Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 26 of 2022
Date of Notice: 29th April 2022

Note: An addendum amending this statement was received by the Inquiry on 11 Nov 2023 and can be found at WIT-105748 to WIT-105759. Annotated by the Urology Services Inquiry.

Witness Statement of:

Dr John Simpson, Medical Director SHSCT, Aug 2011 to July 2015

I, John Simpson, will say as follows:-

SCHEDULE
[No 26 of 2022]
General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1. I was the Medical Director and responsible officer (as per the General Medical Council, GMC) of the SHSCT from August 2011 to July 2015 inclusive. During this period the Trust employed over 600 doctors: approximately 200 consultants, 100 non-consultant staff grade/specialty (SAS) doctors and well over 300 trainee doctors.

1.2. The following paragraphs refer to emails retrieved from the archive relating to any matters concerning Mr Aidan O'Brien, Urology or Clinical Governance.

a) I was copied into an email from Mr Eamon Mackle, Associate Medical Director (AMD) for surgery on the 5th August 2011 (email from Eamon Mackle to Dr Diane Corrigan HSC Board, doc ref 20110805) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/ 20110805_Cystectomies in the Southern Trust) having just taken up my post as Medical Director, regarding a completed external review of cystectomies carried out by Mr Aidan O'Brien in the SHSCT. The conclusion was that there were no major concerns apart form the need for the Urologists to involve the Microbiologists when considering treatment which involved antibiotics. I

quality improvement and patient safety, indeed I would say that focusing on these matters is the best way to improve efficiency and sustain good practice.

72.7. The initial provision and support for medical leadership in the newly formed SHSCT in 2007 was well intentioned but was, in retrospect, inadequate for the task in hand. Medical leaders were recruited from the ranks of the more senior and respected doctors who were willing to come forward and who were then expected, by dint of their clinical seniority and expertise, to be able to take on quite complex leadership and management responsibilities. Those with the required skill set, competencies, training and experience were in short supply. I did try to remedy this by creating a training programme in medical leadership and management for Clinical Directors and lead clinicians in the Trust, also open to any interested consultant or non-consultant grade doctor, in line with material produced by the newly formed Faculty of Medical Leadership and Management.
A positive development has been that over the past decade or so, medical leadership and management has been recognised as a subspecialty in its own right by all of the medical Royal Colleges.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____ Personal Information redacted by the USI

Date: __29th June 2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

Note: An addendum amending this statement was received by the Inquiry on 11 Nov 2023 and can be found at WIT-105748 to WIT-105759. Annotated by the Urology Services Inquiry.

USI Ref: Notice 25 of 2023

Date of Notice: 19th October 2023

Witness Statement of: Dr John Simpson

I, John Simpson, will say as follows:-

Monopolar and Bipolar Resection

1. The Policy on the Surgical Management of Endoscopic Tissue Resection HSS(MD)14/2015 was introduced in May 2015 (WIT-54032-54055).

   The policy refers to the 'significantly improved safety profile' for bipolar techniques, noting that *'Significantly, the TUR syndrome has not been reported with bipolar equipment. A recent systematic review and meta-analysis comparing traditional monopolar TURP with bipolar TURP established in 22 trials that the TUR syndrome was reported in 35/1375 patients undergoing M-TURP and in none of the 1401 patients undergoing B-TURP. Even taking into account that one study alone was responsible for 17 of the 35 cases, the accompanying editorial states, "the elimination of TUR syndrome alone has been a worthy consequence of adopting bipolar technology.'"* [WIT-54041]

   At [WIT54042], it is noted that: *'NICE, in February 2015, also issued guidance for the public on this topic. They indicated that, "the TURis system can be used instead of a surgical system called 'monopolar transurethral resection of the prostate'. Healthcare teams may want to use the TURis system instead of monopolar TURP because there is no risk of a rare complication called transurethral resection syndrome and it is less likely that a blood transfusion after surgery will be needed. Therefore, the case for moving from a monopolar to bipolar technique for resection of the prostate would appear to be well established as safer with regard to the development of the TUR syndrome…'*

(b) Were you concerned by any delay in the introduction of this approach?

3.02 No, I was not aware of any reason why I should have been concerned. As mentioned previously by Margaret Marshall (see *29. 20141112 E to MM re Medical Leaders Forum Notes 3 11 2014*), initial safety measures had already been put in place, a key safety indicator being the intraoperative measurement of sodium levels. I wrote to Julian Johnston on the 19 Dec 2014 to check how his liaison with clinicians in the SHSCT was going (*30. 20141219 E from JJ re Glycine Issue*). He responded positively and also commended the implementation of that key safety measure of recording the patients' sodium levels (in order to alert the theatre team of any risk of hyponatreamia) during the procedures in question in SHSCT theatres.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Signed: Personal Information redacted by the USI

John Simpson

Dated: 27/10/23

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 26 of 2022
Date of Notice: 29th April 2022

Section 21 Notice Number 25 of 2023
Date of Notice: 19th October 2023

Addendum Witness Statement of: John Simpson

I, John Simpson, will say as follows:-

1. I wish to make the following amendments and additions to my existing Section 21 responses, namely:

   i. Response dated 29th June 2022 to Section 21 Notice Number 26 of 2022, dated 29th April 2022; and

   ii. Response dated 27th October 2023 to Section 21 Notice Number 25 of 2023, dated 19th October 2023.

Amendments to existing paragraphs of my response dated 29th June 2022 to Section 21 Notice Number 26 of 2022, dated 29th April 2022

2. I wish to correct the following minor errors:

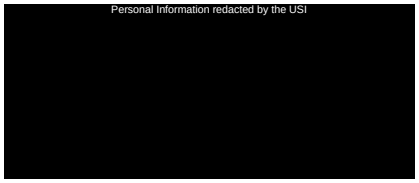
   i. At paragraph 45.3 (WIT-25721/ page 47) I have wrongly named the GMC Employment Liaison Adviser (ELA) as Anne Donnelly. The correct name of the ELA for Northern Ireland is **Joanne** Donnelly.

Urology Services Inquiry

vi. I would have expected that Gillian Rankin, as Operational Director, and Eamon Mackle, as AMD, would have been responsible for overseeing the next steps and providing assurances of same to the Assistant Director for Clinical Governance, Debbie Burns. I believe that this was the appropriate course of action. To the best of my knowledge, I was not subsequently alerted to any further issues.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

_____

Date: 9th November 2023

Urology Services Inquiry

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

Qualifications:

- General Medical Council Specialist Register Number: 2703824
- MB BCh BAO with commendation in Midwifery and Gynaecology (Queens University Belfast, 1981)
- Psychiatry Regional Training Scheme, Northern Ireland (1982 – 1992) (Training in General Psychiatry, Liaison Psychiatry, CAMHS, Psychiatry of Old Age, Learning Disability, Psychotherapy and Psychosexual Medicine.)
- Member of the Royal College of Psychiatrists (1987)
- Galloway Medal, awarded for Research in Quality Improvement, Mental Health Department, Queens University Belfast (1992)
- UK Medical Leader of the Year, Royal College of Psychiatrists (2010)

Occupational History:

See my answer to question 5 which sets out my occupational history.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

Consultant Psychiatrist, Southern Health and Social Care Trust, Northern Ireland. 1992 - 2015	Consultant Psychiatrist in community and inpatient care for the Newry catchment area. Reporting to Dr Patrick Loughran, Medical Director. (no job description available)
Clinical Director of Mental Health, Newry and Mourne Health Care Trust,	Clinical Director of Mental Health, founding three multidisciplinary teams as well as leading on the development and integration of a range of community

Northern Ireland. 1994 – 2007	facilities. Reporting to Dr Patrick Loughran, Medical Director. Responsible for 3 consultant psychiatrists, 4 trainees and middle grade doctors, a mental health manager (Ian Sutherland) and 3 multidisciplinary teams (approx. 60 staff). (no job description available)
Associate Medical Director of Mental Health and Learning Disability, Southern Health and Social Care Trust, Northern Ireland. 2007 – 2011	Together with the operational Director, initiated and completed a major redesign of mental health services from the traditional hospital base to a community-based service with an admission unit on a general hospital site (The Change In Mind Project). Reporting to Mr Francis Rice, Director of Mental Health and Learning Disability Services. Responsible for two Clinical Directors (Dr Neta Chada and Dr Joan McGuinness), 24 consultant psychiatrists and approximately 24 trainees and middle grade doctors. (no job description available)
Mental Health Medical Advisor, Health and Social Care Board, Northern Ireland. 2009 – 2011	Medical advisor on performance management and service improvement in mental health and disability services across N. Ireland. Reporting to Mr Seamus Logan, Assistant Director
Executive Medical Director, Southern Health & Social Care Trust, Northern Ireland. 2011 – 2015	Executive Medical Director with a diverse patient safety/governance portfolio as well as responsibility for the provision of resolved medical opinion to the Trust Board. Responsible Officer to the General Medical Council for medical revalidation. Delivering professional leadership and guidance; managing a medical leadership system to ensure a high level of clinical engagement; construction of, and leading on a robust appraisal and revalidation system, chairing the local negotiating committee with the

