Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 53 of 2022

Date of Notice: 4th May 2022

An Addendum amending this Section 21 Statement can be found at WIT-96844 to WIT-96847.

Witness Statement of: Melanie McClements, Director Acute Services

I, Melanie McClements, will say as follows:-

General

Q1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1. I have been the Director of Acute Services since 7 June 2019 to current day (due to retire 31 August 2022). My job role and function is to operationally manage the vast array of acute services and maximise the collective working arrangements of Divisional Medical Directors, Assistant Directors, Heads of Service and their operational multi-disciplinary teams. I describe in my response to Questions 7 and 49, the various one to one (1:1) and group approaches that I mobilise to ensure the services delivered are in line with the Trusts objectives of delivering safe, quality, patient centred care and improving services. The detailed description of the issues raised, the meetings that I attended and the decisions that I took to address these concerns are described in my response to sections ***Concerns regarding the urology unit and Mr O'Brien*** of this notice

2. Another important function relates to the requirement to liaise with the Medical Director and her Deputy Directors, the Executive Nurse for Nursing, Midwifery & Allied Health Professionals, the Executive Director of Social Work and Director of Human Resources & Organisational Development, as appropriate, to consider and effectively deal with all work related and professional issues. As a member of the Trust Senior Management Team and Trust Board, I am

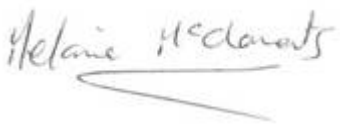
691. The roles of commissioning teams in HSCB/ SPPG are inextricably linked to the Trust role and function particularly with regard to resourcing the Trust to fulfil its obligations to quality, safe care and well governed systems and processes. In scrutinising the Trust, I feel the Inquiry needs to consider the commissioning intent of the HSCB/ SPPG. The volume of administrative support has been an issue across the Trust as has the equity position which has resulted in teams feeling they need additional resource to improve their service approaches. The need for redressing the resource allocations to Southern Trust as a provider organisation could ultimately result in improved patient services and higher professional satisfaction.

692. I believe I have covered the remainder of my information throughout my answers and welcome the opportunity to have been involved in the last 3 years with Acute Services.

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

Statement of Truth

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



Signed:

Date: _____08/07/2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 53 of 2022
Date of Notice: 4th May 2022

Addendum Witness Statement of: Melanie McClements

I, Melanie McClements, will say as follows:-

I wish to make the following amendments to my existing response, dated 8th July 2022, to Section 21 Notice number 53 of 2022.

1. At times in my statement I have stated that I commenced the Acute Director post on an interim basis on 10th June 2019. This is not correct as I commenced this post on 7th June 2019. I would therefore like to make the following amendments to the following paragraphs:

a. At paragraph 28 (WIT-34130), I have stated *' I commenced the Acute Director post on an interim basis on 10th June 2019 to cover sick leave for Esther Gishkori.'* This should state *'I commenced the Acute Director post on an interim basis on **7th** June 2019 to cover sick leave for Esther Gishkori.'*

b. At paragraph 35 (WIT-34136), I have stated '*In my role as Director of Acute Services from 10 June 2019, I am responsible to ensure that the urology service within the Southern Area is delivered in line with Commissioner Intent with respect to workforce, performance, governance and finance.'* This should state *'In my role as Director of Acute Services from **7th** June 2019, I am responsible to ensure that the urology service within the Southern Area is delivered in line with Commissioner Intent with respect to workforce, performance, governance and finance.'*

c. At paragraph 144 (WIT-34164-34165), I have stated *'In an email exchange on 12 June 2019, two days after I commenced post, from Mr Mark Haynes,*

*specialty meetings, dedicated to cases being discussed, reviewed, and appropriate actions taken and planned for (**Multi Disciplinary Meeting (MDM)).** A combined Anaesthetics and Surgical **MDM** is held on a Quarterly basis. I am not a member of these*.

4. At paragraph 160 (WIT-34168), I have stated '*As an interim measure, I allocated some capacity from the two Quality Improvement Officers (1 day per week per Assistant Director) from within the Directorate to prioritise areas for action and support Assistant Directors and their teams to implement leaning and action plans set out in SAI reports.'* This should state *'As an interim measure, I allocated some capacity from the two Quality Improvement Officers (1 day per week per Assistant Director) from within the Directorate to prioritise areas for action and **to** support Assistant Directors and their teams to implement **learning** and action plans set out in SAI reports.'*

5. At paragraph 186 (WIT-34174), I have stated '*In 2020, the Clinical Nurse Specialist posts were increased within Urology Services by two positions; Patricia Thompson (appointed 03/08/2022) and Jason Young (appointed 31/08/2020), with commissioner support to meet growing demand*.' This should state '*In 2020, the Clinical Nurse Specialist posts were increased within Urology Services by two positions; Patricia Thompson (appointed 03/08/**2020**) and Jason Young (appointed 31/08/2020), with commissioner support to meet growing demand*.'

6. At paragraph 560 (WIT-34252-34253), I have stated '*The gentleman had not yet had a biopsy and there was no outpatient letter on NIECR from his outpatient appointment with Mr O'Brien on 16 October 2019*.' This should state '*The gentleman had not yet had a biopsy and there was no outpatient letter on NIECR from his outpatient appointment with Mr O'Brien on 16 **August** 2019*.'

Statement of Truth

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

Melanie McClements

Signed:

Urology Services Inquiry

Date: 8th June 2023

I had contact with both Anne and Ronan through clinical directorate meetings throughout the overlap in their tenure and mine, usually in different formats and on average about 1-2 times weekly.

(b) what you took to be being communicated to you by these *middle managers*, and

They both adopted a defensive approach to my questions around clinical and social care governance. The general explanation for this appeared to be that when staff were asked about any activity in the past that they had felt criticised. This then seemed to have set the tone across the Acute Directorate. I was left with a strong sense that they viewed me as interfering and that inquisitiveness was viewed as questioning with a negative agenda rather than curiosity in a bid to understand. Comments were made about me being an outsider. The approach to me at times was of sarcastic comments being made particularly by Anne to me in front of others if I asked questions even as a relatively new person learning my way in a new organisation. When I drew others' attention to this there seemed to be an acceptance that this was the way business was done in the Trust and couldn't be challenged. This was disappointing as, when I worked in a previous Trust and had studied together with Anne (Ulster University Business School – MSc in Health and Social Services policy Management), I had thought the working relationship was constructive.

On one memorable occasion in 2019 I was in the patient flow control room with senior nurses and Anne reviewing patient activity in the context of overcrowding and waits in Craigavon Emergency Department. I asked why pathways that had been agreed the previous week were not being implemented. Anne abruptly left the room demanding to speak to me in her office stating that she had "had enough of" me and she wouldn't be asked questions like this again. I spoke to her but her determined attitude was that I was interfering and

and responses to the questions that I asked in relation to systems and processes. I think, you know, one of my concerns in referring Mr. O'Brien to the GMC was in relation to insight. I also think, looking back on all of that, we didn't have full insight either in terms of how we managed that process.

Q. You have mentioned you didn't know anybody at the time. Sometimes that can be an advantage in a new job where you don't have friends or enemies. You are coming in as a new brush and that gives you the opportunity to do things that are more difficult had you been promoted from within. Essentially your answer is you got a little bit of push back from some staff. You felt they thought your queries were criticisms. Did that play a part in your decision making as to how to manage this situation?

A. I don't think so, but I do think it made it a bit more difficult.

Q. Can you expand a little bit more on what that criticism was aimed at and how it may have impacted your choice of behaviour at that time?

A. There were, certainly, on a number of occasions, when I was very robustly challenged by middle managers within the Trust -- not Martina Corrigan and not any of the other people who worked to her -- in relation to what my role and function was, why I was asking these questions, and I think were a bit alarmed, I think, about the level of curiosity in relation to how this worked. That didn't stop me asking the questions but

TRA-01439, Lines 1 – 20

it did make it more difficult in that I had to keep coming back and back and back to try to get the answers that I needed.

Q. Did you consider that to be a difficult working environment, that the culture of being robust towards the Medical Director –

A. Yes.

Q. -- probably a little bit ambitious for people to take on the most senior medic in the SMT. Did you see that as a sign there was some reluctance to do things differently?

A. Yes.

Q. You've mentioned who it wasn't. You haven't mentioned who it was in your Section 21. You're clearly not going to say any names. You're very free to do so now if you wish to, but obviously the Inquiry would like the opportunity to ask certain individuals, if we had the information, how their behaviour may have impacted on clinical decision making. I'll leave that thought with you.

2. The Inquiry asks that you:

(i) Identify by name and position the *middle managers* to whom you referred in your oral evidence.

Mrs Anne McVey Assistant Director Acute Medicine;
Mr Ronan Carroll Assistant Director ATICS and Surgery and Elective Care.

(ii) Set out the detail of your interactions with these individuals, including:

(a) the content of discussions and dates/times/locations as appropriate,

she would not engage with me. I spoke to Vivienne Toal, Director of HR, and explained the situation and was then asked to the office of Melanie McClements, Director of Acute Services. Melanie was angry that Anne had been “upset” and reiterated that I had to stop asking questions. I discussed this with the Chief Executive, Mr Devlin, and his view was aligned with mine: that as Medical Director I should be curious in relation to patient care. I discussed this at a later stage with Melanie when she was less irritated and explained that she had only been given one side of the story and that I was disappointed that she would choose to give credence to an Assistant Director and none to an Executive Director with a responsibility for Patient Safety and Governance. I reminded her that I would not be able to do my job if I didn’t try to understand how systems worked. She accepted this and acknowledged this and stated that she had not had a full appreciation of the role of Medical Director.

Until she retired the relationship with Anne was professional but not warm. This was disappointing. I don’t believe that she recognised the impact that her behaviours had on the relationship. I also was aware that she had the capacity to be extremely kind towards others, particularly patients.

I was very mindful of the fact that, as someone who was recently new into the role of Acute Director with limited experience in that Directorate, Melanie was extremely dependant on the support of the ADs in order to get the job done. Particularly before the onset of the pandemic, the organisation felt quite split at times. Acute held onto its own information under the guise at that time of managing its own governance, which is a system that had been instigated in the past. As a result of this it was very difficult for the Director of Nursing and me, as Medical Director, to access the governance information we required in order to provide accurate assurance to the organisation. By the same

(a) Providing specialist advice to the Trust Board, Chief Executive and other Director colleagues and their teams on all areas of Pharmacy and Medicines Management across the organisation.

(b) Responsibility for the delivery and clinical governance of the Pharmacy service and all aspects of the management of Pharmacy staff throughout the Trust including the hospitals and community sectors.

