Urology Services Inquiry

UROLOGY SERVICES INQUIRY

See letter from SHSCT to USI dated 31 January 2023 at WIT-91875 to WIT-91880 detailing corrections to this witness statement. Annotated by Urology Services Inquiry.

USI Ref: Notice 27 of 2021

Date of Notice:

Witness Statement of: Richard Wright

I, Dr Richard Wright, will say as follows:-

This response has been compiled with the assistance of Mr Mark Haynes (Associate Medical Director, Surgery) and Mr Francis Rice, (former Chief Executive) only in relation to the issue of the date of the initial notification by Mr Haynes to me, of the issues involved and my subsequent meeting with Mr Rice. (See Question 1, ii and question 36)

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.**

Roles, Responsibilities and Duties

Timeline of involvement:

1.1. I have given an overview narrative below in response to Question 1 but will provide further detail regarding some of these issues in later answers.

Urology Services Inquiry

71.1. I believe the questions already asked to have satisfactorily covered the areas of interest.

Statement of Truth

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

Signed R E RichardWright_____

Date: 16th June 2022_____

UROLOGY SERVICES INQUIRY

See letter from SHSCT to USI dated 31 January 2023 at WIT-91875 to WIT-91880 detailing corrections to this witness statement. Annotated by Urology Services Inquiry.

USI Ref: Notice 43 of 2021

Date of Notice: 29th April 2022

Witness Statement of: Dr Richard Wight

I, Dr Richard Wright, will say as follows:-

This response has been compiled with the assistance of Mr Mark Haynes (AMD Surgery) and Mr Francis Rice (former Chief Executive) only in respect of the provision of information concerning the date of the initial notification by Mr Haynes to me of the issues involved and my subsequent meeting with Mr Rice.

General

1. ***Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. 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 using the form provided.***

1.1 My knowledge of and involvement in the MHPS process in respect of Mr O'Brien has been set out in detail in my response to Section 21 Notice No. 27 of 2022, in particular in my answers to Questions 1 (from para 1.4 to 1.21), 49, 54, 55, 60, 63,

Statement of Truth

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

Signed: R E Richard Wright

Date: 16/06/2022

HSC Business Services Organisation

Directorate of Legal Services
2 Franklin Street, Belfast, BT2 8DQ

FAO: Anne Donnelly
Urology Services Inquiry
Bradford Court
1 Bradford Court
Belfast
BT8 6RB

Date:
31st January 2023

Dear Madam

Re: Dr Richard Wright

We refer to the two witness statements of Dr Richard Wright (the first dated 16 June 2022 in response to s.21 Notice No.27 of 2022 [WIT- to WIT-17900] and the second also dated 16 June 2022 in response to s.21 Notice No.43 of 2022 [WIT-18421 to WIT-18453]). We also refer to Dr Wright's recent consultation with Inquiry Counsel on 20 January 2023 and to his forthcoming evidence session on 1/2 February 2023.

As discussed at the said consultation, a number of errors in the statements of Dr Wright have come to our attention and we understand that Dr Wright will seek to correct these at the appropriate point at the start of his oral evidence on ½ February 2023.

In ease of the Inquiry, and as discussed at his recent consultation, we understand the errors that Dr Wright will seek to amend to be as follows (the Inquiry will note that many of the errors are the same mistake repeated several times):

Dr Wright's First Statement of 16 June 2022 – S.21 Notice No. 27 of 2022

1. WIT-17829 - The relevant S.21 Notice number is wrongly recorded as '27 of 2021' when it should be '27 of **2022'**.
2. WIT-17830 – Para 1.5 – The sentence *'I was not privy to the March 2016 meeting or letter at the time'* should be amended to *'I was not privy to the March 2016 meeting* ***but was, on 30 March 2016, sent a copy of the letter along with confirmation that Mr Mackle had met with Mr O'Brien and given him the letter (TRU-282022)****'*.
3. WIT-17831 - Para 1.7 - The words in brackets that have been crossed out should be deleted: '(~~*Previously* Clinical Director *but now Associate Medical Director)'.~~
4. WIT-17831 - Para 1.7 - The following words that have been crossed out should be deleted: '*Mr Haynes ~~was newly appointed as Surgical Associate Medical Director and~~ had discovered …'~~.
5. WIT-17840 – Para 7.3 – the words in brackets '(initially Mr Mackle and then Mr Haynes)' should be amended to '(initially Mr Mackle**, then Dr McAllister,** and then**, following a short gap,** Mr Haynes)'.
6. WIT-17841 – Para 8.1 - the words in brackets '(initially Mr Mackle and then Mr Haynes)' should be amended to '(initially Mr Mackle**, then Dr McAllister,** and then**, following a short gap,** Mr Haynes)'.
7. WIT-17872 – Para 46.2 - the words '… after that I supported Mr Haynes formally and informally …' should be amended to '… after that I supported **Dr McAllister and then** Mr Haynes formally and informally …'.
8. WIT-17848 – Para 17.3 – The last sentence, *'Between March 2016 and December 2016 …'* should be amended to, *'Between March 2016 and December* ***2017*** *…'*.
9. WIT-17850 – Para 20.1 – *'Autumn 2016'* should be amended to *'Autumn* ***2017'***.
10. WIT-17862 – Para 36.4 – *'September 2015'* should be amended to *'September* ***2016'***.
11. WIT-17863 – Para 37.1 - *'Autumn 2016'* should be amended to *'Autumn* ***2017'***.
12. WIT-17876 – Para 48.1(a) – This paragraph should have added to the start of it the following words in bold: *'****Apart from the matters raised with me by Mrs Trouton and Mr Mackle in January 2016 which were the subject of a letter to Mr O'Brien in March 2016 (as detailed above at, e.g., paras 1.4 and 1.5),*** *I was not aware …'*.

13. WIT-17877 – Para 49.3 – The first reference to *'September 2018'* should be amended to ***'February 2018'*** and the second reference to *'September 2018'* in brackets should be amended to ***'Autumn 2017'***.
14. WIT-17879 – Para 52.3(vi) - The date of the meeting should be amended from *'30th January 2016'* to *'30th* ***December*** *2016'*.
15. WIT-17882 – Para 55.3 – The description of Mr Haynes in brackets should be amended from *'(Associate Medical Director)'* to ***'(Clinical Director)'***.
16. WIT-17884 – Para 56.4 - The date *'30th January 2017'* should be changed to *'30th* ***December 2016'***.
17. WIT-17884 – Para 56.6 - The date *'30th January 2017'* should be changed to *'30th* ***December 2016'***.
18. WIT-17886 – Para 58.1 - The date *'30th January 2017'* should be changed to *'30th* ***December 2016'***.
19. WIT-17891 - Section 64.2 - The date *'30th January 2017'* should be changed to *'30th* ***December 2016'***.
20. WIT-17894 – Para 67.4 – The reference to 2016 in the following sentence should be amended to **2017**: *'I observed the interactions between my AMDs and I was convinced that this was beginning to yield dividends around Autumn 2016.'*
21. WIT-17895 - Para 67.9 - The reference to autumn 2016 in the following section should be amended to autumn **2017**: *'I believe that, by autumn 2016, we had made considerable progress in developing a well-informed, highly trained senior medical team within the Trust. They realised the significance of the findings in relation to Mr. O'Brien and had the confidence to escalate. Historically, this had not been the case in relation to the surgical team.'*
22. WIT-17897 – Para 70.2 – The sentence that begins *'I did appreciate the full implications…"* should be amended to *'I did* ***not*** *appreciate the full implications …'*.

Please also note that we have identified an error in the question numbering in the body of Dr Wright's first witness statement. The number of Question 4 appears somehow to have dropped off the statement so that the question numbers on the statement between questions 4 and 21 (inclusive) do not match those in the corresponding Section 21 Notice (see, in

particular, WIT-17816 vs. 17837 plus WIT-17818 vs. 17851). However, as the text of each question has been faithfully reproduced in the body of the witness statement ahead of each of Dr Wright's answers, we trust that this will not have caused any difficulty.

