

Professor Sam Eljamel, MBBCh, MD, FRCSir, FRCSEd, FRCS(NS), ACS/ALB,
Consultant Neurosurgeon

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Date: June 24th 2013

Mr Phil McLoughlin
Clinical Director
Specialist services and oncology
Ninewells Hospital & Medical School
Dundee DD1 9SY

MEDICAL DIRECTOR

24 JUN 2013

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Dear Phil:

Thank you for meeting with me on Friday 21st 2013 at 13.00. I am very grateful for your supportive approach to resolve the recent concerns.

Further to our meeting on Friday 21st 2013, I have now reflected on what you have said. At this juncture, I would like to put in writing the mitigating circumstances leading to these concerns, and how I have addressed them. Meanwhile I welcome the independent college review of neurosurgical services in Tayside including my practice and the proposed supervision of my practice. I would like this letter to be forwarded to the college reviewers along with the review request.

I would also like to discuss and agree the following details in advance:

- 1- The terms of reference of the review.
- 2- The extent of the review.
- 3- What information will be provided to the reviewers?
- 4- I would appreciate advanced knowledge of who will perform the review.
- 5- The extent of the supervision of my practice:
 - a. Who will be doing it?
 - b. The roles are clearly defined.
 - c. What happens to my on call commitment?
 - d. What junior support I will have? And what their roles will be?
- 6- What happens to my other admin, teaching and research commitments?

Mitigating circumstances:

1- Workload:

As I am the most senior consultant on the neurosurgical service in Tayside, taking over one of the biggest neurosurgical practices in the area of the late Ivan Jacobson in 1995. In addition to the practice I have inherited I started skull base surgery in Tayside performing all the acoustics. My practice grew significantly when Mr TRK Varma left to Liverpool in 1998, as I took over his pain, DBS, epilepsy, pituitary and neurosurgery for mental disorders. I was only supported by locum consultants for a long period of time, from 1998 to 2000. After the

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appointment of Mr Ballantyne in 2000, I have had to support him in addition to my own workload and he was able to take off Pediatric neurosurgery and intrathecal pump service, which I was doing when Mr Varma was here in addition to my general practice and skullbase. When Mr Mowle joined later, he was able to take the vascular service. Lately the pain surgery was gradually taken over by Mr Ballantyne. Gradually however, the pediatric and vascular subspecialties weathered away due to circumstances and outside pressures.

I established a joint clinic to review pituitary patients with Prof G. leese, a joint skull base clinic with Mr M Hussain, a joint DBS clinic with Dr Swingler and a joint malignant brain tumour clinic with Dr Hannah Lord. Consequently, long waiting times for review patients to come to clinic for review had arisen. As a consequence I thought it was correct to:

- a- Run concurrent general review clinic with my subspecialist clinics where the SpR saw the general review patients. However, as it turned out some of the SpRs were not able to handle or spot difficult patients and alert me to see them. SpRs were less experienced as years went by.
- b- Reduced but not cancelled my clinics when I was on leave. However, as it turned out some of the SpRs were not able to handle or spot difficult patients.
- c- I agreed to create an emergency clinic ran by the SpR, as it turned out some of my patients who could not be seen in the normal clinic due to long waiting times were booked to this clinic. However, as it turned out most of these patients were difficult to handle by SpRs.
- d- To accommodate increased workload year in, year out for over 17 years, it was necessary to book new and review clinics based on a minimum of two doctors seeing patients in the clinic; a consultant and SpR. Inevitably this led to some patients being added to waiting list by SpRs or more recently by advanced nurse practitioners. This led to some patients unsatisfied not seeing me in person.
- e- Initially I had two full days operating lists, which was great as I was able to keep waiting times under control, then my theatre sessions were reduced to 1.5 days per week in theatre with additional one Friday each third week. I was just keeping waiting times reasonably down. Four years ago one of my colleagues (Mr Ballantyne) was appointed Neurosurgery Network Director and reduced his NHS-Tayside commitments by 4 sessions. This change in service configuration was not discussed with me in advance. I did therefore

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take additional session in theatre, which was great as I was once again able to keep my waiting times at bay.

