
Expects the evidence base is not there to support the therapy but clinical experience supports use.
He expects an independ inspection will not support the therapy but then patients will be unhappy.

Notes of a phone call to Dr Jean O Driscoll Microbiologist
1145 22 4 09
PL explained the situation as per meeting on Monday
PL explained that ND believes the IV therapy is inappropriate
ND describes the existence of oral prophylaxis, and the identification and treatment of symptomatic patients using cultures.

JOD agrees – she has never heard of the IV therapy used for prophylaxis – is familiar with the oral regimen. She has recently given a lecture on urinary infections and researched prior to that lecture. She will check with some colleagues in Bristol, look again at the literature, and send me a summary email.

Notes of call aob 22 4 09
6pm
Pl explained he had contacted jod and no backing for treatment
Aob said the rx was because of the cohort morbidity 18 cases – only evidence is our draft paper he agreed to look at converting some cases to orap proh
Pl asked if he would look at all cases for alternative treatments
Aob wants an in depth look at the cohort.. not just telephone contact with specialists

Southern Health and Social Care Trust

Medical Directorate

Memorandum

Our ref:	PL/lw	**Your ref:**	
To:	Dr Gillian Rankin, Interim Director of Acute Services		
From:	Dr Patrick Loughran, Medical Director		
c.c.	Mr Eamon Mackle, AMD for Elective Care/Surgery Division, Acute Roberta Wilson, Governance Lead		
Date:	2nd September 2010		
Subject:	Urology Services		

Dear Gillian

Since the end of March 2009 the Trust has been examining the practice of IV antibiotic and fluid therapy as a prophylaxis for recurrent UTI's. I have received expert advice from Mr Mark Fordham (an acknowledged expert from Manchester) and Dr Jean O'Driscoll Consultant Microbiologist in Stoke Mandeville Hospital.

As a result of the expert external opinions and following several meetings and related correspondence with Mr O'Brien and Mr Young, I met with the 2 Urologists on 4th August 2009. During this meeting the surgeons agreed:

a) to compile an accurate list of patients who were on the IV programme
b) that each surgeon would review the treatment regime for each patient
c) that a multi-disciplinary group would be convened to look at a treatment plan for each patient. The core of this treatment plan would be to convert the patient from IV to oral therapy or another non-intravenous treatment (review/watchful waiting ??).

On 7th August 2009 Dr Damani and I agreed that he would provide Microbiology support for point's b and c above.

In the intervening period I understand that there has been a significant reduction in the number of patients within the cohort. I had expected that the number of patients would be extremely small by now and that the patients with central venous lines or long peripheral lines would have had the lines removed. You, Mr Mackle and I met on Wednesday 1st September 2010 and discussed the progress of this matter.

It is of concern to me that the agreement as set out above has not been followed by Mr Young and Mr O'Brien. In particular I understand that there are at least 7 patients remaining on the IV treatment and that 2 (and possibly 3) have permanent intra venous access. We agreed that Mr Young and Mr O'Brien should be informed of the meeting on Tuesday and should also be informed that I remain concerned that <u>any</u> patient is receiving this intra venous treatment.

TRU-259410

Heather
Wo meets

Stinson, Emma M

From: Rankin, Gillian
Sent: 06 July 2010 18:34
To: Stinson, Emma M
Subject: FW: IV Antiobiotics IV Fluids update
Attachments: Patients who attend for IV Fluids.doc

From: Corrigan, Martina
Sent: Tuesday, July 06, 2010 6:34:27 PM
To: Rankin, Gillian
Subject: IV Antiobiotics IV Fluids update
Auto forwarded by a Rule

Dear Dr Rankin,

Please see attached update on IV Fluids and Antibiotic recent admissions. I checked with Shirley if any of these had involvement from bacteriology and she has advised:

These are the routine elective patients who are admitted and treated prophylactically irrespective of positive or negative culture results. To my knowledge the Consultants have not discussed ant of them with Dr Damanis team.

I hope this is the information that you need.

Kind regards

Martina

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

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

07/07/2010

Patients who attend for IV Fluids/IV Antibiotics

Mr O'Brien

Hospital Number	Name	Update 5 July
Personal Information redacted by the USI		Planned adm: 12 May-20 May *Insertion central line to have IV fluids and IV Antibiotics*
		Planned adm: 9 Jun-16 Jun *IV fluids and IV antibiotics*
		Planned adm: 10 Mar-12 Mar Planned adm: 18 Mar-19 Mar *IV Fluids and IV antibiotics pre and post conduioscopy*
		A&E Adm: 31 May – 10 Jun
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		Planned adm: 3 May – 7 May *Iv fluids and IV antibiotics*
		Admitted to Ambulatory day 26 Apr – 30 Apr 8 Jun – 12 Jun Due in 26 Jul – 30 Jul *Iv fluids and IV antibiotics*
		Attended Ambulatory day unit 26 Apr – 30 Apr 8 Jun – 12 Jun Due in 26 Jul – 30 Jul *Iv fluids and IV antibiotics*
		No recent admission
		Planned adm:10 Jun-14 Jun *Iv fluids and IV antibiotics*
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		No recent admission
		Planned adm cancelled no beds but Adm throu A&E on both occasions:

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES
Interim Director: Dr Gillian Rankin
Tel: Personal Information redacted by the USI

MEETING RE IV FLUIDS AND ANTIBIOTICS AND CYSTECTOMIES

Date: Thursday 9th September 2010
Time: 6.00 pm
Venue: Meeting Room, Admin Floor

NOTES FROM MEETING

1. Dr Rankin and Mr Mackle outlined the issue raised by Dr D Corrigan's letter (Commissioner) to Dr Loughran regarding the continued use of IV fluids and antibiotics for patients with recurrent UTIs. The statement in the letter that the use of central venous access for such therapy would be of serious concern was discussed.

2. A statement setting out a case review process chaired by Ms Sloan, Clinical Director of SEC, involving Dr Damani, consultant Microbiologist was tabled. Mr O'Brien stated that patients may become less well as a result of withdrawal of IV antibiotics. He agreed to remove the PICC line in a patient who is due to have surgery in 2 week's time. The process of case review will commence in the next few days, reviewing those with central venous access as a priority.

3. A pathway outlining the treatment of people with recurrent UTIs by oral therapy was tabled. The pathway outlines that if there is future consideration of IV fluids/antibiotics there requires to be a case review as outlined in paragraph 2 above.

