

UROLOGY SERVICES INQUIRY

USI Ref: Notice 78 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Helen Forde

I, Helen Forde, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

General

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

1.1 In response to this question please see points:

- a) 12.2
- b) 18.1
- c) 18.2
- d) 20.3
- e) 26.1
- f) 26.2

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: _____ Helen Forde _____

Date: _____ 21 October 2022 _____

(O3/2007)

Craigavon & Banbridge Community HSS Trust
POLICY FOR THE SAFEGUARDING, MOVEMENT &
TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST
RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

Title:	Policy for the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust Records, Files and other Media Between Trust Facilities	Ratified by Relevant Executive Directors: Yes / No	
Ownership:	Craigavon & Banbridge Community HSS Trust	Status:	Current
Publication Date:	August 2006	Next Review:	July 2009
Author(s)	Records Management Manager		
V1_0 March 2007		Policy For the Safeguarding, Movement & Transportation of Records, Files and Other Media Containing Personal Information Between Trust Facilities	

1.0 INTRODUCTION

- 1.1 The aim of this policy is to ensure that staff safeguard all confidential information whilst traveling from one facility/location to another during the course of their working day.
- 1.2 This may include confidential information contained within work diaries, notebooks, case papers, patient/client notes, Trust documents, 'lap top' computers etc.
- 1.3 This policy has been developed in addition to, and is to be read in conjunction with, the Policy Statement on Data Protection & Patient Confidentiality and the Good Practice Guidelines on Data Protection & Patient Confidentiality (currently under review).
- 1.4 It is the responsibility of all staff to familiarise themselves with the contents of this policy.

2.0 GUIDING PRINCIPLE

- 2.1 The HPSS Guidance for the 'Protection and Use of Patient and Client Information' (June 1999), states that 'everyone working for or with the HPSS who records, handles, stores or otherwise comes across information has a personal common law duty of confidence to patients and clients and to his or her employer. This applies equally to those, such as students or trainees, on temporary placements'.
- 2.2 Staff must notify their line managers immediately on suspicion of loss of any confidential information.

- 2.3 Managers must ensure staff are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information.

3.0 TRACKING / TRACING RECORDS

- 3.1 Managers must ensure that effective systems are in place for tracking the location of files containing confidential information. The type of system should be appropriate to the type of confidential information concerned (e.g. a card index system may be appropriate to a small department, while larger scale libraries may benefit from a computerised tracking system – e.g. PAS). Detailed guidance on tracking/tracing systems should be documented in departmental procedures and should take into account relevant professional standards where such exist. The following points should be incorporated into Departmental guidelines:

- A clear record of the files which have been removed from the designated storage area, and by whom, should be maintained;
- Files should be logged out to the borrower, who will be responsible for them whilst out of their designated storage;
- The tracking/tracing system should be updated by the borrower if the files are passed on, prior to being returned to the storage area;
- The minimum number of files required for the purpose should be removed;
- Files should be returned as soon as possible;
- A system for following up outstanding returns should be implemented;
- Responsibility for ensuring the availability of the files should be assigned to one individual within the Department.

4.0 MOVEMENT OUTSIDE THE WORK BASE

- 4.1 Movement of records off-site may be required for a variety of reasons, e.g.

- To facilitate care or treatment at a different Trust facility;
 - To facilitate care or treatment at a different facility outside of the Trust;
 - To facilitate patient/service user access;
 - Recruitment, selection and other personnel functions;
 - For domiciliary visits;
 - To meet legal or statutory requirements;
 - Delivery of drugs/specimens;
 - For home working (where absolutely necessary)
- (This list is not exhaustive)*

Your role

- 4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

4.1 I have had three roles during my employment in the Southern Trust:

- a. Head of Admin Services – Oct 2007 – 4/10/2009
- b. Head of Health Records – 5/10/2009 – 4/12/2020
- c. Admin Manager (zero hours) – Feb 2021 to date

(A) Head of Admin Services – Oct 2007 – Oct 2009

4.2 I was responsible for the line management and provision of admin services in the Community. This was a new role in the newly formed SHSCT and was established to look at admin in the community, with a view to implementing standard working practices and staffing efficiencies.

(B) Head of Health Records – Oct 2009 – Dec 2020

4.3 The role of the Head of Health Records was to ensure the provision of a comprehensive, efficient and effective health records service which included responsibility for Ward Clerks, Outpatient receptionists, Emergency Department and Minor Injuries Admin staff for the Acute Directorate in the Southern Health & Social Care Trust.

4.4 In addition to the responsibility of the above services I also had line management responsibility for the admin staff in these services.

4.5 I retired from this post on 4/12/20.

Please see 1. JD Head of Health Records and Admin Services Band 8a

Policy Checklist

Name of Policy:	Policy for the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust Records, Files and Other Media between Facilities
Purpose of Policy:	To ensure that Trust staff follow a corporate approach towards the transportation of records between facilities and understand the importance of same
Directorate responsible for Policy	Performance & Reform
Name & Title of Author:	Claire Graham, Head of Corporate Records
Does this meet criteria of a Policy?	Yes
Trade Union consultation?	Yes
Equality Screened by:	Claire Graham
Date Policy submitted to Policy Scrutiny Committee:	14 January 2008
Members of Policy Scrutiny Committee in Attendance: Siobhan Hanna, Claire Graham, Roisin Toner, Kevin Gribben, Danny McKeivitt, Anita Carroll, Carmel Harney, Mary Logan, Marie Austin & Fiona Wright	
Policy Approved/Rejected/Amended	Approved with amendments
Communication Plan required?	Yes
Training Plan required?	Yes
Implementation Plan included?	Yes
Any other comments:	
Date presented to SMT	8 February 2008
Director Responsible	Performance & Reform
SMT Approved/Rejected/Amended	Approved
SMT Comments	
Date returned to Directorate Lead for implementation (Board Secretary)	
Date received by Office Manager (HQ) for database/Intranet	11 February 2008
Date for further review	2 year default

Southern Health & Social Care Trust
Policy for the Safeguarding, Movement & Transportation of
Patients/Clients/Staff/Trust Records, Files and Other Media Between Facilities V2_0
August 2012

**POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION
OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER
MEDIA BETWEEN FACILITIES**

1.0 INTRODUCTION

- 1.1 The aim of this policy is to ensure that staff safe-guard all confidential information while travelling from one facility/location to another during the course of their working day.
- 1.2 This may include confidential information contained within work diaries, notebooks, case papers, patient/client notes, Trust documents, 'lap top' computers etc.
- 1.3 This may also include from time to time the necessity to store confidential information overnight in staff members own home.
- 1.4 All Trust staff are bound by a common law duty of confidentiality.
(See 9.0)
- 1.5 It is the responsibility of all staff to familiarise themselves and to implement practice of the contents of this policy.

2.0 GUIDING PRINCIPLE

- 2.1 The DHPSS Code of Practice on Protecting the Confidentiality of Service User Information (January 2012) states that "staff working within health and social services have an ethical and legal obligation to protect the information entrusted to them by users of the services."
- 2.2 Staff must notify their line managers immediately on suspicion of loss of any confidential information.
- 2.3 Line Manager must inform/notify Information Governance Team of any loss and contact Claire Graham, Head of Information Governance, Ferndale, Bannvale Site Gilford. Tel: Personal Information redacted by the USI
- 2.4 Managers must ensure staff, are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information.

3.0 TRACKING / TRACING RECORDS

Southern Health & Social Care Trust
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August 2012

- Disciplinary Investigations;
- For home working
(In some circumstances, records may be stored at the patient's home e.g. maternity notes, domiciliary care records and NISAT assessments etc. Confidentiality of the records stored in the client's home is the responsibility of the client/family members and they should be informed of their responsibility in this matter by the professional involved).

5.0 SAFEGUARDING OF PATIENT/CLIENT/STAFF RECORDS TRANSPORTED BETWEEN FACILITIES/LOCATIONS

- 5.1 It is recommended that employees should avoid taking confidential information outside the work base wherever possible. However, it is accepted that there are certain circumstances where this will be necessary or unavoidable. **Departmental procedures should detail the level of authorization required for the removal of files from Trust premises** or from one Trust premise to another.
- 5.2 Records should be transported in sealed boxes or sealed pouches when being transported between Trust sites and locations within the Southern Trust area.
- 5.3 All records should be prepared and tracked from the current location to the new location on PAS, Clinical manager or manual tracking system (or other relevant administration system) to ensure traceability at all times.
- 5.4 Transport boxes are used by health records departments. Each box is security sealed using the tamper evident seals by health records staff and collected from the health records department on a daily basis by Trust transport staff.
- 5.5 Charts must be securely transferred by SHSCT transport vans or on occasion, staff personal cars. Charts should never be left in a vehicle on view to the public and must be stored in the locked boot when being transported.
- 5.6 Transport boxes used for health records are delivered to the health records department at each site, emptied in health records department

Southern Health & Social Care Trust
Policy for the Safeguarding, Movement & Transportation of
Patients/Clients/Staff/Trust Records, Files and Other Media Between Facilities V2_0
August 2012

Policy Checklist

Policy name:	Policy for the safeguarding, movement and transportation of Patient/Client/Staff/Trust Records, Files and other media between facilities.
Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Director responsible for Policy:	Aldrina Magwood
Directorate responsible for Policy:	Performance & Reform
Equality Screened by:	Claire Graham
Trade Union consultation?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Policy Implementation Plan included?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Date approved by Policy Scrutiny Committee:	8 th January 2019
Date approved by SMT:	
Policy circulated to:	Directors and Information Governance Committee
Policy uploaded to:	Sharepoint

Version Control

Version:	Version 2.3		
Supersedes:	Version 2.2		
Version History			
Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
V2.3	Amendments to include GDPR	09012019	Catherine Weaver

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3.0 TRACKING / TRACING RECORDS

- 3.1 Managers must ensure that effective systems are in place for tracking the location of files/records/documentation containing confidential information. The system in place by managers/service leads should be

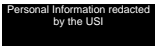


Southern Health
and Social Care Trust
Quality Care - for you, with you

Information Technology Security Policy 1.3 March 2021

Lead Policy Author & Job Title:	Stephen Hylands, Head of Information Technology
Directorate responsible for document:	Performance & Reform
Issue Date:	01 March 2021
Review Date:	01 March 2023

while waiting for Mr O'Brien to return triage to the booking centre. This system was agreed following consideration by the AMD, Director of Acute Services, HOS, and myself as a safeguard. At no point did this process set aside the responsibility for Mr O'Brien to complete triage.