- f- However, from 2011 my fourth colleague was appointed without any additional operating time. My colleagues did not have the capacity to change their weekly schedule, so I stepped in instead and altered my weekly schedule from Monday and Thursday operating days to Monday only, I moved my new clinic and neuromodulation clinic to Thursdays PM. The effect of that I lose several Monday lists due to public holidays. The effects of all these changes meant longer waiting times.

2- Changes to infrastructure and support:

- a. Due to changes to immigration laws, a significant number of SpR posts remained vacant or filled with doctors who were not performing at a level expected. This has meant increasing the demand on my time.
- b. The main training SpR post rotating with Glasgow was normally at ST3. Instead three years ago due to problems in Glasgow we were forced to accept an ST1 on the service, his second year was ST2 which involved significant time out of service. I was surprised that a run through trainee stayed in Tayside for 3 years and had not spent a single full month in my service. Every time he was due to come and work with me he was sent out of neurosurgical service.
- c. Two years ago because of recruitment problems, two of the SpR positions were replaced with 2 advanced nurse practitioners, who were skilled their work but not to the level of an SpR. Furthermore appointment of a fourth consultant with reduction of junior staff numbers from 6 to 4 reduced their day time availability and continuity of care.
- d. Trainee support in the ward has deteriorated over the last few years to the extent that hand over of my patients was not sufficiently done to enable me to deal inpatient problems proactively.
- e. Direct access of MRI and CT to GPs resulted an increased referrals and conversion ratio from outpatient to waiting lists. Furthermore availability of radiology reports to GPs prior to my review of the MRI and CT and their correlation to physical findings led to increased phone calls to my secretary and requests to expedite patients' outpatient appointments.

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- f. Due to overwhelming workload and increased waiting times made worse by time to treatment guarantees resulted in increased phone calls to my secretary overwhelming her to the extent that she could not cope anymore and leading to a flurry of complaints which were not helped by her line managers.

3- Time to treatment guarantees:

- a. Implementation of the TTG put an excessive pressure on my service and my secretary. There were no additional resources put in place in terms of secretarial, admin, operating time or locum consultant to do the extra work necessary.
- b. Simply asking an overstretched service to do more evening lists, Saturday lists and evening clinics was not ideal, this did not lead to permanent solution and evening clinics added more and more patients to the waiting list. As it turned out patients seen by SpR, Physiotherapy or Advanced Nurse Practitioners either at the outset or on review clinics were a source of some of complaints and dis-satisfaction of patients, leading to ongoing complaints, which are wearing everyone down including myself.

Due to aforementioned mitigating circumstances, human errors have occurred, however, I have always acted in the best interest of my patients and their safety was always my top priority at all times.

What has changed recently to resolve these issues:

- 1- I see all new patients before they are put on the waiting list.
- 2- All patients are reviewed before surgery after admission to make sure their condition had not changed since they went on the waiting list.
- 3- All spinal surgery patients get an intraoperative X-ray to confirm the level of intervention required.
- 4- I have moved my review clinic to Friday afternoon so that I can see my patients by myself. This will allow my subspecialty clinics to run separately and I will be able to see patients personally in both clinics.
- 5- I have moved my neuromodulation clinic from Thursday afternoon to Wednesday am so that all my subspecialist clinics fall on the Wed am. In essence from Aug 1st 2013 I will be performing three clinics per week.
- 6- I will cancel all my clinics when I am on leave.

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- 7- I will not agree to elective patients to be seen in the neurosurgery emergency clinic and myself will screen referrals to the physiotherapy clinic.
- 8- I will be reducing the number of patients on my operating lists inline with other colleagues and when I have an emergency procedure I will cancel elective procedures to make room for the emergency/ urgent procedure.
- 9- I have discontinued my private practice from Monday 24th June 2013 till further notice to reduce my workload.

As you can see there were mitigating circumstances that led to a flurry of complaints and dissatisfied patients and I have made significant changes in my practice to prevent these complaints in future and improve patients' experiences under my care.

Yours sincerely:

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Prof Sam Eljamel,
Consultant Neurological Surgeon

Copy to:

✓ Dr Andrew Russell
Medical Director
NHS Tayside