4. The further issue raised by the Commissioner of the disproportionate rate of cystectomy undertaken in Craigavon Area Hospital was set out by Dr Rankin and Mr Mackle. A statement setting out the screening process which the Trust proposes to commence was tabled. The results will be made available to Mr O'Brien when the screening is complete.

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

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

From: Tedford, Shirley
Sent: 14 September 2010 16:01
To: Corrigan, Martina
Subject: IVfluids/IVatibiotics

Martina,

Further to our conversation regarding Personal Information redacted by the USI who Michael wanted admitted for IV Fluids and IV antibiotics. The patient was discussed with Dr Damani both by myself and Michael. He was informed that Personal Information redacted by the USI had attended with me 3 weeks ago for IV gentamycin but due to poor venous access it was administered Intramuscularly. The infection had not completely cleared and he was commenced on Oral prophylactic antibiotics by the Urology Registrar. He remained symptomatic at home and following a culture obtained on a further sample he was commenced on 7 day course of Trimethoprim. he remained symPtomatic and his last culture showed that his urine was sensitive only to Gentamycin and Augmentin. We were also concerned that Personal Information redacted by the USI renal function has detoriated since his last admission to CACU, and he has had an ultrasound scan arranged. The following instructions were issued by Dr Damani, as he feels the patient may have pyelonephritis

* Admit to Urology ward for IV Fluids and 14 day treatment regime of Gentamycin - Personal Information redacted by the should only have to remain in hospital for 4-5 days to recieve the IV fluids and the reamining days of IV gentamycin treatment regime can be given as an outpatient
* Send a repeat MSSU sample which is to be directed for the attention of Dr Damani
8 full assessment by medical staff

Regards

Shirley

Shirley Tedford
Urology Services Coordinator
Southern Health and Social Care Trust

Tel: Personal Information redacted by the USI
Bleep Personal Information redacted by
Mobile: Personal Information redacted by the USI

email: Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

Process to review all cases of people currently and intermittently receiving IV fluids and antibiotics for recurrent UTIs.

Steps required:

- Each patient who is currently on a regular or intermittent regime of IV antibiotics to have a case review, in order to agree a management plan which may require oral antibiotics but not IV antibiotics and not regular admission as an inpatient.

- The case review meeting will be chaired by Ms S Sloan, Clinical Director for Surgery & Elective Care, and minuted by Mrs M Corrigan, Head of Urology. The relevant urologist will present each case and Dr Damani, Consultant Microbiologist, will provide expert advice on appropriate antimicrobial therapy.

- If agreement cannot be reached for a particular patient on oral therapy, a further meeting will be held to involve Mr E Mackle, Associate Medical Director for Surgery and Elective Care, and involving the same team as before.

- Please note that there are unlikely to be circumstances accepted by the Commissioner or the Southern Trust where the use of IV fluids and antibiotics is an evidence based or acceptable treatment for a patient with recurrent UTIs.

9th September 2010

Southern Health and Social Care Trust

Quality Care - for you, with you

Urology Pathways

Recurrent Urinary Tract Infections

Step 1 Nurse Led Service

Urine cultures- frequency to be determined by Consultant Nurse to obtain and monitor results and liaise with Consultant regarding any change to pathway including frequency of sample.

Oral antibiotic regime prescribed and altered by Consultant Urologist as per culture with input when necessary from Bacteriology

Step 2

If the symptoms cannot be controlled through Step 1, a case discussion is required involving:

- Consultant Urologist
- Consultant Microbiologist
- Specialist Nurse
- Clinical Director for Surgery and Elective Care

Under no circumstances is central venous access to be used for treatment of recurrent UTIs.

9th September 2010

ANNUAL APPRAISAL 2010 MR. AIDAN O'BRIEN

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on **Form 3** and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary:

Aidan qualified in 1978, holds full GMC registration and has been in the same Consultant Urologist post since 1992. He is a Fellow of the RCS in Ireland, and is a member of several general and urological societies. Description of his job reflects a broad urological practice. This includes MDM oncology involvement and a special interest in lower urinary tract dysfunction. Current rota is 1:3. The population base covered is geographically wide, and hence patients are from both urban and rural backgrounds.

A log of individual list of operations performed for 2008, 2009 and 2010 is impressively long, defining a constant and hard working pattern.

No formal complaints nor critical incidents are logged by the Trust. The Trust however has had discussions with reference to patients being treated with IV fluids and antibiotics. This has been satisfactorily concluded.

An audit of prostate biopsy outcomes is recorded. Several of the hospital mandatory courses have been attended.

Action agreed: For next appraisal

- log of total volume of outpatient activity, day cases and operations.
- audits in current time frame
- log Defence Organisation
- formally log mandatory courses

8. Any other points

Aidan is the Principal Investigator at Craigavon Area Hospital of an international study into a new drug treatment for Angiomyolipoma (Ref 09/H0502/82).

IV fluids/Antibiotic issue

Aidan has regarded the changes resulting from the ward reconfigurations of 2009 as particularly disruptive, since it had taken many years to build and had predicted the deleterious effects of such changes. Eventual restoration to a definitive urology unit has been a very important point, and for the Trust to recognise this precise point.

A further major change in practice has been the centralisation of radical pelvic cancer surgery imposed by the Department of Health. This has resulted in the loss of this provision at Craigavon Area Hospital, and negative consequences for patients. There is general discontentment in the decision making process conducted by the recent Regional Review of Urology. Aidan has concerns that this will have significant knock on effects for services in the area in the future.

Action agreed:

IV fluids/Antibiotic issue has been improved by a new care-pathway defined by the Trust.

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 15 June 2011 16:33
To: O'Brien, Aidan; [redacted]'; Rankin, Gillian; Walker, Helen; Trouton, Heather
Subject: Antibiotics and Urology Patients

Dear Aidan

I am seriously concerned that you don't seem to recall our conversation at the meeting last thursday. At that meeting I informed you that if you wanted to admit a patient for pre-op antibiotics or for IV fluids and antibiotics that a meeting had to be held with Sam Sloan and a microbiologist and that this prerequisite was non negotible. You have also been given this in writing following a previous meeting with Dr Rankin and myself.
I now find that you initially planned to admit a patient this week without having discussion with anyone and then when challenged you only spoke to Dr Rajesh Rajendran.
Would you please provide me with an explanation by return.