444. Following many attempts to constructively address the requirement to triage with Mr O'Brien, putting processes of escalation in place, reducing his triage workload, amending registration systems and processes to ensure chronological management of patients was maintained, and following many conversations with senior Trust staff regarding non-compliance, in January 2016 Mr Mackle and myself met with Dr Richard Wright (Medical Director) to escalate concerns again and seek direction on next steps. Dr Wright felt that it was time to put all the recurrent concerns in writing to Mr O'Brien and seek a plan to address. The final agreed letter to Mr O'Brien of March 2016 is attached (*located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Heather Trouton 20160822 Email Confidential-*  *).*

Holding Patient Notes at home for prolonged periods.

445. Mr O'Brien would have taken patient notes home potentially for 2 reasons:-
- a. For use at his Private Practice clinic in his own home.
 - b. To undertake patient recording at home.
446. While there were not clear Trust guidelines forbidding the taking of patient notes home, there were guidelines on how patient notes were to be tracked and managed. Please see Policy for the Safeguarding, Movement and Transportation of Patients, Client, Staff Trust Records, *located at Section 21 2 of 2022, Safeguarding Movement Transportation.*

intervention to return triage, and there were periods where he appeared to be returning same appropriately, but then delays would occur again.

463. The standard against which referral triage is to be returned was, as I recall, 72 hours.

464. During the time of the weekly performance meetings chaired by Dr Rankin and Mrs Burns, consecutive Directors of Acute Services, Mrs Catherine Robinson, Head of the Booking Centre, presented triage times for review at performance meetings with outstanding triage data being presented, discussed and action required. Mrs Robinson also held weekly meetings with the Heads of Service to discuss all issues pertaining to clinic booking, triage and attendance. I was aware of this at the time.

Patient notes

465. There were not sufficiently robust actions in place to address this issue. It was reliant on Mr O'Brien understanding the risks for patient safety associated with no patient notes being available in hospital for emergency admission and other clinics and being vigilant in returning patient notes in a timely manner. There was no mechanism put in place to fully ascertain the situation regarding patient notes retained at Mr O'Brien's home.

Review backlog

466. I was assured by the Head of Service and the Operational Support Lead at the time that all that could be done to reduce the review backlog, in light of other competing pressures, was being done and that the systems and agreements to address same were working as far as was possible. I believe that these assurances were correct. As already noted, the finite capacity of the Urology team was used to meet a number of competing demands with red flag referrals and cancer patients requiring prioritisation.

Doctor's Induction – Admin Processes

Please see below some information which will help you in the processing of the patient through their journey in hospital from an admin point of view.

INPATIENTS

1. **DISCHARGE LETTER** - Discharge letters are typed on ECM and must be completed at the time of the patient discharge. When you are completing your discharge letter remember you must **AUTHORISE** them on ECM. If they aren't authorised they can't be printed and follow up actioned, e.g. making patient review.
2. **FOLLOW UP** – you must record the specific timeframe of the review, e.g. 2 months, or if you are referring the patient on to another consultant you must record the consultant's name, specialty and what hospital they are working in. This information **MUST BE** recorded in the **Follow up section**. Admin staff do not read the body of the letter so if the review is recorded in the body of the letter but not under the Follow Up section then it will be missed.
3. **TESTS/INVESTIGATIONS** - If you are arranging further tests/investigations for the patient you must use the appropriate referral form – the ward clerk will help you with this.
4. **CHANGING THE DISCHARGE LETTER** – On occasion you may need to change the discharge letter e.g change of medication, update results – if you do then you **must always** advise the ward clerk so they can print out the most up to date letter for the chart, and they will also check in case the follow up has changed.
5. **PATIENT DOCUMENTATION** – It is everyone's responsibility to ensure the safekeeping of patient charts therefore if you take a chart out of the trolley you must put it back where it came from. Please do not leave patient documents lying around work stations or wards – this poses a risk of information going missing, being misfiled and can cause serious breaches in patient data confidentiality.
6. **PATIENT CHARTS** - We have five sites in the SHSCT and each site at one time had their own chart, so you will be working with charts from CAH, DHH, STH, BPC and ACH charts. The majority of the charts are now filed in specialty order, but some of the older CAH and BPC charts are filed in chronological order. A filing protocol has been provided on each ward for your reference, and the ward clerk will also help you if you need guidance on where to look in the chart.
7. **PAGES AND LABELS** - When you are putting patient information/labels into a chart make sure that you put the right patient's information into the right chart. Another patient's information going into a chart will lead to Datix being completed, but more seriously may impact on the patient's care, so always check – right patient, right information.

31	All services	Complete Database of Location of Records	All Managers	complete	complete
32	All services	Review Business Continuity Plans and update	All Managers	Review Nov 16	For Review in Nov 16
33	All services	Review current SOPs to ensure they are up to date and revise as appropriate	All Managers	ongoing	
34	All services	Review mandatory training for all staff and ensure this is kept up to date	All Managers	ongoing	Sept 16 - majority of staff training now up to date - monthly monitoring commenced
35	All services	Update Risk Register for each area	All Managers	ongoing	
36	All services	Review Major Incident documentation	All Managers	complete	Review on annual basis - Review due Sept 2017
37	All services	Update KSF/PDP for all staff	All Managers	ongoing	All PDPs to be completed by Dec 2016
38	H Records	Clear CAH account 9 (BBH records)	Pamela	Jan-17	Complete
39	All services	Review shared managers shared drives and move information to the HHR shared drive where appropriate	Managers	Jun-16	Complete
40	All services	Create and update generic risk assessments for each area	Managers		Workshop arranged with Jennifer Taylor in Oct to complete
41	All services	Roll out of NIECR to staff	Managers		
42	RENAL	To get update from Lesley Anne Hadden with regards to capturing diagnostic activity in Renal	Helen McCaul	On going	meeting arranged 15/09/16 in this regard
43	ED DHH	Move ED records off site and records to car park store from lower ground (with Kate's teams help)	Helen McCaul	On going	
44	Renal	acquire extra storage cabinets for renal unit to store renal records securely	Helen McCaul	On going	stainless steel cabinets installed
45	Renal	Undertake KSFs with all staff in renal and ed	Helen McCaul	On going	majority of mandatory training up to date ksf to commence sept 16
46	ED DHH	Have booth like structures erected in ED reception to provide confidentiality between patients.	Helen McCaul	On going	awaited
47	Ward Clerk	set up a managers booklet with all information in relation to the role of the manager	Sinead Corr		
48	Ward Clerk	set up mini charts for each ward to help with 'how to file'	Sinead Corr	On-going	
49	Ward Clerk	look at allocation of staff and try to get as close to the ward clerk model as possible	Sinead Corr	end of August 16	This is still ongoing, very hard to get people into post.
50	H Records	Look at safety of staff working on their own in filing areas.	Pamela/Kate	Oct-16	Look at panic buttons
51	REN/ ED DHH	Risk assessment of ed reception and renal office	Helen		meeting with Jennifer Taylor 20th October 16
52	Ren/ED	KSF PDPS ED & Renal admin staff	Helen		Commenced
53	ED DHH	Undertaking training in UDDAof as many staff as poss			ON GOING
54	Ward Clerk	Set up induction for ward clerks	Sinead Corr	On-going	this will always be on-going
55	Ward Clerk	re-address SOP for e-discharges with other SA's	Sinead Corr	completed	24/11/16, a new SOP will be send out as soon as other SA's take a look at revised one
56	Health Records	To continue recalling off site boxes from Oasis,	Pamela/Kate	On-going	13/01/2017 recall Physio boxes to ward 2 Armagh