Dr Wright's Second Statement of 16 June 2022 – S.21 Notice No. 43 of 2022

1. WIT-18421 - The relevant S.21 Notice number is wrongly recorded as '43 of 2021' when it should be '43 of **2022'**.
2. WIT-18430 – Para 7.13 – The description of Mr Haynes in brackets should be amended from '(AMD)' to '(**CD**)'.
3. WIT-18430 – Para 7.14 – The description of Mr Haynes in brackets should be amended from '(Associate Medical Director)' to '(**Clinical Director**)'.
4. WIT-18432 – Para 9.1 – The description of Mr Haynes in brackets should be amended from '(Associate Medical Director)' to '(**initially Clinical Director, then** Associate Medical Director)'.
5. WIT-18433 – Para 10.2 – Delete the words '*when he became AMD for Surgery*'.
6. WIT-18436 – Para 13.1(i) – Delete the words *'(AMD Surgery, representing Acute Services)'*.
7. WIT-18442 – Para 18.1 - The description of Mr Haynes in brackets should be amended from '(Associate Medical Director, Surgery)' to '(**Clinical Director**)'.

Finally, we wish formally to repeat the apology that was offered in respect of the above errors at our recent consultation, in particular, we apologise for any inconvenience caused to the Inquiry as a result.

Yours Sincerely

Emmet Fox
Solicitor

Business Services Organisation
Directorate of Legal Services
2 Franklin Street, Belfast, BT2 8DQ

Email: Personal Information redacted by USI

Contact:

From: Wright, Richard
To: Scullion, Damian; Tariq, S; Weir, Colin; Haynes, Mark
Subject: Temporary management arrangements
Date: 11 November 2016 09:57:50

You will be aware that Dr McAllister has stepped temporarily stepped aside as AMD for surgery and anaesthetics to facilitate an ongoing internal Trust process. During this period I would expect management issues to be dealt with by the Clinical Directors in liaison with Mrs Gishkori and myself in relation to professional issues. I will update you if the situation changes.
Regards
Richard Wright

Sent from my iPad

Urology Services Inquiry

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.**

Your position(s) within the SHSCT

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

4.1. My qualifications are:

- M.B. (Bachelor of Medicine) QUB
- B.Ch. (Bachelor of Surgery) QUB
- B.A.O. (Bachelor of Obstetrics) QUB
- F.F.R.R C.S.I. (Fellow of the Faculty of Radiologists of the Royal College of Surgeons of Ireland)
- F.R.C.R. (Fellow of the Royal College of Radiologists)
- M.Phil. (Master of Philosophy, research, Q.U.B)
- P.G.Dip. Med Law (Post Graduate Diploma, Medical Law, Northumbria University)
- M.A. Biblical Studies and Contemporary Theology (University of Cumbria, 2020)

4.2. I am a founding member of the Faculty of Medical Leadership and Management (FMLM)

4.3. I was appointed Medical Director of the Southern Health and Social Care Trust on 1st July 2015. Prior to this I had not worked for SHSCT in any capacity. I had been an Associate Medical Director and Consultant Radiologist in the Belfast Health and Social Care Trust. I held the post of Medical Director for approximately 3 years before retiring from full time medical work in August 2018. Because of a period of illness, I effectively stood down as Medical Director in February 2018 until my formal retirement in August. As Medical Director I also acted as the Responsible Officer (RO) for all medical staff within the Trust. I was responsible for the professional standards of medical practice of all doctors within the organisation.

4.4. As Medical Director I served as part of the Executive Trust management team and as part of the Trust Board. I was directly responsible to the Trust Chief Executive. During my tenure there were several different interim Chief Executives between 2015-2018 (Clarke, Donaghy, Rice, and McNally) until Mr Shane Devlin was appointed in early 2018 into a substantive position.

4. 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.

5.1. I qualified in medicine in 1985 working as a junior doctor in the Belfast City and Royal Victoria Hospitals. I trained in radiology from 1987 until 1993 mostly within Northern Ireland but with placements at Alder Hey Hospital, Liverpool and the Royal Marsden, London.

5.2. I was appointed to the Ulster Hospital in 1993 as a Consultant Radiologist becoming Clinical Director of the Clinical Diagnostics Directorate 2000-2005.

5.3. I was appointed to Belfast Health and Social Care Trust as a Radiologist in 2005. I accepted the position of Associate Medical Director in 2010 with initial responsibility for Clinical Services including Anaesthetics,

Imaging and Laboratory services and subsequently Specialist Hospitals which included RBHSC, RJMH, Musgrave Park orthopaedic centre, ENT, and the Dental Hospital. I was the BHSCT appraisal lead for 4 years until 2015.

5.4. In July 2015 I was appointed to the Southern Health and Social Care Trust (SHSCT) as Executive Medical Director. I had not worked in any capacity for the SHSCT prior to this.

5.5. I retired from the SHSCT in August 2018 to pursue a different path outside of medicine. I was unwell in February 2018 and had to take a period of sick leave [redacted]. Returning to work in March 2018, I agreed with the Chief Executive, Mr Devlin, that I would not return to the role of Medical Director. My duties were being carried out temporarily by Dr Khan. Instead, I carried out several specific reviews regarding job planning and medical recruitment. My direct involvement with the issues relating to Mr O'Brien therefore ceased in February 2018. The relevant job plan has been included in the evidence provided by the Trust to the inquiry *(this can be located at Relevant to HR, reference no 15, 20150800-REF15-Dr R Wright - Medical Director Job Description)*

5. 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. In my role as Medical Director, I was answerable directly to the Chief Executive of the Trust. At the time of appointment this was Paula Clarke, however, over the relevant period there were several interim Chief Executives including Francis Rice and Stephen McNally. Mr Shane Devlin was then appointed into a substantive position in 2018. The Trust Board Chair was Mrs Roberta Brownlee.

6.2. My Responsible Officer was the Director of Public Health who was Dr Harper at the time of my appointment to SHSCT in 2015.

answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. ***Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS') and the 'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').***

Policies and Procedures for Handling Concerns

4. ***In your role as Medical Director what, If any, training or guidance did you receive with regard to:***
   - ***I. The MHPS framework;***
   - ***II. The Trust Guidelines; and***
   - ***III. The handling of performance concerns generally.***

4.1 I was involved in applying the MHPS process throughout my time as Associate Medical Director in the Belfast Health and Social Care Trust between 2010-2015 and then as Medical Director in the Southern Health and Social Care Trust 2015-2018.

4.2 During that period, I had experience of many MHPS cases (more than 30). In Belfast I would often have acted as Case Investigator or Case Manager as defined by the MHPS process but in SHSCT my role was more so focused in the Oversight team.

4.3 I have included in this response a summary of courses that I attended and received but also courses that I delivered and helped to create. The rationale for this is that, in creating and/or delivering such a course, there is often more learning than if one is simply a passive receptor of information. The direct engagement with other participants and the opportunities for group learning with question and answer sessions is often a much more powerful means of learning than simply receiving information.

4.4 I have also included evidence of attending courses where available.

4.5 I helped devise and deliver training sessions to medical trainees in association with the Health and Social Care Leadership Centre from 2013-2015 as part of the regional leadership and management course. This would have included a brief introduction to the MHPS process.

4.6 On 30th April 2014, I attended the Revalidation Skills Development Workshop at BHSCT.

4.7 On 4th December 2015, I attended the Onboard Training offered by David Nicholl which included discussion of governance issues. Please find attached certificate *located at S.21 43 of 2022, Attachments- Appendix 1*.

4.8 During March 2016 and 2017, I lectured at the Staff Grade and Associate Specialist (SAS) regional conference hosted by the SHSCT. I covered some of the issues related to MHPS in those lectures but only on a superficial level. Please find attached *located at S.21 43 of 2022 attachments- Appendix 2*.

4.9 Between 5-6th July 2016, I attended the National Patient Safety Conference in Manchester. There were several sessions where the MHPS process was discussed.

4.10 On 28th June 2016, I jointly delivered a talk at the NHS Confederation conference on clinical leadership which including some discussion around MHPS.

Southern Health and Social Care Trust

Quality Care - for you, with you

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), Research & Development 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. To lead in the development of a framework to ensure a strong infrastructure of medical leadership within the Trust, including the development of a competency framework to drive succession planning.

2. 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.

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

4. 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.

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

a) 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.

b) 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).

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

d) 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.