(c) Responsibility for managing the procurement of medicines and associated pharmaceutical products to ensure pharmaceutical clinical effectiveness was in line with accepted best practice standards

(d) Responsibility for research and development, quality improvement and clinical audit activity within the Pharmacy Department.

(e) Achieving outcomes which improved patient and service user experience, provided safe services and improved the environment to provide excellent patient care.

4.3 I also held the position of Controlled Drug Accountable Officer for the Trust under the Controlled Drugs (Supervision of Management and Use) Regulations 2013. I was responsible for the management of controlled drugs, the related governance issues in the organisation and also compliance with the legislation in relation to production of quarterly Occurrence Reports and representing the Trust at the regional confidential Local Intelligence Network meetings.

4.4 In October 2014 I was asked by the then Director of Acute services, Mrs Deborah Burns, to manage the Acute Governance team for a few weeks while the Acute Governance Lead post was being recruited. This was because the previous post holder, Margaret Marshal, had moved into the Corporate Governance Lead role. I was asked to take this on as, out of the six Assistant Directors in the Acute Directorate, I had the most governance experience. I had set up the Northern Ireland Medicines Governance Pharmacist Team in a previous post and I also completed a post graduate Doctor of Pharmacy practice on the subject of medication related patient safety.

4.5 Shortly after this I was told at an Acute team meeting that the Acute Governance lead was not going to be replaced as the salary had been given up as a cost efficiency saving. I was not happy about this decision as I had been told that I would be managing the team on a temporary basis until the post had been filled. I already had an extremely large workload as Director of Pharmacy and Trust Accountable Officer.

4.6 In February 2016 the Director of Acute Services at the time, Esther Gishkori agreed to the replacement of the Acute Governance Lead *(Attachment 2)* and Trudy Reid was recruited into the role. She started this role on 4th April 2016.

4.7 Ms Gishkori was not prepared to take back direct responsibility for interfacing with the Acute Governance Lead despite it being part of her remit. I was told of this decision verbally at one of my 1:1 meetings with the Director. I do not believe that there is a note of what was said at this meeting. Therefore I continued to mentor and support the Governance Lead as they needed someone to facilitate their work. This involved meeting Trudy Reid every Tuesday morning to discuss any issues the team were having and accompanying her to brief Ms Gishkori on Governance issues once per week.

4.8 I put this weekly governance briefing meeting into Ms Gishkori's diary when I realised that she was not going to take back the Director's responsibility for Governance. I decided that the meetings were necessary as Ms Gishkori was attending Senior Management Team meetings where issues of governance and risk were being discussed. In my opinion she needed to be briefed to be able to represent the Acute Directorate position accurately. Unfortunately the meetings were often cancelled by Ms Gishkori. I do not have any notes of these meetings, as they would have been in my paper diary for the year which I no longer have in my possession. Ms Reid may be able to provide notes of these meetings.

4.9 During Ms Gishkori's time as Director, I was also often asked to chair the monthly Acute Governance meeting, the Acute Clinical Governance meeting and the twice monthly Standards and Guidelines meetings, in her place.

4.10 Around that time, Ms Eileen Mullen (Chair of the Trust Governance Committee) asked me to attend the full Trust Governance meetings in future, which I did. Up until that point I had only attended the beginning of the meeting in my role as Director of Pharmacy to present the Medicines Safety report. After I did this I left the meeting. This allowed me to assist Ms Gishkori, when necessary, with any Non-Executive Directors' questions about Acute Governance issues.

4.11 When the next Director of Acute Services (Melanie McClements) took up post in June 2019, she immediately took back her responsibility for Governance as the Director of Acute Services. I stopped the weekly briefing meetings as they were no longer necessary as she had scheduled 1:1 meetings with the Acute Governance Lead and routinely chaired the various Acute governance meetings each month.

Attachment 2 Governance coordinators recruitment post email Feb2016

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.**

5.1 My operational line management was undertaken by the Director of Acute Services throughout my employment as the Director of Pharmacy and Medicines Management in the SHSCT and I reported directly to that role. My appraisals were carried out by the Director of Acute Services.

5.2 The Acute Directors that were my line managers were as follows:

O'Brien's patients with outstanding results or clinic letters. I actioned the results and where necessary flagged up cases that required further review to ensure a safe management plan was in place. I supplied a list of this work to Mrs Corrigan. I have no knowledge of how Mr O'Brien's workload and performance was monitored upon his return to work later in 2017, this process was not shared with me by the trust management.

48.3 In May 2017, I was interviewed about the same issues by Dr Chada, Associate Medical Director, on behalf of the trust. My statement from that interview has been supplied to the USI.

49. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

49.1 I do not feel that I have been supported in my role by my line managers or the medical or operational hierarchy in the trust. Interaction between the medical managers and myself was very limited before 2020. Only when the Minister Swann announced the USI did the senior managers engage with the Urology Consultants. Despite all the problems in the trust the remaining urology consultants are asked to take on more activity to cover service gaps and address the patient risks identified by the various inquiries. This feels overwhelming and I have said so at meetings with Shane Devlin, Maria O'Kane and Melanie McClements. I will not take on more work when I know that I cannot safely deliver it. I have not received any specific support other than signposting by Dr O'Kane to occupational health and psychology should I feel that I need to self-refer.

Concerns regarding the Urology unit

50. The Inquiry is keen to understand how, if at all, you engaged with the following post-holders:-

(i) The Chief Executive(s);

(ii) The Medical Director(s);

(iii) The Director(s) of Acute Services;

with the full extent of issues raised regarding the Implementation Plan and the extent to which these were reflected in Trust governance documents, minutes and/or Risk Register.

119. The Trust Delivery Plan (TDP) in 2017 – 2018 reported that waits over 52 weeks in March 2017 across 9 specialties including Urology continued to fall below baseline targets due to increased demand, insufficient capacity, and lack of recurrent investment in capacity gaps. The Delivery Plan in 2017 – 2018 also recognised that it was unlikely for the Trust to achieve its objective of meeting the target of 75% of patient not waiting longer than 9 weeks for diagnostic test due to inability to increase capacity even with additional resources due to competing urology input demands.

120. The Trust Delivery Plan also noted that patients referred to 5 specialty areas including Urology continued to wait longer than 52 weeks for inpatient/ day case treatment. This was despite the offer from the Department of Health of additional resources, as the Trust would be unable to source increased capacity required to reduce the number of patients waiting over 52 weeks, particularly in Urology where complexity of case mix affected the ability to utilise the Independent Sector.

121. From when I assumed post as Director of Acute Services, breaches in waiting times, waiting lists, and cancer pathway targets relating to Urology were regularly highlighted in performance and governance meetings including risk registers. (Detailed in Q12 including actions taken).

122. The responsibility for ensuring that risk was identified, defined, mitigations put in place and other control mechanisms were detailed in the Risk Register, sits with the affected Division – Assistant Director, Mr Ronan Carroll (SEC), Mr Barry Conway (Cancer Clinical Services), Divisional Medical Director, Mr Mark Haynes now Mr Edward McNaboe (SEC), Dr Shahid Tariq (Cancer Clinical Services) Head of Service, Mrs Martina Corrigan now Ms Wendy Clayton (SEC), Mrs Fiona Reddick on sick leave now covered by Ms Clair Quinn (Cancer Clinical Services) and Clinical Director, Mr Edward McNaboe previously now vacant post (SEC), Dr David McCaul previously now vacant post (Cancer Clinical Services). If the risk is contained in one Division, the risk sits on the Divisional Risk Register. If the risk crosses more than 1 Division in the Directorate, it sits on the Directorate Risk Register. If the risk affects Directorates across the Trust, it sits on the Corporate Risk Register for example access to services which can relate to a range of service areas. The responsibility for including the risk at the Corporate Risk Register sits with the Directors of the Senior Management Team.

123. The risks currently included are within the Directorate, SEC and Corporate Risk Registers (5. *20220512 Q7.35 Summary Corporate Risk Register to Governance Committee located in S21 53 of 2022 Attachments)*.

138. Over the past 1-2 years, we had permission from the Health and Social Care Board to veer the funding from the 7th urologist post (91. *20201001 Q16.138 IPT - Expansion of Urology Services - 7th Urology Consultant located in S21 53 of 2022 Attachments*) we could not recruit to other elements of the service including additional clinics, extended multidisciplinary attendances at multidisciplinary meetings including pathology, radiology, oncology and a Band 5 post to be Administrative Officer to support the MDT chairs (90. *20210329 Q16.137 IPT - Staffing Support Requirement for SAI Inquiry – Urology)*. This was an attempt to address the shortcomings of the regionally commissioned resource for comprehensive participation and decision-making at the cancer related MDT's.

139. Macmillan (Cancer Support Charity) also entered into agreements with the Trust on improving cancer care, recovery service improvement. Mary Haughey, Cancer Services Improvement Lead, previously funded by Macmillan and subsequently by HSCB/SPPG, has supported the Trust to roll out baseline assessments using the National Clinical Assessment Service (NCAS) audit tool as part of the service improvement approach of achieving compliance with the 9 SAI report recommendations (11 recommendations in total).

140. Also, the Trust has secured funding in May 2022 for the new Lithotripsy/ Stone Treatment Centre (£500,000). 92. *20220401 Q16.140 IPT - Stone Treatment Centre 2021-22 located in S21 53 of 2022 Attachments*

141. Currently scoping is under way with Planning Colleagues and Urology team to consider the options of additional or improved space outside of the two acute hospitals, which may be an option for relocation of some urology services.

142. During my tenure equipment resource concerns were highlighted within Surgical Services which included equipment within the Urology Services. Questions 17 portrays the timeframe and mechanisms followed to address the equipment resource concerns with Urology Services. 93. *20220622 Q16.142 Theatres Equipment Capital Budget Allocation (Urology) - 2020-21 located in S21 53 of 2022 Attachments*

17. Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

143. I have been aware of the staffing problems within the urology unit since I commenced post as Director of Acute Services as evidenced in my response to question 16. The lack of capacity in the medical workforce has been an ongoing problem before and since my tenure with a dedicated focus on retaining current staff and attracting new recruits.

144. In an email exchange on 12 June 2019, two days after I commenced post, from Mr Mark Haynes, Associate Medical Director to the Medical Director,

Dr Maria O'Kane (shared with me by Mr Carroll), Mr Haynes had summarised his concerns as (94.*20190612 Q17.144 MH Email re Elective Capacity located in S21 53 of 2022 Attachments*):

"In short, no we are not working at elective capacity or at maximum efficiency. Simply because we do not have the resource to do so…..