A	B	C	D	E	I
1	Head of Health Records				
2	Key Priorities 2015				
5	Service	SMART Objective	Responsibility	Completion Date	Progress Update
6	DHH H Rec	Nursing notes - sorted and forwarded to Villa	Kate		Completed Aug 2015
7	ED	Implement numerical filing system for ED, DHH	H McCaul	5.1.15	Complete
8	ED	Streamline ED Dashboard Business Obj reports	Irene / Helen McC	Jan-15	Complete
9	ED	Scan all information to internal departments	Irene / Helen McC	Jan-15	Complete
10	ED	Assist with the implementation of UDDA coding in ED and MIU	Irene/Helen McC	Apr-15	MIU commenced on 5.1.15 CAH commenced in April with admin staff
11	ED	Move to typing correspondence on eEMS	Irene/Helen McC		
12	ED	Clear Ramone store of 2014 records	Irene	26/11/2015	Records moved to ward 5 St Lukes
13	ED	Descruction of CAH ED Records	Irene		Irrelevant information redacted by the USI
14	ED	ED DHH to start admitting ALL patients coming through ED	Helen McC	May-15	Complete
15	ED	ED DHH to start admitting ALL patients coming through ED	Helen McC	May-15	Complete
16	ED	Decant of records - out of space for end of 2015 notes	Irene		Ongoing
17	H Records	Weed of all sites	HR managers		ACH - BBPC - ongoing - staff on long term sick leave STH - complete CAH - further weed taking place owing to

					lack of space on CAH site DHH	
18	H Records	Destruction of records on St Luke's site	HR managers	Jan-15	Complete	
19	H Records	Carry out a small pilot to look at paperless clinics	HR managers	Jan-15	Spoke to some consultants but none willing to commence pilot at the current time	
20	H Records	Implement Savience kiosks in the remainder of the OPD areas	HR managers		Cabling for Phase 2 to be completed by Sept 15. Mapping and clinic details given to Barrie - Aug 15	
21	H Records	Move maternity charts from Clanrye to Ward 2 SLH	Kate		complete	
22	H Records	Merge ACH charts into CAH and DHH charts to reduce the ACH charts	HR managers	ongoing		
23	H Records	Move CAH charts from Closed Store	HR managers		Commenced Dec 14 -	
24	H Records	Destruction of charts in OASIS	Kate / Helen	ongoing		
25	H Records	Transfer of Mental Health Records in OASIS to Mental Health Directorate	Kate	complete	complete	
26	H Records	Transfer of CYP Records in OASIS to CYP Health Directorate	Helen			
27	H Records	DHH Fractures to move to Kate Watters	Kate	complete	complete	
28	H Records	DHH Fractures - processes to be developed	Kate	complete	Complete July 15	
29	H Records	Review of STH Record working processes	Pamela	complete	complete	
30	H Records	Reduce staff numbers in ACH and move to Villa	Kate	complete	Complete	
31	H Records	New system of filing CAH reserves in the Villa to be implemented to make better use of existing space	HR managers	Mar-16	Commenced Sept 15	
32	H Records	Plan use of space of canteen accommodation on the SLH site		ongoing		
33	H Records	Resolve issue of overcrowding in dermatology secretaries office	Pamela	Aug-15	Complete	
34	IS	Complete Validation of IS information	Sinead		commenced May 2015, still ongoing hope to have all validation completed by 1st december	
35	IS	Update review patients on the IS WL with the Date Required information	Sinead	6.5.15	Complete	
36	IS	Complete filing of all older IS patient information	Sinead			
37	IS	Finalise all IS patients for VFM	Sinead	Complete	Complete	
38	MIU	Review storage of patient cards in MIU	H Forde	Jan-15	All records destroyed.	
39	MIU	Investigate scanning of MIU patient information onto eEMS	H Forde	May-15	Irrelevant information redacted by the USI	
40	Renal	Work on PAS recording issues to ensure all patient activity captured in Renal	Helen McCaul		Being taken forward with Information Team, awaiting advice on recording of diagnostics i.e 24hr bp, US etc	
41	Ward Clerk	Carry out a Ward Clerk review to determine if changes are made in the current ward clerk provision to meet the needs of the wards	Helen/Sinead		Proposal put through for extended hours for winter pressures in Sept 15	
42	Ward Clerk	work towards discontinuation of the manual Ward Return	Sinead /Lisa			
43	Ward Clerk	Review of ward clerk processes between CAH and DHH	Sinead			
44	Ward Clerk	Move DHH Ward Clerks to Sinead	Helen/Sinead	Jul-15	Complete	
45	Ward Clerk	Validate charts tracked to each ward to ensure tracking is up to date and complete	Sinead			
46	Ward Clerk	Assist with the implementation of bi-directional PAS on FLOW	Helen/Sinead/Lisa	complete	complete	
47	Ward Clerk	Commence validation of data quality reports re inpatient and day case information recorded on PAS	Helen/Sinead/Lisa		Agreed with Data Quality which reports to prioritise and start validation process on these. Aug 15 - 5 reports now validated.	
48	Ward Clerk	Improve filing of inpatient information in the CAH chart - provide further training	Sinead			
49	All services	Improve Customer Care in all reception areas	All Managers		New Customer Care developed and signed off by FSS Aug 15 for dissemination to staff	

50	All services	Improve the IT skills of the staff	All Managers		e-learning available. Link to e-learning for IT forwarded to managers for cascading to staff by Helen - Jan 15	
51	All services	Complete Database of Location of Records	All Managers	complete	complete	
52	All services	Review Business Continuity Plans and update	All Managers	ongoing		
53	All services	Review current SOPs to ensure they are up to date and revise as appropriate	All Managers	ongoing		
54	All services	Review of current practices to ensure all practices are documented in an SOP	All Managers	ongoing		
55	All services	Review mandatory training for all staff and ensure this is kept up to date	All Managers	ongoing	Aug 15 majority of staff now have mandatory training up to date.	
56	All services	Assist in the NIECR validation of information to ensure quality of data.	All Managers	ongoing	Inpatient information forwarded to each ward as appropriate. July 15 OPD reports run and sent to reception desk for validation.	
57	All services	Create a Risk Register for each area	All Managers	ongoing		
58	All services	Complete Induction/Training plan for each area	All Managers	Jul-15	All areas have specific Induction Programme in place	
59	All services	Sharepoint - start moving SOPs to Sharepoint for ease of access for all managers and staff. Helen to work with Valerie to get this set up.	All Managers	ongoing		
60	All services	Review Major Incident documentation	All Managers		First meeting held Jan 15	
61	All services	Update KSF/PDP for all staff	All Managers	ongoing		
62	DHH Records	Libraries 1 and 2 on the lower ground had additional lights fitted. Charts checked for misfiles (1) and R.I.P's .	Kate/Cathrina/Villa 3	completed 20.11.15	Library 1 had 45 big charts removed and library 2 had 60, however this increased Villa 3's work as they had also to pull and merge the NN's	
63						
64	Villa 3	Closed Records store on the Armagh site has transferred 34 cages of charts to villa	Kate/Pamela	ongoing	10 cages of MFB's, 16 cages of APE's and	
65					8 cages of AAS. Work not yet completed as V3 staff need a breathing space. Will recommence in a few weeks	
66						
67	Villa 3	2007 CAH adult ED records removed from	Louise/Deborah	completed	All CAH ED 2007 adults records disposed of. Area under tables in Villa 3 is now clear.	
68		Villa 3		31.12.15		
69	Clanrye House	All bays numbered	Cathrina/Ramone	completed	Bays have not been renumbered since	
70	DHH			22.12.15	transfer of NIMAT charts to Villa	

	A	B	C	D	E	F	G
1	Head of Health Records						
2	Workplan Key Priorities 2017						
5	Service	Objective	Responsibility	Completion Date	General Progress Update	Helen McC	Kate
6	All services	Improve Customer Care in all reception areas	All managers				
7	All services	Improve the IT skills of the staff	All managers				
8	All services	Review Business Continuity Plans and update	All managers				
9	All services	Update Job Descriptions	All managers				
10	All services	Develop standard for answering phones for HHR areas.	All managers				
11	All services	Review current SOPs to ensure they are up to date and revise as appropriate	All managers				
12	All services	Review mandatory training for all staff and ensure this is kept up to date	All managers				
13	All services	Update Risk Register for each area	All managers	complete			
14	All services	Review Major Incident	All managers				