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

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

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

a) 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.

b) Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by SMT, within the wider Clinical and Social Care Governance arrangements of the Trust.

c) Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to SMT, Governance Committee and Trust Board.

8. Professional lead in relation to Information Governance, specifically the Trust's nominated Caldicott Guardian, and chair of Trust Information Governance Committee.

SERVICE DELIVERY

9. Strategic management and co-ordination of effective Emergency planning within the Trust, including Pandemic Planning.

10. Responsible for ensuring a Major incident policy is in place for the Trust, and suitable support is in place for the testing, recording and subsequent modification of the policy and attached plans are reviewed constantly and reported on at agreed intervals.

11. Responsibility for Controls Assurance Standards (CAS) for Emergency Planning and Research Governance with provision of Annual Reports to Trust Board.

12. Management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.

13. Responsible for the strategic management of the clinical aspects of HCAI and Infection Control within the Trust, including the line management of the Infection Control Team and responsibility for CAS for infection control and provision of Infection Prevention and Control Annual Report to Trust Board. The postholder will liaise as appropriate with the Director of Acute Services who is responsible for environmental hygiene.

14. Develop and implement health surveillance methodologies for the Trust.

15. Responsible to Trust Board for the discharge of medical statutory functions.

LITIGATION

16. To provide medical leadership advise to the Director of Human Resources & Organisational Development in respect of medical litigation including effective integration with wider clinical governance systems and engagement and involvement of other Directorates.

17. Lead Director for the Trust's Medical Negligence and other related committees to:

    a) provide an investigation and management service on behalf of the Trust in relation to claims of litigation in respect of clinical negligence and associated matters

    b) assist HM Coroner with enquiries and the preparation of statements prior to inquests

    c) liaise with the HSCB and/or the Department of Health as necessary for follow up action subsequent to sudden death or significant adverse incidents.

18. Lead decision-maker for management of medical negligence. Provision of regular reports to SMT, Governance Committee and Trust Board to provide assurance of effectiveness of Litigation function, systems and processes.

MEDICAL EDUCATION, & TRAINING

19. The postholder will be responsible for the quality of medical education and training within the Trust working closely with education and training bodies and ensure the Trust has a highly skilled career grade medical workforce. This will include accountability for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.

20. Lead on the post graduate training of junior doctors in training within SHSCT, including managing the relationship between NIMDTA and the Trust, and ensuring the Trust and NIMDTA work in partnership to maintain a high standard of education and related patient safety.

21. Lead on the work related to the newly established “Sub Deanery” for Queens University (QUB) Medical School within SHSCT, including managing the relationship between QUB and the Trust, and ensuring the Trust and QUB work in partnership to maintain a high standard of education and supervision of the Medical students placed with SHSCT. This work includes an Annual report and financial report on the funding provided to SHSCT by QUB in respect of the work of the sub-deanery.

22. Management of the Associate Medical Director (AMD) for postgraduate Medical Education, induction and training for Junior Doctors, QA / evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.

23. Responsible for the development and maintenance of professional standards and education liaising with professional and education bodies as necessary.

24. Provide advice on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to patients and clients.

25. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC’s guidance ’Duties of a Doctor’, ‘Good Medical Practice’ and related documents, and succeeding and replacement documents or the GDC’s lifelong learning requirements.

26. Ensure the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

RESEARCH & DEVELOPMENT

27. The postholder will be responsible for the strategic and operational management of Research and Development within the Trust, including the line management of the AMD for Research and Development and associated support staff. This role includes responsibility for CAS for Research and provision of Research and Development Annual Report to Trust Board.

28. Responsible for the Trust’s Research Committee to agree a programme of research and development and ensure the extant legal and regularity permissions are obtained.

QUALITY

29. Promote the highest possible standard of medical practice, advice and support to ensure the development of a quality culture with an emphasis on the need for continuous improvement.

30. Promote quality initiatives such as Investors in People and Charter Standards in the Trust and support the development and delivery of a Trust Quality Improvement Framework.

31. Ensure that medical standards are clear and defined in contracts/service level agreements for the provision of services to other Trusts or with independent service providers.

32. Continue to develop and maintain appropriate Quality Indicators, including a comprehensive Mortality Report and provide information and assurance on the intelligence from such indicators to operational Directors, Chief Executive and Trust Board.

33. To ensure that the Mortality and Morbidity process within the Trust underpin and quality assure the mortality indicators and other indicators of quality and opportunities for learning and improvement.

34. Keep up to date with policies and guidelines on good practice from the Royal Colleges, GMC, universities etc. and identify opportunities to enhance the quality of services provided by the Trust.

FINANCIAL AND RESOURCE MANAGEMENT

35. Responsible for the management of the directorate's revenue budget and ensure the meeting of all financial targets.

36. Participate in contract and service level negotiations with commissioners.

37. Advise and assist in the development of capital investment strategies across the Trust, ensuring these reflect and contribute to meeting targets set by the HSCB and the Trust's Corporate Plan.

CORPORATE MANAGEMENT

38. Contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.

39. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

40. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

41. Establish collaborative relationships with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

42. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

43. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

44. Ensure appropriate risk management arrangements are in place to deliver safe medical services to patients and minimise the potential for actions against the Trust.

45. Participate in the assurance that an effective system of clinical risk management and adverse event reporting is in place.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

46. Ensure the development of strong medical leadership in the Trust.

47. Oversee, and participate in the arrangements for consultant and associate grade appraisals.

48. Participate in arrangements for recognition of clinical excellence including providing advice on nominations and citations for Distinction and Meritorious Service awards.

49. Ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.

50. Support managers both in establishing and reviewing performance targets with individual consultants, recognising workloads and other pressures on medical staff, and ensuring that adequate mechanisms are in place for the welfare of medical staff.

51. Provide advice and guidance on medical workforce policy driving forward a culture of change, innovation and development and modernisation of services.

52. Responsible, in association with HROD for the management of disciplinary matters and complaints relating to medical staff.

53. Review individually, at least annually, the performance of immediately managed staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

54. Maintain staff relationships and morale amongst staff.

55. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

56. Participate, as required, in the selection and appointment of Trust staff in accordance with procedures laid down by the Trust.

57. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

58. Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

59. Actively promote the development of an emergency management strategy with the Directorate to ensure a state of preparedness to respond to a range of internal and external emergency situations.

GENERAL REQUIREMENTS

60. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

61. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

62. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - Standards of attendance, appearance and behaviour

63. All employees of the Trust are required to be conversant with the Trusts policy and procedures on records management. Trust Directors are responsible to the Chief Executive for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

64. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

65. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

66. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

67. To understand this Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

68. To be aware it is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION

JOB TITLE Medical Director

Ref No 73815013

Notes to applicants:

1. ***We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;**

2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted****. Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so will result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE

1. Hold full registration with the GMC with a licence to practice[5].

2. Have a minimum of 2 years' experience in a senior medical management[1] role in a major complex organisation[2].

3. Have at least 2 years' experience of managing major change programmes addressing significant[3] organisational, managerial or service change demonstrated through personal involvement in;
    a) Risk management,
    b) Planning and implementation of service development and/or organisational change,
    c) Evaluating the impact of the change in transforming services for the better

4. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[3] improvements demonstrated through personal involvement in;

    a) The associated strategy development,
    b) Implementation and;
    c) Sustainability of the objectives

5. Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders ;

    a) To successfully implement a significant[4] change initiative,
    b) Building sustainable commitments in developing and maintaining networks through lasting working relationships,
    c) Where the contribution of others is encouraged.

6. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS

7. Have an ability to provide effective leadership at a Strategic level to enable the ongoing development and improvement of services.

8. Demonstrate evidence of high level skills in;

    a) effective planning and organisation
    b) Governance and Risk Management
    c) People Management

9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

10. Demonstrate highly effective communication skills to meet the needs of the post in full.

The following further Clarification on the terms used in the Specification is provided below;

[1] 'senior medical management' is defined as experience gained at Medical Director, Associate Medical Director, Deputy / Assistant Medical Director, Co Director (Medical) or Clinical Director or equivalent level in a major complex organisation.

[2]'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders

[3]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

[4]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

[5] The Trust reserves the right to review and consider, as appropriate, the information available about you on the GMC register as part of this selection process. This information will be treated in confidence and will not debar you from appointment unless the selection panel considers that it renders you unsuitable for appointment.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the NHS Leadership Model.