….Regarding efficiency in what we deliver, one aspect that is eternally frustrated is equipment investment. Within Acute services and from my perspective SEC/ATICS we have multiple items requiring investment sitting on a long list (attached). In total there are 54 items of equipment, totalling approximately £2.6 million…

….As you know, bed capacity is a major issue. In order for secondary care to deliver elective care at maximum capacity and maximum efficiency we need to fix the unscheduled care issues. Fundamentally this means an increase in bed capacity. No trust can manage elective care while bed occupancy runs in the high 80's to 90+%.....

…A first step in moving towards this is a corporate recognition that the primary issue affecting the trust is a lack of capacity for unscheduled care.

…Regarding increasing demand for trust services, I believe the underlying issue comes down to how services are commissioned and delivered within primary / secondary care…"

145. Consequently, I arranged a 1:1 supervision with Mr Ronan Carroll, Assistant Director for the following week to allow me to fully understand the scale of the problem and the range of actions ongoing and required to be implemented.

146. On 17 June 2019, I carried out my first 1:1 discussion with Mr Ronan Carroll, Assistant Director, where he highlighted a number of vacant posts (1.5 vacant urologist consultant post out of 6 funded posts) and the added load on the core consultants resulting in the need for locum cover. He also highlighted that 3 South ward (surgical ENT/urology) was operating with 80% agency/ non-core staff and four beds had been closed as a patients' safety measure (two of these beds reopened in November 2019 which indicates the scale of the nurse staffing problem and the benefit of taking action until the situation improves). He also noted the range of ongoing re-banding Agenda for Change submissions including ward staff and nurse Endoscopists in Urology. A range of ongoing processes to increase capacity, address vacancies, allocate available medical time to priority patient in outpatients, inpatient, theatre lists, and also holding a risk register on the equipment concerns with a range of control measures to increase patient safety (95. *20190617 Q17.146 ADs 1-1 meetings proforma- Ronan Carroll located in S21 53 of 2022 Attachments*).

147. On 8 July 2019, in a follow up 1:1 discussion with Mr Carroll, he informed me that the risk to promoting safe and high-quality care in 3 South remained

Weekly communications were established to HSCB and ultimately to the Urology Accountability Group at Department of Health.

377. This is evidence that once clinical governance risk was identified, appropriate approaches were instigated and embedded in line with governance frameworks.

Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

378. I had no concerns that governance issues were not being identified, addressed or escalated. There was a thorough process which included incident reporting, identifying concerns, screening concerns for review against SAI criteria, active engagement with families, progressing complaint responses. I also got evidence on two occasions of effective monitoring against expected levels of compliance and oversight of practice anomalies, both relating to Mr O'Brien.

379. The delay in progressing SAI's from 2016 to 2020 (5 x 2016 cases reviewed by Mr J Johnston) I believe prevented earlier pick-up of issues regarding the care given by Mr O'Brien to patients. I became aware of this delay on 10 September 2019, when the Clinical & Social Care Governance Coordinator (Patricia Kingsnorth) brought to my attention for the first time that there were five 2016 Serious Adverse Incident reviews, relating to urology which had not yet been completed by the external panel. These were subsequent to an Index case Patient 10 [redacted] (2016). All were patients of Mr O'Brien.

380. I also feel if there had been greater transparency and openness regarding previous issues before my tenure, there could have been a greater identification and action with regard to concerns. I also feel the 28 records found in Mr O'Brien's office once he retired and the range of results and reports requiring his approval could and should have been escalated by his secretary. He retired in July 2020, Covid-19 hit in March 2020, with many staff working from home. I am unsure if this was a causative factor but the organisation should have contingency arrangements to prevent such eventualities.

381. Mr Carroll has indicated to me on a couple of occasions that one of the things that kept him awake at night was the lack of capacity to fully focus on governance issues within his Division. An example of this was the inability to progress action plans and implementation of recommendations following Serious Adverse Incidents or to deal with the volume of incidents that required active management and the complex complaints that required attention. There was a review of Clinical and Social Care Governance corporately in September 2019 which looked at the system within the Trust and the potential to realign structures and increase resource available for the clinical and social care governance function. It was my hope that this would present the opportunity for additional support into the operational Directorate teams.

396. The Operational Support Leads collate information with regard to Integrated Elective Access Protocol detailing compliance with targets from referral, triage, assessment or cancer pathways access and treatment targets. This included individual patient level data so that patients can be matched for follow up.

397. I do not have any greater knowledge on the use of these systems or their potential to identify concerns over and above the concerns relating to individual patients for individual clinical review.

Q43. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

398. Overall, the data efficacy of the systems that capture patient data depends on timeliness of clinicians reading results, dictating letters and following up patient episodes. This will result in the patient data being accurately recorded on NIECR. The system is not sophisticated enough to alert if clinicians are not dictating in a timely way and this places a reliance on the secretary to disclose that in the backlog report. This is dependent on accuracy, openness and transparency by the secretarial staff.

399. E-triage was a development to replace paper-based referrals from 2016 and works effectively with no changes since then.

400. Patient Administration System (PAS) and its case note tracking functionality has not really changed. I am aware that there have been occasions when records have not been traceable. I am aware there was a previous issue with records being retained in Mr O'Brien's home and had to be collected. The 4 key actions relating to Mr O'Brien's administrative practices which were subject to review by Mrs Corrigan, monitored the compliance against these. The two breaches referenced earlier, regarding non-compliance in September 2019 did not include patient record issues.

401. Mr O'Brien was reported to me by Mrs Corrigan in and around the time of his retirement, not to have used his office during the COVID-19 period (from March 2020). Following the escalation by Mr Haynes of the 10 cases of concern on 11 June 2020, Mrs Corrigan was asked as an action from the Urology Oversight Meeting to liaise with his secretary, Mrs Noeleen Elliot to identify if there were any further issues. At that time, Mrs Corrigan informed me she was disappointed to discover that there were 28 patient records in Mr O'Brien's office and a series of patient results were with his secretary as they required reviewing and sign off with regard to diagnostics and decisions regarding subsequent patient treatment pathways.

402. Reports can be run on case note tracking so that we are fully aware where records are. One of the impacts of COVID was that staff including secretaries were displaced from their offices to reduce risk and footfall in the building. This may have impacted on why these 28 notes were not flagged with HOS. In addition, 28 records may be appropriately with the Consultant for action

aware also. Often, and especially during the pandemic, situations would arise late into the day which resulted in plans becoming no longer suitable. I did not leave until a plan had been made and recall numerous times meeting with the Infection Control team up to 9pm at night to try to find a solution. I never left until my areas were safe and a plan was in place.

21.14 I worked various shift patterns and worked over planned annual leave. I changed my working pattern at no notice to support my teams as required. Throughout the pandemic as well as working predominately in 3 South, I also covered gaps in Orthopaedics, Trauma Ward and Fracture Clinic having to function at times as nurse in charge. I feel I adhered to my roles and responsibilities throughout, and took on more responsibility and a significantly increased workload in order to support the service.

Question 22: What is your overall view of the efficiency and effectiveness of governance processes and procedures within Urology as relevant to your role?

22.1 I would say I found some of the governance processes and procedures to be outdated with regard to Nursing. I say this as I felt there had been no updating or refreshing of audit frameworks for many years. Within my Ward Sister role, I was continuously reviewing and updating my own templates that provided me with assurance over the standards within my ward. Every month I reviewed the findings and if there was anything missing I would update the template to monitor thereafter.

22.2 In reply to the Director Mrs Melanie McClements, who asked if I was going to improve NQI results, I said that the audit would need to be improved first as I did not find that it reflected what was actually happening. I recall her being taken aback by this comment. At the time the Ward Sister completed all the NQIs. I felt this enabled a potentially “better picture” to be presented than was actually the case. My intention was that on completing my independent documentation audit that the findings would match the findings in the NQIs. This proved to be very effective as teams now knew I was completing

independent audits that could contradict what was recorded in their NQIs and built a much more honest approach to auditing and assurance. I felt the staff on the wards saw audit as a paper exercise. It was only with a different approach and encouragement for Ward Sisters to include all staff in improvements that the mindset towards audit changed. Teams started to take pride and wanted to improve. This was particularly so in Ward 3 South.

22.3 The process of completing KSF, Supervision and Revalidation was sufficient in that a monthly reminder emails were sent to all managers. However, as previously mentioned the Post Dimensions library is not adequate: there are numerous roles with no specific dimensions, which is a void when advising of specific responsibilities and guidance for line managers.

22.4 I believe there was a disjointed nature to governance. The issues at a nursing level did not seem to filter to clinical teams and vice versa. There did not seem to be many forums or links for governance managers to provide oversight and support to Lead Nurses in improving standards. I felt it was all too self-directed and it was only after Covid that there were, for example, dedicated monthly meetings set up to review NQI results with all Lead Nurses. I think there needs to be more visibility and support at ward level from Governance teams.

22.5 The Governance for Cancer Nurse Specialists was managed by the Acute Surgical Team but I feel there was nothing available from a Governance perspective. As discussed, there were no audit processes for assessing their particular roles and responsibilities, no specific meetings for me as a Lead Nurse to be supported in managing staff from a Cancer specialty. It was only when my then HOS Mrs Wendy Clayton asked if the CNS rotas could be looked at to accommodate the Nurse Lead Clinics that the entire job planning and KPI framework became known to me. Even then there was no other supporting documentation than the Job Planning guidance for medical staff as demonstrated in *Appendix Forty- Seven*. When I researched this, I linked with Mrs Lisa Houlihan, who had come from the

382. Whilst the proposals of the 2019 Review were presented to SMT in September 2020, they were not fully accepted and required further work with regard to the corporate vs operational implementation of same. In November 2021, a further presentation to SMT agreed to establish a Clinical and Social Care Governance working Group to strengthen assurance mechanisms and to realign the resources into a corporate team to facilitate standardisation and equalisation of processes and workloads, with delivery arms within each operational Directorate. 137. *20190513 Terms of Reference Clinical and Social Care Governance Review, 138. 20190801 Draft Report Clinical and Social Care Governance Review, 139. 20190925 Clinical and Social Care Governance Review Response located in S21 53 of 2022 Attachments*

383. In the interim, I was conscious of the request for additional governance support within each Division, and in the absence of adequate commissioned governance posts, I realigned some support from the recently established Quality Improvement team in Acute Services, to support the Assistant Directors and Heads of Service to address some of the backlogs in incidents and action plans. This was in place from summer 2021 and by May 2022 I had secured investment for 4 Divisional Governance Officers, 1 for each Division which as I write are in recruitment.

384. Acknowledging that there had been escalated concerns to me about the lack of capacity to fully address governance, I was concerned that there was potential risk of inadequate identification of governance concerns and thus, the potential for lack of appropriate action to address and escalate same. That was my driver, for allocating interim resource and remaining focused on this unmet need until I had secured the resource to progress to recruit the governance posts. It was my expectation that the 4 pillars of operational management, namely, performance, governance, human resources and finance all had equal priority and therefore the operational team were aware of the need to afford dedicated time for identification and prioritisation of governance issues.