Subject: workplan for HHR managers.xlsx

From: Forde, Helen

To: Corr, Sinead

Personal Information redacted by the USI

, Lawson, Pamela

Personal Information redacted by the USI

, McCaul, Helen

Personal Information redacted by the USI

, Watters +1 More

Sent: 06/04/2017, 13:35:05

Message

workplan for HHR managers.xlsx

	A	B	C	D	E
1	Head of Health Records				
2	Key Priorities 2016				
5	Service	SMART Objective	Responsibility	Completion Date	Progress Update
6	ED	Move to typing correspondence on eEMS	Irene		
7	ED	Destruction of CAH ED Records	Irene		Irrelevant Information redacted by the USI
8	ED	Decant of records - out of space for end of 2015 notes	Irene		ED notes filed in old canteen. 2015 notes in process of moving Aug 16
9	H Records	Weed of all sites	HR managers	STH complete Villa Complete	CAH, DHH and BBPC ongoing
10	H Records	Destruction of records on St Luke's site	HR managers	complete	Complete
11	H Records	Carry out a small pilot to look at paperless clinics	HR managers	Aug-16	Complete. Until IT system available to record information on cannot go paperlight
12	H Records	Implement Savience kiosks in the remainder of the OPD areas	HR managers		BBPC up and running - Sept 16 Dermatology will commence 3/10/16 when trollies around STH - Jacinta waiting on benching and computer from IT to be sent over CAH and DHH implemented ENT/Paeds - waiting for trollies Neurology - Pamela to see Dr Forbes
13	H Records	Merge ACH charts into CAH and DHH charts to reduce the ACH charts	HR managers	ongoing	
14	H Records	Move CAH charts from Closed Store	HR managers	Complete	Complete March 16
15	H Records	Destruction of charts in OASIS	Kate / Pamela	ongoing	100 boxes destroyed Jan 16
16	H Records	Move maternity from Closed Store	Kate	Mar-17	Started in Sept 2016
17	H Records	Transfer of CYP Records in OASIS to CYP Health Directorate	Helen		Commence in Jan 2017
18	H Records	New system of filing CAH reserves in the Villa to be implemented to make better use of existing space	HR managers	Mar-16	Complete
19	H Records	Plan use of space of canteen accommodation on the SLH site		ongoing	ED records moving to canteen - commenced April 16 Maternity moving in and Deep Storage area set up. Lights to be fixed in freezer and doors removed from fridge area
20	CAH H Rec	Decant libraries for refurbishment work in basement	Ciaran	complete	Completed April 16
21	IS	Complete Validation of IS information	Sinead		
22	IS	Complete filing of all older IS patient information	Sinead	complete	
23	MIU	Investigate scanning of MIU patient information onto eEMS	H Forde	May-15	Irrelevant Information redacted by the USI
24	Renal	Work on PAS recording issues to ensure all patient activity captured in Renal	Helen McCaul		Being taken forward with Information Team, awaiting advice on recording of diagnostics i.e 24hr bp, US etc. Further meeting on 19.9.16 with Information to get codes built on PAS.
25	Ward Clerk	work towards discontinuation of the manual Ward Return	Sinead / Lisa		Commenced with 4 South and 1 South in May 16.
26	Ward Clerk	Validate charts tracked to each ward to ensure tracking is up to date and complete	Sinead	on-going	commenced with 1 north in May,
27	Ward Clerk	Commence validation of data quality reports re inpatient and day case information recorded on PAS	Helen/Sinead/Lisa		
28	Ward Clerk	Improve filing of inpatient information in the CAH chart - provide further training	Sinead	end of jun 15	setting up mini charts for each member of staff for each chart type
29	All services	Improve Customer Care in all reception areas	All Managers		New Customer Care developed and signed off by FSS Aug 15 for dissemination to staff
30	All services	Improve the IT skills of the staff	All Managers		e-learning available. Link to e-learning for IT forwarded to managers for cascading to staff by Helen - Jan 15

		documentation				
15	All services	Update KSF/PDP for all staff	All managers			
16	All services	Create and update generic risk assessments for each area	All managers			
17	All services	set up a managers booklet with all information in relation to the role of the manager	Sinead			
18	All services	Missing lists - complete and up to date list of all records which are lost	All managers			
19	All services	Scanned lists - review scanning of information	All managers			
20	All services	Remove all faxes	All managers			
21	ED	Move to typing correspondence on eEMS	Sinead			
22	ED	Destruction of CAH ED Records	Sinead			
23	ED	Learn eEMS	Sinead & Helen McC			
24	ED DHH	REN/ ED DHH Risk assessment of ed reception and renal office	Helen McC			
25	ED DHH	Undertaking training in UDDAof as many staff as poss	Helen McC			
26	ED DHH	Assist with ED process mapping	Helen McC			
27	H Records	Weed of all sites	Kate & Pamela			
28	H Records	Destruction of records on St Luke's site	Kate & Pamela			
29	H Records	Savience - increase usage	Kate & Pamela	end of August 16		
30	H Records	Merge ACH charts into CAH and DHH charts to reduce the ACH charts	Kate & Pamela	Oct-16		
31	H Records	Destruction of charts in OASIS	Kate & Pamela			
32	H Records	Look at safety of staff working on their own in filing areas.	Kate & Pamela			
33	H Records	Assist with implementation of e-triage	Kate & Pamela			
34	H Records	Work on overdue tracked charts to get them returned to the libraries	Kate & Pamela	completed		
35	H Records	FLOW admissions - implement system for identifying new admissions requiring charts	Kate & Pamela			
36	IS	Complete filing of all older IS patient information	Sinead			
37	Renal	REN/ ED DHH Risk assessment of ed reception and renal office	Helen McC			
38	Ward Clerk	work towards discontinuation of the manual Ward Return	Sinead			
39	Ward Clerk	Validate charts tracked to each ward	Sinead			

1 : 1 Meetings

Pamela Lawson 13 December 2018	
Staff Recording up to date Staff in Post Leavers Sick Leave	Updated
Mandatory Training update including PDP	Being monitored and some long term sick and maternity leave. PDPs are behind and are to be focused on in January 19.
Work Plan	Updated
Risk Register	Updated.
Data Validation	Duplicate referral episodes – List to be sent by Conor for validation. All staff trained referral source and appointment type. All changing the general con to the named consultant.
Health and Safety	Bays discussed – charts going to be taken from the top and sent to Villa. All problems with equipment dealt with immediately. Maternity assessments being carried out.
Security and Confidentiality	No issues
Records Management Issues	Destruction for next year to be discussed and signed off. SOP to be developed for Infected Bloods Inquiry.
Staffing Issues	<div>Personal Information redacted by the</div> <div>leaving – being replaced by Agency until permanent replacement.</div> <div>Personal Information redacted by the USI</div> <div>leaving – Pamela to put in an e-req</div> <div>BPC reception post – waiting for a position number</div>
Contingency for Chaplains report from BOXI	SOP to be developed (HF)
Letter folder for Fractures	Not under contract. Complete

Pamela Lawson 13 December 2018	
Rheu charts no input from BPC	No work to be done by the BPC staff. Pamela to check with Paul re direct transport to BHSCC
Management of APE charts in Villa	HF to talk to Louise about moving these to the weed section of the charts.
Anita's visit to STH and one member of staff not friendly	Team meeting carried out and reminded to help staff.
Storage in STH	Review of the rooms in STH
Cover for Paed sec in STH	Not resolved. Next time secretary on leave queries are to be put through to Daniel
Destruction of charts (Infected Blood Inquiry) Revised SOP developed with Orla?	Orla and Pamela to revise
New method of destruction of charts for 2018	Meet in Jan 19 to review and sign off
Missing List update	Database updated. List of missing charts to be given to staff for them to look out for when going round wards/offices.

Subject: RE: Missing Charts - confidential

From: Hanna, Siobhan

Personal Information redacted by the USI

To: Forde, Helen

Personal Information redacted by the USI

Carroll, Anita

Personal Information redacted by the USI

Cc: Graham, Claire

Personal Information redacted by the USI

Sent: 17/01/2017, 13:48:29

Thanks Helen. It is good to know that Pamela has been involved and a thorough check has been made. Hopefully the remaining 13 casenotes will be returned soon.

I have copied Claire into this email as it was agreed last week that if any records remained outstanding, Dr Wright would meet with Claire to discuss how this would be handled.

Regards,

MRS SIOBHAN HANNA

Assistant Director of Informatics

✉ Southern Health & Social Care Trust

Ferndale

Bannvale Site

10 Moyallen Road

GILFORD

Co. Down

BT63 5JX



Personal Information redacted by the USI



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From: Forde, Helen
Sent: 17 January 2017 13:40
To: Hanna, Siobhan; Carroll, Anita
Subject: Missing Charts

I've spoken to Martina today regarding the missing charts from Mr O'Brien's house. There are 13 missing.

Pamela Lawson has searched Mr O'Brien's office and his secretary's office thoroughly for these charts but they cannot be found. These charts have no urology episode on PAS – Martina says that Mr O'Brien used the CAH chart for his private patients.

Anita - Pamela is going to add these 13 to our missing list, and we will place *alert tracers in the libraries for them, so if they are returned to Records we will be alerted to this.

**If there is a missing chart we put file an Alert Tracer Card where the chart should be filed – then if the chart is returned to Records and filed the person filing will take the chart and the Alert Tracer Card to Pamela and she can investigate where the chart was sent from, and take the name from the missing list.*

Helen Forde

Head of Health Records

Admin Floor, CAH

Personal Information redacted by the USI

I interviewed the Head of Information Governance for the Trust, Mrs Claire Graham and she referenced GMC guidelines in relation to note keeping and storage of notes. In particular she highlighted the regional guidance on Good Management of Notes/Records, as well as Health Informatics Unit guidelines, duty of confidentiality principles and data/information protection guidelines. Mrs Graham advised that when pulled from medical records, it was expected, in line with best practice, that case notes would be returned immediately after use. She highlighted that a large volume of notes being kept in a private home is a serious data protection/ information governance risk for the Trust.

I also interviewed the Head of Health Records, Mrs Helen Forde and the R&B Centre Manager, Mrs Katherine Robinson. I was able to establish that there is no clear system for tracking notes through PAS. Notes may be tracked out on PAS to a staff member without knowledge of their location. There is no mechanism for medical records staff to be able to determine that a bulk of records is tracked out to one individual for long periods of time.

I was advised that when notes were sought from Mr O’Brien for other clinics these were usually returned promptly. There was really only an issue if someone was admitted as an emergency, as notes were not available because they were not on the hospital site. It was indicated that at times Datix reports were completed by medical records staff in relation to notes not being returned. This would have been escalated to Martina Corrigan who addressed the issue with Mr O’Brien upon which the notes would have been returned. Martina Corrigan indicated the letter to Mr O’Brien in March 2016 did ask for all notes to be returned. She believed at that time 30 case notes were returned. Managers indicated they had no idea of the scale of records in Mr O’Brien’s home. No check or review was done to determine the extent of the problem in March 2016 or at any other time prior to this investigation.

