

**Neurology recall Cohort 3**  
**April 2021**  
**Frequently Asked Questions**

**1. What is the background to the recall of neurology patients under the care of Consultant Dr Michael Watt?**

Concerns in relation to a small number of patients were raised in late 2016 and early 2017 regarding the care and treatment provided by Consultant Neurologist Dr Michael Watt. This prompted a review process by the Belfast Trust which led to the Royal College of Physicians being asked, in July 2017, to conduct a wider independent review of his practice.

Restrictions had been imposed on the specific areas of his practice that were under review from December 2016, culminating in Dr Watt ceasing all patient care and treatment from the summer of 2017, both in HSC and private sector.

The Royal College of Physicians delivered its independent report in April 2018. Acting on its expert findings and recommendations, the Belfast Trust recalled some 2,500 patients, between May and August 2018, who were still attending Dr Watt's clinics prior to his cessation of active practice (Cohort 1).

A number of patients who were under the care of Dr Watt in the private sector were also recalled. The Ulster Independent Clinic reviewed 82 patients and Hillsborough Private Clinic reviewed fewer than five patients.

The outcomes of the recall of patients in Cohort 1 has been published by the Department of Health [available here](#).

In November 2018, following a review of case notes from recently discharged patients, a further 1,044 patients were recalled (Cohort 2). [The Department of Health has published the findings from this review here](#).

The Regulation Quality and Improvement Authority (RQIA) is also conducting a review of patients or former patients of Dr Watt who have died over the past ten years to ensure their care was managed appropriately. This work is ongoing.

**2. Who is being recalled in April 2021?**

The people recalled today are former patients of Dr Watt who were seen and discharged between 1996 – 2012 and who are taking certain prescribed medications for specific neurological conditions.

Those people affected will have received a letter asking them to contact us to set up a telephone review with a consultant neurologist. The purpose of this appointment is to review the medication a person is taking and to assure ourselves it is appropriate for their condition. Should anyone require a further face-to-face appointment that will be arranged for a different day. Extra clinics have been set up to facilitate this and we plan to have completed all telephone reviews within 4 weeks.

While we have asked 209 people to make an appointment with us, it should be stressed that through a review of medical records we have been able to identify several thousand individuals who do not need a review appointment. We would therefore ask that patients who do not receive a letter should not be concerned and have no further action to take.

If patients are unsure, or need support we would ask that they contact the Neurology Advice Line on **0800 980 1100**.

The advice line is operational from 9am-8pm until Tuesday 27<sup>th</sup> April. After this date the opening hours will return to 9am to 5pm daily with the exception of weekends and public holidays.

Additionally, the Trust has asked a number of GPs to confirm if 495 people remain correctly on certain non-neurological long-term medications, like Aspirin, who were seen by Dr Watt between 1996 and 2012 at a neurology clinic and who have not been reviewed by a consultant neurologist in the intervening years. If a GP would like the Trust to review any person they are unsure of, we will ensure that happens.

#### **4. Why are you recalling these patients now?**

Out of several thousand medical records, we would like to speak to 209 people. The patients recalled today are former patients of Dr Watt and they will have been within the health and social care system for a very long time. Many will have been reviewed by a GP or other health professional in that time – but they won't have been reviewed by a consultant neurologist. This is a review to assure ourselves that their medication remains correct for their condition.

While the likelihood is the vast majority of people will be taking medication appropriately, it is nonetheless important that we confirm that.

Patients should continue to take the medication they have been prescribed until advised otherwise by a consultant neurologist.

#### **5. Did you miss these patients during previous reviews?**

Not at all. The patients recalled in May 2018 were those Dr Watt had been treating when he was restricted from clinical duties in June 2017, and therefore the highest clinical priority. Similarly, those in November 2018 were patients who had been discharged from his care relatively recently and who were on very specific medication.

The patients recalled today are former patients of Dr Watt, discharged from 1996 through to 2012. They will be on certain medications and they will not have been seen by a neurologist in the intervening years.

## **6. Will patients being recalled be offered face-to-face review appointments?**

We have written to patients and we have asked them to arrange an initial telephone review with us. If a further face-to-face appointment with a consultant neurologist is required this will be arranged for a different day.

## **7. I've received a letter. What should I do now?**

Please follow the instructions in the letter and contact us to arrange a telephone review. If you are taking medication, please do not stop. Please continue to take it as normal.

If you need any further information or advice please contact the Neurology Recall Patient Advice Line on **0800 980 1100**.

The advice line is operational from 9am-8pm until Tuesday 27<sup>th</sup> April. After this date the opening hours will return to 9am to 5pm daily with the exception of weekends and public holidays.

## **8. I'm a concerned patient/carer. Where can I get further information or support?**

Anyone who is worried and who is seeking further support should phone the **Neurology Recall Patient Advice Line on 0800 980 1100**. The advice line is operational from 9am-8pm until Tuesday 27<sup>th</sup> April. After this date the opening hours will return to 9am to 5pm daily with the exception of weekends and public holidays.

Alternatively, anyone who is seeking further support should contact their GP or private healthcare provider (if appropriate).

## **9. Will there be another recall after this?**

No. We do not foresee the need to recall any further patients once this is complete. We have now reviewed the medical records of every patient seen by Dr Watt and have recalled those people we would most like to see.