Eamon Mackle
AMD

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 30 January 2012 15:08
To: Stinson, Emma M
Subject: FW: IV Antiobiotics

From: Mackle, Eamon
Sent: Monday, January 30, 2012 3:08:01 PM
To: Hall, Sam
Cc: O'Brien, Aidan; [redacted]; Corrigan, Martina; Rankin, Gillian
Subject: IV Antiobiotics
Auto forwarded by a Rule

Dear Sam,

I have been advised that a patient [redacted] may have been admitted last week to Urology by Mr O'Brien and under his instruction was given IV Antibiotics the latter necessitating a central line to be inserted.

I have checked with Dr Rajendran and he advises me that no discussion took place prior to the administration of the antibiotics.

I would be grateful if you could formally investigate this and advise me of your findings.

Many thanks

Eamon

Willis, Lisa

From: Trouton, Heather
Sent: 15 July 2013 09:02
To: Corrigan, Martina; Mackle, Eamon
Subject: FW: For info: Antibiotic Ward round summary
Attachments: June summary UROLOGY.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Martina and Eamon

Please see below and attached.

Heather

From: Boyce, Tracey
Sent: 05 July 2013 11:18
To: Trouton, Heather
Subject: FW: For info: Antibiotic Ward round summary

Hi Heather
Mr O'Brian seemed to have another patient on gentamicin this month with no evidence of infection – I am sure Anne has the patient's details if you want to look at their reason for admission further.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

Personal Information redacted by the USI

From: McCorry, Ann
Sent: 05 July 2013 08:33
To: Connolly, David; Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc: Corrigan, Martina; Trouton, Heather; Damani, Nizam; Boyce, Tracey; Muckian, Donna; Collins, Cathal
Subject: For info: Antibiotic Ward round summary

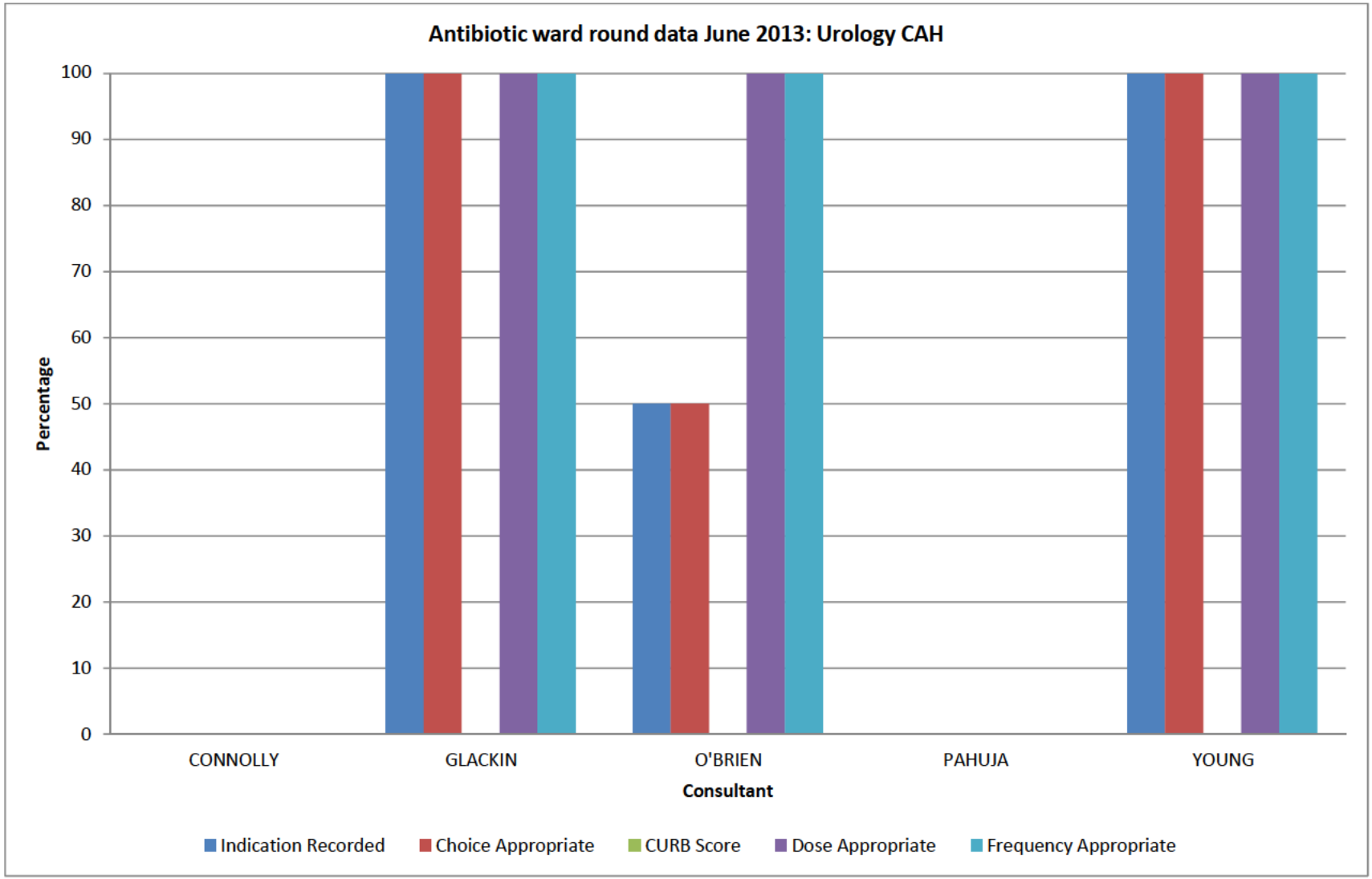
Hi All,

Please find attached the antibiotic ward round summary for June.

Kind regards
Ann

Ann McCorry

Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: [redacted] / Mobile: [redacted]



SUMMARY: Ward rounds conducted on 11th & 25th June.
8/18 patients on antibiotics

Received from SHSCT on 02/02/2022. Annotated by the Urology Services Inquiry.