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

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

67.1. Having now worked through the documentation available to me and the results of RCA SAI reviews and the MHPS investigation findings, I have reflected extensively about what went wrong.

67.2. On occasions there was a tendency for the directorate and urology team to work around Mr O'Brien rather than appropriately deal with issues when they initially arose. This may have been out of deference to his seniority within the unit.

67.3. When I initially came to the Trust in July 2015, it became apparent to me that there was a lack of trust between Consultant medical staff and some of the senior medical and non-clinical leaders over a number of preceding years. This seemed to be an issue particularly within the surgical and anaesthetic teams. There was also a lack of knowledge among many of the medical and non-clinical leadership staff regarding possible options open to them for dealing with difficult issues among colleagues. Mr O'Brien was probably the most senior colleague in the entire Trust which was an added factor. This may have led to a reluctance for medical staff to escalate some significant issues

67.4. I spent considerable time in my first year as Medical Director rebuilding the senior clinical leadership team, starting at Associate Medical Director level based on a sense of real teamwork, openness and trust. I observed the interactions between my AMDs and I was convinced that this was beginning to yield dividends around Autumn 2016. By the time I left post we had an excellent, fully functioning, gender and ethnically diverse AMD team with the correct skillset to move forward.

67.5. The multiple changes of Chief Executive over the time period (six Chief Executives from March 2015 to March 2018) meant that it was difficult to move strategically important decisions forward. (I had been keen to strengthen the medical leadership team by appointing two deputies who could focus more on governance and professional issues but this proved impossible in my time).

67.6. My educational team designed a bespoke training programme for all clinical leaders from a medical background which received high approval ratings and included training on MHPS matters. I purchased additional training from NCAS for the medical leadership team. This resulted in almost all the medical leadership positions in the Trust being populated by September 2016. Team Surgery was the last team to be fully populated. In retrospect this may have partly because there was some 'local intelligence' regarding the Mr O'Brien issues and therefore a reluctance to get directly involved.

67.7. In short, I believe there was a lack of knowledge of possible solutions to the Mr O'Brien issues among the medical team and a lack of confidence that issues they raised would be appropriately addressed. This lack of trust was unfortunately based on past experiences within Team Surgery and previous failed escalation attempts. In Dr Chada's (Case Investigator) report she referred to Mrs Trouton (Assistant Director), Mrs Corrigan (Head of Service) and Mr Young (Consultant Urologist) all having been aware of triage issues since 2014. Mr Mackle suggested there were issues predating 2012. In the report, Dr Chada comments that Mr Mackle took 'a step back' from managing concerns in or around 2012. Instead of addressing the issue directly, it appears that 'workarounds' were put in place.

67.8. Mrs Gishkori (Acute Services Director) had also been working hard to improve the team dynamics form her perspective, having joined the Trust like myself in 2015.

67.9. I believe that, by autumn 2016, we had made considerable progress in developing a well-informed, highly trained senior medical leadership team within the Trust. They realised the significance of the findings in relation to Mr O'Brien and had the confidence to escalate. Historically, this does not seem to have been the case in relation to the surgical team.

67.10. I have a personal view that the management structure within the Trust (similar to most others in NI at the time) was confusing. The Associate Medical Directors reported both to me for professional issues and to the Acute Services Director for all other issues. In real life (in my opinion) professional and operational

Stinson, Emma M

From: Wright, Richard <Richard.Wright@southerntrust.hscni.net>
Sent: 09 February 2016 10:57
To: Gishkori, Esther
Subject: Fw: **URGENT** Personal Information redacted by USI -v- NORTHERN HEALTH & SOCIAL CARE TRUST & SOUTHERN HEALTH AND SOCIAL CARE TRUST
Attachments: COMMENTS regarding Personal Information redacted by USI .docx

Hi Esther. This almost sounds like a cry for help. We should discuss! Richard

---

From: Fitzsimons, Marian
Sent: Tuesday, February 09, 2016 09:41 AM
To: Wright, Richard
Cc: White, Laura
Subject: FW: **URGENT** Personal Information redacted by USI -v- NORTHERN HEALTH & SOCIAL CARE TRUST & SOUTHERN HEALTH AND SOCIAL CARE TRUST

Dr Wright

FOR YOUR INFORMATION

See below and attached the reply received from Mr Aidan O'Brien. He has provided a detailed and comprehensive response to the allegations of negligence noted within the Statement of Claim which I am sure will be of great assistance to the Trust's Barrister.

Marian Fitzsimons

From: O'Brien, Aidan
Sent: 05 February 2016 02:28
To: Fitzsimons, Marian
Subject: RE: **URGENT** Personal Information redacted by USI -v- NORTHERN HEALTH & SOCIAL CARE TRUST & SOUTHERN HEALTH AND SOCIAL CARE TRUST

Marian,

Once again, I regret the delay in replying to your emails.
I am quite sure that it must be difficult to appreciate that something regarded so important could be so delayed.
I have to advise you that I receive so many email regarding patients each day that it can take me two hours to deal with each day's definitively.
As a consequence, if I have already worked for 12 to 16 hours, I do not get to even open all emails.
I am now sending this email at 02.25 am, Friday, having begun working at 07.00 am yesterday.
As a consequence of spending some hours compiling the attached comments, I have not yet opened yesterday's emails, and I start again at 09.00 am.
And that is how it is, day in, day out.

I do hope that you will find the attached comments to be of assistance,

Thank you for your forbearance,

Aidan.

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. **Patient Notes at home**

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle
Associate Medical Director

Heather Trouton
Assistant Director

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Irrelevant information redacted by USI

Stinson, Emma M

From: Wright, Richard [redacted]
Sent: 09 May 2016 15:47
To: McAllister, Charlie
Subject: Re: Problems

That seems a fairly accurate summing up. can't all be fixed in a day. Should we have a get together to work up an action plan? regards Richard

Sent from my iPad

On 9 May 2016, at 15:41, McAllister, Charlie [redacted] wrote:

> Dear All
>
> Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:
>
> 1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
> 2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
> 3. FY1 rota issues. Not enough so non-compliant.
> 4. Paeds interface very poor and not resolved.
> 5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
> 6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
> 7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
> 8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
> 9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
> 10. Ortho. Job plans still not agreed.
> 11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
> 12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
> 13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
> 14. I am not aware that sign-off of results is secure. Governance risk.
> 15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
> 16. Interface between gastroenterology and GI surgeons.
> 17. Breast service teetering. Radiology support precarious.
> 18. Significant backlog of IR1s/SAIs. Governance risk.

Corrigan, Martina

From: Corrigan, Martina
Sent: 17 August 2016 17:07
To: Wright, Richard
Subject: RE: confidential

Hi Richard,

See updated position below:

1. Untriaged outpatient referral letters

There are currently 174 untriaged letters dating back to May 2016

2. Current Review Backlog up to 31 July 2016

Total in Review backlog = 679

2014	243
2015	244
2016	180

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Wright, Richard
Sent: 09 August 2016 09:21
To: Corrigan, Martina
Subject: confidential

Hi Martina. Did we ever make progress with regard to the issues raised re Urology which Eamon had been dealing with? Regards Richard

48.1.

(a) I was not aware of significant problems within team urology until early September 2016 when Mr Haynes highlighted the issues around the patient administration performance of Mr O'Brien. These had come to the fore because Mr O'Brien was on sick leave and the directorate had appropriately arranged for his patients to be reviewed by other consultants.

(b) The issues raised are outlined in the meetings of the Oversight team meetings from September 2016 onwards and the subsequent report presented initially by Mr Weir. This report initially outlined the extent of the initial concerns. Mr Weir (Clinical Director) assured the Oversight team that there were no immediate safety concerns for patients.

(c) Reassurance was provided via Mrs Gishkori's operational team to the Oversight team meeting. The Acute Services Director was asked to develop a return to work plan for Mr O'Brien that included close monitoring of patient triage, clinic dictation and the other issues raised in Mr Weir's report.

(d) See (c).

(e) Reassurance was provided by the Acute Services Director and this was tested by the weekly monitoring of compliance carried out by the Head of Service, Mrs Corrigan.

(f) See (e).