## **10. I have not received a recall letter. What should I do?**

It is important not to cause undue alarm to anyone who has ever attended one of Dr Watt's clinics in the past.

This phase of the recall is concentrating on specific groups of patients. If you are a past patient and have not received a letter, you do not need to take action or to get in touch.

It is important that all those who receive a letter do not stop or make any adjustments to their medications until they have been reviewed by a consultant neurologist at their appointment.

### **11. What about the Blood Patch Review?**

Separate to the neurology recall, Belfast Trust undertook a case note review of 66 patients who had a blood patch procedure under the care of Dr Michael Watt, and who did not have a clinical review as part of the recall process. The internal review established that 46 patients had care that was unsatisfactory and fell below a standard we would expect. Additionally, the review established that for 45 patients there was no clinical evidence to support that a blood patch procedure was required. We are deeply sorry for this and for the undue hurt these patients experienced.

We agreed with the Royal College of Physicians to undertake an independent quality assurance process in relation to the Trust's own review of blood patching. The College is concluding its work and will provide a final report in early May 2021. However, the College have been able to provide an interim update that their findings are generally consistent with those of Belfast Trust.

### **12. How is the system coping with this additional pressure?**

We fully understand how worrying it is for any person who has been recalled, and equally worrying for their families and carers. Staff are working very hard to ensure that patients are recalled as quickly as possible. Additional staff and clinics have been put in place specifically for patients involved in this recall. The recall will not impact on the other work of neurology services and no patient will be disadvantaged as a result of the recall. The plan is that all patients recalled in April 2021 will have had their appointment within 4 weeks.

### **13. What are the implications on the neurology services continuing to work under this pressure?**

Our staff are working extremely hard. The whole system has come together to ensure that recalled patients are seen and staff are fully committed to seeing each patient requiring an appointment and discussing their individual care with them. Crucially, these appointments are additional and are not impacting on the core neurology service which continues.

The Neurology service like all services has felt the impact of Covid-19 in the past 12 months as we have prioritised the care of the most ill patients. As a result, we have not been able to hold our regular appointment lists and waiting times have slipped.

This is an unfortunate result of the pandemic and one we will need to prioritise addressing across the Trust as we emerge from the latest surge.

### **14. What about the progress of the Review of Neurology Services in Northern Ireland?**

The Department of Health is leading on the Review of Neurology Services. [You can read the update from the Minister here.](#)

### **15. Has any harm been caused to patients?**

We would like to apologise to every person who has been recalled by us, either in April 2021 or in 2018. We know this whole process has been very painful and worrying for a lot of people, and for that we are sincerely sorry.

All the information available to us, including the recently published outcomes report tells us that a certain number of people may have been put on incorrect medication, or will have been given an incorrect diagnosis. Therefore, it is really important that we see the people we have invited back and so assure ourselves and them that their medication is correct for their diagnosis.

We sincerely regret all the hurt and pain caused over the last number of years and for the harm that has been undoubtedly been done.

The focus of the work to date has been to reassure patients, families and the wider HSC that every individual is on the correct care pathway and all individual patients are informed of the outcome of their review by the neurologists that see them.

### **16. What is being done about the redress scheme?**

The Department of Health is leading on this. [You can read the update from the Minister here.](#)

### **17. What is happening with Dr Watt?**

Dr Watt is no longer employed by Belfast Trust and he is restricted from all clinical duties pending an investigation by the General Medical Council (GMC).

### **18. Have you an update on Statutory Public Inquiry?**

The establishment of an Independent Panel-led Inquiry was announced by the Permanent Secretary of the Department of Health in May 2018. The Minister for Health, Robin Swann, converted the Independent Panel-led Inquiry to a Statutory Public Inquiry on 11 December 2020.

The Inquiry Panel will carry out an independent statutory inquiry of an inquisitorial nature. More information can be found here [www.neurologyinquiry.org.uk](http://www.neurologyinquiry.org.uk).

[You can read the update from the Minister here.](#)

### **19. How will Health and Social Care review the wider issues and ensure lessons are learned?**

There are clearly important wider questions which will need to be addressed both to fully understand and assess the impact of what has happened and also to ensure that we can have confidence in the safety of neurology services now and in the future.

Belfast Trust has made significant changes to strengthen our internal processes and controls to ensure something like this cannot happen again.

The Department of Health has previously directed the Regulation Quality and Improvement Authority (RQIA) to undertake a review of governance of outpatient services in Belfast Trust with a particular focus on neurology services. The review was then extended as part of its rolling programme of inspections to cover all HSC Trusts in NI.

The Department has also asked the RQIA to commission a parallel piece of work to ensure that the records of all patients or former patients of Dr Watt who have died over the past ten years are subject to expert review.

The Department of Health has also commissioned its own Review of Neurological Services in Northern Ireland and it has published an interim report. Once finalised, the full Report will set out a clear strategic direction for how neurological services are delivered across Northern Ireland.

There is a Statutory Public Inquiry ongoing. We will embrace the lessons learned that come from this. More information can be found here [www.neurologyinquiry.org.uk](http://www.neurologyinquiry.org.uk).

[You can read the update from the Minister about all these items here.](#)