	BMA and leading on conflict resolution. Lead Director for the prevention of Health Care Acquired Infections. The Trust has one of the most successful records in the UK. Lead Director for research and development. The Trust is an internationally recognised centre for research and innovation in cardiology. Additional Director level accountability and leadership function for the following: – Litigation – Medical Education – Information Governance – Emergency Planning – Drug and Therapeutics Governance Responsible for 11 Associate Medical Directors and approximately 20 Clinical Directors. Supported by one Band 8 Medical Manager (Ann Brennan) and associated clerical staff. (see doc ref 201506016 re Medical Directorate restructuring) This can be located at Attachment folder S21 26 of 2022 Attachment 4. Reporting to Mrs Mairead McAlinden, Chief Executive Medical Director Job Description (see doc MD JD 2011) This was an accurate reflection of my duties. This can be located at Attachment folder S21 26 of 2022 Attachment 5.
Associate Consultant, HSC Leadership Centre, N. Ireland Health and Social Services 2015 – Present	Associate Consultant for Health & Social Care Leadership Centre in Northern Ireland. This work has included chairing Level 3 Serious Adverse Incident Reviews, clinical leadership consultancy, case investigations under Maintaining High Professional Standards for doctors and chairing the clinical work-stream on behalf of the Department of Health to implement the recommendations of the Public Inquiry into Hyponatraemia Related Deaths (N. Ireland).
Medical Advisor and Second Opinion Appointed Doctor to the RQIA (Regulation and	This role includes undertaking site inspections and audits of mental health facilities as well as providing second opinions in specific cases. In addition to mental health duties, the role extends to inspections

Quality Improvement Authority, N. Ireland. 2017 – Present	and thematic reviews of clinical governance systems and quality improvement in healthcare services. Reporting to Mrs Lynn Long, Director, Mental Health and Disability.
Chair of Serious Adverse Incident Reviews, SHSCT 2020 – Present	Chairing serious adverse incident reviews, principally in the Mental health and Disability Directorate. Reporting to Dr Damian Gormley, Deputy Medical Director. (job description, see doc 'Independent SAI Chair contract 15/12/2020') This is an accurate reflection of my duties. This can be located at Attachment folder S21 26 of 2022 Attachment 6.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6.1. As per Q5.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

7.1. The responsibility for the operation of Urology services belonged entirely to the Director of Acute Services (Dr Gillian Rankin followed by Mrs Deborah Burns, in conjunction with the Associate Medical Director (AMD) for Surgery. The AMD (Mr Eamon Mackle) with the support of the two Clinical Directors (Mr Sam Hall and Mr Robin Brown) and the Lead Clinician (Mr Michael Young) had particular responsibility for clinical governance.

7.2. My responsibility was to respond to professional issues which were escalated to me regarding medical professionals in that service by the AMD for Surgery, normally after consultation with Director of Acute Services (as per all other parts of the Trust).

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, Associate Medical Director, the

Southern Health and Social Care Trust

Job Description

JOB TITLE	Medical Director
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Medical Director is an Executive Director and member of Trust Board. The postholder will advise the Trust Board and Chief Executive on all issues relating to professional Medical workforce, clinical practice and quality and safety outcomes.

The postholder is the Trust's nominated Responsible Officer and will also carry lead Director responsibility in a number of organisationally critical areas including Health Care Acquired Infection (HCAI), Litigation and Emergency Planning.

As a member of the Trust Board and the senior management team he/she will inform and shape Trust strategies, support the communication and consultation on such strategies, share corporate responsibility for the achievement of the Trust's corporate objectives and for driving forward a culture of change, innovation, development and modernisation.

KEY RESULT AREAS

GOVERNANCE

1. Provide professional leadership and guidance to support Associate Medical Directors (AMD's), Clinical Directors (CD's) and Lead Clinicians throughout the Trust in relation to governance of the medical workforce including clinical practice and service change.

2. Work with other Directors to inform, support and provide assurance on the effective identification and management of clinical and organisational governance concerns, ensuring that any learning is incorporated into professional practice and systems.

3. As a member of the Senior Management Team and Trust Board, the Medical Director has corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.

4. As the designated Responsible Officer for the Trust, the postholder will have responsibility and accountability for the following key areas;

   - The effectiveness of medical appraisal of the medical workforce, for quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.

   - The provision of expert advice and assurance to the organisation in relation to the Trust's processes for addressing concerns about a medical practitioner's fitness to practice (as set out in the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance).

   - The designated Trust officer for referring concerns about a medical practitioner to the General Medical Council.

   - Providing professional advice to SMT as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of SMT Governance, to regularly review this information, and to provide assurance or expert input into necessary steps to address any issues arising from same.

   - Providing regular 'Responsible Officer' reports on the medical workforce to SMT, Governance Committee and Trust Board

5. Designated lead Director for strategic management of Patient Safety initiatives, and the link Director with the Patient Safety Forum and other regional Fora.

6. While the operational responsibility and accountability for patient safety rests with operational Directors, the postholder will be responsible for;

   - Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.

South Eastern Trust, Mr Charlie Martyn.) My Responsible Officer was the Medical Director of the Public Health Agency, Dr Carolyn Harper.

27.2. Appraisal Documents were hard copy only during my tenure. I have only been able to retrieve my appraisal documents for 2013 and 2014 (see '2013 Appraisal' and '2014 Appraisal' documents) (these can be located at Attachment folder S21 26 of 2022 Attachments 7 and 8). As per medical appraisal guidelines, my PDP (Personal Development Plan) is included for both years. The 2013 PDP is recorded as having been reviewed and signed off by Dr McKinney in 2014 and a PDP for 2015 is agreed by both appraiser and appraisee.

27.3. For my first two years, approximately, I was required to have regular one to one meetings with the chief executive Mairead McAlinden as an informal performance review. These became less frequent thereafter. My overarching objectives were as follows: to provide resolved medical opinion to the Trust Board, to carry out the functions of Responsible Officer to the General Medical Council for medical revalidation, to deliver professional leadership and guidance, to manage the medical leadership system to ensure a high level of clinical engagement, the construction of a robust appraisal and revalidation system, the chairing of the local negotiating committee with the BMA and leading on conflict resolution.

27.4. As lead Director for the prevention of Health Care Acquired Infections, my objective was to maintain the Trust's high performance. (The Trust had one of the most successful records in the UK.) As lead Director for research and development, to ensure the Trust continued as an internationally recognised centre for research and innovation in cardiology.

27.5. In addition, I held Director level accountability and leadership function for the following:

- Litigation
- Medical Education
- Information Governance
- Emergency Planning
- Drug and Therapeutics Governance

27.6. See Medical Director Job Description (doc MD JD 2011) (these can be located at Attachment folder S21 26 of 2022- Attachment 5).

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

reasonably mitigate the problem with cover from the general surgical registrars.

n) I responded to a review led by the Director of HR, Kieran Donaghy of Directorate responsibilities at senior management level by suggesting that the Director of Nursing should take responsibility for Infection Prevention and Control from me, in order to free up more of my time for clinical governance generally. However, this was not agreed by the chief executive, Mairead McAlinden (see email of 11th Aug 2014, doc ref 20140811) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20140811_RE CX RESPONSE TO DR SIMPSON IPC management review.pdf).

o) To illustrate the prevailing culture of the time across the NHS and the emphasis in the SHSCT placed on financial breakeven and year on year efficiency savings, I would draw attention to the following.

The Trust was asked to provide the HSC Board and Department of Health with a contingency plan to produce efficiency savings in July/August 2014. My response to the chief executive (see emails on 13th and 14th August 2014, doc ref 20211208, doc ref 20140813) (these can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211208_FW Medical Directorate Contingency Plans 1.pdf and Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20140813_Medical Directorate Contingency Plans.pdf) was that my medical Directorate was unable to contribute to this because the activity of the Directorate was focused entirely on professional governance and patient safety. Indeed, the instruction to Trusts from the Chief Executive of the HSC Board (see doc ref 20140815 Confidential TB minutes, page 2 paragraph iii) (this can be located at can be located at Attachment folder S21 26 of 2022- Attachment 1) was that none of the contingency plans should negatively impact patient safety. Despite this, the chief executive, as Director for clinical governance, decided that all clinical governance activity could be stepped down and so return those in post to front line clinical duties. In this was to be included the Band 3 post for patient safety audit from my Directorate. I did not agree with this and expressed my reservations about these proposals to Trust Board at a special meeting in August 2014 (see doc ref 20140815 Confidential TB minutes, last paragraph page 4) (this can be located at can be located at Attachment folder S21 26 of 2022- Attachment 1) . However, the minutes go on to state that 'members approved the draft contingency plan for submission' (penultimate paragraph page 5). On reflection, I do not believe this was an accurate record of my position. During the meeting, I remember clearly asking for my reservations to be contained in any correspondence to the HSC Board and Department. These were, essentially, that clinical governance would be even more important if service provision was to be reduced or paused in order to achieve financial

RE: CX RESPONSE TO DR SIMPSON: IPC/management review

McAlinden, Mairead <[redacted]>

Mon 11/08/2014 14:38

To:Simpson, John <[redacted]>;

Thank you John, will you sort/agree the IPC nursing issue with Francis when he gets back - I don't think he has any strong views either way so will be content to accommodate your preference I am sure.

Do you want to meet or does this conclude matters?

Mairead

-----Original Message-----
From: Simpson, John
Sent: 11 August 2014 10:38
To: McAlinden, Mairead
Subject: RE: CX RESPONSE TO DR SIMPSON: IPC/management review

Mairead,
This seems reasonable to me,
John

-----Original Message-----
From: McAlinden, Mairead
Sent: 08 August 2014 18:22
To: Simpson, John
Subject: CX RESPONSE TO DR SIMPSON: IPC/management review

Dear John,

I refer to your letter to Kieran Donaghy of 8 July setting out your recommendation that the Director of Nursing proposed in the Trust's management review should take on the role of lead Director for Infection, Prevention and Control. Kieran has confirmed to me that he has now met with you to discuss your views on the lead Director role and responsibility, and that Kieran has advised you that this is not a matter for SMT debate but rather that you should discuss further with me as it concerns the relative responsibilities of Directors. I fully understand that you have not yet been able to arrange to meet with me given the many demands on both our time this week, and so I am providing this email to set out my position and to allow you to consider it before we meet. I have discussed this with the Chair to ensure our mutual understanding of your role as lead Director and independent advisor to the SMT and Trust Board.