(g) The initial monitoring of the return to work plan revealed good compliance with Mr O'Brien's restrictions and support measures. I was involved up until February 2018 during which time the MHPS Case Manager was of the opinion that compliance continued to be good. I understand these arrangements were subsequently less successful.

(h) See (g).

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

36.2. The initial issues of concern regarding the Patient Administration relating to Mr O'Brien were brought to my attention by Mrs Trouton (Assistant Director) in January 2016. At that stage I did not appreciate the full extent of the problem. It was Mr Haynes who was then the Clinical Director for surgery and subsequently became Associate Medical Director for surgical services who highlighted the extent of Mr O'Brien's variance from good practice.

36.3. I understand that there had been a history of concerns being addressed within the directorate by informal means by a system put in place by Mrs Gishkori and the previous Associate Medical Director, Mr Mackle. Mrs Trouton recalls a meeting with me in January 2016 at which she shared some of the triage issues with me. I cannot recall the details of this meeting. At that point, she agreed to write to Mr O'Brien outlining these issues and asking him to amend his practice accordingly. However, I did not appreciate that this issue had not been resolved until Mr Haynes contacted me in early September 2016.

36.4. I was reassured that Mr Haynes brought these matters to my attention but disappointed that the local measures that had previously been put in place seemed to have been unsuccessful. Once Mr Haynes took up the post of AMD, the lines of communication to my office were robust. Whilst Mrs Trouton states that we met about this issue first in January 2016, I have no recollection of being informed about the apparent failure thereafter of Mr O'Brien to remedy matters and adhere to standard practice until Mr Haynes informed me in September 2015. I would have expected the Associate Medical Director at the time (Mr Mackle) to have fully briefed me on this issue had he still been in post. Mr Mackle, however, had stood down from his AMD role shortly after the March letter was sent and it took several months to identify a permanent replacement. With hindsight, the change of personnel over this period may explain why this was not brought to my attention sooner.

36.5. I was unaware of any concerns being brought from outside the Urology unit.

.

Corrigan, Martina

From: Corrigan, Martina
Sent: 18 August 2016 13:57
To: Gibson, Simon
Subject: RE: CONFIDENTIAL - Dr A O'Brien
Attachments: RE: confidential; RE: confidential

Hi Simon,

As discussed, please see attached information that I had forwarded to Richard and we can catch up on Monday PM to discuss in detail

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Gibson, Simon
Sent: 18 August 2016 09:50
To: Corrigan, Martina
Cc: Wright, Richard
Subject: CONFIDENTIAL - Dr A O'Brien

Dear Martina

Richard has briefed me on the above, and asked that I commence a discreet piece of work on issues of concern and actions taken to date.

Could you forward any relevant information you have on file, and we can meet for an initial discussion next week.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

administrative practices and impact on patient care, so protective measures could have been immediately implemented and monitored. From my experience over the years advising on cases, the role within MHPS for monitoring and managing risk (which is not well defined in the Framework) needs to lie with the immediate line manager to avoid any possible disconnect. They must remain accountable for ongoing line management and must update the case manager (in the context of formal MHPS investigations) on the actions they have taken. NHS Resolution can be very helpful in helping to draw up detailed action plans as necessary, I have attached a sample one into evidence that we have used previously as an example.

39.3 An assessment of an initial incident for its risk, so that the correct measures can be put in place to protect patients, has to take precedence over everything else. In my view this is the most critical aspect within MHPS. For example, by correctly identifying that a risk associated with a trigger event is low, sufficient reassurance can be gained that the issue is not a concern and can be dealt with as a learning incident. However as preliminary enquiries are undertaken and further events occur or information comes to light, the risk may vary, so a trigger initially classed as a low risk incident may rise to medium or high if other instances come to light or you have a doctor with little insight. Clinical Managers (taking advice when necessary) must continue to reassess risk as often as is necessary as part of their line management role. Case managers (as assigned under MHPS) should then seek the assurance they need from clinical line managers that all necessary protective measures are in place. We need to ensure managers are trained and supported to undertake this task.

39.4 I understand a screening report was completed in September but it is not clear why this was done by the Assistant Director in the Medical Directors office – this should have been the clinical manager who should have been responsible for retaining ongoing oversight. Input from NCAS (now NHS Resolution) could have provided additional support if this was needed to assist with the review of notes.

39.5 It is not clear to me why it took an SAI investigation in December 2016 to instigate formal action– I'm not clear if these were new concerns arising or if a closer review earlier would have uncovered them. Unfortunately it would seem the earlier inaction led to a delay to the formal investigation as there was still a need to determine the full extent

collate the detail. Given the numerical patient and clinic activity detail in the Screening Report, input would have been required from Acute Services managers.

13(iv) As outlined above, Simon Gibson documented the summary of concerns as at August 2016 in the 'Screening Report on Dr O'Brien' **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160906 Attachment_AOB Screening Report)** . It is unusual that Simon Gibson as an Assistant Director in the Medical Director's office would have been the author of a screening / preliminary enquiries report given that the person responsible for this role in both MHPS and the 2010 Trust Guidelines is the Clinical Manager. In this case, the Clinical Manager of Mr O'Brien would have been Mr Colin Weir, Clinical Director. My recollection is Dr Wright had been seeking assurances from managers in Acute Services in August 2016 that the concerns raised with Mr O'Brien earlier in 2016 had been addressed. My understanding is that when he did not receive satisfactory assurances, he then asked Simon Gibson to take forward some enquiries on his behalf. Simon Gibson may be able to confirm who he liaised with in Acute Services to enable him to complete the screening / preliminary enquiries report, and to confirm the involvement, or not, of Mr Colin Weir, the Clinical Manager. Given the opportunity to now reflect on this part of the process, the report to Oversight Group should have been undertaken by Mr Colin Weir, the Clinical Manager and not Simon Gibson as per para 2.4 of the Trust 2010 Guidelines and MHPS Section 1 Para 15. I have no doubt, however, as Clinical Manager, Mr Weir would have needed to have relied on Acute Services Managers to provide the activity data in respect of Mr O'Brien's untriaged referrals and outpatient review backlogs in order to complete such a report. As far as I can ascertain, Simon Gibson did not seek the advice of any HR Case Manager in relation to the screening / preliminary enquiries process, as per para 2.4 of the Trust 2010 Guidelines.

13(v) The same four concerns included in the 23rd March 2016 letter were outlined in the Screening Report prepared by Simon Gibson in September 2016,

Southern Health & Social Care Trust

Medical Directors Office

Screening report on Dr Aidan O'Brien

Context

The Medical Director sought detailed information on a range of issues relating to the conduct and performance of Dr O'Brien. This report provides background detail and current status of these issues, and provides a recommendation for consideration of the Oversight Committee.

Issue one – Un-triaged outpatient referral letters

When a GP refers a patient into secondary care, the referral is triaged to consider the urgency of the referral. If triage does not take place within an agreed timescale as per the Integrated Elective Access Protocol (IEAP), then health records staff schedule the referral according to the priority given by the GP. This carries with it the risk that a patient may not have their referral "upgraded" by the consultant to urgent or red flag if needed, if triage is not completed. This may impact upon the outcome for a patient.

In March 2016, Dr O'Brien had 253 untriaged letters, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 174 untriaged letters, dating back 18 weeks; the rest of the urology team triage delay is 3-5 working days.

Issue two – Outpatient review backlog

Concerns have been raised that there may be patients scheduled to be seen who are considerably overdue their review appointment and could have an adverse clinical outcome due to this delay.

In March 2016, Mr O'Brien had 679 patients in his outpatient review backlog, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 667 patients in his outpatient review backlog, dating back to 2014: whilst outpatient review backlogs exist with his urological colleagues, the extent and depth of these is not as concerning.

Issue three – Patients notes at home

Mr O'Brien has had a working practice of taking charts home with him following outpatient clinics. These charts may stay at his home for some time, and may not be available for the patient attending an appointment with a different specialty, making the subsequent consultation difficult in the absence of the patients full medical history.

For a period in 2013/14, instances when charts were not available were recorded on the Southern Trusts Adverse Incident Reporting (IR) system: there were 61 consultations where charts were not available. In speaking to the Health Records Manager, Mr O'Brien is currently continuing this practice although this is not now recorded on the IR system.