- Connolly: No patients.
- Glackin: 1 patient. CURB score n/a.
- O'Brien: 2 patients. CURB score n/a.
    - **Indication not recorded and compliance not assessable in 1pt:**
        - 1pt on IV gentamicin 240mg OD, no documentation of antibiotics in notes, no documented evidence of infection.
- Pahuja: No patients.
- Young: 5 patients. CURB score n/a.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

asked my legal representative to provide to the USI the details of the three patients I saw so that the USI can consider their cases. I provide a very brief summary below to try to illustrate the issues (the references to Patients 1, 2 and 3, and the text in square brackets are my attempts to ensure anonymity for the patients concerned):

Patient 1

I. Patient 1 was referred to CAH by a GP in June 2010 with haematuria. They underwent TURBT in July 2010 in CAH; histology sarcomatoid bladder cancer with CT scan demonstrating no metastatic disease. The presence of high grade aggressive sarcomatoid bladder cancer should have triggered immediate discussion about cystectomy irrespective of there being no detrusor muscle in the specimen. However, the patient underwent another TURBT in August 2010 which confirmed the same pathology. The patient also had a bone scan in August 2010 which was also negative (bone scan is not a recommended investigation for bladder cancer). The patient was then readmitted to CAH in September 2010 and had another CT scan which demonstrated regrowth of the tumour at which point a decision was made to proceed with cystectomy in Craigavon at the end of September 2010. In Mr O'Brien's letter to the GP he wrote:

> *"As you are now aware, a decision was made by officials in the Department of Health, in conjunction with the Commissioner, to cancel [Patient 1] admission and to have his further management transferred to Mr Hagan, Consultant Urologist at Belfast City Hospital, and with whom I gather that an appointment has been arranged for [date] September 2010. [Patient 1] and [their] family have been gravely distressed by the cancellation of [their] admission. [Patient 1] is suffering gravely from severe lower urinary tract symptoms. I do hope that [their] further management can be expedited as soon as is possible."*

Mr O'Brien further wrote to the patient:

"*Dear [Patient 1]*

I write to express my deepest regret that I was not permitted to proceed with your admission to Craigavon Area Hospital on [date] September 2010 as had been planned. I entirely acknowledge your continued suffering and the urgency with which you deserved to have your suffering relieved. I also entirely acknowledge the additional distress that the cancellation has inflicted. I do hope that your management under the care of Mr Hagan, Consultant Urologist at Belfast City Hospital, will take place as soon as is possible."

I assessed the patient on 27 September 2010 following discussion at the regional Multi-Disciplinary Meeting (MDM) and admitted the patient to BCH that day for surgery. The surgery was to take place the following week. Surgery was uneventful and the patient is alive today. It must be noted however that there was an unnecessary re-resection of the tumour in CAH and unnecessary investigations which delayed definitive treatment.

Patient 2

II. Patient 2 was admitted to CAH in July 2010 and had TURBT, pathology of which demonstrated muscle invasive bladder cancer obstructing the right kidney. CT demonstrated extensive lymphadenopathy – inguinal, iliac, para-aortic and mesenteric that would suggest metastatic disease. The patient was then scheduled for another cystoscopy at the end of August 2010. It is not clear what the rationale was for that. The patient also underwent a bone scan, the reason for which is unclear. Mr O'Brien wrote to the patient's GP at the end of September 2010:

"I had intended to proceed with [Patient 2] admission to our department on [date] October 2010 for right nephroureterectomy,

to have [their] surgery at Craigavon Area Hospital, but instead that [they] would be referred to Mr Hagan, Consultant Urologist at Belfast City Hospital, and with whom I believe an appointment has been arranged for [date] September 2010. [Patient 3] was advised of this decision on [date] September 2010. When I contacted [them] by telephone subsequently, I found [them] to be most distressed by this decision. I gathered from [them that [their] greatest fear was that Mr Hagan would not agree to [them] having a cystectomy performed.

I advised [Patient 3] that we had reviewed [their] case at our multi-disciplinary meeting on [date] September 2010, and when it was agreed by my colleagues here that the optimal form of management would be cystectomy and ileal conduit urinary diversion, followed by adjuvant chemotherapy, and for all of the reasons previously detailed."

Mr O'Brien also wrote to me on the same day:

"I enclose recent correspondence pertaining to this [age] [Patient 3], who has muscle-invasive, poorly differentiated, transitional cell carcinoma of [their] urinary bladder, and which has undergone squamoid differentiation, and which is associated with several, small volume, bilateral pulmonary lesions, and which are probably metastatic. [They are] particularly keen to proceed with cystectomy and ileal conduit urinary diversion as soon as is possible, as [their] bladder is particularly troublesome, even though [they have] an indwelling urethral catheter, and so that [they] may proceed with adjuvant chemotherapy thereafter.

I do believe that it is important to advise you that [Patient 3] has been [personal circumstances] for some years. [They have a

Personal Information redacted by the USI

[They] lives alone, though does have the support of friends. [They]

would have much preferred to have [their] surgery here at Craigavon Area Hospital and will find the prospect of surgery at Belfast City Hospital all the more detached from [their] tenuous support base. However, even more importantly, [their] present dread is that you would not agree to proceed with cystectomy. I do hope that you will agree to do so. I dread to think of the distress, if you were not to agree."

This assessment contrasted with the CAH MDM discussion at the end of September 2010. Dr McAleese had seen the patient by the date of the MDM in September 2010, commenced Patient 3 on steroids and deemed them unfit for any treatment at that stage. Dr McAleese had planned to review Patient 3 in two weeks.

I also met the patient at the end of September 2010 to discuss their treatment options. Their bladder symptoms were better controlled but unfortunately they had lost a considerable amount of weight, suggestive of systemic metastatic disease. At the meeting with the patient, I explained that the unanimous decision of the regional MDM, given the presence of quite extensive pulmonary metastatic disease, was that palliative chemotherapy was the best option and I explained that unfortunately their bladder cancer was not curable.

Unfortunately, the patient's bladder cancer progressed rapidly and they died in the early part of 2011. Given their poor performance status in the context of metastatic bladder cancer it was my view, supported by the regional MDM, that cystectomy was not appropriate. This is a very major operation that takes many months to recover from and by subjecting a patient to this in the last months of life with no benefit (and likely detriment) I considered to be poor judgement. I have worked as a cystectomy surgeon for 17 years in the regional unit and saw very few patients who may have benefited from palliative cystectomy. In patients in this situation, with intractable urinary symptoms, often a catheter or

Southern Health and Social Care Trust

Interim Director of Acute Services
Administration Floor
Craigavon Area Hospital

27th September 2010 Ref: GR/pl/lw

Mr A O'Brien
Consultant
CAH

Dear Mr O'Brien

I am in receipt of correspondence in relation to 3 patients. In each case you have written to the patient, the General Practitioner and Mr Hagan Consultant Urologist in Belfast City Hospital.

Each of these patients has been transferred to the City Hospital for further management by Mr Hagan. I understand that you expected and wished to carry out this surgery yourself in Craigavon Area Hospital, but following contact from our Commissioner the Trust was obliged to refer the patients to Belfast.

It is of great concern that you have indicated to a patient, (in advance of a care pathway being agreed) your preferred management of the case. I believe that this puts inappropriate pressure on the receiving team and is regrettable. I understand that the transfer of these patients, with whom you may already have formed a good therapeutic relationship, was somewhat unexpected.