Q41. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

385. Concerns raised by the Clinical and Management Teams were discussed with the Clinical and Social Care Governance Coordinator, risk assessed and control mechanisms/mitigations were included in the Divisional and Directorate Risk Register as appropriate. For example, since September 2012 an inability to meet the performance standard for 62-day cancer performance was entered into the Acute Directorate Risk Register, this remains on the register and is updated regularly. In October 2021, it was recorded, that all tumour site pathways continue to have capacity problems affected by the ongoing pandemic, referral levels for the majority of tumour sites have continued to increase and are now back to pre-Covid-19 levels or higher. Most are affected by limited access to Surgery and the Trust participates in regional equalisation meetings to review priority patients and decisions regarding allocation of theatre sessions across the region. Fortnightly cancer checkpoint

Terms of Reference Southern Health and Social Care Trust

Clinical and Social Care Governance Review

- The purpose of the review is to ensure the Trust has a robust governance structure and arrangements in place which offers assurance on patient safety and that helps people learn.

Objectives

- The Trust is seeking to undertake a comprehensive review of the current governance structure and recommend what a good structure should look like.
- It will review existing governance processes and particularly governance assurance, moving the Trust towards a position where there is a whole governance approach to the organisation. It will include a review of both clinical and social care governance.
- Specifically the work will include:
    - *gaining an understanding of the current governance structure and processes in place*
    - *meeting stakeholders to identify what works well and areas for improvement*
    - *undertaking a benchmarking exercise to identify best practice*
    - *review of existing and draft documentation including a new Governance Assurance Strategy*
- The outcome will be a written report outlining key findings from the review and recommendations.

Executive Summary

In April 2019 the Southern Health and Social Care Trust (the Trust) requested that the Health and Social Care (HSC) Leadership Centre undertake an independent review of clinical and social care governance within the Trust, including governance arrangements within the Medical Directorate and the wider organisation.

The independent review (the Review) was undertaken during the period from mid-May to end August 2019. A total of 15 days were allocated for the Review. The Review was undertaken using standard methodology; review and analysis of documentation and stakeholder meetings (Section 2).

During the course of the Review senior stakeholders provided the context to the development of integrated governance arrangements from the Trust's inception in April 2007 and from recommendations arising from an internal Clinical and Social Care Governance Review that was undertaken during 2010 and implemented in 2013 and the subsequent revisit of the 2010 Review undertaken in April 2015. Senior stakeholders identified that there had been many changes within Trust Board and the senior management team over a number of years which had had a destabilising impact upon the organisation. They cited the number of individuals who had held the Accountable Officer/Chief Executive in Interim and Acting roles as having the most significant impact and welcomed the appointment of the Chief Executive in March 2018. It was also noted that the role of Medical Director had also been in a period of flux since 2011.

There were many areas of good practice outlined during interviews with senior stakeholder including; leadership walk rounds conducted by members of Trust Board, a Controls Assurance Group to continue to focus on systems of internal control and patient and service user experience initiatives including the development of a lessons learned video on engagement with a mother who had been involved in a Serious Adverse Incident review following the death of her child. This video has been used regionally at Department of Health, Inquiry into Hyponatraemia-related Deaths Stakeholder events for shared learning.

The analysis has demonstrated that many of the building blocks for good integrated governance are in place. The Trust has an Integrated Governance Framework incorporating a governance committee structure, a Board Assurance Framework and Corporate Risk Register and a risk management system with underpinning policies and procedures for example adverse incident reporting, health and safety, and complaints and claims management. The analysis has identified good practice across these systems, however, a number of areas for improvement and gaps in control have been identified which will require action. Similarly, there are areas of good practice as identified above which have been developed in operational Directorates which stakeholders consider have not necessarily been shared or applied across the organisation. Some senior stakeholders identified a lack of connectivity across the Integrated Governance Framework. Many stakeholders referred to the lack of a robust streamlined accountability and assurance reporting framework which added to the perception that integrated governance was being delivered in silos.

In considering recommendations for the Trust the Reviewer took account of the Inquiry into Hyponatraemia-related Deaths (IHRD) Report and Recommendations and the ongoing work of the IHRD Implementation Group and Department of Health (DoH) Workstreams.

The Report has identified 48 recommendations to improve the effectiveness and robustness of the integrated governance systems. The recommendations are contained throughout Section 4 (Findings and Analysis) and are broadly categorised under the following themes;

- Board Governance;
- Culture of Being Open;
- Controls Assurance;
- Risk Management Strategy;
- Management of SAIs, Complaints and Legal Services;
- Health & Safety;
- Standards and guidelines;
- Clinical Audit;
- Morbidity & Mortality;
- Learning for Improvement;
- Datix;
- Clinical and Social Care Governance Structures.

A summary of the Recommendations is provided in Appendix 1.

Clinical and Social Care Governance Review – Draft August 2019
This draft response comprises of the response to the review report and recommendations (including areas not referenced in the review)

	Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.		accountability and assurance	weakness section below	
19. L	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers	Accepted	Improvement in accountability and assurance	See potential weakness section below	
20. M-L	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.	Accepted	Improvement in accountability and assurance	See potential weakness section below	
21. M	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.	Accepted	Improvement in accountability and assurance	See potential weakness section below	
Potential Weakness	- Whilst these 5 recommendations reflect the elements necessary to implement the risk management strategy they do not consider the pre-requisite resource aspects required to deliver upon them. The training cost, release of staff time, investment in Datix, as the risk management system and required supporting staff. - The review of the integrated governance framework (recommendation 12) would need to examine the linkages for operationally and corporately reporting assurance on risk. - The report does not reflect how the Board Assurance Framework and Corporate Risk Register integrate. - The housekeeping nature of recommendation 5 will require engagement across directorates for template design and system development, otherwise the opportunity for standardisation will not be realised. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Management of Adverse Incidents including SAIs**	**Draft Response Opinion Accepted /**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**

Clinical and Social Care Governance is defined as: "A framework through which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (A First Class Service, DOH 1998).

*Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

	systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below).		connectivity		
Potential Weakness	- The review acknowledges that adequate resourcing is required to optimise the learning outputs from M&M forums. This will require an exercise to benchmark against other models of M&M facilitation and embedding learning, as well as the assurance function to be provided by the Oversight Group on the systematic review of all deaths. - The review does not reference a requirement for an additional level of objective review of mortality and morbidity cases which is currently being considered regionally and has implications for clinician review time, training and ICT infrastructure to aggregate themes across an organisational system. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Shared Learning for Improvement**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
43. S-M	The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.	Partially accepted	Systematic Improvement in cross-directorate approaches Improve Connectivity across the Integrated Governance Framework	See potential weakness below	High
Potential Weakness	The review does not reflect the elements and pre-requisites necessary for the sharing and implementation of 'lessons learned' systematically across the organisation and supporting the necessary multi-disciplinary involvement.				

Clinical and Social Care Governance Review – Draft August 2019
This draft response comprises of the response to the review report and recommendations (including areas not referenced in the review)

	- The resourcing and form of this function or options for it are not described - The implementation of this recommendations will be influenced by the 6 IHRD recommendations which refer to 'learning' including clinician being afforded time to consider and assimilate learning and feedback from SAI investigations within contracted hours and Director level training - The lessons learned forum will have pre-requisites of clinical engagement to review the ToR, specification of the assurance reporting required, capacity (i.e. the experts, admin support, ICT infrastructure) to support the information and assurance. - Capacity and Demand Modelling for the Governance areas vs Manpower (any benchmark comparisons to other HSCs or NHSFTs)				
4.0. Findings & Analysis / Timescale	**Review Recommendations:** **Governance Information Management Systems (Datix)**	**Draft Response Opinion Accepted / Not Accepted**	**Improvement / Gap Identified**	**Dependency / Pre-Requisite**	**Priority**
44. S-M	To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below).	Accepted	Improvement in accountability and assurance	Engagement, specification of the assurance reporting required, capacity (i.e. the experts, admin support and Datix and other IT infrastructure investment) to support the information and	High

Clinical and Social Care Governance is defined as: "A framework through which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (A First Class Service, DOH 1998).

*Short Term (S) action within 3 months, Medium Term (M) action within 6 months, Long Term (L) action within 9-12 months.

Service and subsequently signed off by the Assistant Director and Divisional Medical Director. It is a joint responsibility between Assistant Director and Divisional Medical Director to ensure job plans reflect work to be undertaken.

Q55. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

557. On 27 August 2019, I first became aware of issues regarding Mr O'Brien. It followed a communication from the GMC Triage Team seeking further information from Dr O'Kane following Dr O'Kane's referral of Mr O'Brien to them on 3 April 2019. 10 points were raised by the GMC seeking a response in advance of 6 September 2019. Dr O'Kane forwarded the email to Mr Simon Gibson, Assistant Director Medical Director's Office, Siobhan Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs Vivienne Toal, Director of Human Resources and Organisational Development. On 10 September 2019, I was further copied in to an email reminder for the requested information to the same email recipient as above.

558. On 16 September 2019, an email exchange commenced following two breaches to the post MHPS formal investigation Action Plan. This was from Mrs Corrigan to Dr Ahmed Khan and Mrs Hynds. By 4 October 2019, this email exchange was shared with me by Dr O'Kane who requested an Oversight meeting for 8 October 2019 to prepare the Trust response to the GMC with the attached email trail of the escalated breaches. In preparation for the meeting planned for 8 October 2019, Dr O'Kane forwarded the MHPS Return-to-Work Action Plan for Mr O'Brien which I forwarded on to Mr Carroll following the Oversight meeting taking place. This was the first time either of us had seen the MHPS Return-to-Work Action Plan.

559. Following the Oversight meeting of 8 October 2019, Dr O'Kane shared draft notes of the meeting including discussion on the escalation of concerns with regards the action areas of the agreed MHPS Return-to-Work Action Plan including timely triage processes, undertaking digital dictation immediately following each contact and not holding notes at home.

560. Dr O'Kane noted that Mr O'Brien's secretary had not engaged with the monitoring of the action plan, which required Mrs Corrigan to go on the electronic care record (NIECR) to check if notes have been uploaded. It was also noted that an incident report (1R-1) had been submitted on 3 October 2019 regarding a delay with a cancer patient. This gentleman, Patient 112 [redacted] had been discussed at MDT on 27 June 2019, and the outcome was Mr O'Brien was going to organise a renal biopsy. On 24 July 2019, Mr Haynes emailed Mr O'Brien and his secretary, Noeleen Elliot, to advise that a further referral had come in about this gentleman's renal lesion which Mr Haynes was triaging. He asked Mr O'Brien in the email *"had you the biopsy in hand?"* On 4 October

Mrs Vivienne Toal, Director of Human Resources and Organisational Development). I shared progress reports detailing the risks, concerns and actions of the Urology focused oversight meetings and operational meetings focused on patient reviews and plans to address service concerns within governance and performance frameworks.