Mr O'Brien was spoken to about this issue in 2012 by Dr Rankin, and twice in 2014 by Mrs Burns, the Directors of Acute Services at the time, seeking a change in behaviour, although none of these meetings were formally recorded.

Issue four – Recording outcomes of consultations and inpatient discharges

Whilst there has been no formal audit of this issue, concern has been raised by his urological colleagues that Mr O'Brien may not always record his actions or decisions regarding a patient following a period of inpatient care or outpatient consultation. This may cause subsequent investigations or follow up not to take place or be delayed.

Summary of concerns

This screening report has identified a range of concerns which may be counter to the ***General Medical Councils Good Medical Practice*** guidance of 2013, specifically paragraphs 15 (b), 19 and 20:

15. ***You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:***

- *a. Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
- *b.* ***Promptly provide or arrange suitable advice, investigations or treatment where necessary***
- *c. Refer a patient to another practitioner when this serves the patient's needs.*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. ***You should make records at the same time as the events you are recording or as soon as possible afterwards.***

20. ***You must keep records*** *that contain personal information about patients, colleagues or others securely, and* ***in line with any data protection requirements.***

Conclusion

This report recognises that previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm.

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

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

2.2 Concerns[1] should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

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

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

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

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

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

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

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

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

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

write to Mr O'Brien, outlining her concerns and asking him to amend his actions in line with best practice in line with that of his colleagues.

55.2. I would have met with Mr Mackle on a couple of occasions in his role as Associate Medical Director informally between July 2015 and March 2016. I do recall discussing other team surgery issues such as the safety of the service in Daisy Hill Hospital, junior doctor rotas and Staff vacancies amongst the wider surgical team but I have no specific recollections regarding discussions concerning Mr O'Brien.

55.3. Mr Haynes (Associate Medical Director) contacted me by telephone in early September 2016 to alert me of the issues subsequently addressed by the MHPS process. After that phone call I would have spoken directly to Mrs Toal (Director of Human Resources) and to Simon Gibson (Assistant Director, Medical Director's Office) to establish and arrange an Oversight Committee meeting to discuss the issues raised. I asked Simon Gibson to contact the National Clinical Assessment Service (NCAS) prior to the oversight meeting to discuss possible approaches to addressing the issues raised. The Oversight meeting was then arranged for 13th September 2016. Mrs Gishkori was invited but was unable to attend so Mr Carroll (Assistant Director) attended in her place.

55.4. Most of the discussions I had regarding Mr O'Brien are recorded in the minutes of the Oversight meetings. The relevant meetings took place on 13th September 2016, 12th October 2016, 22nd December 2016, 10th January 2017 and 26th January 2017.

55.5. In addition to this:

i. I met briefly with the Chief Executive (Mr Rice) and then the Trust Chair to update them on the MHPS process in the last week of December 2016, in particular to request that they identify a designated person from the Trust Board to oversee the process I discussed the case with NCAS on 28th December 2016 and again just before Mr O'Brien's return to work in late January 2017.

ii. I held a meeting on 30th December with Mr O'Brien, accompanied by his wife, with Human Resources Manager Lynne Hainey.

NHS
National Clinical Assessment Service

NCAS
N I office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN

Tel: 028 90 690 791

www.ncas.nhs.uk
Jill.Devenney@ncas.nhs.uk

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

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

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

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

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

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

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

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

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

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

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

Relevant regulations/guidance:

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

Review date:

7 October 2016.

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

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

I hope the process has been helpful to you.

Yours sincerely

Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

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

Oversight Group Meeting

Tuesday, 13th September 2016 @ 10:00am in
The Chief Executive's Office, Trust Headquarters, Craigavon Area Hospital

NOTES & ACTION POINTS

Present: Dr Richard Wright
Mrs Vivienne Toal
Mrs Esther Gishkori

In attendance: Mr Simon Gibson
Mr Malcolm Clegg

Medical MHPS Cases, Doctors in Difficulty, GMC & NIMDTA Issues

Personal Information redacted

Irrelevant information redacted by USI

AOB:

The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

Personal Information redacted :

Irrelevant information redacted by USI

[redacted]

Personal Information redacted by USI

Irrelevant information redacted by USI

[redacted]

NHS
National Clinical Assessment Service

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Jill.Devenney@ncas.nhs.uk

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

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

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

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

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

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

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

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

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

1.9. At the Oversight meeting on 13th September 2016, we were informed that a formal letter had been sent to Mr O'Brien on 23/03/16 by the Acute Services management team including Mr Mackle (Associate Medical Director at the time), outlining several concerns about Mr O'Brien's patient administration practice. He was asked to develop a plan detailing how he was intending to address issues relating to his patient administration. No plan, however, had been submitted. A preliminary investigation had taken place conducted by Mr Weir (Clinical Director). After this, Simon Gibson (Assistant Director, Medical Director's office) was asked to draft a letter for Colin Weir (Clinical Director), and Ronan Carroll (Assistant Director Surgery) to present to Mr O'Brien. On this occasion Mrs Gishkori (Acute Services Director) was not in attendance but instead was represented by Mr Carroll (Assistant Director, Acute Services).

1.10. I subsequently received an email from Mrs Gishkori (Acute Services Director) on 15th September asking for a further three months grace for the local team to implement remedial action regarding Mr O'Brien. In response, I asked for her to share their response plan before any change was made to the original plan.

1.11. At the oversight meeting on 12th October 2016 *(2016 10 12 Oversight group notes **Bates Reference TRU-00031-TRU-00032**)* Mrs Gishkori (Director) explained that Mr O'Brien was going on sick leave for essential surgery in November 2016 and was likely to be off work for a lengthy period. She acknowledged that, to date, the issues raised at the previous oversight meeting had not been formally discussed with him but gave an assurance that this would happen when Mr O'Brien returned from sick leave. It was noted that a plan was in place to deal with the patient issues identified.

1.12. An ongoing Serious Adverse Incident (SAI) investigation within the Trust identified a urology patient who may have had a compromised outcome because the GP referral was not triaged by Mr O'Brien. A Root Cause Analysis of the issues (ID 52720) regarding this incident 06/Jan/ 2016 was initiated by Acute Services Governance and signed off 15/March/2017. In November 2016 I was informed of some of the issues that were coming to

Gibson, Simon

From: Gibson, Simon
Sent: 13 September 2016 14:12
To: Gishkori, Esther; Toal, Vivienne; Clegg, Malcolm; Wright, Richard
Cc: Stinson, Emma M; White, Laura; Mallagh-Cassells, Heather
Subject: CONFIDENTIAL - Letter to AO'B - first draft
Attachments: Letter to AOB - 1st draft 13-9-16.docx

Dear all

Draft of letter for comments back please.

Esther – I phoned Martina with regard to what is a realistic yet challenging target with regard to the outpatient review backlog. Her view was 229 in the month of October (19 additional clinics) would not be achievable, and we don't want to set him a target we know he can't reach, and then penalise him. So, we have gone with 70 per month, every month, until end of December. Operationally, this is your call, but just wanted you to be aware of the thought processes behind the target chosen

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI

Southern Health and Social Care Trust

Draft letter

21st September 2016

Dear Mr O'Brien

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

I am writing to inform you of the Southern Trusts intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practice. At this stage, we will be taking an informal approach as outlined within MHPS, but following the outcome of this we may proceed with a formal investigation.

This investigation should be seen in the context of the letter written to you on 23rd March (copy attached), in which a number of concerns were raised and a plan was sought from you to address these concerns. No plan was provided and the same concerns still exist.

This informal approach will consider four areas of your practice, and be time bound as indicated below.

Area 1 – Untriaged letters

In August 2016, you had 174 untriaged outpatient referral letters, dating back 18 weeks. It is the expectation of the Trust that by the time you commence your next Urologist of the Week session, on 21st October, this backlog is eliminated. Furthermore, it is the expectation of the Trust that at the end of your week as Urologist of the Week, you are completing the triage of outpatient referral letters within the Trust standard of 72 hours.

Area 2 - Outpatient review backlog

As at 31st August 2016, you had 658 patients on your outpatient review backlog, including 229 going back to 2014. It is the expectation of the Trust that this 2014 backlog is reduced to zero by the end of the calendar year, with a reduction of a minimum of 70 patients per month.