Mr O’Brien acknowledged he had returned the bulk of the case notes to the Trust in January 2017 when the issue of concern was addressed under the MHPS process. He believed this had not had an impact on care from other specialities as he had always returned notes when they were sought for other clinics.

On returning the notes, Mr O’Brien had attempted to process as many as he could. He focussed on those he deemed most urgent. He indicated that those he had not processed still had lengthy delays after they were returned. He reported there was no detriment in any event to patients, as they were placed on the waiting list for procedure/investigation at the point they would have been when seen at clinic.

IV antibiotics

467. I was assured through the oversight of the Clinical Director, the Ward Sister, and evidence of reduced / eliminated inpatient practice that systems and agreements were working.

[41] Did any such agreements and systems put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

468. This question overlaps with Questions 38, 39 and 40 and I would refer to my answers to those questions where I give my view on whether the actions taken remedied each relevant concern. Below, I offer my views on the reasons for the lack of success of the measures adopted (save in respect of the IV antibiotics issue, which I believe was remedied successfully, as explained above).

469. In respect of the Review backlog, this improved but was not remedied. I believe that this was primarily due to the continuing mismatch between demand and capacity including, in particular, demand for new referrals and additional new referral outpatient clinics creating additional review demand with no matching additional review capacity. There was very little that could have been done differently and a review backlog remains today.

470. Regarding patient notes, this issue was not remedied. I believe this to have been due to a disregard on the part of Mr O'Brien for the needs of other clinicians and services who may have needed patient notes. As the remedy necessitated a change of mindset of Mr O'Brien, the only other option would have been to check Mr O'Brien on leaving the Building each night. This was not practicable nor should it have been required in relation to an experienced clinician.

:-

6. I am aware that on a regular basis Leanne Brown who is the Supervisor in the RBC and who had responsibility for urology would have raised issues regarding triage within her area which is urology . The issues related specifically to Mr O'Brien. These issues were flagged with the Director, the Assistant Director for surgery and the Head of Service for urology.
7. A triage report went out every Friday and there were regular delay issues with Mr O'Brien's triage.
8. Around December 2015 I sent an e-mail to my Assistant Director colleagues advising that there were delays . I did not specifically name any Consultant but I highlighted that the triage was not being done in line with the IEAP guidance. I sent this to Heather Trouton, Barry Conway Ronan Carroll, Anne Mcvey and Simon Gibson. The purpose of my e-mail was to agree a process whereby if triage was not done and returned the patient would be categorised as per the GP referral. This was agreed at that time.
9. The default process commenced around December 2015. In earlier 2015 referrals were waiting but staff in the booking centre were probably already adding patients to the lists as per the GP category on the referral. In general there wouldn't have been many referrals downgraded or upgraded. The Referral and Booking Centre get around 180,000 referrals every year.
10. Other than there were delays with triage I don't know anything about patient care delay or harm.
11. I know the IEAP was meant to be regional guidance which recommends 72 hours for triage. There would have been delays outside of this across specialities but in the main it was generally done within a week which I feel is reasonable. Some of the other specialties may not have had the same level of referrals as urology.
12. In terms of notes, within PAS and case note tracking, charts are generally tracked out to an address which on the system may just have been 'Aidan O'Brien'. There would be no way of knowing that notes are not in the office or in the secretary's office. The only time an issue regarding charts might be escalated to me is if a chart is to be pulled for a clinic and it can't be found. Generally staff would check with the secretary for the chart if it can't be found. I am aware the secretary may have said Mr O'Brien had that set of notes at home and he would bring them in. There was no specific issue being flagged to me on a regular basis about charts.
13. A few times Mr O'Brien's name would have come up and so I suggested we put a Datix in to alert that a chart was not available for a clinic. I was advised to refer such issues to the Head of Service. Debbie Burns told my head of health records Helen Forde not to put Datix's in the system for charts. Helen shared this information with me and I accepted that maybe this wasn't the right mechanism for flagging the issue.

I am not persuaded by the justifications provided by Mr O’Brien for why the 9 private patients highlighted above were seen in the timeframes outlined. I would conclude that these patients seen privately by Mr O’Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over HSC patient’s with the same clinical priority.

Mr O’Brien’s explanation for patient Patient 124 was that he undertook surgery for this patient, a personal friend, in an additional theatre session and therefore no HSC patient was affected. If an additional session was available in Theatre, patients from the waiting list should have been seen in chronological order.

Term Of Reference 5

To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

It was confirmed by a range of witnesses that they were aware of the difficulties in respect of Mr O’Brien’s administrative practices.

Senior managers indicated they were aware of issues with regards to triage but not the extent of the issues. There had been attempts to raise this before 2016 with Mr O’Brien and in response, things would have improved for a while but then reverted again. I believe managers must have known there were significant ongoing issues of concern, given that a default system was put in place in 2015. However it was noted the default system meant this issue was no longer escalated to senior managers as the default system meant the triage was allocated as per the GP’s impression. It was noted senior managers agreed with Mr Young that he would undertake Mr O’Brien’s triage for 6-8 months whilst Mr O’Brien chaired a regional group. Clinics were also shortened to allow more admin time, extra PAs were paid for, admin time and no day surgery was scheduled after a SWAH clinic. It was indicated MDM letters which were always dictated were very long and detailed, and if theatres were unused Mr O’Brien would ask to increase his theatre time, i.e. additional time for his admin was being used in other ways.

Senior managers were aware Mr O’Brien took clinic notes to his home after the SWAH clinics and there were delays in notes being brought back. However, there is not a robust system in place for determining how many charts are tracked out to one consultant, nor how long the notes were gone for; as such managers were not aware of the extent of the problem.



Urology Services Inquiry

meant to be off for a short period) I was not replaced and I didn't hand over the monitoring, nor (I understand) was it picked up in my absence. During this period, when I wasn't monitoring and keeping in contact with Mr O'Brien, I know he deviated from dictation and notes at home (I only became aware of this on 4 October 2018 whilst I was still off [Personal Information redacted by the USI] and I was contacted by phone by Ms Wendy Clayton and Mrs Brigeen Kelly to talk through how I monitored Mr O'Brien's return to work. After the conversation, I logged into my work computer and checked the deviations and I detailed this along with how I did this and forwarded to Mr Carroll. And whilst he got back on track and I began to monitor him again on my return [Personal Information redacted by the USI], he did deviate again in September 2019 which again I confirm that it was through my monitoring that this was picked up and I escalated and I can confirm by end of September 2019 he had got back on track. So, in my opinion the methods that I was using worked and also the fact that I did this on a weekly basis meant that the monitoring was constantly under review. (add in the other escalation emails around this period that are in discovery)

Documents attached namely:

20181004-email return to work action plan

20181004-email return to work action plan – attachment

And can be located in folder: Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan

60.5 The two areas that in my opinion were weak were as follows:

- a. The method I had to use in respect of the storage of patients' records issue - This was difficult to monitor as it was dependent on manual checks. Whilst I was doing this, I found no issues. However, if a set of patient notes had been 'Casenote tracked' to Mr O'Brien's borrower's code but they were not in his office I had no way of knowing where they were as any member of staff could have picked them up from his office and not changed the borrower's code and this would have led to issues of trying to locate those notes.

Forde, Helen

From: Forde, Helen [Personal Information redacted by the USI]
Sent: 24 February 2015 13:42
To: Reid, Trudy; Devlin, Louise; Corrigan, Martina; Nelson, Amie; Burke, Mary; Murray, Eileen; McStay, Patricia; McGeough, Mary; Reddick, Fiona; Carroll, Kay; Fitzsimons, Marian; McCausland, Audrey; Haffey, Raymond; Loughran, MarieT; Cunningham, Andrea; Cunningham, Lucia; McGinn, Noreen; OHanlon, Carmel; Rafferty, Lauri; Corr, Sinead; Hewitt, Irene; McCaul, Helen; Robinson, Katherine; Clayton, Wendy; Glenny, Sharon; Richardson, Phyllis; McAreavey, Lisa
Cc: Lawson, Pamela
Subject: Tracking of Charts

Tracking of patient charts on PAS

Would you please remind all your staff that it is absolutely crucial that every chart is tracked when moved from one location to another.

Recently, due to a chart not having it's tracking codes updated, a patient's operation was cancelled. The chart was later found in a different service and in a different building. The consultants have stated that from now of if the chart is not available they will not operate on the patient.

If you take a chart you MUST TRACK it to the new tracking code. If you don't have access to PAS to do this then you MUST LEAVE A MESSAGE for a member of staff from the area that you taken the chart from giving them details of where the chart is going and asking them to track this for you,.

This is not just a request to help staff when looking for charts, but this has a direct impact on the care we are providrking to our patients – no chart – no surgery/ no appointment.

Would you please circulate to all your staff.

Many thanks.

Helen Forde
Head of Health Records
Operations Room, Admin Floor, CAH

Tel [Personal Information redacted by the USI]

Mob [Personal Information redacted by the USI]

Subject: FW: CHART WITH AOB

-----Original Message-----

From: Carroll, Anita Personal Information redacted by the USI

Sent: 15 October 2013 11:28

To: Forde, Helen Personal Information redacted by the USI

Subject: FW: CHART WITH AOB

For info

From: Trouton, Heather

Sent: 14 October 2013 19:01

To: Carroll, Anita

Subject: RE: CHART WITH AOB

I emailed him with the details but no response.