649. With specific reference to the concerns raised on 11 June 2020, regarding Mr O'Brien's patients, there was a requirement to focus on increased patient reviews to ascertain if there were patient safety issues that needed identified. The 18-month period from January 2019 to June 2020 was the starting point agreed, as likely to contain the higher risk patients who would require earlier review/follow up (logic being the patients from earlier years may have already been seen by Mr O'Brien, potentially entered the service through other Consultants or as emergency admissions).

650. As patient reviews commenced, we collated an Investment Proposal Template (IPT) to secure additional resource for Consultants, Independent Sector contracts, clinical auditors and extended tracking outside the commissioned 31- and 62-day cancer pathway model (as follow up post-62-days on cancer pathway had been identified as a gap).

651. The Corporate Risk Register was updated in May 2022, identifying the risk of medical workforce shortages, nursing shortages, high usage of agency and locum staff, delay in accessing planned services including outpatients and elective procedures and the oversight of red flag referrals. Reference was made to the delay in accessing services and the delay in cancer pathways. The May 2022 update also identified the capacity risks in urology and the Trust potentially being unable to undertake the Lookback into service users under the care of Mr O'Brien in a timely way. It also included the Trust being unable to implement all aspects of the Urology SAI action plan in a timely and complete way. It also includes risk of reputational damage to Trust brought about by the SAI's.

Learning

Q67. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

652. I was not initially aware that In addition, to Mr O'Brien's sub optimal administrative processes, which delayed the management of referrals and treatment of patients, that there were also clinical issues. These came to light following the 11 June 2020 escalations by Mr Haynes, of the 10 patients of Mr O'Brien's, requested by Mr O'Brien to be added to the Urgent Bookable list on the same day.

653. One of the themes identified to date is with regard to compliance with standards and guidelines for the prescription of medication (Bicalutamide in this

instance). The usual mechanism following identification of medicine governance concern within the Trust, is to record an incident on Datix, escalate serious issues to me through the Director of Pharmacy and include the issues in the quarterly Medicine Report to Governance Committee. However, with regard to this specific medication, Bicalutamide is prescribed by General Practice on the advice of the urology consultant and therefore, the clinical team or the Pharmacy Department in the Trust would not have been aware of the anomalies. If a GP receives a dosage of medication for prescription from a Urologist, they may be guided by the Urologist's clinical expertise and not query what appears to be an unusual dose. This highlights the necessity for effective auditing of systems and processes used by individual clinicians across primary and secondary care interfaces.

654. I was aware of governance concerns regarding the urology service from early June 2019 as described in earlier responses, including the aggregation of several SAI's that were related to Mr O'Brien's patients. As I have progressed within the Acute Director post, I have become more aware of things I didn't fully appreciate including:

- Dr Neta Chada and Mrs Siobhan Hynds did the MHPS Investigation into Mr O'Brien with governance and patient safety at the core;
- Mr O'Brien had been previously excluded from work;
- Dr Ahmed Khan's Case Determination report was based on the MHPS Investigation;
- The Determination report had been shared with the CEO and was paused due to the grievance being lodged by Mr O'Brien;
- One of the recommendations in the MHPS Case Determination report was for a system wide review in Acute, broader than urology;
- There appears to have been enough concern in 2016 to merit close monitoring and further scrutiny to proceed;
- I didn't know when I commenced my tenure in June 2019 that Mr O'Brien had been referred to GMC in April 2019;
- I didn't know from the outset how many SAI's were 4 years old and not completed, how many had been significantly linked to Mr O'Brien and pro-rata appeared at a higher level than other urology Consultants.

655. At the heart of all of these concerns were ongoing governance and patient safety concerns and they should have been triangulated and acted upon. It is important when new in post to receive an effective induction and to ensure the post holder is appraised of ongoing issues to allow for effective monitoring and oversight. I was in post for 13 months before Mr O'Brien retired.

656. There were two significant issues in that time which were picked up. The first regarding non-compliance with the Return-to-Work Administrative Action Plan and on 11 June 2020, the concerns leading to the significant patient reviews. The resultant large volume of patient reviews has highlighted issues that could have been prevented. This has led to SAI's, the need for patient

recorded in reports from the Executive Nursing team and formed the basis of the action plan with the operational team including recruitment, training, capacity building, retention strategies and quality nursing care bundles and approaches (Nursing Early Waning Scores, Pressure Ulcers and Falls Prevention and Management).

531. From a medical perspective, ongoing recruitment of consultants and locum doctors and implementation of new posts including clinical fellows and physician associates were all in response to the risk of reduced medical capacity to deliver the service and the implementation of new posts to stabilise the team.

532. The potential risks to patients were clearly identified in the risk registers at Directorate and Corporate level including 62-day cancer performance, impact of appropriate and nurse staffing levels on the ability to provide safe, high-quality care, and access to inpatient, outpatient, day cases, and treatments outside clinically indicated timescales.

Deficiencies in Practice

533. The two main issues that were escalated to me of a more serious nature during my tenure as Acute Services Director were the breaches already cited regarding the MHPS Return-to-Work Action Plan escalated by Mrs Corrigan (September 2019) and the escalation from My Haynes in June 2020 prior to Mr O'Brien's retirement.

534. With regard to the MHPS agreed Action Plan, the breaches were clearly identified on 16 September 2019 that Mr O'Brien had 26 paper referrals outstanding and on e-triage 19 routine and 8 urgent referrals. This was in breach of the 1st Concern that was to be addressed within the action plan and monitoring arrangements – *that Mr O'Brien when urologist of the week (once every 6 weeks) must action and triage all referrals for which he is responsible. This will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters, it must be ensured that the Secretary will record receipt of these on PAS (Patient Administration System) and then all letters must be triaged. All referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends. Red flag referrals must be completed daily.*

535. The second concern related to the action on digital dictation which was not complied with. On 16 September 2019, Mrs Corrigan noted –

"Clinics held in Thorndale Unit (Craigavon Area Hospital)
CAAOBTDUR 20 August 2019 had 12 booked to clinic, 11 attendances and 1 CND (cancelled on the day) but no letters at all.
CAOBUO 23 August 2019 had 10 attendances and only 1 letter on NIECR

there is a greater need for further professional support, I would involve the Medical Director as appropriate.

73. Medical staff within the Urology Service attend monthly specialty meetings, dedicated to cases being discussed, reviewed, and appropriate actions taken and planned for (Morbidity and Mortality - M&M). A combined Anaesthetics and Surgical M&M is held on a Quarterly basis. I am not a member of these.

Potential Conflict between Operational and Professional Escalation

74. On occasions, I believe medical staff can find it difficult to differentiate when they escalate to a professional line or an operational line. This can be manifest in the first approach being to the Medical Director and a resultant delay in the Acute Director being made aware of the concern or any decision made. With respect to urology, there are occasions as a result of these blurring of line management and professional accountability lines where communication and timely escalation could be improved.

75. For example, on 16 September 2019 when the breaches in Mr O'Brien's agreed administrative Return-to-Work Action Plan were escalated, an email was sent detailing the breaches from Mrs Corrigan to Dr Ahmed Khan, Case Manager and copied to Siobhan Hynds, Deputy Director of Employee Relations and Engagement (47.-50. *20191004 Q8.75 Escalation of Breaches AOB, A1-A3 located in S21 53 of 2022 Attachments*). These related to non-compliance with Trust Policies and Procedures, in relation to triaging of referrals, contemporaneous note keeping, storage of medical records and private practice, following issues originating in 2016. Mrs Martina Corrigan, HOS, was monitoring his administrative processes. In the email communication, it was highlighted that non-compliance had been identified with lack of timely triage of referrals, some of which were urgent which was in breach of his agreed action plan. The second concern related to the action on digital dictation which was not complied with.

76. A follow-up email included Mr Gibson and subsequently Dr Khan informed Dr O'Kane on 18 September 2019. By 30 September 2019, Mr Haynes was copied in and I was informed by Dr O'Kane about the breaches on 4 October 2019 as a meeting had been called to respond to the concerns (47. *20191004 Q8.75 Escalation of Breaches AOB located in S21 53 of 2022 Attachments)*.

77. Previously, on the 27th August 2019, I was copied into an email from Dr O'Kane requesting further information to be provided to GMC, after her April 2019 referral of Mr O'Brien, as a result of the MHPS Case Determination report (51.-53. *20190827 Q8.77 GMC Referral - AOB, A1-A2 located in S21 53 of 2022 Attachments*). This was the first time I was aware of and I received the MHPS Case Determination Report from Dr O'Kane, in that email.

Assistant Director

relation to time limits not being met, there are a number of actions that have been taken as a result:

- The in-patient/day case planned backlogs, which include Urology, have been on the Divisional Surgery and Elective Care risk register from October 2016, and the access waiting times for outpatients and inpatient/day cases have been on the Divisional risk register from April 2019 (82. *20190607 Clinical and Cancer Services Risk Register, 81. 20190607 Surgery and Elective Care Risk Register located in S21 53 of 2022 Attachments*);
- The Cancer performance is on the Directorate risk register due to cancer pathway capacity issues in Urology and other tumour sites. *(80. 20220301 Acute Services Directorate Risk Register located in S21 53 of 2022 Attachments*);
- The ongoing increase in demand pressures within the urology service has been raised with the Commissioners and a business case / Investment Proposal Template (IPT) for a seventh consultant urologist was developed in October 2020 with the aim to reduce the gap between capacity and demand and the time patients wait to see a consultant urologist (91. *20201001 Q16.138 A1 IPT - Expansion of Urology Services - 7th Urology Consultant located in S21 53 of 2022 Attachments*);
- Independent sector contracts have been established and continue for new out-patient urology referrals with ongoing care and treatment where possible;
- Ongoing Regional capacity initiative through Regional Priority Group (RPOG) - the purpose of the group is to equalise the waiting time for clinically urgent patients across Trusts. 142. *20211004 RPOG Meeting Notes located in S21 53 of 2022 Attachments*

Q36.1 How did you assure yourself regarding patient risk and safety in urology services in general?

319. In general, assurance requires me to be confident in both individual clinicians and the team's ability to deliver on reducing risk and keeping patients safe. I was assured that all operational approaches within urology services (as detailed in question 35) were being maximised to address the performance in the service, despite the many challenges regarding demand, capacity, workforce and risk of patient harms with delays in accessing assessment and treatment.