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

Area 3 – Patients notes at home

I am aware that you have had a practice of taking notes home with you, and this has been discussed with you previously, yet this practice has continued. It is the expectation of the Trust that all hospital notes at your house are returned to Martina Corrigan, Head of Service for Urology, within 24 hours of the date on this letter.

There are to be no exceptions to this.

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

Area 4 - Recording outcomes of consultations and inpatient discharges

It has been brought to my attention that on occasion you might not make contemporaneous notes following an outpatient consultation or inpatient discharge. It is the Southern Trusts expectation that, from the date on this letter, you make contemporaneous notes to ensure that your colleagues are aware of the clinical management plans for any patient.

A clinical note review will be undertaken of 20 sets of notes seen by yourself in the four weeks following the date on this letter, to assess your compliance with this expectation.

In late October, an assessment will be made on your progress towards the targets in these four areas of practice, as outlined above. Should the Southern Trust conclude that sufficient progress has not been made, or other issues are identified during the four week period of assessment, then a formal investigation will be commenced under the terms of MHPS.

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

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

Yours sincerely

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

Stinson, Emma M

From: Gishkori, Esther <[redacted]>
Sent: 14 September 2016 13:17
To: McAllister, Charlie
Subject: FW: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Thanks Charlie.
At least you have a starting point.
I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
We owe this to a well respected and competent colleague.
I can confirm that you will have communication in relation to this before the end of the week.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: McAllister, Charlie
Sent: 14 September 2016 12:25
To: Gishkori, Esther
Subject: FW: Confidential - AOB

Hi Esther

Further to our meeting today here is the only communication that I have received on this subject.

Regards

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

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

Secretary Jennifer Personal Information redacted by USI

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

FYI below.
……and my response will be?

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

Personal Information redacted by USI

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

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

Sent from my iPad

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

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.
>
> I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.
>
> Happy to discuss any time and I will of course brief the oversight committee of any progress we make.
>
> Many thanks
> Best
> Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust

Gibson, Simon

From: Wright, Richard <Personal Information redacted by USI>
Sent: 15 September 2016 18:05
To: Gibson, Simon
Subject: Re: *HOLD* Meeting with Simon, Colin Weir and Ronan re Investigation

Classic Esther. About turn after the meeting. I've asked her to outline her plans in detail for us to consider. We haven't agreed to any change yet. R

Sent from my iPad

On 15 Sep 2016, at 15:33, Gibson, Simon <Personal Information redacted by USI> wrote:

> Dear Richard
>
> Please see below – has there been an update in relation to the meeting regarding Dr O'Brien?
>
> Kind regards
>
> Simon
>
> Simon Gibson
> Assistant Director – Medical Directors Office
> Southern Health & Social Care Trust
> Personal Information redacted by USI
> Mobile: Personal Information redacted by USI
> DHH: Personal Information redacted by USI Ext Personal Information redacted

---

From: Stinson, Emma M
Sent: 15 September 2016 15:30
To: Gibson, Simon
Subject: RE: *HOLD* Meeting with Simon, Colin Weir and Ronan re Investigation

Dear Simon

Yes – I understand that Esther spoke to Dr Wright

Many Thanks
Emma

Emma Stinson

PA to Mrs Esther Gishkori
Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital

<image001.png> **Direct Line:** Personal Information redacted by USI **Direct Fax:** Personal Information redacted by USI
<image002.png Personal Information redacted by USI

Please consider the environment before printing this email

26(iii) The lack of Clinical Management input to the Oversight Group in the 2010 Trust Guidelines was problematic, and meant that the Oversight Group was driving the decision making in relation to the early actions in September 2016, as opposed to the Clinical Manager. Whilst the role of the Oversight Group as outlined in para 2.5 of the 2010 Trust Guidelines, was described as a quality assurance role, the absence of the Clinical Manager at the meetings meant that the Oversight Group determined the actions to be taken. On reflection, this resulted in an approach in September 2016, which was, in effect, contrary to Section I Para 15 MHPS, which outlines that the role of the Clinical Manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. What happened in the Mr O'Brien case was that a non-medical Assistant Director, Simon Gibson took the lead in the Preliminary Enquiries in September 2016 in conjunction with, I assume, Acute Services' staff such as Martina Corrigan and Ronan Carroll, and presented the report at the Oversight Group meeting without the Clinical Manager, Mr Weir, Clinical Director, there. The absence of the Clinical Manager, Mr Weir also permitted a divergence from what was the agreed course of action at the Oversight Meeting on 13th September 2016 by Directors. Those agreed actions were subsequently debated outside of the meeting by the Clinical Managers, Mr Weir, Clinical Director, and Dr McAllister, Associate Medical Director, with Esther Gishkori, Director of Acute Services. As a result, the agreed actions from 13th September 2016 Oversight Group meeting subsequently changed after further discussion between Esther Gishkori, Francis Rice, Interim Chief Executive and Dr Wright, Medical Director, a number of days after. If Mr Weir, as Clinical Manager had been present in the Oversight Group meeting in September 2016 there may have been greater discussion, about not only clearing the backlogs, but also more about checking and reviewing if any of the patients in those backlogs had come to harm. I very much regret that those discussions did not happen robustly enough and there was not more focus on ensuring that work commenced urgently after the meeting on 13th September to check if the patients in the backlogs had come to any harm. This issue was further exacerbated by the fact that both Mr Weir and Dr McAllister were off on sick

Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:

Mr A O'Brien
Mrs Gishkori reported that Mr O'Brien was going for planned surgery in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 18 October 2016 13:23
To: Weir, Colin
Subject: RE: Job plan

Grand!

Aidan

From: Weir, Colin
Sent: 18 October 2016 13:20
To: O'Brien, Aidan
Subject: RE: Job plan

That's great

No if you want to put on paper what you think a reasonable representative job plan looks like for you
If you work different patterns in different weeks I will need to see that say you went to SWAH week 2 and 3 out of a 7 week cycle to include urologist of the week. It all sounds very complicated but not really once we get started.

Will need to ensure you include SPA and CPD activity and any private work even if outside normal day (in that case it doesn't affect your calculation)

I can do the electronic bit

Colin

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

Secretary Jennifer [redacted]

From: O'Brien, Aidan
Sent: 18 October 2016 12:14
To: Weir, Colin
Subject: RE: Job plan

Thank you, Colin.

I will be in contact with you on Monday 24 October to arrange a time on Tuesday 25 October when we can meet. As I have not previously had such a meeting, is there anything that you would wish me to bring to the meeting in preparation?

Aidan.

From: Weir, Colin
Sent: 18 October 2016 08:44
To: O'Brien, Aidan
Subject: RE: Job plan

Hi Aidan

Prob next Tues morning or afternoon If that suits

Colin

From: O'Brien, Aidan
Sent: 17 October 2016 18:02
To: Weir, Colin
Subject: FW: Job plan

Colin,

In fact, I will be on call as urologist of the week from Thursday 20 October to Wednesday 26 October, inclusively.
I would probably be able to meet with you most times that would suit you during that period,

Thank you,

Aidan

From: O'Brien, Aidan
Sent: 17 October 2016 16:04
To: Weir, Colin
Subject: RE: Job plan

Colin,

I would be grateful if you would call me on Personal Information redacted by USI to arrange a time to discuss my job plan.
I am on leave tomorrow, Tuesday 18 October, if that would suit you.
I am also available before and after PSM on Wednesday 19 October if that would suit you,

Aidan.

From: Weir, Colin
Sent: 05 October 2016 14:15
To: O'Brien, Aidan
Subject: Job plan

Hi Aidan

Could I go through your job plan with you very soon. Im happy to sit down with you we can write it out and then I have the horrible task of entering it onto Zircadian, which you then can agree if you are happy

Let me know when you are free maybe an hour would cover it

Colin

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

Secretary Jennifer Personal Information redacted by USI

Toal, Vivienne

From: Gibson, Simon <Personal Information redacted by USI>
Sent: 21 December 2016 12:11
To: Toal, Vivienne
Subject: FW: AOB

See below for context

Kind regards

Simon

Simon Gibson
Assistant Director - Medical Directors Office Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI Ext Personal Information redacted by

-----Original Message-----
From: Gibson, Simon
Sent: 21 December 2016 11:45
To: Wright, Richard
Subject: RE: AOB

Dear Richard

Yes. I will come in to DHH and web-cam in; I think we should involve Viv, she is in CAH and free all day.