I will try to get to see him personally this week.

Heather

From: Carroll, Anita

Sent: 14 October 2013 09:44

To: Trouton, Heather

Subject: FW: CHART WITH AOB

Heather Another one for AOB have you managed to speak to him yet anita

From: Forde, Helen

Sent: 14 October 2013 09:39

To: Carroll, Anita

Subject: FW: CHART WITH AOB

See below – sll happening with charts a t Mr O’Brien’s house. Thanks.

Helen Forde

Head of Health Records

Admin Floor, CAH

Personal Information redacted by the USI

From: Lawson, Pamela

Sent: 14 October 2013 08:36

To: Forde, Helen

Subject: Important notice - PAS Tracking of Charts

From: Forde, Helen

To: Evans, Marie

Cunningham, Andrea

Cunningham, Lucia

Rankin +41 More

Cc: Carroll, Anita

Carroll, Ronan

Trouton, Heather

McVey +9 More

Sent: 24/01/2016, 19:37:12

Would you please remind all your staff of the importance of tracking a chart when moving from one location to another. If your staff do not have the functionality to track charts on PAS they must leave details for one of the admin team who will then update PAS.

If a chart is moved without being tracked then Records/secretarial/ward clerk staff will not be able to find it, and this can lead to appointments and admissions being cancelled.

I would be grateful if you would emphasise the importance of this with all staff.

Kind regards.

Helen Forde

Head of Health Records

Admin Floor, CAH

Tel

Mob

safe and secure storage of charts, ensure they are available as required and to manage the life cycle of the chart in line with Good Management Good Records framework.

24.4 (xii) Operation of the Patient Administration System (PAS). I am responsible for my staffs input of data into PAS – for the accuracy of information and the correct use of the system. This is governed by the Technical Guidance of PAS and also in line with IEAP guidelines on booking appointments. I run monthly data quality reports which provide information on incorrect recording on PAS. This information is then corrected and the individual member of staff informed of the errors. Refresher training is provided if there is a persistent problem. *Please see 23. PAS Technical Guidance for Recording Delayed Transfers of Care Definitions and Guidance - Feb 2021*

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

25.1 I would gather all the information and if it is an issue that cannot be resolved within my own area then this should be raised with the Head of Service for the specific area, while also informing my own Assistant Director. A Datix would be raised detailing out the issue. Due to the formation of the Datix reporting system all those with responsibility for the concern would be notified for their input into the investigation of the issue, eg, if the Datix is coded as a breach of confidentiality this would trigger Datix to include the Information Governance team.

25.2 If the issue was a concern that could be addressed within my area I would add it to my Risk Register.

charts. It had not been our practice to complete a Datix when the chart was at Mr O'Brien's home but as the problem continued we started to complete a Datix each time a chart was in Mr O'Brien's house commencing in May 2013, and continuing until we were told not to complete any more Datix by the Director of Acute Services at the time, Debbie Burns. (see 22.3)

22.2 My view regarding the effectiveness of this process would be that it was not effective as no change in working practices were ever made, and I was not made aware of what action was taken in the management of the Datix.

22.3 We were asked to stop completing the Datix related to Mr O'Brien having charts at home by the Director of Acute Services at that time, Debbie Burns. This was a conversation on the corridor. I cannot recall the date of this conversation but our Datix stopped on 1/8/14 (with only one in 2016 and one in 2019) and Debbie Burns moved from Acute in approximately April 2015, so I would put the date in the region of August 2014 – April 2015. Debbie Burns stated that Mr O'Brien was being helpful to her and she did not want him annoyed. I had mixed feelings about this as my staff were annoyed about having to search for charts to find that they were not in the office, and therefore their time was wasted in the search by having to chase up to get the chart the next day from Mr O'Brien and the situation did not improve. However, my manager was filling in a Datix each time this occurred but nothing was being achieved, and so her time was being wasted. It felt as if there was no point in us highlighting this concern as nothing was going to be done about it.

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

the time and within the culture of Acute Services during those years; a culture that was focussed on Performance and Financial Efficiency. Both the Head of Service and I, as non-medics, found it very difficult to challenge Mr O'Brien's clinical practice. We were reliant on his clinical colleagues to provide that clinical challenge and this, I believe, did come, but only at a later stage when a number of new consultants came into post, who had experience outside the Trust and outside Northern Ireland, who knew what was acceptable practice and what was not, and who were not afraid to speak up.

502. I believe that, at the time, concerns were escalated appropriately by ourselves, solutions sought, support offered and work-around processes put in place. However, 6 to 13 years later, experiencing the developments in clinical governance systems, learning from national reports, and through my experience in my current role as Director of Nursing, Midwifery and AHPs, I believe there was too much tolerance for his resistance to change and not enough focus on the patient pathway, experience and outcome and this was reflective to the culture of the organisation at that time.

503. I take my share of responsibility for that and, on reflection, I could have challenged more and suggested increased independent audit into patient outcomes and patient experience. I also refer to my response in paragraph 485

504. Whilst I do not believe that I could have done more to meet the demands of the service with the resources available, including eradicating the review backlog, having reflected on the matter and with what I know now, I regret not having zero tolerance for triage delay, with robust weekly checking mechanisms and monitoring of it in place in the same way that we monitored patient access data. So I accept there were missed opportunities to fully address the risk to patient safety.

52. In your view, would the systems of governance now in place prevent these concerns arising again? If yes, please explain. If no, please explain why not

Buckley, LauraC

From: Corrigan, Martina
Sent: 29 September 2019 05:21
To: Hynds, Siobhan
Cc: Buckley, LauraC
Subject: FW: FW: triage not returned
Attachments: file.pdf

Importance: High

Regards

Martina

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

Telephone:

Personal Information redacted by the USI (Internal)

Personal Information redacted by the USI (External)

Personal Information redacted by the USI (Mobile)

From: Carroll, Ronan Personal Information redacted by the USI

Sent: 19 July 2017 16:13

To: Corrigan, Martina; Weir, Colin

Subject: RE: FW: triage not returned

Importance: High

Martina/Colin

3rd feb chart is almost 6mths. So...

having notes in his office is against the action plan he received

Notes must not be stored in Mr O'Brien's office. Notes should remain located in Mr O'Brien's office for the shortest period required for the management of a patient.

why the need to have this volume of notes in his office?

AOB has not raised any workload concerns so again why the volume of notes in his office?

Because this was not managed previously 13 sets of notes tracked to AOB are unaccounted for, we know this and we are allowing it to happen again

Helen Forde is running a report on the volume of notes tracked to all surgeons, so we can have a comparator

My view is all the notes need to be returned.

Ronan

Ronan Carroll

Assistant Director Acute Services

ATICs/Surgery & Elective Care

Personal Information redacted by the USI

From: Corrigan, Martina

Sent: 19 July 2017 15:04

To: Carroll, Ronan; Weir, Colin

Subject: RE: FW: triage not returned

Corrigan, Martina

From: Corrigan, Martina [Personal Information redacted by the USI]
Sent: 05 September 2013 07:24
To: Burns, Deborah; Mackle, Eamon
Subject: RE: CHARTS TO CONSULTANT'S HOME

Debbie

I will speak with him again today and then let Robin follow up on this?

One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for, I will let you both know how I get on

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: [Personal Information redacted by the USI] (Direct Dial)
Mobile: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]

From: Burns, Deborah
Sent: 05 September 2013 06:38
To: Mackle, Eamon; Corrigan, Martina
Subject: FW: CHARTS TO CONSULTANT'S HOME

? We need this addressed
D

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

From: Brown, Robin
Sent: 04 September 2013 21:17
To: Burns, Deborah
Subject: RE: CHARTS TO CONSULTANT'S HOME

I will try to get to meet Aidan week after next. I am Sow next week.

Robin

From: Burns, Deborah
Sent: 03 September 2013 15:11

To: Corrigan, Martina; Mackle, Eamon; Brown, Robin
Subject: FW: CHARTS TO CONSULTANT'S HOME

I know you have tried before – this is a governance issue – Robin can you discuss again with Mr O'Brien - or do we need to escalate?

D

Debbie Burns
Interim Director of Acute Services
SHSCT

Tel: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 03 September 2013 10:11
To: Burns, Deborah
Cc: Corrigan, Martina; Forde, Helen
Subject: FW: CHARTS TO CONSULTANT'S HOME

Debbie how do you think its best to deal with this , should the HOS discuss with mr o brien can they arrange to get charts back or do we need to discuss at governance as part of the problem is they aren't even tracked out
Happy to discuss
Anita

From: Forde, Helen
Sent: 27 August 2013 18:15
To: Trouton, Heather; Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: CHARTS TO CONSULTANT'S HOME

Please see below – Mr O'Brien continues to have charts at home. This is causing problems for records as per Pamela's e-mail. What can be done to resolve this?

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Lawson, Pamela
Sent: 27 August 2013 11:06
To: Forde, Helen
Subject: CHARTS TO CONSULTANT'S HOME

Helen – can you please raise this issue with the appropriate person? I have been submitting IR1 forms regarding this but the problem is getting worse instead of better.

We are wasting a lot of valuable time searching for charts that are not tracked properly and we are falling behind. Last week was particularly bad and we are short-staffed which doesn't help matters.