320. With specific reference to patient risk and safety in urology services, my first challenge came in October 2019. Mrs Corrigan (Head of Service) had escalated concerns to Dr Ahmed Khan and Siobhan Hynds in September 2019, subsequently notified to me by Dr O'Kane on 4 October 2019 (136. *20191008 AOB Oversight A1 located in S21 53 of 2022 Attachments*). There were reported breaches with two of the four elements relating to administrative processes in the Action Plan agreed following the MHPS formal investigation, regarding triage of referrals, contemporaneous note keeping, storage of

medical records, and private practice. I was informed by Mrs Corrigan that this was the first breach detected by her following ongoing monitoring for a 2-year period. Ongoing monitoring was agreed as part of the assurance going forward and this continued with no other non-compliance noted in this regard until Mr O'Brien retired in July 2020.

321. For the year 2020/2021, my key objectives in my Individual Performance Review, agreed with the Chief Executive (Mr Shane Devlin), included ensuring maximum patient safety and best outcomes for care delivery for patients during the pandemic which had taken hold in our community. It also included addressing the urology concerns first escalated on 11 June 2020, with a focus on patient safety and quality care (128. *20200323 Melanie McClements Individual Performance Review 20-21 located in S21 53 of 2022 Attachments*). An early alert was completed and submitted (*Early alerts are a process of escalating to Trust Board, SPPG and Department of Health, issues which may be of regional media interest or where patients might have come to harm*).

322. Throughout the year, I implemented a work plan and monitored progress on the patient safety and risk issues that were raised. This included weekly/fortnightly Trust Urology review meetings, HSCB meetings and DOH Urology accountability meetings. At each of these meetings a live picture of the various patient cohorts was shared, describing those identified, stratified and prioritised for review in line with potential for risk and harm aligned with available capacity to review the patients. The urology clinical team, in particular Mr Haynes was actively involved in working with the operational team to identify clinical risk, offer patient reviews, face to face or desk top and ensuring patients were on the correct treatment plan or if required, transferred to an alternative pathway. A series of questions were devised, based on learning from BHSCT and HSCB to standardise the patient assessment and review. Whilst 4 questions was the minimum dataset required for patient safety assessment, 10 questions were used by Mr Haynes and Professor Sethia (Subject Matter Expert commissioned form England), facilitating a more comprehensive, historical review of care and treatment to those patients.

323. I oversaw the operational team devising and implementing patient reviews for patients who had been under the care of Mr Aidan O'Brien for the January 2019 to June 2020 period. A work plan to meet evolving requirements for patient and staff was implemented, governance arrangements were embedded including risk identification, adding same to risk register with mitigating actions, Serious Adverse Incident screening and investigations were completed. Early learning from SAI's was shared with the clinical teams and the Acute Clinical Governance meeting. As part of sharing the learning came the expectation of embedding that learning within each Division in the Directorate by the operational and clinical team.

324. A Task and finish group was established focused on implementing the overarching recommendation of the 9 Urology SAI's completed by the external panel chaired by Dr Dermot Hughes (2021) (120. *20211011 TOR Trust Task and Finish Group into Urology SAI Recommendations located in S21 53 of 2022*

CAOBUO 30 August 2019 12 booked to clinic, 1 CND, 1 DNA (did not attend) and 0 letters on NIECR
CAOBUO 3 September 2019 8 booked to clinic, no letters on NIECR"

536. The escalation from Mrs Corrigan confirmed that the concern regarding the two issues above were a clear breach and properly identified on Trust systems. The remaining two actions being monitored were complied with namely; no notes were stored off premises nor in Mr O'Brien's office (confirmed on the basis that there had been no issues raised regarding missing charts that Mr O'Brien had) and no more of Mr O'Brien's patients that had been seen privately as an outpatient had been listed in the Trust.

537. The impact of these is the potential of the referred patients not having been triaged or prioritised by the consultant, therefore delaying access to appropriate treatment pathways and potential risk of harm. With regard to contemporaneous dictation following clinic attendances at the Thorndale Unit, some letters not having been dictated will have delayed communication, and therefore access to information by GP or other clinicians on Northern Ireland Electronic Care Record (NIECR). There is also the potential of delay in the referral for follow-up diagnostics or treatment plans as the output of the clinic assessment is not available.

538. The learning from the Serious Adverse Incidents (April 2021) regarding Mr O'Brien's patients has shown delays in accessing triage, assessment, diagnostics and appropriate treatment pathways caused significant harm to patients.

539. The second serious concern that was escalated to me, Dr O'Kane, Mr Carroll and Mrs Corrigan on 11 June 2020, was the incident relating to patients identified by Mr Haynes that Mr O'Brien had requested to be added to the urgent bookable list which should have been added to the waiting list anytime between 18 July 2019 and 4 June 2020. This was as a result of an email from Mr O'Brien on 7 June 2020 to Linda Neville and Jacqueline McIlveen (temporary Secretarial cover) adding the 10 patients who required urgent admission and he had advised Mr Glackin of same on 4 June 2020. Mr Haynes had already arranged to admit 1 of those patients to Kingsbridge Private Hospital.

540. This is a serious concern as the standard procedure is that a patient is added to the PAS waiting list at the time of listing and not a time of offering a date for surgery. The concern expressed by Mr Haynes was that there could be other patients who were not administratively on the waiting list but should be with a risk that patients could be lost to our care. Out of the 10 patients that were reviewed by Mr Haynes, 3 were classified as having malignant disease and 1 with potentially malignant disease.

541. A response from Dr O'Kane on 11 June 2020 highlighted how concerning this finding was and the need for an urgent meeting to be planned to assure ourselves that these patients were safe, identified others that had been delayed and referencing the spirit of openness regarding conversations

with patients that might be made to make them aware. She also was concerned that this appeared to be a continuation of the behaviours that led to the Serious Adverse Incidents previously.

Q51. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q65 will ask about any support provided to Mr O'Brien).

542. In the earlier days of my tenure as Acute Services Director, the support for the team focused on building capacity, recruiting medical and nursing staff (substantive preferably and locum/ agency if necessary), stabilising the teams focusing on quality care and involving the professional Executives, Medical Director and Executive Nurse, in operational plans that required professional support and oversight, reducing bed complement to improve the nurse to patient bed ratio and reducing patient safety risks.

543. Once the more serious concerns noted above were communicated to the urology team, the need for additional patient reviews on an already stretched team, with vacant posts and significant backlogs, waiting lists and waiting times, increased anxiety levels. As a result of the announcement of a Public Inquiry into urology services, regular meetings were set up to check in with the team, offer 1:1 or peer support if they felt that would be helpful, and access to psychological support internally within the Trust or via INSPIRE was offered (independent contract available for staff health and wellbeing). The Director of Human Resources was kept appraised of the concern among urology staff as the psychology services and wrap around support sits within her brief.

544. Regular team meetings were offered at the pace and level that the team requested, monthly in the first instance and then scheduled whenever a communication needed to be shared. This offer was one of support with the spirit of one team working on resolving the issues together, staying united and strong and focused on patient safety. Having the Medical Director, Chief Executive and Executive Nurse in attendance was an opportunity to discuss any concerns among the team.

545. The consultants were concerned regarding the displacement of their priority patients by the need to review Mr O'Brien's patients as identified. As their concerns related to lack of capacity, subject matter experts were sourced from British Association of Urology Specialists (BAUS) to offset some of the demand of the patient reviews. In addition, an independent sector contract was agreed for approximately 236 oncology patients to be reviewed as a matter of priority. These approaches were an attempt to retain some capacity for their priority patients.

Service and subsequently signed off by the Assistant Director and Divisional Medical Director. It is a joint responsibility between Assistant Director and Divisional Medical Director to ensure job plans reflect work to be undertaken.

Q55. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

557. On 27 August 2019, I first became aware of issues regarding Mr O'Brien. It followed a communication from the GMC Triage Team seeking further information from Dr O'Kane following Dr O'Kane's referral of Mr O'Brien to them on 3 April 2019. 10 points were raised by the GMC seeking a response in advance of 6 September 2019. Dr O'Kane forwarded the email to Mr Simon Gibson, Assistant Director Medical Director's Office, Siobhan Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs Vivienne Toal, Director of Human Resources and Organisational Development. On 10 September 2019, I was further copied in to an email reminder for the requested information to the same email recipient as above.

558. On 16 September 2019, an email exchange commenced following two breaches to the post MHPS formal investigation Action Plan. This was from Mrs Corrigan to Dr Ahmed Khan and Mrs Hynds. By 4 October 2019, this email exchange was shared with me by Dr O'Kane who requested an Oversight meeting for 8 October 2019 to prepare the Trust response to the GMC with the attached email trail of the escalated breaches. In preparation for the meeting planned for 8 October 2019, Dr O'Kane forwarded the MHPS Return-to-Work Action Plan for Mr O'Brien which I forwarded on to Mr Carroll following the Oversight meeting taking place. This was the first time either of us had seen the MHPS Return-to-Work Action Plan.

559. Following the Oversight meeting of 8 October 2019, Dr O'Kane shared draft notes of the meeting including discussion on the escalation of concerns with regards the action areas of the agreed MHPS Return-to-Work Action Plan including timely triage processes, undertaking digital dictation immediately following each contact and not holding notes at home.

560. Dr O'Kane noted that Mr O'Brien's secretary had not engaged with the monitoring of the action plan, which required Mrs Corrigan to go on the electronic care record (NIECR) to check if notes have been uploaded. It was also noted that an incident report (1R-1) had been submitted on 3 October 2019 regarding a delay with a cancer patient. This gentleman, Patient 112 [redacted], had been discussed at MDT on 27 June 2019, and the outcome was Mr O'Brien was going to organise a renal biopsy. On 24 July 2019, Mr Haynes emailed Mr O'Brien and his secretary, Noeleen Elliot, to advise that a further referral had come in about this gentleman's renal lesion which Mr Haynes was triaging. He asked Mr O'Brien in the email *"had you the biopsy in hand?"* On 4 October

2019, Mr Haynes again emailed Mr O'Brien and his secretary Mrs Elliot to advise that this gentleman's case was discussed again at MDT on 3 October 2019 regarding clarity re investigations. The gentleman had not yet had a biopsy and there was no outpatient letter on NIECR from his outpatient appointment with Mr O'Brien on 16 October 2019. Mr Haynes asked if the biopsy was on hand and could Mr Haynes help by organising whilst he was in Belfast City Hospital. Mr O'Brien responded on 4 October 2019 that we would update the MDT the following week.