Under the Trust's Governance structures there are a number of Directors who carry a lead Director role without operational responsibility for the staff or the services delivering that function. Indeed this separation where possible from the operational role is deliberate and intended, as the lead Director is charged with giving independent and expert advice and support to the operational Director, SMT and Trust Board without any conflict of interest with an operational role.

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

70.1. I am not aware of any specific mistakes having been made by myself or others.

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

71.1. I was concerned that, as far as I was aware, I was the only Medical Director of a Trust in Northern Ireland who was not also the Director of Clinical Governance. Therefore, I did not have an overall view of patient safety and did not have the resource at my disposal to improve and develop clinical governance. Matters of concern would be escalated to me by the Assistant Director for clinical governance on an ad hoc basis.

71.2. As with my predecessor, I was the Director responsible for Infection Prevention and Control (IPC) rather than the Director of Nursing (DoN) as is usually the case. When the opportunity arose with the review of Directors' responsibilities by the HR Director (see Q1 paragraph n) I did suggest that IPC should revert to the DoN and that I would then have the capacity to expand my role in clinical governance. However, this was not agreed by the chief executive, Mairead McAlinden. Whether or not this would have made a difference with regard to problems within Urology I do not know.

71.3. I believe that at some point after my tenure, the role of Director responsible for clinical governance was restored to the Medical Director.

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1. On reflection, I would say that medical leadership and management across the NHS (with respect to professional matters, patient safety, medical oversight, performance management and clinical governance generally) was in its infancy during my tenure as Medical Director. Its growth was probably inhibited by the relentless focus on activity, efficiency, savings and financial breakeven.

72.2. However, progress was made in medical leadership and clinical governance during my tenure. For example, I initiated a reform of the pre-existing Morbidity and Mortality (M&M) meetings and other clinical governance activity throughout the Trust (see memo to all medical staff and operational managers July 2013 doc ref 20130702) (can be located at

I sincerely hope we will not be asked to take forward these radical measures but we have to put them in the plan for our superiors/the Minister to decide if the money is more important than some of these functions/important work.

Also can I ask that you include stepping down the Patient Safety reporting/projects and freeing up of Colum Robinson etc as part of the Admin replacement plan. If I am offering up Audit and Evualuation staff in its entirety it makes no sense not to also extend this to Colum's work.

Mairead

From: Simpson, John
Sent: 12 August 2014 13:52
To: McNally, Stephen
Subject: FW: FW: Contingency Plans

Stephen,

A number of suggestions in relation to savings were included in the first drafts of a Trust Contingency Plan.

1. Pause Medical Revalidation for 6 Months

Medical revalidation is a statutory requirement. 2014/15 is year two of medical revalidation. Although a five year cycle, the bulk of non-training grade doctors working within the Trust are required to be revalidated by end of year three, March 2016.

The following are the salient points to inform the SMT discussion regarding the potential for pausing the process until the end of the financial year;

1. Revalidation is required of doctors and designated bodies (the employers) by statute.
2. The RO (the medical director) is required to recommend doctors for revalidation to the GMC.
3. Revalidation dates for all doctors in the SHSCT have been set by the GMC until March 2016. There is no option for a designated body to postpone/delay dates.
4. Over one third of doctors have already been revalidated.
5. Revalidation is key to assuring patients of the competency/safety of the medical workforce.
6. Doctors who are beginning to experience difficulties have been brought to my attention through the process.
7. Revalidation provides a framework by which to manage these difficulties.
8. The revalidation process in the SHSCT is an important driver for quality improvement.
9. The process has been widely commended by doctors in the SHSCT despite initial reservations.
10. My experience is that the current process is necessary to fulfil my statutory obligations as a Responsible Officer.

My advice is therefore that it would unworkable and unsafe to pause this process.

2. Pause Litigation

The drivers for PL/EL and MN litigation are outside of our control. The potential costs of not providing defence are much greater than any potential savings in this area.

Responding to the Coroner's office is a statutory obligation outside of our control.

Medicolegal subject access services are also provided by this department. There is a £50 charge per request. This is a requirement for the organisation under the Data Protection Act. Demand for these services are outside of our control.

3. Reduction in Water Testing

A meeting of the Water Safety Group has been organised to consider options for reduction in testing. Dr Damani has agreed to provide expert advice in this area.

In summary, I have considered all other areas in my remit. As these are predominately driven/funded by external bodies I am unable to put forward any contingency plans at this time.

Regards,
John

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

Minutes of a confidential meeting of Trust Board held on Friday, 15th August 2014 at 9.00 a.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT:

Mrs R Brownlee, Chair
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs M McAlinden, Chief Executive
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing
Dr J Simpson, Medical Director

IN ATTENDANCE:

Mrs D Burns, Acting Director of Acute Services
Mrs P Clarke, Director of Performance and Reform
Mr M Crilly, Acting Director of Mental Health and Disability Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mr S McNally, Director of Finance and Procurement
Mrs A McVeigh, Director of Older People and Primary Care
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr R Alexander, Non Executive Director
Mrs D Blakely, Non Executive Director
Mrs S Rooney, Non Executive Director

Mr Graham asked for clarification regarding the term 'flexible workforce' to which he was advised that this refers to bank, agency and locum staff. Mr Graham then asked if there was a danger that by reducing flexible workforce, this could have an unforeseen adverse impact on some essential services. Mrs McAlinden advised that the proposal in the draft contingency plan seeks to mitigate against impact on critical services that use flexible workforce for safe staffing levels by redeploying staff from less critical areas of the permanent workforce.

Dr Mullan expressed his concern at the short-term nature of the proposals and therefore the lack of strategic coherence. He questioned whether the task of saving £28m is a 'doable ask'. Mr McNally acknowledged that the proposals are of necessity focused on those areas where money can be saved over the period of six months and accepted that this resulted in a very different approach to that of a more strategic approach to reduction in spend. He advised that this was highlighted through the prioritization and risk based approach set out in the draft Plan.

The impact on the Trust's performance was discussed. Mr Graham commented that performance against Ministerial standards will be catastrophically impacted on by the proposals in the draft Plan and Directors endorsed this view. Dr Mullan asked if there was any indication that performance targets would be relaxed given the financial context to which Mrs McAlinden advised that the HSCB had already paused transferring additional patients to the Independent Sector from early July 2014 and, as a result, waiting times are increasing in those areas where the IS capacity is needed to meet demand. Mrs Clarke stated that the awaited Commissioning Plan would have to provide the context and implications for the next six months and this would change the performance agenda as a system.

Mrs Burns referred to the impact on performance of winter demand experienced in previous years and it was agreed to factor the impact of winter pressures into the proposals. Dr Simpson raised his concerns about the potential adverse impact on quality by the proposals in the draft Plan to temporarily redeploy resources to critical front line services from areas such as patient safety, audit and evaluation.

In discussion on the draft Contingency Plan, Trust Board members agreed a number of key concerns and instructed Mrs McAlinden to convey these concerns in her letter to accompany the draft Contingency Plan. These agreed key concerns were as follows:-

- The relative efficiency position of the Trust means that the impact on service provision in the Southern area will be deeper and more profound that in other areas;

- Explicit Ministerial/Commissioner permission will be required for the majority of measures therefore it is important that this permission is secured as soon as possible if the funding is to be released to the level identified;

- A system wide approach is necessary - all non critical work stood down across the total HSC system and resources focused at and redirected to protecting the front line of care;

- While Trust Board is prepared to deliver on its responsibilities as set out in the Permanent Secretary's letter by enacting the approved elements of the draft Plan, it would not be supportive of doing so given the detrimental impact of such actions on service users and staff.

The Chair emphasised the need to include in the covering letter accompanying the draft contingency plan that early decisions will be needed to enable any prospect of delivering the level of funding needed for in year breakeven.

Members approved the draft Contingency Plan for submission. In relation to the next steps, Mrs McAlinden advised that the HSCB and PHA will assess Trusts' contingency plans prior to Departmental consideration for advice to Minister.

2. i) **Month 3 Finance Report**

The Finance Report as at end June 2014 had been previously circulated. Mrs McAlinden referred to the Trust's proven need for £18m in year support and stated that if this had been forthcoming with the other contingency measures the Trust has underway, this

TRU-250591

C and SC Gov

Simpson, John

Fri 25/11/2011 13:17

To: McAlinden, Mairead < Personal Information redacted by the USI >;

Cc: Burns, Deborah < Personal Information redacted by the USI >; Brennan, Anne < Personal Information redacted by the USI >; Rice, Francis < Personal Information redacted by the USI >; Rankin, Gillian < Personal Information redacted by the USI >; Morgan, Paul < Personal Information redacted by the USI >; McVeigh, Angela < Personal Information redacted by the USI >;

About those mortality reports.
They are a work in progress.
However they are one of but a number of windows on the quality of clinical activity. They seem to me to be useful but need to be more fully embedded into our gov systems. I don't think they should be seen as something that only belongs to the medical directorate (although I appreciate it was the right place to get the thing started), it's a much bigger and broader issue.
And the more I think about it I see a need to integrate all of our reporting on C&SC governance - both upward to trust board and downward to clinical teams (not just medics).
I believe some trusts in England produce an annual or biannual quality report which brings together all of the intelligence on C & SW governance. I think we should be aiming to do that in 2012,

John

Southern Health and Social Care Trust

Quality Care - for you, with you

By email Memorandum

To: All Medical Staff

Cc: Associate Medical Directors / Clinical Directors / Chairs of M&Ms, Operational Directors, Assistant Directors & Heads of Services Acute, Non Acute Hospitals, CYP, Mrs M Marshall, Mrs C Reid, Mr T Black, Mrs D Johnston, Mrs Z Parks, Mrs H Forde, Mrs A Quinn, Effectiveness & Evaluation Manager

From: Dr J Simpson, Medical Director

Date: 01st July 2013

Subject **Re-launch of M & M Process**

Involvement in M&M meetings is one of the key activities that a doctor must engage in to assure patients that he/she is safe to practice. There is a responsibility on all of us not just to attend, but to actively participate and further develop a system that is more meaningful and produces outputs which improve patient outcomes. M&M meetings have made significant progress in that respect of late.