Please see list of IR1 forms to date

27/08/13	AOB	3 charts
23/08/13	AOB	2 charts
22/08/13	AOB	3 charts
14/06/13	AOB	1 chart
31/05/13	AOB	2 charts

Forde, Helen

From: Lawson, Pamela
Sent: 04 December 2020 10:49
To: Forde, Helen
Subject: RE: Datix for missing charts

Personal Information redacted by the USI

Helen – please see below

14/01/2019 – 1 chart

17/10/16 – 1
08/05/13 – 1
20/05/13 – 1
16/05/13 – 1
31/05/13 – 2
14/06/13 – 1
22/08/13 – 3
23/08/13 – 2
27/08/13 – 3
30/08/13 – 2
16/09/13 – 1
18/09/13 – 1
15/10/13 – 1
20/09/13 – 1
03/10/13 – 6
14/10/13 – 1
15/10/13 – 1
04/11/13 – 1
15/11/13 – 6
11/12/13 – 6
08/01/14 – 2
09/01/14 – 2
21/01/14 – 3
24/01/14 – 3
11/02/14 – 2
02/04/14 – 2
08/04/14 – 4
23/04/14 – 2
24/07/14 – 1
01/08/14 – 1

From: Forde, Helen
Sent: 04 December 2020 08:52
To: Cunningham, Andrea; Lawson, Pamela
Subject: Datix for missing charts
Importance: High

Do you remember when AOB took charts home we did a Datix out and were then told to stop this.

Well out of the urology review that is one of the things that is coming out as being useful. So this would be for charts that can't be found – how many a week do you think that would be?

Any thoughts on this?

Corrigan, Martina

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

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

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

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

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

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

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

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

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

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



Adverse Incident Reporting (IR1) Form

Reference:

Personal Information
redacted by the USI

This form should be used for reporting all incidents (including near misses). If incidents are openly reported and analysed/reviewed, it allows the individuals and the Trust to identify areas for learning/remedial action to try to prevent the same/similar incident from happening again.

* = mandatory field | Click to view and select from a drop down list | Dates must be entered in the format dd/mm/yyyy Alternatively, click to select the date from a calendar | Click the icon for help with a particular field. The form fields use predictive text so simply start typing.

Details of person reporting the incident

Full name Pamela Lawson

Your e-mail address pamelalawson@southemtrust.hscni.ni

Must be in the format of
firstname.surname@southemtrust.hscni.ni
et

WHO?

Enter details of person(s) associated with the incident (incl staff, service users, witnesses, others etc) Only select those that apply : The form will expand for you to enter further detail - it will be useful to have patient / client chart to hand

State if any person(s) were associated with the incident. No

Only select No if this incident did not involve people.

WHAT happened, WHEN & WHERE?

Description consultant had chart at home

Anonymise the names of people involved.
Enter facts, not opinions.

Current approval status In holding area, awaiting review: AWAREV

Action taken requested that his secretary ask him for this chart. Chart required for clinic attendance.

Enter action taken at the time of the incident Record persons informed e.g. next of kin, family member, person in charge etc

Learning (initial) no charts to be taken to consultant's home

Enter any immediate learning or actions from this incident which you feel could improve patient/client/staff safety.

Incident date (dd/mm/yyyy) 14/01/2019

If not today, please select the correct date

Time of incident (hh:mm) 12:30

Use 24 hour clock. Enter estimate if exact time not known

Directorate Acute Services: ACUTE

Please note this will be the Directorate who will take the lead in the investigation of the incident

Division Functional Support Services: FSS

Service Area Health Records: HEALTH

Speciality / Team Health Records: RECORD

Site Armagh Community Hospital: ACH

For Site, Location Type and Location Exact: enter the details of the place where the incident occurred

Location (Type) Outpatient Clinic: OUTCLIN

Location (Exact) Urology Clinic: UROLOG

Incident Severity (Level of Harm)

Initial Severity Minor: MINOR

Click [here](#) to view the Impact Levels table which will help you determine the actual impact (severity) of the incident at the time of occurrence.

FALLS, EQUIPMENT and MEDICATION INFORMATION

Did a patient / client fall? No

Did faulty equipment cause this incident? No

Is this an incident relating to confidentiality? Yes

Was this a medication incident? No

Is this a Haematology / Blood Transfusion-related or Laboratories-related Incident? No

25.3 In addition to the formality of completing a Datix and adding to a Risk Register I would also alert the Head of Service and my AD either verbally or via email to ensure that everyone was aware of the issue in a timely manner.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, or any other matter regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

26.1 The only concern I had regarding urology services was the fact that Mr O'Brien kept a large volume of charts in his office and also took charts home without telling anyone. I do have to comment that when we needed a chart for an admission or for an outpatient clinic, and asked Mr O'Brien to bring the charts back to the hospital he always did so the following day. We were only aware of a chart being in Mr O'Brien's house if we went to retrieve it if we needed it for an admission or outpatient clinic and went to look for it in Mr O'Brien's office. After a search of his office, and his secretary's office, if the chart could not be found the Records staff or the secretary would contact Mr O'Brien to see if he had it in his house, and then he would be requested to bring the chart with him the next day. I can only comment on the charts that Health Records requested Mr O'Brien to return from home, and cannot comment on how often or how quickly Mr O'Brien would return charts not requested by Health Records to the hospital.

26.2 This concern was raised verbally and via e-mail with the Head of Service, Martina Corrigan and Martina Corrigan said she would raise this with Mr O'Brien. I see in one of my emails that I have commented that Simon Gibson was dealing with this – unfortunately due to the period of time that has passed I cannot remember what discussion took place with Simon Gibson but I think it was that Mr O'Brien was being investigated and this would be dealt with via that

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

29.1 I did not risk assess the impact as it was not my risk to assess, in that I could not control it or be in a position to make a change. I advised the Head of Service, Martina Corrigan of the concern and informed my Assistant Director Anita Carroll. Anita Carroll did raise the issue with the Assistant Director for Surgery and Elective Care – Heather Trouton to ask Heather if she had included this on her Risk Register. *Please see 35. 20150127 Aob and charts at home*

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

30.1 There could have been a risk to the patient if the chart contained specific information relating to the patient condition that would not be available electronically. The majority of clinical information is now available on NIECR with the exception of some investigations such as pulmonary function tests and cardiology investigations involving TOMCAT. If a consultant had made some handwritten notes in the chart which were not transcribed in the letter then this would not be available for the consultation. I do not recall there being an instance when the chart was not brought into the hospital by Mr O'Brien in time for the admission or the outpatient clinic.

30.2 When asked to bring a chart in from home Mr O'Brien always brought it in the next day, however, there was an instance where a patient was in the Emergency Department and the chart was requested. As it was in Mr O'Brien's house we had to contact him urgently, and fortunately he had not left the house at the time and was able to bring the chart in to the hospital with him. The Head of Service, Martina Corrigan was aware of this. This is the only example of an emergency request for a chart that was in Mr O'Brien's house. *Please see:*

6. Around 2015/2016 there was a change in structure and so I was not involved and wasn't aware of any issues.
7. I know there are other Consultants who don't triage within 72 hours but Mr O'Brien was known as particularly poor in completing the triage. I know Katherine would have chased to get things triaged but would then have taken whatever the GP referral letter had indicated to triage the referral. I think this was agreed.
8. In terms of notes, the only tracking code was for Mr O'Brien's office for charts tracked out to him. The only time we would know if a chart wasn't there was if we needed it and went looking for it. I know it would have been a regular occurrence that Mr O'Brien would have had charts at home. He generally would have returned them the next day if a chart was being looked for.
9. There is a checking mechanism to check on how long notes are tracked out for and to whom. We unfortunately don't have the capacity to do those checks. I know it was raised a number of times with the AD and HOS that charts were at home. At a point Datixs were completed. As far as I know Debbie Burns said she was working with Mr O'Brien and staff were told not to fill in Datix as she didn't want him annoyed. This was around 2014.
10. There was never any similar issue raised about any other Consultant in terms of notes. I don't know how many charts were at home. I know when Mr O'Brien was on sick leave in 2016 all charts were asked to be returned and Martina Corrigan said Mr O'Brien was going to do some work on them and then he brought them back.
11. I believe there are still 11 charts missing all of which are tracked out specifically to Mr O'Brien.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	



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the best of my recollection, that it was difficult to get folders due to budgetary constraints.

432. One Saturday, I was working and opened the current folder. The filing was in a mess. The plastic straps securing pages in place had become undone due to the volume of pages within the folder. The pages of hand-written notes were lying loosely both within and some outside the folder. The latter were folded and creased. I therefore removed some of the oldest sheets from the rear of the oldest folder, moving records back into chronological order to make room for the pages of hand-written clinical notes at the front of the patient's current chart. It took me some time to do it. In my frustration, I wrongly and unwisely placed the old sheets which I had removed in the bin in the nurses' station. I accept, and accepted at the time, that it was wrong for me to do this. I was issued with an informal 6-month warning [see AOB-00277].

(iv)

433. I fully accept that, in an ideal world, records should not be kept at home, other than perhaps for a very short period if it is not possible to carry out work required by reference to the records while at the Trust's premises. However, I worked in a service that was far from ideal, which led to me often working from home. In more recent years, with the increasing reliance on electronic care records (ECR), it became easier to work remotely without having paper records to hand.