561. It was agreed at the Oversight meeting that Dr O'Kane would ask Mr McNaboe to discuss the concern with Mr O'Brien and to make him aware that this had been raised with the MHPS Case Manager, Dr Ahmed Khan. Dr O'Kane also agreed to consider the escalation including potential option to exclude and also to consider progressing the full system review noted in the 28 September 2018 MHPS Review. This later point references the final conclusion/recommendation in the MHPS Case Manager Determination Report dated 28 September 2018 authored by Dr Ahmed Khan, which states:

"The Report highlights issues regarding systemic failures by managers at all levels both clinical and operational within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in the practice of Mr O'Brien. No one formally assessed the extent of the issues or properly identified the potential risks to patients. Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there were wider issues of concern to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien. In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."

562. I became aware from having received documents in preparation for 8 October 2019 Oversight meeting that the MHPS formal investigation had taken place in September 2018. The MHPS Case Manager Determination Report (Dr Ahmed Khan 28 September 2018) under section 4 Investigation findings stated that –

"It was found that Mr O'Brien did not undertake non red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged and Mr O'Brien had accepted this fact. The same section of the report also highlighted that Mr O'Brien returned 307 sets of patient notes in January 2017. In addition, it was found that there were 66 undictated clinics by Mr O'Brien during the period of 2015 and 2016. Finally, it was found that Mr O'Brien scheduled 9 of his private patients sooner and outside clinical priority in 2015 and 2016".

Stinson, Emma M

From: OKane, Maria
Sent: 08 October 2019 14:51
To: Haynes, Mark; McClements, Melanie; Khan, Ahmed; Hynds, Siobhan
Subject: AOB OVERSIGHT MEETING - UPDATED
Attachments: URGENT :AOB concerns - escalation- oversight meeting request please ; Action plan

Discussion- draft notes :

1. Concerns re escalation
2. Concerns re process
3. Concerns re pp and making arrangements for investigation through the NHS -?Interface with pp policy – letters no longer on NIECR – now the patients are on list without letter- consider how tracking
4. Plan point :1: How can each be monitored and how is this escalated if concerns? Monitor through the information office

2. concerns re notes at home – weekly spot check? Meant to sign notes out – he has a condition on his action point that he is not to take notes home – make assumption that if notes not in his office or clinic or theatre they are in his home? No transport to take notes between cah and swah. Monitoring difficult
3. Martina can only monitor what she is given – his secretary has not engaged. Martina has had to go onto ECR to check if notes uploaded.
5. IR1 went in from MDT on Wednesday last re 1st delayed cancer patient – AOB letter on patient sent Friday
6. 2nd patient did not come to harm following escalation to MDT by trackers which builds contingency checks in to system for all clincians in urology

Plan :
1. Will ask Mr McNaboe to discuss concerns with AOB to make aware that this has been raised with the MHPS case manager – on leave until Monday
2. Will consider escalation plan including option to exclude
3. Will consider the full system review September 2018 and progress

Stinson, Emma M

From: Hynds, Siobhan
Sent: 14 February 2020 16:50
To: OKane, Maria; McClements, Melanie; Toal, Vivienne; Gibson, Simon; Carroll, Ronan; Khan, Ahmed
Subject: Meeting of Oversight Group - MHPS case Mr A O'Brien

Importance: High

Dear All – please find note of the meeting on 12 February 2020. Please let me know if you have any amendments.

Regards,

Siobhan

Meeting of Oversight Group - MHPS case Mr A O'Brien

12 February 2020
17:20

In attendance:

Maria O'Kane
Melanie McClements
Vivienne Toal
Simon Gibson
Siobhan Hynds

Via Video Conference

Ronan Carroll

Via Phone

Ahmed Khan

Siobhan gave an overview of the process and investigation. Discussions were held in respect of the outstanding actions to be progressed and how these would be taken forward including recent correspondences from GMC and RQIA.

Melanie provided an update on the SAI processes and the sign off.

Actions:

- Maria - To have a meeting / conversation with Ted McNaboe, Clinical Director regarding him meeting with AOB regularly and seeking assurances through that supervisory process that AOB was working in accordance with the triage process, was not holding notes at home and was undertaking all digital dictation immediately following each individual clinical contact with a patient.

- Maria - to speak with Ted McNaboe and Mark Haynes to ensure an agreed job plan is in place for AOB as a matter of priority or to escalate to the next stage of the job planning process.
- Maria to seek assurance from Damien Scullion to ensure AOB is completing annual appraisals.
- Maria to draft a response to GMC and RQIA in respect of their recent correspondences to the Trust seeking additional information about the case.
- Siobhan to draft a terms of reference for the independent review of the SAI recommendations and the MHPS review recommendation. Terms of reference to go to the Group for agreement.
- Melanie to share SAI reports and recommendations with Siobhan for drafting of the TOR.
- Maria to speak to Dr Rose McCullough (GP) to undertake the independent review.
- Maria to update Shane
- Vivienne to progress AOB's Grievance process.

Website: www.gmc-uk.org
Telephone: Personal Information redacted by USI

From: OKane, Maria Personal Information redacted by USI
Sent: 14 July 2020 19:58
To: Chris Brammall Personal Information redacted by USI Toal, Vivienne Personal Information redacted by USI ; Haynes, Mark Personal Information redacted by USI ; Wallace, Stephen Personal Information redacted by USI ; Joanne Donnelly Personal Information redacted by USI
Subject: RE: General Medical Council - Mr O'Brien

Mr Brammall, I have not yet received a response from Mr O'Brien about any agreement (or otherwise) to cease seeing private patients following correspondence to him sent on Saturday 11th July.

His solicitor has been in contact earlier this afternoon to ask that 2 sets of NHS casenotes are collected from his home tomorrow afternoon. She has also stated that "All other matters, including those referred to in Mr Haynes letter of 11 July, are reserved subject to further definitive response" . Please ensure any further correspondence is sent to this office".

I have shared the other queries with the relevant colleagues and we will respond by the 21st July.

Many thanks

Dr Maria O'Kane
Medical Director and Responsible Officer

From: Chris Brammall Personal Information redacted by USI
Sent: 14 July 2020 11:52
To: OKane, Maria; Toal, Vivienne; Haynes, Mark; Wallace, Stephen; Joanne Donnelly Personal Information redacted by the USI
Subject: RE: General Medical Council - Mr O'Brien

Good morning Dr O'Kane, many thanks for arranging for the information to be sent to me, I can confirm safe receipt of this through the secure email system. Please would it be possible to clarify:

- whether you have received a response from Mr O'Brien about any agreement (or otherwise) to cease seeing private patients following your correspondence?
- whether the independent review of relevant administrative processes, recommended by Dr Khan (MHPS case manager determination 28 Sept 2018) has been completed?

Please would it also be possible to send me the relevant medical records for service user A and service user B as identified in the information (these were the cohort 2 patients as identified in the email exchange between yourself and Joanne Donnelly). I appreciate it may take a little longer to get these together but I would be grateful if these could be sent to me by 21 July. If this won't be possible for any reason, please could you let me know?

Many thanks for your help with this Dr O'Kane

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street, Manchester, M3 3AW

Email: Personal Information redacted by USI
Website: www.gmc-uk.org
Telephone Personal Information redacted by USI

Hynds, Siobhan

From: Wallace, Stephen [redacted]
Sent: 21 July 2020 23:02
To: OKane, Maria; Toal, Vivienne; Haynes, Mark; Carroll, Ronan; Hynds, Siobhan; Corrigan, Martina
Subject: FW: General Medical Council - Mr O'Brien

Follow Up Flag: Follow up
Flag Status: Flagged

From: Wallace, Stephen **On Behalf Of** OKane, Maria
Sent: 21 July 2020 23:00
To: Chris Brammall ([redacted]) [redacted] Joanne Donnelly [redacted]
Subject: General Medical Council - Mr O'Brien

Thank you Chris,

Further to previous email below please see an update on additional information has requested.

- Mr O'Brien's solicitor has confirmed that Mr O'Brien will refrain from seeing any private patients at his home or any other setting
- The independent review of relevant administrative processes as recommended by Dr Khan has not yet been completed, this is scheduled for conclusion by September 2020

The medical records for service user A and service user B as identified in the information previously shared in the 'summary of concerns' are still subject to screening for advancement as potential Serious Adverse Incidents, we are awaiting the completion of this process. I will provide an update on this in due course.

I also wish to inform you that Mr O'Brien's contract of employment has now ceased with the Southern Health and Social Care Trust as of the 17th July 2020 as a result of Mr O'Brien's planned retirement.

Regards

Dr Maria O'Kane
Medical Director

From: Chris Brammall [redacted]
Sent: 15 July 2020 07:30
To: OKane, Maria
Subject: RE: General Medical Council - Mr O'Brien

That's great, many thanks Dr O'Kane

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street, Manchester, M3 3AW

Email: [redacted]

Hynds, Siobhan

From: Corrigan, Martina [redacted] >
Sent: 31 July 2020 12:35
To: Wallace, Stephen; OKane, Maria; Haynes, Mark; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject: RE: Terms of Reference - Review of Administrative Processes

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks Stephen and just to confirm that Rose and Mary are meeting with me next Thursday afternoon to commence

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT [redacted]
[redacted] (External)
[redacted] (Mobile)

From: Wallace, Stephen
Sent: 31 July 2020 12:33
To: OKane, Maria; Haynes, Mark; Corrigan, Martina; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject: Terms of Reference - Review of Administrative Processes

Dear all,

Please see below terms of reference for the review of administration processes as per MHPS recommendation, these have been reviewed by Dr Khan. Dr's Rose McCullagh and Mary Donnelly have agreed to conduct this work and will commence next week.

Regards
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

- The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources
- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes
- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

Timing

The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

Governance and Methodology

The Reviewer will be accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

Hynds, Siobhan

From: Toal, Vivienne [redacted]
Sent: 29 September 2020 13:36
To: Hynds, Siobhan
Subject: RE: Adminstrative review

Follow Up Flag: Follow up
Flag Status: Flagged

I had no words for it. None at all.

From: Hynds, Siobhan
Sent: 29 September 2020 12:56
To: Toal, Vivienne
Subject: FW: Adminstrative review

Surely this can't be it?????

From: Corrigan, Martina
Sent: 29 September 2020 08:33
To: Carroll, Ronan; Gormley, Damian; Haynes, Mark; Hynds, Siobhan; McClements, Melanie; OKane, Maria; Toal, Vivienne; Wallace, Stephen
Subject: Adminstrative review

Dear all

Can we discuss please (document 2 is what Mary sent me and I for ease I have attached what the TOR were) as conscious this needs to be complete and sent to RCS by tomorrow

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT [redacted])
[redacted] (External)
[redacted] (Mobile)

From: Donnelly, Mary
Sent: 21 September 2020 12:39
To: Corrigan, Martina
Cc: 'rose mccullagh'
Subject: FW: Document2

Hi Martina
Just to let you know Rose is going to complete this as I have taken on some additional duties with Bannview practice.
If you have any comments would you mind emailing them to Rose at her gmail account as above as she is on leave this week.