2.30pm?

Kind regards

Simon

Simon Gibson
Assistant Director - Medical Directors Office Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI Ext Personal Information redacted by

-----Original Message-----
From: Wright, Richard
Sent: 21 December 2016 11:26
To: Gibson, Simon
Subject: AOB

Hi Simon. Esther rang me re worrying developments re AOB and lost notes. Ronan is to report tomorrow with preliminary findings. I will come in tomorrow. If you are about could we set up a meeting with Ronan and if possible

Mark Haynes to consider findings (Esther is off) and next steps. I don't think we can wait for the formal completion of SAI . Regards Richard

Sent from my iPad

Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number W48461 is complete.

The remit of Patient 10's Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials Personal Information redacted by USI) chart was not able to be found on Trust property at this time. Personal Information redacted by USI's chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Personal Information redacted by USI's consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Personal Information redacted by USI's patient chart could not be found on Trust premises. Personal Information redacted's chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Personal Information redacted by USI's letter was not triaged by week ending 30 October 2014. Personal Information redacted by USI was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

Summary of key points of concern – Patient 10 SAI

- Patient 10 was one of 8 patients not triaged during the week in question in Oct 2014. The team reviewed the 7 other patients to check they had been seen and were okay. 6 were found to have had an appointment and not suffered any adverse harm. The 7th patient's notes were missing but had been tracked to the consultant concerned. When asked, the secretary sent another email requesting their urgent return. The notes were returned on 28th November with dictation to be typed in relation to the patients care, requesting that they are booked for an intervention. Mr Glackin is going to review the patient's case urgently.
- As the secretarial team knew triage letters were going missing they kept a copy so that if the letter did not return with a plan, they could add the patient as routine (or as per GPs suggestion). This does seem to have been a known and accepted approach – not just something the secretaries developed themselves? They have kept a log of these cases since the middle of 2015. Between 28 July 2015 and 5th October 2016, there are 318 letters which were not triaged in this specialty.
- Trust notes were being transported via the individual consultant's car, against the Trust procedure. A number of notes seem to be tracked to the individual concerned and not returned – as per the 7th patient above. A report needs to be run to ascertain are any other notes tracked to this person and not on Trust premises.
- The check on the 7 patients above also raised a new concern into the timely dictation of letters. The 7th patient had been seen in January 2015 however the letter was not presented for typing until 11th November 2016. The Trust does monitor the number of charts needing audio-typing, but is there a process to monitor if post-consultation dictation has been completed? Is there a way of checking if this consultant has further patients in the same situation as patient 7?

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

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

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of sick leave, but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

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

Appendix 6
Role definitions

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

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

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

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

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

From: Carroll, Ronan
Sent: 28 December 2016 11:15
To: Boyce, Tracey; Wright, Richard; Gibson, Simon
Subject: FW: Management of PP's / non chronological listing
Attachments: Personal Information redacted by USI .pdf

Importance: High

Please see email received from Mr Haynes which is self-explanatory. Mr Haynes came across this letter as a result of reviewing this pt with AOB being off sick & pulled this letter off NIECR
AOB Waiting time for routine – 149wks & urgent 139wks for TURPs
I have asked Wendy to run a report on all AOB TURP's completed (which is what this man had) to see are there others who have been listed the same way.
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by USI

From: Haynes, Mark
Sent: 23 December 2016 10:39
To: Carroll, Ronan
Subject: Management of PP's / non chronological listing

Morning Ronan

I mentioned in discussion the management of PP's by Mr O'Brien. I suspect that he is not the only individual who brings patients into the NHS and onto NHS theatre lists. However, given recent events I feel this practice should also be looked into.

Attached is a PP letter from Mr O'Brien. This patient was seen by Mr O'Brien on 5th September privately (given the headed paper the letter is on) and placed on his NHS theatre list on weds 21st September, waiting a total of 16 days. His actual NHS waiting list has many other patients awaiting a routine TURP (which this man had) waiting significant lengths of time. I believe, if his theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable.

Do you think this should be fed into the overall investigation?

Mark

National Clinical Assessment Service

NCAS
NHS Litigation Authority
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ

Website: www.ncas.nhs.uk

General Enquiries and Advice Line: 020 7811 2600
Direct Fax: 020 7931 7571
Email: casesupport@ncas.nhs.uk

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

Dr Richard Wright
Medical Director
Southern Health And Social Care Trust
68 Lurgan Road
Portadown
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Dr Wright

Further to our telephone conversation on 28 December 2016, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

In summary, this case which my colleague Dr Fitzpatrick had previously discussed with Mr Gibson, involves Dr 18665, a senior consultant urologist about whom there have been increasing performance concerns. The allegations are of poor record keeping, and slowness of triaging referrals and arranging reviews. Dr 18665 is also reported to have removed a very substantial numbers of charts from the Trust's premises without bringing them back; despite requests that these be returned many charts remain outstanding. Dr 18665's colleagues have, on occasions, seen patients for whom there have been no notes. Dr 18665 is currently on sick leave, but has indicated that he is returning to work in January 2017.

A recent Serious Adverse Incident (SAI) has caused concern that there is potential for patients to be harmed by the ongoing situation. You are awaiting the report of the SAI but on the information available to date, you feel the Trust will need to undertake a formal investigation of Dr 18665. The Trust is also considering exclusion.

As you are aware, the concerns about Dr 18665 should be managed in line with local policy and the guidance in Maintaining High Professional Standards in the Modern HPSS (MHPS). We discussed that as the information to date - no noted improvement despite the matter having been raised with Dr 18665 - suggests that an informal approach (as per paragraphs 15-17 of Section I of MHPS) is unlikely to resolve the situation, a more formal process is now warranted.

Any formal investigation should be undertaken to robust and specific Terms of Reference (ToR) and in line with the guidance in paragraphs 28-40 of MHPS Section II. The Case Manager should write to Dr 18665 as per paragraph 35 informing him of the name of the Case Investigator and Designated Board Member; any objections by Dr 18665 to the appointment of nominated individuals should be given serious consideration. The investigation should not be an unfocused trawl of Dr 18665's work but we discussed that if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/ look back to ensure that patients have received the appropriate standard of care. We noted that further preliminary information (such as from the SAI and taking account of Dr 18665's comments) may be helpful in deciding the scope of the investigation and therefore the ToR.

As well as being outwith the Trust's Information Governance policies, the allegations, if upheld, may mean that the legislation (DPA) has been breached, and once more information is available you may wish to take further advice on this. Paragraphs 20 and 21 of the GMC's Good Medical Practice also set out standards for record keeping including a requirement that records are kept in line with data protection duties.

Dr 18665 is due to attend Occupational Health to ascertain whether he is fit for work; if he is not, we noted that there would be no need at this time to consider exclusion but you may then wish to ask the Occupational Physician whether/when Dr 18665 would be fit to participate in an investigative process.

If Dr 18665 is deemed fit for work, we discussed the criteria for formal exclusion, and the option of an interim immediate exclusion for a maximum of 4 weeks (as per paragraphs 18-27 of Section I MHPS). The latter would allow for further information to be collated and to take account of Dr 18665's comments about the allegations, before deciding whether there are reasonable and proper grounds for formal exclusion such as a concern that the presence of the practitioner in the workplace would be likely to hinder the investigation. I note that there had been a concern expressed previously about a record missing for 2 years inexplicably appearing on a secretary's desk. In line with paragraph 22 of Section II MHPS, there is an obligation to inform other organisations, including the private sector, of any restriction or exclusion of a practitioner and a summary of the reasons for it.

Dr 18665 should be encouraged to contact his defence organisation/ BMA for help and advice. He may also benefit from staff support such as counselling, at what is likely to be a stressful time for him. Dr 18665 should be told of the involvement of NCAS and you are welcome to share this letter with him if you think this would be helpful.

As discussed, and as Dr 18665 may be excluded, NCAS will keep this case open and I will review it with you in approximately 1 month. Please call in the interim if you have any queries.

Relevant regulations/guidance:

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

Review date:

27 January 2017