Enhancing the multidisciplinary input, as well as including the patient experience, will make the process more meaningful. M&M chairs will be inviting relevant nursing colleagues to the meetings to bring the nursing perspective and, where possible, the patient experience.

To improve patient outcomes the output from M&Ms will need to be more formally structured:

- learning points should directly link to our organisational education systems
- issues which require further investigation should determine topics for audit activity
- identification of action points to drive system-wide improvements.

It is therefore imperative that our M&M meetings are brought together in a systematic way across the Trust. After lengthy discussions with medical and operational leads the Trust has decided to move all M&M meetings to a rolling audit calendar from September. The “surgical” and IMWH meetings are already held on these rolling audit dates. Medical M&Ms (CAH and DHH) and the cross-site paediatric M&M will now move to the rolling audit dates effective from September 2013. The Non Acute Hospitals will continue to participate in the Medical M&M on the CAH site

This shift to the rolling audit calendar will ensure there will now be cross-specialty clinical discussion at each of the monthly M&Ms e.g. ED, Diagnostics (including Labs), Paediatrics, Anaesthetics/ICU.

Mortality and Morbidity Reform Project Update May 2015

Dr John Simpson
Medical Director
SHSCT

Southern Health and Social Care Trust

Quality Care - for you, with you

Development of 'SHSCT Lessons Learned' Shared Learning Outputs

Progress to date	Future actions
• 'Lessons learned' letter currently being drafted	• 'Lessons learned' letter to be implemented
	• M & M Chairs to identify cases/issues that have Trust wide relevance and in conjunction with the relevant clinical teams complete the Safety and Quality Learning Letter template for dissemination to other appropriate M & M and escalation to appropriate governance forums • M & M Chairs consider HSC Regional Safety and Quality Learning Letters, disseminate and stimulate discussion of relevant cases. • M & M Chairs consider Litigation Lessons Learned, disseminate and stimulate discussion of relevant cases.

Quality Care - for you, with you

Stinson, Emma M

From:	Thompson, Norma [redacted]
Sent:	12 September 2013 11:47
To:	Christine McGowan [redacted]
Cc:	Brennan, Anne; Shields, Katie
Subject:	APPRAISEE TRAINING / APPRAISER CLINIC
Attachments:	Appraisee Slides Sept 2013.pptx; Appraiser Slides Sept 2013.pptx; Nominations for 2013-2014 courses.xlsx

Christine – as discussed this morning I've adjusted the slides slightly (attached) – I've also taken out the reference to the mapping exercise as there's enough on the slides to give them good examples. Also attached are the names to date for both 18th and 26th September. I've some copies of appraisal forms done to bring with me and I've the course register and evaluation forms for both days.

See you next Wednesday 9 am up at the main hospital Boardroom.

Kind regards
Norma

Doctors Role

- Participate fully in appraisal
- Identify an appraiser and schedule appraisal meeting (directory of appraisers)
- Prepare for the appraisal meeting and make the appraisal folder available to the appraiser at least 10 working days in advance
- Agree personal objectives, actions and personal development plan for the coming year
- Identify factors that may inhibit performance
- Prepare supporting information for revalidation with GMC
- Seek to achieve defined objectives and fulfil individual learning and development plan.
- Complete form/s clearly written and legible.
- Inform the appraiser of any performance or professional issues.
- Send the signed originals of all Forms 1 to 7 to the Medical Director's Office, Clanrye House, DHH, along with Appendix 2 Appraisee Feedback Form

HSC Leadership Centre

Review of Practice

- Significant events – required annually
  - participation in meetings to discuss incidents
  - Lessons learnt; preventative actions
- Can use team based information with reflection on your practice

- A report extracted from the Trust Datix incident management system has been forwarded to you.
- A Structured reflective template is available to assist you in demonstrating reflection/learning from incidents

HSC Leadership Centre

the really good surgeon, his outcomes can initially look poor. You need to do a lot more drilling down on the fitness, etcetera, of the patient and the complications, etcetera, to decide is his data as poor as it initially seems. That's just one of the disadvantages of it. As an overall tool, it can be very useful for helping to pick things up like that, yes. 11:35

MR. WOLFE KC: You were in this role eight years. Did you feel, at least on a personal level, generally supported by each of the medical directors you worked under? 11:35

A. Reasonably well, yes. Paddy Loughran was new. He had been Daisy Hill based but I worked probably with him. Richard Wright only arrived in the summer before I -- he arrived in the summer and I ceased to be AMD in the following April, so there was not a lot of time or interaction with him in that respect. Most of the time then would have been more John Simpson. I was moderately supported. 11:36

MR. WOLFE KC: That suggests a lot more could have been done to help you?

A. Well, shall we say, I suspected more of an interpersonal relationship. I thought I was alone but then I realised other AMDs had the same, felt there was an interpersonal relationship. I thought initially it was just me, but later on talking to them, they felt it was -- maybe it was the nature of how he did things, how he related to people, etcetera. 11:37

TRU-250634

RE: job plans

Mackle, Eamon

Mon 19/11/2012 16:24

To:Simpson, John <[redacted]>;

Cc:Donaghy, Kieran <[redacted]>; Rankin, Gillian <[redacted]>;

John

Thanks for your email. [redacted]. I raised this matter 4 weeks ago with my CDs Robin Brown and Sam Hall. Robin has been doing CAH Gen Surg and Urology and Sam Hall has ENT and T&O. I will raise it with them again and will copy you in and will organise to meet you when I am back.

Eamon

From: Simpson, John
Sent: 19 November 2012 13:02
To: Mackle, Eamon
Cc: Donaghy, Kieran; Rankin, Gillian
Subject: job plans

Eamon,
I met with Zoe this morning from HR. Our external auditors have criticised our WLI arrangements and documentation thereof. Essentially it looks as though a very significant amount of WLI activity is carried out 9 to 5.
We would be much better able to explain our position except that the lack of signed off job plans leaves the trust at a disadvantage.
All of the other AMD's have made significant progress in this regard. Your performance in this area is a matter of concern.
Could we meet to discuss how the situation may be recovered?
John

Southern Health and Social Care Trust

Notes from the AMD Meeting
Friday 6th June 2014

Present: Dr J Simpson, Dr C McAllister, , Dr A Khan, Mr S O'Reilly, Mr E Mackle, A Brennan, Dr N Chada, Mr C Weir, Dr P Sharpe

In Attendance: N Thompson (Items 1.2, 4.2)
Z Parks (Item 1.3)
K Donaghy (Item 4.1)

Apologies: Dr M Hogan, Dr P Murphy, Dr S Hall, Dr P Murphy, Dr P Beckett

Minutes listed as per agenda not chronological order

ITEM	NOTES	*ACTION*
1.1	**Clinical Coding – Histopathology Results** A Brennan presented paper on Histopathology results for use in clinical coding. A Brennan stated that a recent issue with colorectal coding highlighted a gap in coding processes. Coders required access to histopathology laboratory systems to ensure that cases re correctly labeled and identified. Dr Simpson told the group that the Trust coding level is already well above the regional benchmark however this was required to further strengthen systems. AMDs agreed that coders should have access to the histopathology results.	***A Brennan to progress with coders using histopathology system for coding***
1.2	**Mentoring Proposal** N Thompson presented a proposal for Introducing a Mentoring Scheme for Medical Staff. Agreement was sought from AMDs to establish a Mentoring Scheme within the Southern H&SC Trust and to issue an Expression of Interest to gauge level of interest for Mentors, after which a selection process will take place then appropriate training developed. AMD's agreed that although mentoring exists in some form a formal role would be helpful. Mr. Mackle also stated that individual specialties should also have a responsibility to ensuring mentoring was available for	***N Thompson to progress mentoring scheme,***

	o How to Manage Meetings o Other topics such as Lean, Audit, Research & Development etc. Dr Simpson told the group that ultimately, it is intended these proposals will increase retention rates and improve morale within the medical workforce. AMD's agreed the proposal based on the paper. **4.3 NCAS CASE INVESTIGATOR AND CASE MANAGER TRAINING PROGRAMME** Dr Simpson explained the NCAS Case Investigator and manager programme which was aimed at HR, Medical and senior managers and is valuable training. Dr Simpson was supportive of this scheme and was currently trying to secure funding for the Trust to participate.	***events***
5.0	**GOVERNANCE REPORTS** Dr Simpson asked AMD's to report Governance issues by exception: **Mr Mackle** Mr Mackle brought to attention the following items: • Ongoing urology regional review • Trust T&O Expansion • Issues with staffing in Breast surgery **Dr McAllister** • Dr McAllister referred to the ongoing SAI regarding a female ICU death. **Dr Chada** • Dr Chada referenced the recent attack on a doctor by a patient in Bluestone this week, SAI to follow. **Dr Khan** • Dr Khan referred to ongoing Paediatric staffing issues. • Unavailability of 24/7 radiology services in the Trust. This is recorded on the CYPS risk register. Dr Simpson asked was this on the corporate register however this was not known currently.	