There is another difficult area which we are currently examining – the intravenous therapy (IVT) cohort. Since we have internal agreement that the future care pathway of these patients will be subject to a multi-disciplinary decision I do not want you to write to any of these patients individually. Any outcome of the multi-disciplinary team should be "signed off" by that team and only an agreed communication sent/provided to each patient.

Please acknowledge your agreement by return.

Yours sincerely

Personal Information redacted by the USI

Dr Gillian Rankin
Interim Director of Acute Services

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Fax No Personal Information redacted by the USI Email Address Personal Information redacted by the USI

<ray.hannon[redacted]>
Subject: RE: urology patients - confidential

Tony and Ray,
Whilst the letters sent about these patients were unhelpful, I think it misses the point with these patients and the governance issues that have been raised.
To put in a wider context, in 2002 NICE issued guidance (improving outcomes in urological cancer, IOG) specifically stating that surgeons performing <5 pelvic cancer operations / annum (radical prostatectomy and radical cystectomy) should cease. Furthermore, units performing less than 50 / year of these operations should cease immediately. In addition, there was firm guidance that all new urological cancers should be discussed at an MDT that comprised urologists, oncologists, radiologists, pathologists and CNS.
Outside Belfast, NI was slow to adopt these changes due primarily to a combination of hubris and ignorance. However, in 2007/8 with the establishment of NiCAN, NICE recommendations were largely adopted here. Since then, all hospitals bar Craigavon have referred patients to BCH for radical pelvic surgery as we are the only unit treating a population >1M and carrying out approx 80 – 90 procedures per annum. CAH still does not have a properly functioning MDT and has refused to engage with the regional MDM at BCH (all other hospitals either tele-link or attend in person). In the last 2 years, CAH have performed < 10 urological pelvic cancer operations / annum.
The Northern Ireland review of Urology signed off by the Minister of Health further cemented this guidance by stipulating that from March 2010, all urological pelvic cancer surgery should be performed in BCH. Despite this, these 5 patients were the first to be referred to BCH.
Before I saw these 5 patients, they were all discussed at the regional MDM; present were 3 urologists (Hagan/ Keane/ Rajan), 3 oncologists (Harney/ Stewart/ Mitchell), 2 radiologists (Grey / Vallely), 2 pathologists (O'Rourke/ Grey) and 1 CNS (Kelly). There was considerable variance with the management plans proposed by Craigavon Urologists and I think this is where the governance issue lies.
Patient 1. [redacted]. This [redacted] year old [redacted] presented with metastatic bladder cancer and obstructed left kidney. The standard of care in this case would be relief of urinary obstruction followed by palliative chemo. The Craigavon urologist was proposing primary surgery (cystectomy) and chemo after. Reference to a properly constructed MDT would have prevented this error. This patient was admitted to BCH [redacted], had nephrostomy today and is due to commence palliative chemo next week. It is highly likely that surgery has no role to play in this [redacted] palliative care.
Patient 2 [redacted]. This [redacted] year old [redacted] presented with bladder cancer and extensive retroperitoneal nodal disease. The standard of care would be neo-adjuvant chemo and if there is a satisfactory response, then proceed with either surgery or radiotherapy. The Craigavon urologist was proposing primary surgery (cystectomy) and it would appear from the notes that there was not an appreciation of the extensive nodal disease. Again, reference to a properly constructed MDT would have prevented this error. This [redacted] is to see the oncologist in BCH this week and will hopefully start chemo next week.
Patient 3 [redacted]. This unfortunate [redacted] was diagnosed with a highly aggressive sarcomatoid bladder tumour in [redacted]. At that stage [redacted] should have been offered cystectomy as soon as possible. For some unknown reason, [redacted] was brought back for a second endoscopic resection towards end July / early August by which time the tumour was found to have increases in size. [redacted] remained very symptomatic during August and September and was given a date for cystectomy in CAH [redacted]. It was not clear to the regional MDM why this [redacted] had not been offered definitive surgery sooner and reference to a properly constructed MDT would have prevented this error. [redacted] is having definitive surgery tomorrow.
Patient 4 [redacted]. This [redacted] has low – intermediate risk prostate cancer and was due to have radical prostatectomy last week in Craigavon. [redacted] operation was cancelled and [redacted] has been in contact with media. There is no issue with the treatment offered. When I met [redacted] on Monday I was going to offer [redacted] a date for surgery [redacted]. However as is customary with patients with prostate cancer there are many options for treatment and after discussion [redacted] has chosen to explore brachytherapy.
Patient 5. This [redacted] has low – intermediate prostate cancer and had been scheduled for radical prostatectomy (no date in CAH). There is no issue with the treatment offered. However, [redacted] is overweight, type II DM, and has had previous endoscopic prostate surgery that would make a radical prostatectomy technically more difficult with poorer outcomes by all measurements (continence, cancer

HSC Public Health Agency

South Office
Tower Hill
ARMAGH
Co Armagh
BT61 9DR

Tel : [redacted]
Fax :
Web Site : www.publichealth.hscni.net

Dr P Loughran
Medical Director
Southern Trust HQs
College of Nursing
68 Lurgan Road
PORTADOWN
BT63 5QQ

CONFIDENTIAL

1 September 2010

Dear Dr Loughran

In the context of the Urology Review implementation process, I was present at a recent meeting with Trust staff to discuss progress. I had already noted from the written submission that there appeared to be a high proportion of elective urology episodes at CAH which did not have an operative procedure. This is being explored further, but in a brief discussion with the Clinical Director for Surgery it appeared that the practice of some urologists of admitting patients for intravenous fluids and antibiotics as a treatment for chronic urinary tract infections has not ceased. If I understood the position correctly, some patients may now be receiving this treatment via central lines. I would be very concerned if this was the case. I forwarded to Mr Mackle the email correspondence to your secretary which set out my opinion on this practice back in January. I had assumed steps were being taken to bring this to an end.

Following the recent meeting I re-read the external expert reports relating to the use of IV therapies at CAH (Appendices of the draft document I was asked to comment on last January). There was one sentence which read "Whether these patients have been well served by the major bladder surgery they have undergone is difficult to say as the records do not include the original letters leading up to the surgery." In the context of my unease at the ongoing use of a treatment at CAH which had not been supported

CYSTECTOMY CASES UNDERTAKEN FOR BENIGN URINARY CONDITIONS, SOUTHERN TRUST OF NORTHERN IRELAND.