Belfast Scoping reviewers pts before closure

JJ, Paul, Carol, Daniel, Jane, Mel, Ryan

Matters Ned

Urology

8/10/12

1. Data & Concerns to date – Martina

[redacted] spoke to [redacted] – Pattern of behaviour in Services allow this to happen "ownership" issue in all; Risk

2. Closer look into Systems / processes – Anita, Peter, Katherine & Rose "other Trust leads"
> QA Systems (SAI Rec, MHPS, + work to date)
+ Secretary – Scoping results / charts + Martina (250)

3. Operation HOS release & backfill + Helpline + internal admin / hub support

4. Name of cont? – DLS – Viv to follow
JJ – patient confidentiality will come out quickly

5. Date 19th / 20th + Comms Plan
BE SURE WHAT YOU HAVE GOT [redacted]

6. Early Alert – Clinical new findings – Across BHSCT Contact
(verbal update to Rebecca) – EA
Comprehensive report to DOH via HSCB
NEED key elements

7. Letters to patients (pts) + letters?
+ GP – local / regional comms > 2 RJP
Martina – Rose role ? Check BHSCT when to contact

8. [redacted] notification on the day

9. Prev SAI's – do we need to conclude?
The final timescale
Group SAI
do we advise bigger group?

MOB > Spirit [illegible] B/Head

Mona – [illegible]
Chairman [illegible]

From: Carroll, Anita
Sent: 19 October 2020 16:07
To: McClements, Melanie [redacted]
Subject: FW: UROLOGY

Melanie can you substitute with this version sorry for messing that up
From: Carroll, Anita
Sent: 09 October 2020 16:16
To: McClements, Melanie [redacted]
Cc: Forde, Helen; Robinson, Katherine
Subject: UROLOGY

Melanie ,

following on from our conversation I have included a few things for consideration

1. Admin review doc : looked at what Rose/ Mary produced and added some context and redid the recommendations :if you are content myself and Katherine can chat through with Rose/ Mary

2 .Re your concerns with regards to charts and volumes of charts I can advise : All patient charts must be tracked on PAS using a tracking code which gives information on the current location of the chart. Every time a chart moves location the tracking code must be updated. Not only does this help in the relocation of the chart but it also serves as a governance tool to show who has access to the chart and when.

PAS provides the facility to run a report giving the number of charts tracked to a specific code, and the patient details. These reports are not run routinely but can be run as and when requested, eg in a ward move to ensure all charts are accounted for. Health records staff retrieve charts from the various offices and are aware of where there are large volumes of charts and would bring this to their Line Managers attention if there was an issue, eg large volumes of charts not normally in the office, or so many charts that finding a chart was difficult.

The volume of charts held in an office are indicative of the working practices for that consultant/specialty and not that there is a problem with the working practices – eg number of tests performed, audits being carried out, or if due to the nature of the patient's treatment there are regular enquiries re the treatment/drug regime it is easier to have the chart readily available. If a chart cannot be found the Health Records staff carry out a thorough search of all areas that the chart has been tracked to. If the chart is not found it is added to a Missing List and kept under review. A Datix is not usually completed for a missing chart as it is usually that someone has taken the chart to another location without tracking it appropriately.

3.with regards to your concern that there maybe other issues , we had a chat with martina and she agreed to send some details to Katherine so that Katherine would check pas logs etc to assure that the issue lay firmly with the consultant

As you know we haven't been heavily involved but I attach a work flow that would be useful as an overview of triage and appropriate escalation that acute services needs to adopt and implement

Hynds, Siobhan

From: Corrigan, Martina [redacted]
Sent: 10 November 2020 19:39
To: Kingsnorth, Patricia; Carroll, Ronan; Gormley, Damian; Haynes, Mark; Hynds, Siobhan; McClements, Melanie; McKimm, Jane; OKane, Maria; Toal, Vivienne; Wallace, Stephen
Subject: Admin Process V3 - 10 Nov 2020
Attachments: Admin Process V3 - 10 Nov 2020.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Dear all

As discussed at our meeting earlier.

Attached admin processes for comments – and as discussed the actual numbers in the '*description of issue'* is just for us internally so as to provide you with the scale of the issue at the time. These figures will be removed for whoever will be looking at this for us independently.

So I would welcome any comments/ amendments and thoughts on this document and also on who we should ask to critically review this, so that it is independently reviewed.

Thanks

Martina

Admin Review Processes

Issue Identified	Description of issue	Gaps that led to the problems	Policies or processes in Place	Ongoing Risks/flaws
1. Triage	**783 letters not triaged.** GP referrals were sent to Consultants in paper form and were added to the PAS system as per the clinical priority that the GP had put on their referral letter. Because of the longer waiting times for a first appointment if the consultant didn't triage then this may have disadvantaged a patient who should have been upgraded	This gap only applied to Routine and Urgent letters as referrals sent in by GP's as a Red Flag went a different route, Previously a business objects report had been ran regularly and this picked up that a patient had not been added to an outpatient waiting list and was escalated to OSL/HOS/AD for addressing. A decision was made in April 2014 by the Director of Acute services that where there was a significant delay in triage, then ~~referrals would~~referrals would be added to the OP waiting list by the clinical priority that the GP deemed on their letter. This meant that all patients were added to a waiting ~~list but~~list but also meant that any patients who should have been triaged and upgraded may not ~~necessarily have~~necessarily have been done if the consultant didn't triage —the letters. Copies of all letters were kept by the booking centre so if a consultant didn't return the letter	The introduction of ETriage has increased the ~~visibility of~~visibility of the triage process and the implementation ~~?? are we doing this as much as required~~ of robust escalation protocols throughout the management structure to include clinical management teams. Patients are not added to waiting list until they have been triaged by the consultant. The recent roll out (October 2020) of the new escalation process as per March 2019	Consultant to Consultant referrals including outside Trust cannot be added to the ETriage (this is being addressed and should be available in January 2021) so this is currently a risk if the secretary and the consultant do not action this. There are a few specialties that still do not triage using ETriage and this is being addressed. ~~Attach o/s list ?~~ For Consultant to Consultant referrals all Consultants need to be reminded ~~?? is this correct~~ that when using Digital dictation they need to highlight that a letter is Red Flag or urgent so that secretary will give priority to typing these letters

Comment [GD4]: Date this was implemented in urology?

Comment [GD5]: Also need to stat that as a result of SAI recommendations the process of default to GP priority was stood down?

Comment [GD1]: Should we be refererncing the IEAP from april 2018? Was this the protocol in place at the time? It states the following

All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records 35 manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day. 3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

I think this was mostly to facilitate the booking rather than consider this as replacing the triage process

Comment [GD2]: Do we have a paper trail of this decision

662. As I have reflected, I appreciate that this is actually not about a single practitioner but about a system that has the potential to allow sub-optimal practice to go unnoticed or clinicians not be held to account. This is probably similar across all Trusts. This leads me to think of our operational and medical structures and the link to the broader governance and to clinical and social care governance systems. We need to get to a better place that clinicians including doctors are held to account in a collaborative way rather than within professional lines, which has the potential to operate in silos. I feel that the MHPS escalated through the Medical/ Chief Executive lines with no communication to the Director or Assistant Director at that time, even though actions contained within it were expected to be operationally progressed, was a missed opportunity. Whilst this is in line with due process and respects the confidentiality within that process, there is a requirement to connect our services professionally and operationally at a higher level.

663. A main mechanism that needs to be absolutely water tight is the MDT whereby individual patient cases are presented in a quorate, representative forum where the range of skilled clinicians discuss the cases, agree the actions and have a follow up mechanism to ensure that all actions are delivered. Since the 9 SAI (April 2021) recommendations, considerable efforts have gone in to addressing the recommendation in this regard. This required additional investment in MDT chair support, tracking of actions post meetings, and each tumour specialty taking responsibility for improvement approaches and evidencing same. This approach needs to be rolled out to other areas across administrative processes so that results, reports and referrals are actioned in a timely way and escalated if there are concerns. The review of administrative processes has resulted in a systematic way to prevent these untimely delays and due escalation to address.

664. In addition, a peer reviewed model was not in place to use the clinical expertise available within the MDT's to review their working model. This has now been embedded across all tumour specialties to ensure evidence-based guidance from the National Cancer Action Team is used to assess the practices within the MDT and learning applied to facilitate more effective multidisciplinary team working.

Q69. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

665. From a governance perspective, it has to be considered that if the actions of one person are not at the required standard, then there is the potential for other clinicians also to be acting in a similar way. The focus therefore has to be on improving governance systems and processes, including effective clinical audit, that aim to reduce risks of patient harm, improve patient safety and learn from and apply that learning across the system.

of performance data is shared and discussed within that Committee with escalation to Trust Board as required.

498. As Director I am a member of the regional interface meetings with Health and Social Care Board (HSCB now known as Strategic Planning and Partnership Group, SPPG) with Assistant Directors, Heads of Service and Operational Support Leads. These meetings consider waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets.

499. The first agreement that I was aware of since my tenure was the Action Plan that was implemented during the 2017/2018 MHPS Investigation and Determination Report. This was agreed with Mr O'Brien during that period and was monitored weekly by Mrs Corrigan, then Head of Service in Urology. She completed this by reviewing the backlog reports, cross referencing Patient Administrative System (PAS), Northern Ireland Electronic Care Record (NIECR) patient data and E-Triage and whilst non-compliance was picked up in September 2019, Mr O'Brien did not agree monitoring should have still been in place post the MHPS formal investigation. This frustrated the Return-to-Work monitoring process and attempts to meet him to discuss.

500. Following the MHPS Determination report, the lodging of the grievance by Mr O'Brien and the subsequent appeal, resulted in an inability to act until the outcome of these were known. We now know this resulted in further patient harm.

501. Following the significant SAI's , "Index case" in 2016, 5 subsequent 2016 SAI's reported in 2020, the 9 SAI's in April 2021, an implementation plan to address recommendations required a Service Improvement Task & Finish group to be established. The focus of this was to ensure learning was applied across all cancer services and specialities and required the engagement of DMD's, CD's AD's, HOS and operational teams with service users to address deficits in systems and processes including MDT quorate meetings, ensuring the inclusion of a range of clinical opinions, better decision-making and following up actions and patient outcomes. This also has escalated to Commissioners the importance of appropriately resourcing cancer services and specialities including urology.

502. In addition, a better system of administrative and clerical escalation processes has been agreed to address issues regarding timely triage, case note tracking and following up referrals and diagnostics and acting on diagnostic results in a timely way. All of these are designed to prevent patients coming to harm in our care.

v. How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

503. As per response in Question 49 Section iv, I was assured through the 1:1 meetings with Assistant Directors and Divisional Medical Directors, in the