To: Simpson, John
Cc: Mackle, Eamon; Clegg, Malcolm; Corrigan, Martina; Brennan, Anne
Sent: Fri Feb 17 17:56:50 2012
Subject: RE: Urology Job Plans
John,

Very happy with this approach, and presume you will link with Pat Keane to agree this,
thanks

Gillian

From: Simpson, John
Sent: 17 February 2012 17:52
To: Rankin, Gillian
Cc: Mackle, Eamon; Clegg, Malcolm; Corrigan, Martina; Brennan, Anne
Subject: RE: Urology Job Plans

Eamon just phoned me to suggest going to 2 or 2.5 for a fixed period (eg 6wks) to do a specific teaching project for nursing staff for example. To then review said job plan and revert to 1.5 when said task is completed.
Sounds like a runner.
John

From: Rankin, Gillian
Sent: 17 February 2012 17:46
To: Simpson, John
Subject: FW: Urology Job Plans

John,

Thanks for trying on this one. I don't think though we can proceed without a college rep on the interview panel.
My understanding of what has happened when we faced this kind of opposition previously was that we advertised at 2.5 and prior to appointment changed down to 1.5 or held 2.5 for 6 months to do a specific service development and then reviewed down in first year.

We will need to get an agreed position before going forward,

Gillian

From: Corrigan, Martina
Sent: 17 February 2012 16:42
To: Rankin, Gillian; Mackle, Eamon
Subject: Urology Job Plans

Dear Dr Rankin/Eamon,

Malcolm Clegg has just been in touch to advise that John Simpson has spoken today to Patrick Keane, Urology Specialist Advisor about the Urology Job Plans. John has advised Mr Keane of the Trust's view on 2.5 SPA's but Mr Keane is adamant that it has to be 2.5SPA. He has told us that we can go ahead and advertise it as 1.5SPA but that we won't have Royal College Support for training and they most likely will not send anyone to sit on the panel. Mr Keane has agreed that he will go and speak to the Royal College in the meantime.

RE: Personal Information redacted by the USI (Urology) - Strictly Private and Confidential

Simpson, John

Fri 02/03/2012 14:57

To:Weir, Colin < Personal Information redacted by the USI >;

I've also been asked about this and have shared these letters with Robin Brown and Zoe Parks
John
-----Original Message-----
From: Weir, Colin
Sent: 02 March 2012 14:04
To: Roberts, Margot; Young, Michael; O'Brien, Aidan
Cc: Rankin, Gillian; Simpson, John
Subject: RE: Personal Information redacted by (Urology) - Strictly Private and Confidential

Aidan and Michael can we discuss this soon? Are you aware of any immediate concerns?

Colin

Colin Weir FRCSEdin FRCSEng
Consultant General and Vascular Surgeon
Hon Clinical Lecturer QUB
AMD Education and Training
Sec Personal Information redacted by the USI (direct)

-----Original Message-----
From: Roberts, Margot [mailto Personal Information redacted by the USI]
Sent: 02 March 2012 13:04
To: Weir, Colin
Cc: Simpson, John; Gardiner, Keith
Subject: FW: Personal Information redacted by (Urology) - Strictly Private and Confidential

Colin

I thought I should inform you about a doctor who is currently under investigation by the GMC under its Fitness to Practice procedures. I've attached the letter that was sent to Personal Information redacted by the USI regarding this doctor and a letter from the Medical Director of Personal Information redacted by the USI . We are anxious to ascertain whether any concerns have been raised in relation to this doctor. I understand that the Training Programme Director for Urology has spoken with Michael Young and Aidan O'Brien and there have been no complaints or concerns about patient safety or probity.

We will be responding accordingly to the GMC unless you are aware of any other concerns raised.

Margot

Margot Roberts
Administrative Director
Northern Ireland Medical and Dental Training Agency Beechill House
42 Beechill Road
Belfast BT8 7RL

Tel: Personal Information redacted by the USI
www.nimdta.gov.uk
Personal Information redacted by the USI

From: Dardis, Pauline
Sent: 02 March 2012 12:29
To: Roberts, Margot
Subject: Personal Information redacted by (Urology)

Weir, AMD for medical education and training, regarding a locum trainee grade doctor in urology who was under investigation by the GMC regarding a previous posting in England. She was enquiring if there were any concerns raised locally about said doctor. The Director of Acute, Dr Gillian Rankin had already received a similar enquiry from the GMC by letter on the 24th Feb 2012, received on the 29th February (doc ref 20211206) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211206_FW Urology LAT 02.04.2012) which she brought to my attention soon after during a discussion on other matters. The GMC letter was then copied to me. I made enquiries through the Clinical Director (CD), Mr Robin Brown (email of 13th March 2012, doc ref 202112106) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20211206_FW re staff grade urology). I believe the AMD, Mr Mackle was on Personal Information redacted by the USI. Mr Brown discovered that a senior nurse, Shirley Tedford (doc ref 20120402) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/ 20120402_FW re staff grade urology) had already raised concerns about the competency of this doctor to the lead clinician for Urology, Mr Michael Young, but this had not been escalated to either of us or to the AMD for medical education and training, Mr Colin Weir. Although this was a matter of concern, the swift and appropriate response by Mr O'Brien did compensate. His written reply (email re staff grade urology doc ref 20120315) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson /20120315_RE re staff grade urology) gave an adequate explanation of the events and clinical context. An appropriate plan of remediation was put in place to the effect that the doctor would be temporarily removed from the out of hours and daytime on-call rota, that he would be accompanied on his ward rounds by the urology registrar Mr Keane and that he would be offered support in his professional development.

However, these events did concern me regarding professional governance and multi-disciplinary working in Urology (email to Francis Rice, 13th March 2012, doc ref 20211206 and his reply, doc ref 20120313) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20120313_RE re staff grade urology). I also relayed this to Mr Robin Brown, Dr Gillian Rankin and the Senior Management Team. I discussed it with Mr Mackle when he returned from Personal Information redacted by the USI (email 5th April 2012, doc ref 20120405) (this can be located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Correspondence John Simpson/20120405_FW Urology LAT 02.04.2012). One specific learning point was that, when nursing staff in Acute are not satisfied that their concerns are being dealt with locally (not just in Urology), they must be encouraged to escalate. As a result, I initiated a series of joint visits with the Director of Nursing, Mr Francis Rice to acute

TRU-250599

staff grade urology

Simpson, John

Tue 13/03/2012 11:32

To:Rice, Francis <[redacted]>;

Francis,
this was kicked off by a letter I got from GMC to inform me this doc is under investigation. Our urology consultants thought he was just about ok.
It seems the nurses have a totally different view. My guess is that there is something amiss in urology re M/D working never mind professional governance,
john

Aimee Crilly

From: Rice, Francis <[Personal Information redacted by the USI]>
Sent: 13 March 2012 14:06
To: Simpson, John; Brown, Robin; O'Brien, Aidan; Rankin, Gillian
Cc: Parks, Zoe
Subject: RE: re staff grade urology

John,Happy to discuss with you and Gillian tomorrow at SMT.Regards Francis

From: Simpson, John
Sent: 13 March 2012 11:30
To: Brown, Robin; O'Brien, Aidan; Rankin, Gillian; Rice, Francis
Cc: Parks, Zoe
Subject: re staff grade urology

Robin/Aidan,
Further to discussions re [Personal Information redacted by the USI] could you provide me with something in writing regarding any concerns re performance.
Aidan,
Could you provide something in writing re your discussion today with said doctor. In particular please detail any proposed restrictions on his practice.
Gillian,
Concerns were expressed verbally to Robin by a senior nurse. Is it possible to have this documented.
Gillian/Francis,
It is a matter for concern that a senior nurse would have significant concerns about the performance of a doctor that don't seem to have been followed through. I think there must be some learning here re clinical governance.
John

91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

[21] Did your role change in terms of governance during your tenure? If so, how?

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.

Southern Health and Social Care Trust

Meeting re Urology Service

Tuesday 1 December 2009

Action Notes

Present:
Mrs Mairead McAlinden, Acting Chief Executive
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Mrs Paula Clarke, Acting Director of Performance & Reform
Mrs Deborah Burns, Assistant Director of Performance
Mrs Heather Trouton, Acting Assistant Director of Acute Services (S&E Care)
Dr Gillian Rankin, Interim Director of Acute Services

1. **Demand & Capacity**
   Service model not yet agreed, outpatients and day patients not finalised, no confidence that this will be finalised. Theatre lists not currently optimised and recent reduction in number of flexible cystoscopies per list. Recent indication that availability for lists in December 2009 will be reduced.

   Action
   - Sarah Tedford to be requested to benchmark service with UK recognised centres regarding numbers, casemix, throughput (eg cystoscopies per list). **Action – urgent within 1 week.**

   - Team/individual job plans to be drafted – Debbie Burns/Mr Mackle/Zoe Parks, for approval at meeting on 11 December 2009. To be sent to consultants and a meeting to be held within a week with consultants, Mr Mackle, Heather Trouton and Dr Rankin.

2. **<u>Quality & Safety</u>**

   <u>Key Issues</u>:-

   1. Evidence-base for current practice of IV antibiotics for up to 7 days repeated regularly requires urgent validation. Current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009.