MARCUS DRAKE, SENIOR LECTURER, UNIVERSITY OF BRISTOL

I am currently practicing as a Consultant Surgeon at the Bristol Urological Institute, Southmead Hospital, Bristol, UK. I subspecialise in Female and Reconstructive Urology, Neurourology and Urodynamics. I am Senior Lecturer in Urology at the University of Bristol, and Visiting Professor in Health and Applied Sciences at the University of the West of England. I am Chairman of the International Continence Society Standardisation Committee and of the Urogenital Specialty Group in the UK's Comprehensive Clinical Research Network. I am Editor of the BJU International Website, and a member of several journal Editorial Boards. I undertook my medical training at the Universities of Cambridge and Oxford and was awarded my Doctorate Thesis by the University of Oxford, studying the physiological effects of spinal cord injury on the human bladder. I have written several publications in peer-reviewed journals.

A brief review of medical records was undertaken to ascertain the key issues relating to the decision processes leading up to cystectomy. This should not be taken as a comprehensive evaluation, in view of the limited time available to me. Below are presented the key features derived from the notes and my opinion relating to management of the patients on whom I was asked to comment

PATIENT [redacted]

Cystectomy Date: 28 July 2010

KEY FEATURES FROM NOTES

Dr Lamont, Consultant Psychiatrist, saw her on 12 March 2008 concluding that there was no evidence of major mental illness. She had been reviewed in the context of a planned urostomy and the overall conclusion appears to support that psychologically, this would not be inappropriate.

Urodynamic studies 23 March 2010. alluded to showing bladder hypersensitivity and detrusor hypocontractility.

Operation note 23 September 2009. Admitted for elective procedure of hydrostatic bladder dilation and mucosal biopsies 23/9/10. Background of recurrent bladder infections for several years. Treated for vesicoureteric reflux (including a reimplantation). Diagnosed with chronic interstitial cystitis. Problems passing urine – self-catheterising, some dysuria.

25th March 2011

Personal Information redacted by the USI

OPINION

I was unable to undertake a sufficient review of this lady's notes.

8.1 Diagnosis of interstitial cystitis needs to have some objective confirmation to describe pain scores, reduced functional bladder capacity (i.e., low maximum void volume on frequency volume chart), and endoscopic procedure in which the bladder was distended to ascertain its maximum anaesthetic bladder capacity- including visualisation to observe the emergence of an ulcer or post-distention glomerulation.

CONCLUSIONS

9.1 The majority of cases appear to have been managed with compassion and consideration

9.2 The cases in general appear to have been supportable clinical grounds.

9.3 The documentation is insufficiently comprehensive, and in order to warrant proceeding to cystectomy, clear description of the following is needed; severe pathology, substantial functional impairment and impact on quality of life, attempts to undertake conservative measures, discussion of risks involved.

9.4 More comprehensive review of notes may identify documentation addressing some of the points in 9.3

9.5 An issue that stands out is failure to plan for possible voiding dysfunction in a lady receiving bladder botulinum injections who was averse to catheterisation.

9.6 Inpatient management of infection as seen in one of the cases should be undertaken in the context of specialist input from a multidisciplinary team including microbiology

Personal Information redacted by the USI

Mr Marcus Drake, MA (Cantab), BA, BM, BCh, DM (Oxon), FRCS (Urol).

Consultant Urological Surgeon, Bristol Urological Institute

HEFCE Senior Lecturer in Urology, University of Bristol

Visiting Professor, University of West of England.

saved at least a month, but would welcome your clinical view as to what should have happened post original resection and pre specialist MDT discussion before we decide on how to proceed.

Thanks
Davinia

From: Hagan, Chris
Sent: 22 June 2016 10:01
To: Lee, Davinia
Subject: RE: query

Sorry its: Patient 127
chris

From: Lee, Davinia
Sent: 22 June 2016 09:13
To: Hagan, Chris
Subject: RE: query

Hi Chris

We can't find anything for patient Personal Information redacted by the USI on CaPPS or ECR – is the HCN definitely correct? What is the patients name?

Thanks
Davinia

From: Hagan, Chris
Sent: 21 June 2016 16:24
To: Lee, Davinia
Cc: Crawford, Jena
Subject: query

Davinia
I'm very concerned about delays in ITT from Craigavon and how we raise this – is it possibly an interface SAI?

patient Personal Information redacted by the USI muscle invasive bladder cancer.
Original resection16.02.206 with multiple local MDT discussions before a regional discussion 09.06.2016 and I see her today 21.06.2016. In my view there are multiple avoidable delays which will potentially lead to an adverse outcome – she is not fit for cystectomy today.

Contrast this with an exemplar. Patient Personal Information redacted by the USI TURBT 25/05/2016 in Derry. Muscle invasive bladder cancer; discussed regional MDT 09/06/2016 and seen today with radical surgery next week.

What do you think?

happy to discuss

Chris

AOB10

MailMeter

Message ID - 98b2777eeb5d4efabe32a36308cf1a29 - 203615745
Archived on 26/08/2016 12:19:54. Printed on 18/05/2023 05:51:20.

Time Sent	26/08/2016 12:19:39
Time Received	26/08/2016 12:19:39
Time Archived	26/08/2016 12:19:54
From:	mitchell, darren < [redacted] >
To	aidan o'brien [redacted]
CC	mcveigh, shauna [redacted]
Subject:	Case for review
Attachments	Patient 127 [redacted]pathway.xls 33.0 KB

Aidan – this was one of the bladder cases flagged up from the review of timelines for muscle invasive bladder cancer – I think she has been seen by Chris Hagan and was deemed unfit for surgery.

We' ll review it here and I suspect you' ll want to do a case note review there and see if there is any shared learning from it either regionally or locally?

Thanks

DMM

Dr DM Mitchell FRCR
Consultant in Clinical Oncology
Northern Ireland Cancer Centre
Belfast City Hospital
Lisburn Road
Belfast BT9 7AB

☎ - [redacted]
✉ - darren.mitchel[redacted]
Secretary - elizabeth.burgess[redacted]

would come back with the relevant information. So it was both a backup, but it was also to see if the relevant pathway information from the Southern Trust could be generated and examined."

(i) What do you understand the reason to have been for copying you into the email? Was it anticipated that you would do anything as a result?

1.01 I fully understand the reason for being copied into the email: when a matter arises regionally I would expect to be copied in, and I am included in quite a few of the emails.

1.02 However, with regards to this email I do not recall reading it or having any knowledge of it. It was only brought to my attention when I received an email from Martina Corrigan on 15th September 2023, including the attached email about the patient in question. I may have read the email at the time and overlooked it but I can't recall for certain, as it was 7 years ago. The email was regarding the timeline for a patient with muscle invasive bladder cancer and the reason for the delays, to see if anything could be learnt from this case.

1.03 Martina had emailed me again on Monday 18th September, asking me to give her a ring, I don't work on a Monday, so I didn't see the email from Martina, (I had logged on to check my emails at 5 that day) and I emailed Martina back to advise I could not shed any light on this case.

1.04 On checking through my emails I couldn't find anything, I checked the patient's pathway on CAPPS and couldn't see any diary comments added in relation to this email, which is what I normally would do in this case, and I would have highlighted the matter to the MDT team (Consultants and the Chair of meeting) and include my line manager so it could be escalated further.

1.05 This matter would have / should have been brought up for noting at MDT meeting to highlight the delay and the issue and see what could be done differently.

(ii) Do you know what was the response, if any, to the email?

1.06 I do not know the outcome or response to this email, if there was any, as I have no recollection of receiving the email. Usually I would have actioned it and taken the above steps .

(iii) Did you do anything as a result of being copied into the email and/or as a result of your knowledge of the concerns raised in it? If so, please provide full details. If not, please explain why not.

1.07 I did not action this email and I do not recall reading it, it was only brought to my attention when Martina Corrigan telephoned me about it. This would not be the case now for emails, as we have a generic cancer tracking email address for each of the tumour sites. In my role I am aware of the need for a quick turnaround for patients diagnosed with muscle invasive bladder cancer. They have to be discussed locally at MDT and added for regional discussion the following week to move their pathway forward.

(iv) Please provide any further comments you may have in response to Dr Mitchell's observations.

1.08 I agree with Dr Mitchell's observations and understand why I was included in the email. This email should have triggered a response, feedback from ourselves. (With this being Mr O'Brien's patient, he should have taken the matter further, but I received no correspondence from him in connection with this patient). I am unsure if there were any emails from Mr O'Brien regarding this patient that I was not included in.

4 SUMMARY OF CASE

4.1 Description of Incident

This RCA needs to divided into separate sections
(1) the episode of care associated with Patient 95 's initial urological surgery 15th July 2009 and
(2) the admission from the 6th July – 21st July – ending with Patient 95 requiring a laporatomy on the 21st July 2010

Episode 1

Patient 95 initially presented electively to CAH for investigation of frank haematuria over the previous 2/3 months. Patient 95 had a cystoscopy on the 14th June which revealed a large bladder tumour which was resected. Patient 95 was discharged on the 25th June to return on the 13th July for planned elective surgery (right nephro-ureterectomy, anterior pelvic exenteration and ileal conduit urinary diversion) on the 15th July 2009.

Patient 95 went for surgery on the morning of the 15th July 2009. Patient 95 surgery commenced at approximately 10.20hrs and finished at approximately 15.45hrs (over five and a half hours). It is recorded that the operation on the 15th July was unremarkable. Blood loss was estimated to be 2 litres. Surgery was performed by Mr 1.

Patient 95 was admitted from theatre electively to ICU where she remained for 5 days. Patient 95 was then transferred to a surgical ward, where her recovery was uneventful and discharged home on the 25th July 2009.

Patient 95 attended the histology Outpatient's clinic CAH 5th Aug 2009 with a plan to have a surveillance CT in 3 months (undertaken 1st October 2009, STH) and review OPD appointment in 4 months **(this appointment never happened).**

Episode 2.

Patient 95 attended CAH A&E on the 6th July 2010 with a two week history of abdominal pain initially under the care of Dr 1 (consultant gastroenterologist).

7/7/10 - Plain Film abdominal X-ray
8/7/10 - Plain Film abdominal X-ray
9/7/10 - CT scan.

9/7/10 - Patient 95 transferred to care of surgeons

10-12/7/10 Recorded that Patient 95 condition improved over the next couple of days - vomiting stopped and Patient 95 able to mobilise around the ward.

12-7-10 – Patient 85 discharged 14.00hrs

14-7-10 Patient 95 readmitted with abdominal pain to 4N at 18.10hrs
14-7-10 transferred to 1 South @ 23.20 with cough.

16/7/10 (Friday) - Plain Film abdominal X-ray – reviewed Dr 2

6 ANALYSIS

This section of the report summarises the analysis conducted during this investigation, which has been complied from a review of the materials generated as a result of the activities outlined in Sections 5.1 to 5.3 of this report. The analysis contained in this report focuses in detail on the immediate postoperative period. The analysis undertaken supports the conclusions reached by the investigation team and the recommendations identified in Section 7 of this report.

The primary issue in this incident is clearly the retention of a swab following surgery. Although the surgeon is ultimately responsible for what happens during surgery the responsibility for ensuring that the swabs are correctly counted prior, during and at the end is delegated to the scrub nurse. The outcome of the inquiry on this occasion highlighted the count was not correct. Because this was a long procedure there was a change of Scrub Nurse and it is unclear from the record which of the scrub nurses was responsible when the error was made. In addition the method of counting the swabs when a swab is left in the patient's cavity was not standardised across all theatres. The method used on that day in that theatre is unclear.

The second issue was the delay in diagnosis; There was a three-month follow up CT Scan of abdomen performed on the 1st October 2009. A diagnosis of retained swab was not made on this scan but the reporting consultant radiologist described a mass measuring 6.5cm in the region of the right renal bed. The differential given for this mass included a seroma or local recurrence. The high-density areas within the mass lesion were described as multiple surgical clips.

Although a diagnosis of a retained swab was not made on the CT Scan report a pathological abnormality was described, however this report was not seen by the consultant urologist as it is his routine practice to review Radiological and Laboratory reports when the patient returns for post-operative follow up. The planned four-month follow up never took place due to the waiting times for review at Outpatients.

Patient 95 subsequently presented and was admitted medically on the 6th (discharged on the 12th when eating and drinking normally) and again on the 14th with symptoms of sub-acute bowel obstruction. A further CT scan of abdomen was performed on the 7th July 2010. This was reported by the same consultant radiologist as showing an unusual appearance to a loop of colon within the pelvis that contained faecalent material and intraluminal linear high-density material suggestive of surgical clips. The reporting consultant radiologist and a consultant physician reviewed this scan and the diagnosis was of small bowel loops in the pelvis and a possible adhesion. She was discharged following surgical review and resolution of symptoms on the 12th July 2010.