Corrigan, Martina

From: Loughran, Patrick [redacted]
Sent: 28 July 2011 09:03
To: Corrigan, Diane
Cc: John Simpson [redacted]); Mackle, Eamon; Brennan, Anne
Subject: Urology Review

Dear Diane,
Thank you for your help with the CEA reviews yesterday. I had intended but forgot to give you an update on the above. The independent assessment of the cystectomies by Marcus Drake from Bristol is almost complete. I have seen the interim report prepared for Gillian and Eamon as I read it there are no gross errors or faults. There are some questions in relation to pre-operative alternative treatment plans and assessments. Overall I expect the final report will be supportive/indeterminate. In the meantime I can assure you that this surgery, nor will it be undertaken in the Southern Trust.
Regards, Paddy

TRU-250590

Meeting re a consultant urologist

Rankin, Gillian <[redacted]>

Fri 02/09/2011 14:16

To: Donaghy, Kieran <[redacted]>; Simpson, John <[redacted]>;

Cc: Mackle, Eamon <[redacted]>; Walker, Helen [redacted];
Stinson, Emma M [redacted];

Dear all,

I think there would be merit discussing current issues around one of our senior staff. Is there any chance we could meet 2-3 pm Monday next?
Eamon and I have this is our diary and as we both go on leave shortly it would be good even if we could get 30 minutes.
Let me know,
Thanks,
Gillian

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.

Thank you

Heather

Southern Health & Social Care Trust IT Department [redacted]

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: Personal Information redacted by 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: Personal Information redacted by USI 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)

TRU-250590

Meeting re a consultant urologist

Rankin, Gillian <[redacted]>

Fri 02/09/2011 14:16

To: Donaghy, Kieran <[redacted]>; Simpson, John <[redacted]>;

Cc: Mackle, Eamon <[redacted]>; Walker, Helen [redacted];
Stinson, Emma M [redacted];

Dear all,

I think there would be merit discussing current issues around one of our senior staff. Is there any chance we could meet 2-3 pm Monday next?
Eamon and I have this is our diary and as we both go on leave shortly it would be good even if we could get 30 minutes.
Let me know,
Thanks,
Gillian

HSC Public Health Agency

South Office
Tower Hill
ARMAGH
Co Armagh
BT61 9DR

Tel : Personal Information redacted by the USI
Fax : Personal Information redacted by the USI
Web Site : www.publichealth.hscni.net

Strictly Confidential

Ms D Burns
Assistant Director Clinical &
Social Care Governance
Southern Health & Social Care Trust
Old College of Nursing
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

14 November 2011

Dear Ms Burns

I refer to the Trust's report on the Root Cause Analysis of this incident. The report is thorough, clearly identifying the chronology of events and making recommendations on actions to avoid recurrence. As might be expected, the report concentrates on the primary event, which occurred during the patient's operation on 15th July 2009 and the x-ray findings which might have aided detection prior to her emergency admissions in July 2010.

The patient was expected to have an outpatient review four months after her major complex cancer surgery in July 2009. It was also expected that at that review attendance the CT scan, undertaken three months post-operatively, would be available for the consultant urologist to see. This scan was done promptly in early October 2009 and the report identified an abnormality. Although not identified as a retained swab, one of the differential diagnoses was recurrence of the patient's cancer.

The RCA report identifies that, due to a backlog in outpatient reviews, in fact the patient was not seen at outpatients in the 12 months after surgery, at which stage she was admitted as an emergency. The recommendation relating to this issue was that outpatient backlog reviews should be cleared. This recommendation is reasonable, albeit not necessarily easy for the Trust to

Stinson, Emma M

From: Rankin, Gillian <Personal Information redacted by the USI>
Sent: 14 November 2011 17:35
To: Burns, Deborah
Cc: Simpson, John; Trouton, Heather
Subject: RE: Re SHSCT SAI ref number - Personal Information redacted by /HSCB SAI ref number - Personal Information
Sensitivity: Confidential

Debbie,

That would be great. This has been discussed with all AMDs on 2 occasions in past year and I think our only specific issue is with one urologist. Heather has been working on this in detail,

Gillian

From: Burns, Deborah
Sent: 14 November 2011 12:23
To: Rankin, Gillian
Cc: Simpson, John
Subject: Fw: Re SHSCT SAI ref number - Personal Information redacted by /HSCB SAI ref number - Personal Information redacted
Sensitivity: Confidential

Hi gillian I know u have a plan and actions re this issue. Can heather anbd I liaise to provide a draft response for u and john to approve for diane?

From: Burns, Deborah
To: 'Heather.Martin Personal Information redacted by the USI <Personal Information redacted by the USI>
Sent: Mon Nov 14 12:21:11 2011
Subject: Re: Re SHSCT SAI ref number - Personal Information redacted by the HSCB SAI ref number - Personal Information redacted Thanks for this heather. The trust has considered this issue and we will respond with our actions in the very near future

From: Heather Martin <Personal Information redacted by the USI>
To: Burns, Deborah
Cc: Magennis, Joscelyn; Diane Corrigan <Personal Information redacted by the USI>; Janis McCulla <Personal Information redacted by the USI>; Julie Connolly <Personal Information redacted by the USI>; Rankin, Gillian; Simpson, John
Sent: Mon Nov 14 11:48:13 2011
Subject: Re SHSCT SAI ref number - Personal Information redacted by /HSCB SAI ref number - Personal Information redacted "This email is covered by the disclaimer found at the end of the message."

Deborah

Please find enclosed letter in respect of the above SAI from Dr Diane Corrigan, Consultant in Public Health Medicine.

Willis, Lisa

From: Burns, Deborah < Personal Information redacted by the USI >
Sent: 12 November 2013 05:56
To: Carroll, Anita; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

Follow Up Flag: Follow up
Flag Status: Flagged

Did the patient get seen? I think if we cant agree with him – John Simpson needs involved. Heather was robin addressing this with him – follow up with robin to check that happened - if it did John is next step D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

A patient was attending Dr Convery's clinic this morning but the chart was tracked to Mr O'Brien in the Thorndale Unit. When records looked for it his secretary said she thought Mr O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9 am this morning. The chart didn't arrive in records and Dr Convery refused to see the patient without the chart. Pamela went to speak to Dr Convery and ask if he would see the patient as she had got as much information as she could for the appointment.

Mr O'Brien's secretary is off today so eventually Pamela got Mr O'Brien's number and phoned him to enquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by the USI
Personal Information redacted by the USI

Willis, Lisa

From: Brown, Robin
Sent: 30 November 2013 14:00
To: Young, Michael; Trouton, Heather
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Heather
I wonder if could you call me on the phone to discuss this I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward.
Aidan is an excellent surgeon and I'd be more than happy to be his patient [redacted], so I would prefer the approach to be "How can we help".

Robin

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Performance data was also reviewed at the Governance meetings and any concerning trends noted.

[39] How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

125. The systems are as detailed in my answers above from Questions 33 to 38. At the time we thought the systems were effective and that concerns, as they arose, were being escalated and action taken. As such we did not have any significant governance concerns.

126. The issue regarding the number of benign cystectomies being performed was appropriately investigated, the practice was stopped and compliance monitored.

127. Likewise the issue regarding IV fluids & IV antibiotics was escalated and a protocol produced to change practice. Compliance was monitored and any breaches/ potential breaches followed up and stopped.

128. Regarding triage, this was an ongoing problem. The first time I became aware of it was approximately 1996. I spoke to Aidan O'Brien and he assured me that the "red flag" patients were being triaged and, in response to the intervention, he then completed his triage. Intermittently over the years it would be noted that he was behind on triage and, when challenged, would catch up. Heather Trouton and the Directors (Gillian Rankin, Debbie Burns) were aware that he was slow at performing triage but that, when he was challenged, he would do it. I did inform Paddy Loughran and John Simpson of the issue but I admit I didn't raise it as a serious governance concern and neither did they question it as being one. On reflection due the repeated failure to perform timely triage a thorough investigation should have been undertaken.

5. The Trust had not been performing particularly well in terms of cancer patients and Mr O'Brien's work on the NICAN group helped change the focus on this. For all Specialties including Urology we are required to work to either a 31 or 62 day pathway for all cancer patients and because this was not happening it was necessary to change the way that the Urology department worked. Mr O'Brien Chaired the NICAN group until September 2016.

6. Since my time in post I have always found difficulties with Mr O'Brien completing triage. This was an issue that was known by many people within the Trust including previous Director's. Mr O'Brien always liked to do things his own way. I am aware that in the past Dr Gillian Rankin, former Director of Acute Services would have addressed the problem with Dr John Simpson in his role as Medical Director and then Debbie Burns, Acting Director would have addressed this issue. I am aware of this through various attendances at meetings when the matter was discussed. I know Mr Eamon Mackle who was the Associate Medical Director tried to deal with the matter on a number of occasions. I would also have escalated the issue to my Assistant Director, Heather Trouton. however I was unaware there was a drawer full of referral letters not triaged.

7. I recall at one point Mr O'Brien being told he could not attend the BAUS conference unless his triage was done and up to date. He did do it all but I know he didn't get to attend the conference because of an ash cloud.