Patient 95 was readmitted medically on the 14th July 2010 with cough and green sputum for 24 hours. On the 16th July abdominal x-rays were reviewed by the Surgical SHO on call and noted no obvious obstruction.

She continued to have episodes of vomiting. A further surgical review by Dr 2, a Surgical Core Trainee was undertaken on the 19th July at 03.00 again regarding evidence of obstruction. There was no evidence of same initially, but he felt that there was evidence of a foreign body within the pelvis aside from surgical clips

I will need assistance when replying to this email.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

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

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

Martina,

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

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

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

Aidan.

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

Please see below for your information and action

Thanks

Martina

Martina Corrigan

Head of ENT and Urology

Craigavon Area Hospital

Tel: Personal Information redacted by USI (Direct Dial)

Mobile: Personal Information redacted by USI

Email: martina.corrigan@ Personal Information redacted by USI

From: Trouton, Heather

Sent: 25 July 2011 15:07

To: Reid, Trudy; Devlin, Louise; Corrigan, Martina

Cc: Mackle, Eamon; Brown, Robin; Sloan, Samantha

Subject: Results

Dear All

I know I have addressed this verbally with you a few months ago , but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them.

Southern Health and Social Care Trust

APPENDIX 4

Revised November 2016 (Version 1.1)

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

SECTION 1

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

9. SUMMARY OF EVENT:

Patient 90 was admitted to Craigavon Area Hospital (CAH) on 09 May 2018 for elective urology surgery (cystoscopy, replacement of ureteric stents and bilateral ureterolysis). Following the procedure on Personal Information redacted by USI Patient 90 condition deteriorated and he was admitted to the Intensive Care Unit (ICU) critically ill. Patient 90 suffered a cardiac arrest which was managed as per Adult Life Support (ALS) guidelines. Following discussion with Patient's Wife cardiopulmonary resuscitation (CPR) was stopped and Patient 90 died on Personal Information redacted by USI. Patient 90 was discussed with the coroner and a post mortem was requested.

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

Causative Factor

The review team concluded Patient 90 had an unrecognised haemorrhage post operatively.

The review team note Patient 90 s post mortem report. Patient 90 death was discussed with the Coroner who recommended a post mortem.
The Cause of death was reported after post mortem as 1(a) Intra-abdominal and retroperitoneal haemorrhage following cystoscopy, insertion of ureteric stents and ureterolysis. 11 Cardiomegaly
The post mortem reported noted *'Death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen……..The post-mortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. Such enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses place upon the body by the effects of the blood loss. Indeed the severity of his heart disease was such that it could have caused his death at any time. Therefore as his pre-existing heart disease would have made him more susceptible to the effects of haemorrhage it would be best regarded as a contributory factor in his death'.*

Willis, Lisa

From: Trouton, Heather
Sent: 02 November 2015 15:33
To: Corrigan, Martina; Mackle, Eamon
Subject: FW: UROLOGY DSU LIST 03/11/15
Attachments: MR O'BRIEN IN PATIENT THEATRE LIST 04/11/15.eml

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dear martina

Have you the lists for this week?

Heather

From: McGeough, Mary
Sent: 02 November 2015 13:51
To: Donnelly, Rachel; Kelly, Brigeen; Corrigan, Martina
Cc: Trouton, Heather; Carroll, Ronan
Subject: RE: UROLOGY DSU LIST 03/11/15
Importance: High

Martina

Please see email below regarding Mr O'Brien's patients for his day surgery list tomorrow. As you will see 3 out of the 5 patients have not been to pre-op. Could you please investigate and advise why these patients were never sent to pre-op as to get this level of notification of their surgery is as I am sure you will agree unacceptable. We are now in a position where we are unable to get these 3 patients pre-assessed due to the extremely tight timeframe before their surgery. I have also attached a second email from Rachel with regard to Mr O'Brien's inpatient list on 4th November and again there are a couple of patients on this list who have not been to pre-op. Have all of these patients been seen somewhere other than at his outpatient clinic? If yes then a system will need to be put in place ASAP in order to ensure that these patients are pre-assessed well in advance of their surgery being scheduled.

Happy to discuss

Mary

Mary McGeough
Head of Anaesthetics, Theatres and ICU
Craigavon area Hospital
Tel: Personal Information redacted by USI

From: Donnelly, Rachel
Sent: 02 November 2015 12:42
To: Kelly, Brigeen; McGeough, Mary
Subject: UROLOGY DSU LIST 03/11/15

Dear Brigeen and Mary

Linda came to me this morning with the attached list – Mr O'Brien DSU AM list for 03/11/15.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

The Review Team conclude there were a number of failings in the Trust's systems and processes which ultimately lead to a delay in diagnosis and treatment and care of Patient 92's cancer. Exacerbated waiting lists, no single formal processes for following up test results, and no formal process for tracking letters or emails were contributing factors. The review team concluded that treatment and care was appropriate following Patient 92's new GP referral on the 17 July 2018 which highlighted Patient 92's overlooked CT report.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The report will be shared with all staff involved in Patient 92's treatment and care for reflection and learning.

16. RECOMMENDATIONS (please state by whom and timescale)

1. The SHSCT to review its current processes of communicating, recording and signing off suspected cancer diagnosis by consultants. The Trust is to consider a single system and process in which results can be communicated to referring clinicians and electronically signed off by the referring consultant. The system should be capable of providing assurances that all results are being viewed and actioned.
   Actioned by: Associate Medical Directors (AMD)/ Assistant Directors (AD), Head of Service (HOS) for Medicine, Surgery, Radiology and Emergency Department.

2. Acute services should explore options for the introduction of a failsafe mechanism that could provide reassurance that reports issued to referring clinicians identifying cancer or query cancer have been action. This may require additional investment.
   Actioned by: AMD/ AD for Medicine, Surgery, Radiology and Emergency Department.

3. The Radiology department should review its policy "Protocol for the Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings". The policy should consider the process for outsourced reports in relation to the alert for the Cancer Tracking Team.
   Actioned: AD/HOS for Radiology.

4. The Review Team acknowledges Urology waiting lists are extensive and this was a contributing factor in this incident. The Review Team therefore advises the Trust to consider implementing a management plan to reduce Urology waiting times.
   Actioned by: AMD/ AD /HOS for Surgery.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? No

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH

secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey[redacted]'; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a [redacted] old lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for discharge tomorrow.
I planned to have a CT scan repeated in May and to review her in June.

Corrigan, Martina

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

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

See you all at Audit in the Ulster ?

MY

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