8. Prior to 2014 and the move to the Urologist of the Week model, referrals would have come in through a variety of routes, e.g. through the Referral and Booking Centre, from GP's, or through the Cancer Team. Some GP's would have addressed referrals directly to Mr O'Brien or Mr Young as they were both long standing consultants and so were well known and then the rest would have been addressed to 'General Urologist'. Pre 2014 albeit there was a Consultant of the Week, the consultant would have continued with his clinical duties and would have had to fit in all the triage during the working week, however when we moved to Urologist of the Week the Consultant on Call receives all the referrals (including named to other consultants) – which all come in via the Referral Booking Centre or Cancer Team (apart from those directly addressed to the consultant from another source as they come via the secretary)

9. When a referral comes in from a GP they will have put a classification on it which will be Routine, Urgent or Red Flag. A Red Flag referral is one where there is a suspicion of cancer. When the referral is received it is the role of the Urologist to triage each referral to determine if there should be any change to the category given by the GP. The Urologist is the specialist in this field and will pick up concerns a GP may not have within their assessment of the patient.

10. The red flag referrals that go through the red flag team are assigned to the Urologist of the Week. All other referrals go through the Referral and Booking Centre and are again given to the Urologist of the Week for triage. I have had been made aware on numerous occasions by the red flag team and the referral and booking centre that Mr O'Brien has not returned his triage. I would have chased Mr O'Brien for these to be returned. . This has been a problem for the past 8 years since I have been in post. On occasions when the red flag being returned from triage has been

delayed I have raised the concern with Mr Young who is the clinical lead and he was happy for me to proceed on authorising the Red Flag Team to appoint these patients without Mr O'Brien's triage. I can't afford to wait with red flag referrals.

11. Mr O'Brien's practice is very different to that of all the other Urologists. On occasion I may have to chase up 1 or 2 outstanding referrals from the other Consultants. I have in the past run lists from PAS for Mr O'Brien's referrals and there may have been 20, 30 or 40 outstanding letters. Sometimes after escalating to him, Mr O'Brien would have a burst of returning them and I would get responses from him, but in the main I didn't get a response.

12. I escalated these concerns to Eamon Mackle and Heather Trouton over the years. I know the issue would have been addressed with Mr O'Brien verbally but I suspect it was never in writing to him. I know it was verbally addressed by Eamon Mackle, Paddy Loughran, John Simpson and more recently Dr Wright. I am aware that on one occasion after Mr Mackle addressed the concerns with Mr O'Brien that Mr O'Brien made an allegation and complaint of bullying by Mr Mackle. As a result of this from Mr O'Brien, Mr Mackle was told to back off. After that Mr Mackle didn't try to address the concerns again.

13. After continuously not getting a response from Mr O'Brien I agreed that the patients should be added to the outpatients waiting list according to the category that the GP had assessed the patient as being . I had met with Anita Carroll and Katherine Robinson and agreed this and Heather Trouton as my AD had confirmed that she was happy with this. At that time the waiting lists had shorter waiting times and were more manageable however, this has changed and the waiting times have become much longer. At one point there was a plan to use available monies to get patients seen out of hours. When all routine and urgent referrals started to be added to the waiting list as per GP category I was no longer able to run a report which showed what patients had not been triaged. It was agreed by Debbie Burns, Heather, Anita, Katherine and I that the attempts to get the triage done didn't work so we needed a way of ensuring that patients were at least on a list so that they were not disadvantaged chronologically. Because by being on this list then we were assured that they were then always allocated an appointment when it was their turn By adding these patients to the waiting list it looked as if they had been triaged so it wasn't being escalated to me anymore .

14. Mr O'Brien complained he didn't have time to do triage because of his patient care or admin commitments. He was offered help and I know at one point Mr Young took his triage for about 8 months. Mr O'Brien would always have said he was determined to give 'a rolls royce service' to his patients and my view along with others was; 'but what about all the patient's you don't see?' I know he felt this wasn't his responsibility. He wanted to do advanced triage but that wasn't what was agreed and there wasn't time for that, so he didn't get much of the triage done at all.

15. Mr O'Brien said he needed 30 mins consultation with each patient. BAUS guidelines set out that appropriate time for review patients is 10 minutes and 20 minutes for new patients. To accommodate Mr O'Brien, clinics were set up with less patients for him on each of the clinics he

Following this, DB found AO'B did comply with her requests and that he became more manageable.

DB unaware that AO'B had returned to triaging before she left this post in August 2015.
However, she indicated that Cancer performance figures improved when he was not triaging.

Q. *Questioned about Informal Default Process (IDP) for dealing with non-triaging.*
A. DB not aware of IDP – even though it started during her time i.e. May '14.

Q. *DB's opinion of IDP?*
A. "Completely ridiculous" because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11/12.

Q. *Discuss AO'B inability to triage. Why could/did he not do it?*
A. "Eccentric" "Disorganised"
Very good with patients when he was aware and dealing with them but left those who he wasn't aware of on the waiting list and unattended.
"He would NOT allow himself to be organised by others."

Q. *What is the evidence that problem was referred to higher authority?*
A. John Simpson MD at that time; Mairead McAlinden CEO and Roberta Brownlee Chairperson of Board.
JS not good relationship with Acute Sector Consultants.
DB cannot remember if she made JS aware of problem.
DB considered issue dealt with when AO'B taken off triaging i.e. no need to refer 'upwards'.
There were also other issues concerning AO'B which were being dealt with.

Q. *Handover of triaging issue with Ester K.*
A. DB considered issue was dealt with, so no need to handover.

Q. *Any other information*
A. In 2007, DB (while in previous post in CAH - Assistant Director of Performance and Reform) found a waiting list – 10 years long.
Worked on this with AO'B and cleaned it up; found no serious issues.

Corrigan, Martina

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

Internal email for those on this circulation only

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

But this is not the approach I want for the Dept

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

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

MY
Lead

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

Dear Michael / Martina

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

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

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

TRU-250625

Antibiotic in Urology

Damani, Nizam

Sun 20/05/2012 12:38

To:Rankin, Gillian <[redacted]>; Simpson, John <[redacted]>;

Cc:Rajendran, Rajesh [redacted];

1 attachments (372 KB)

Letter to Urologist 2010.pdf;

Hi Gillian and John

I attached letter about antibiotic prescribing in urology. We discussed this with Urologists and received no reply. This issue to my knowledge was also highlighted in urology review meeting both by Raj and me.

Regards
Nizam

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

57.1. The only concern raised regarding Mr O'Brien which had the potential to impact on patient safety was the antimicrobial prescribing for indwelling urinary catheters by Urologists generally (see Q1 paragraph f). The direct impact on the individual patients would have been the relatively low risk of side effects from antibiotics and the potential to predispose to infection from other organisms. The greater risk was that the use of long-term antibiotics may encourage the growth and spread of bacteria in the community that have developed resistance to antibiotics. It would not have been possible to assess or quantify such a risk.

57.2. As Director responsible for infection prevention and control (IPC) I brought this to the attention of the associate Medical Director for surgery Mr Eamon Mackle and the Director of Acute, Dr Gillian Rankin (as per the process in other specialties) because the Urology department as a whole had not engaged in discussion with microbiology.

57.3. Adherence to, or divergence from, antimicrobial guidelines was an ongoing discussion in many specialties. I should add that the proactive checking by the Microbiologists of antibiotic prescribing in acute wards was quite an innovative practice, as advised by the consultant microbiologist Dr Damani, AMD for Infection Prevention and Control (IPC). This was a cause for much debate and discussion with consultants in several clinical areas, not just surgery. The requirement for doctors is to follow prescribing guidelines or, to document the reasons why prescribing is outside of guidelines. The usual means by which risks may be mitigated is for each specialty to engage in discussion with microbiology as to how best to implement the guidelines. This often involves major changes in custom and practice, something which is not easily achieved in any specialty and is an ongoing process in all specialties with regard to new and emerging guidelines.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

58.1. The agreed way forward with respect to antimicrobial prescribing was that Mr Mackle would ascertain if their practice had improved in line with Dr Damani's original recommendations and if not then he would ensure that there was appropriate ongoing engagement by the Urologists with the Microbiologists.

TRU-250703

FW: Litigation Department requests: Mr Aidan O'Brien URGENT

Wasson, Karen [redacted]

Fri 17/10/2014 15:23

To:Simpson, John <[redacted]>;

Importance: High

John

See email below that I sent to Eamon....

K

From: Wasson, Karen
Sent: 16 September 2014 15:38
To: Mackle, Eamon
Cc: Renney, Cathy; Craughwell, David
Subject: Litigation Department requests: Mr Aidan O'Brien URGENT
Importance: High

Dear Eamon

We have a number of Medical Negligence cases where we have requested information and involvement reports from Mr O'Brien and we have yet to receive a response. As you are aware from our Interface meeting, it is crucial that we receive this information as soon as possible at an early stage in order to get a feel for a case (strengths and weaknesses), and to keep our costs low.

Please find below a list of the relevant cases and dates of contact made by the Litigation Department to Mr O'Brien:

Case Name

[redacted]

[redacted]

First Request

30.01.14

25.06.14

REASON FOR CONTACT

Query

RR

RR

RR

RR – is involvement report request
Query – is query on Mr O'Brien's report already submitted to DLS and they have raised one query. Note – Original report request was sent to him 30th August 2012 and received report 20th January 2014.

I understand how busy the Consultants are but it is very difficult for us to progress a case if we don't receive reports from the involved medical professionals.

I would appreciate your help in this matter

If you wish to discuss, please give me a call on the number below.

Karen

Karen Wasson
Acting Litigation Manager

DD Tel. No. Personal Information redacted by the USI
EXT: Personal Information redacted by

Southern Health & Social Care Trust
First Floor
Nurses Home
Daisy Hill Hospital
5 Hospital Road
NEWRY BT35 8DR

RE: Litigation Department requests: Mr Aidan O'Brien URGENT

Wasson, Karen [redacted]

Mon 20/10/2014 10:35

To:Simpson, John <[redacted]>;

Thanks John J

From: Simpson, John
Sent: 20 October 2014 10:26
To: Wasson, Karen
Subject: FW: Litigation Department requests: Mr Aidan O'Brien URGENT

Fyi
j

From: Simpson, John
Sent: 20 October 2014 10:26
To: O'Brien, Aidan
Subject: RE: Litigation Department requests: Mr Aidan O'Brien URGENT

Thank you Aidan,
John

From: O'Brien, Aidan
Sent: 19 October 2014 23:20
To: Simpson, John
Subject: RE: Litigation Department requests: Mr Aidan O'Brien URGENT

Dear John,

I gravely apologise for my failure to provide reports regarding the cases listed below.
I seem to have been oblivious to repeated reminders.
I have already replied today regarding the case of [redacted], providing an addendum to my initial report of 20 January 2014.
I have begun to work on the report concerning [redacted].
I do have a very full week ahead, ending with a presentation at a TCFU conference in Belfast on Friday, a presentation which I have yet to prepare.
However, I pledge that I will submit the report concerning [redacted] by the end of this week.
I will have more time to complete the other two reports during the week commencing 27 October 2014, and will have them both submitted by the end of that week.
I sincerely regret these delays.
I will confirm with you by email when each report has been submitted,

Aidan

Attachment folder S21 26 of 2022 Attachment 20). M&M meetings had grown organically in different specialties over many years and appeared to me to be poorly coordinated and governed, particularly with respect to quality improvement outputs. The multidisciplinary input was largely absent, as was the patient experience (other than in Mental Health and Learning Disability where I had completed such a reform in my previous role as AMD in that Directorate). My intention was to rename this as a Trust-wide Patient Safety System (see my Draft Framework for M&M reform, doc ref 20140516 (can be located at Attachment folder S21 26 of 2022 Attachment 21), M&M presentation to regional medical Directors forum May 2015, doc ref 201505 (can be located at Attachment folder S21 26 of 2022 Attachment 22) and sample copy of M&M Monitoring meeting minutes 20140516) (can be located at Attachment folder S21 26 of 2022 Attachment 23).

72.3. My work was subsequently recognised by the Department of Health and referred to in its Regional Handbook for M&M. I also initiated a series of quarterly meetings with each AMD and their aligned Assistant Director to discuss learning points I had extracted from litigation cases as Director responsible for litigation. For example, the sample correspondence (see doc ref 20150216) (can be located at Attachment folder S21 26 of 2022 Attachment 3) refers to my meeting with Dr Martina Hogan AMD for Integrated Maternity and Women's Health (IMWH) and Assistant Director Anne McVey. The agenda for that particular meeting is not referenced here because it contains patients' details.

72.4. Having set the overall direction and put improvements in motion I was acutely aware of the lack of resource available in the Trust, in terms of protected medical time and clerical/managerial support, to ensure that such reforms would be embedded.
As stated above, my abiding memory of that period was of the prevailing preoccupation across health and social care with activity levels, performance, efficiency savings and financial breakeven (see Q1 paragraph o). For example, the first three items on every Senior Management Team meeting of the Trust that I attended were as follows: Chief Executive Business followed by Planning, Performance and Finance with reports from operational managers thereafter. Input from the Medical Director was normally towards the end of the agenda (see sample minutes, SMT notes 12th November 2014) (can be located at Attachment folder S21 26 of 2022 Attachment 24).

72.5. The specific difficulty was, and still is, to embed clinical governance into everyday clinical practice rather than seeing it as an add-on and, further, to embed it in a multidisciplinary rather than uni-disciplinary fashion. The objective being to encourage a culture of good teamwork both clinical and managerial. Where good teamwork exists, any concerns about performance or behaviour can often be addressed by the team and its leadership before a critical level is reached. Raising concerns earlier is therefore more likely to be seen as being helpful rather damaging to colleagues. Governance should then be more of a supportive process at an early stage rather than an investigative process at a later stage. I believe this applies to any human endeavour, not just healthcare.

72.6. This clearly requires investment in training as well as protected time for medical and other clinical leaders with appropriate managerial and clerical support. I believe that this is now well recognised by the Trust and generally across the NHS. My priority was always

66.1. No. I have not been made aware of governance concerns arising out of the provision of urology services during my tenure and employment within the Trust. I have not read any reports regarding this.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

67.1. From my vantage point I can only make general comments.

67.2. Medical oversight and clinical governance have improved over recent decades and continue to be improved. There is a greater understanding of its importance by doctors, managers and healthcare leaders. Consequently, there has been investment in medical leadership in terms of training and extra resource in terms of protected time, as well as more doctors coming forward to engage in leadership.

67.3. As a result, I would say that issues of concern are more likely to be identified earlier and then managed appropriately in order to reduce or prevent harm being done. However, it will always be difficult, particularly at an early stage, to identify and manage concerns about a senior doctor who is deliberately evasive. It is likely that such a problem would put the best clinical governance system to the test. Indeed, I would suggest that similar problems can, and do, arise with regard to senior people in any profession.

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

68.1. The most important learning is that health care leaders need to ensure there is healthy multidisciplinary team working in all parts of the health service. Team members are best placed to identify an individual colleague's slide into poor performance. Healthy team working is also more likely to bring an individual clinician's poor conduct into sharper relief at an earlier stage. The responsibility of team leaders to make timely and appropriate interventions then becomes much easier.

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

69.1. Having retired from the Trust in July 2015, I am not in possession of the full facts regarding problems within the urology service that have since emerged in order to make such a judgement. In order to make such a judgement it would be necessary for me to have knowledge of all of the engagements with the problems, all of the contextual background that existed and all of the responses to said engagements by those within Urology services.

Medical Report concerning patient SUA
provided by Professor Roger Kirby MA MD FRCS (Urol)

I am pleased to submit a medical report on the management of patient SUA by Mr Aidan O'Brien.

My qualifications for providing this expert opinion include a career in urological surgery with particular focus on prostate cancer of more than 35 years, a publication record of more than 300 peer-reviewed articles and 70 books, mainly focused on prostate disease and men's health, together with editorship of the journal that I launched, *Prostate Cancer and Prostatic Diseases*. I am currently President of the Royal Society of Medicine, President of The Urology Foundation and Vice-President of Prostate Cancer UK.

In order to prepare this report, for the purposes of the Urology Services Inquiry, I have been provided with and relied on the following:

1. ECR records for SUA 1-151
2. MHPS records for SUA 1-67
3. Service User A Patient Records 1-82 (electronic pagination)
4. Craigavon Area Hospital records extracted from Rule 7 bundle
5. DATIX – SUA
6. Chronology
7. Serious Adverse Incident Report
8. SUA Clinical History provided by Mr O'Brien August 2022
9. Mr O'Brien's comments on the SAI report August 2022
10. NICAN Urology Cancer Guidelines (2016)
11. Self-Assessment Peer Review (2017)
12. Letter Tughans to DLS 15 March 2021.
13. Ministerial Statement dated 24 November 2020.
14. NICAN Prostate Cancer Regional Hormone Therapy Guideline and Pathway 2015

I can confirm that I have read in detail all the relevant documents concerning this case.

Case History

SUA, a Personal Information redacted by the USI individual, was referred by his GP to the urology service in the Western Health & Social Care Trust on 13 June 2019 by way of a 'red flag' referral. He had an elevated PSA (19ng/ml). His past medical history included longstanding Personal Information redacted by the USI, and Personal Information redacted by the USI. SUA had been prescribed finasteride 5mg daily in February 2010 for urinary symptoms indicative of bladder outlet obstruction. He had additionally been prescribed oxybutynin MR 10mg daily in 2016 for urinary storage symptoms. He remained on both of these medications at the time of referral by his GP due to the finding of serum PSA levels of 19.16ng/ml in May 2019 and of 19.81ng/ml when repeated in June 2019. The 'red flag' urgent referral was directed to the Southern Health and Social Care Trust, received on 14 June 2019 and triaged by Mr O'Brien, on 17 June 2019.

As a consequence of the issue of prolonged waiting times for new referrals within the Southern Trust at the time, Mr O'Brien sensibly requested that an MRI scan of the prostate and pelvis be undertaken prior to an appointment scheduled for 22 July 2019. The MRI scan took place on 10 July 2019 and revealed some benign enlargement in the central zone of the prostate and, at the anterior portion of the gland, a moderately suspicious (PIRADS 3) area of suspected possible prostate cancer, and some

Reason for Referral/ History of Presenting Complaint

Description: ?left sided renal cancer

Comment: Thanks for seeing this man who had USS abd done in May because of elevated GGT. This showed a lesion lower pole of left kidney. CT scan was suggested and this has now been done. This shows a mildly enhancing lesion lower pole left kidney and recommends urology referral.

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Date recorded
[redacted]	

Past procedures (High and medium priority - all)

Description	Date recorded
[redacted]	[redacted]

Family conditions (All priorities)

Description	Date Recorded
[redacted]	- - -

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
[redacted]		-	-	-	-	-
		-	-	-	-	-
		-	-	-	-	-
		-	-	-	-	-
		-	-	-	-	-
		-	-	-	-	-
		-	-	-	-	-

Recent medication (Any medication issued within last 168 days not shown above)

No recent medications recorded

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Never smoked tobacco		26-Feb-2016

ALCOHOL INTAKE

Description	Comment	Date Recorded
Moderate drinker		22-Apr-2015

BMI

25.4

SOCIAL HISTORY

OTHER PATIENT DATA

Signature of referring doctor (or other professional)

Date