434. This issue needs to be considered in the context of the overall excessive workload I was labouring under, and lack of support from the Trust to deal with it. I have commented on those issues throughout this statement, in the context of the formal investigation and my grievance and will not repeat the detail here. However, I will set out a summary below.



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435. First, in relation to records held at home, I was primarily based at Craigavon Area Hospital (CAH). I also conducted outreach clinics at South West Acute Hospital (SWAH), in the Western Trust. SWAH was exactly 50 miles distant from my home and travelling from home to there through several towns in the early morning and returning each evening took 70 minutes each way. Travelling to an outlying hospital, with the additional time demands that involved, added significantly to the length of my day.
436. I was unaware of any definite system employed by the Trust in relation to the transfer of records between hospitals, and perhaps particularly to a hospital in another Trust. There was no written direction to me in relation to how, or when, they should be returned.
437. The clinic at SWAH took place once each month on a Monday. The Medical Records personnel at CAH would deliver the charts for the patients attending the clinic to my office in CAH on the preceding Friday for me to take to SWAH three days later. I was provided with a container on wheels in which to transport the charts.
438. As a result of the significant pressures I was under, I did not have time to complete all work required on records (in particular correspondence) while at SWAH, as insufficient time was allocated to allow me to adequately review patients, including new and cancer patients, and complete administration work within clinic time. Initially, the clinic commenced at 10.00 am with 16 patients attending until 05.00 pm. More recently, in an attempt to review as many patients as possible, I had 18 patients attending, with the clinic starting earlier at 9.30 am.
439. As nursing staff were understandably keen to leave as soon as possible following the clinic, I developed a practice of bringing the records home to complete administration when I had the opportunity do so, mostly in my own time. I would usually arrive home by 7.00 pm, have dinner, and then attend to administration concerning the most urgent cases. There can be no doubt (as the



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formal investigation accepts) that Trust managers were aware of this practice. As such, the Trust condoned the practice.

440. I also conducted an outreach clinic at Armagh Community Hospital in Armagh. This clinic also occurred once monthly, on a Monday morning. It was a general urology review clinic with 12 patients attending between 9.00 am and 1.00 pm. This clinic was different from the one at South West Acute Hospital as the patients' clinical records were delivered by Trust transport, though occasionally none were delivered at all, due to oversight. The problem I had with completing administration relating to the patients attending this clinic was that the room had to be vacated at 1.00 pm to prepare for a dermatology clinic which began at 1.30 pm. As I did not have any elective session during the afternoon of that Monday, I brought the patients' records home to complete administration, which I was able to do remotely.

441. I had a busy outpatient clinic at CAH each Friday when I would have patients attending for flexible cystoscopies and urodynamic studies concurrently with patients attending for oncology reviews. Having remained at the hospital to undertake as much administration as possible, I found it tempting to bring home some records, usually of those patients who had attended for flexible cystoscopies and urodynamic studies, so that I could join my family for the 'end of the week' dinner at 8.00 pm, and with a view to being able to complete the administration from home remotely, so as not to have to return to the hospital over the weekend.

442. Lastly, the only other patient records that I had at my home were those relating to patients who had attended me privately and those awaiting some kind of report.

443. It was accepted, in the context of the formal investigation report, that if notes were requested from me I would return them promptly.

444. It is clear that by March 2016, the Trust was aware of the practice and indeed appeared to have concerns, hence it being one of the issues identified in the letter



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of 23 March 2016 [AOB-00979]. At that time, no plan, support, guidance or assistance was offered or put in place to address the issue. As the report of the formal investigation notes on page 43, when the issue was identified in March 2016, *“there appears to have been no management plan put in place at the time and Mr O’Brien seems to have been expected to sort this out himself....”* [AOB-10044].

445. The Trust was aware that I continued to have records at home after March 2016. For example, I liaised with Ms Corrigan of the Trust in relation to catching up on administration in late 2016 when I was on sick leave (see pages 13 and 14 of Grievance [AOB-02038] – [AOB-02039]). I was not required to return records then, but rather was encouraged to work on them at home during my sick leave.

446. I accept it was not best practice to have kept NHS patient records at home. There is no suggestion there was any security breach in relation to these records. The records were stored in my private office at my home, which is totally secure.

447. Secondly, in relation to records kept in my office, these originated from two sources. I brought patients’ charts from my clinics in CAH upstairs to my office to complete related administration there, as I preferred the ambience of my office to that of the clinic. My secretary also left patients’ charts in my office when I requested those records or for review with the reports of investigations.

448. I wish to avail of this opportunity to relate that I found it disturbing to learn from my secretary that she was being repeatedly requested by managers to enter my office to count the numbers of charts and to report back, informing them of the reasons for the charts being there. On other occasions, she would receive a call from a manager enquiring whether I was in my office as they intended to come to my office themselves to count charts. I found this activity to be both intrusive and concerning. I found it all the more concerning when, on one date in October 2018, my secretary was able to advise me that there were 52 charts in my office. On that same day, three of my colleagues had 14, 22 and 23 charts respectively in their office, while two consultant general surgeons had 53 and 266 charts



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respectively. I wonder whether they were subjected to the same level of scrutiny as I was. It has been all the more distressing to learn that the Head of Service saw fit to come to my office early each Friday morning to count patients' charts.

449. Thirdly, in relation to patient records in my car, it was necessary for me to carry records with me when travelling to and from outlying clinics, as well as between my home and Craigavon Area Hospital. I wish to emphasise that patients' records were never left in my car at any location; they were placed in the container provided in the boot of my car on departure and removed on arrival at the destination.

450. The practice of having records at home or in my office was not for a malign purpose, quite the opposite. I struggled with the overwhelming administrative burden, with insufficient time allocated by the Trust for me to complete same. That led to me having to complete administration during my own time and hence I kept records at home so that, when I could find time, I would complete any administration work as required.

451. The Trust was aware that records were kept at home by March 2016 when the matter was first formally raised with me. Individuals within the Trust were aware that I had records at home well before that time. At no stage did the Trust implement a system to assist me in coping with the huge administrative burden I was under, which led to me having to do so much work in my own time at home.

(v)

452. As I have related elsewhere in this statement, and summarise again in my response to Question 66 (vi) below, I found it impossible to complete the triage of non-red flag referrals while being Urologist of the Week (UOW) and confirmed that this was the case when my colleagues and I met with personnel from the Appointments Office in early 2015 when we were advised of the Informal Default Process that was being used. We were advised that copies of all referrals were



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multiple objections when it was suggested that he should be reviewing all results therefore an instruction was issued to all consultants informing that it was their responsibility to review all the results of investigations on their patients once they are available.

25. This issue is addressed in more detail below, in particular in my answers to Questions 54-57.

Patient Outcomes and Charts at Home

26. In 2013 Medical Records complained that an ongoing problem with Aidan O'Brien was patient hospital charts in his house and he was advised that this was not permitted. Following the expansion of the urology service to become Team South, outpatient clinics were provided in Enniskillen and patient records therefore needed to be transported to the clinic and back to Craigavon afterwards. The Trust transport was used for all other peripheral surgical clinics but for this service it had been arranged that, after the clinic, the consultant would bring the charts back to the Craigavon. Following dictation of the letter to the GP the outcome for the patient would be recorded (e.g., put on waiting list for surgery, discharged, or review arranged). Aidan O'Brien, however, was bringing the charts to his house after the clinic but not completing the dictation which also meant patient outcomes were not recorded. The Trust became aware in late 2015 of it as a problem but only discovered the extent of the problem, when following Heather Trouton's and my letter in March 2016, he returned the charts.

27. This issue is addressed in more detail below, in particular in my answers to Questions 58-61.

Bullying and Harassment

28. In 2012 I was informed that Aidan O'Brien had spoken to Roberta Brownlee, then Chair of the Trust Board, complaining that I had been bullying and harassing him. I consider this to have been a false accusation and, on reflection, I believe it may have been malicious. Prior to 2012, I had acted as a major challenge to Aidan O'Brien's opinions and views regarding

13 sets of notes are still missing. Dr O’Brien confirmed he did not have these and this has since been accepted by the Trust and the review team.

Mr O’Brien accepted he had kept notes at home but asserted that this did not impact on patient’s clinical management plans/care.

Term Of Reference 3

(a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O’Brien in 2015 or 2016.

(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O’Brien in dictating outpatient clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

Mrs Robinson reported that she became aware in December 2016 from Noeleen Elliott, Mr O’Brien’s secretary, that there were clinics which had not been dictated by Mr O’Brien. She reported this to be unusual for a Consultant. Mrs Robinson reported that Ms Elliot as Mr O’Brien’s secretary would have known the extent of dictation not completed and that she should have been raising this with managers in the Acute Services Directorate. Ms Elliott, indicated that when she arrived to work with Mr O’Brien, the lack of clinics being returned seemed to be a long-standing way he worked and therefore she felt this issue was known. She therefore did not raise or report the issue.

When I interviewed Mr O’Brien he accepted that he did not dictate an outcome for every attendance by every patient at every clinic. I noted with Mr O’Brien that undictated clinics mean GPs don’t know what is happening with their patients and there is nothing on NIECR for other Specialists to look at. Martina Corrigan indicated there had been a complaint from a GP and contact from an MLA as a GP didn’t know what was happening with a patient.

Mr O’Brien acknowledged there were 66 undictated clinics and no dictated outcomes for these. There were no outcome sheets for 68 clinics. He noted he may have typed updates on the CAPP system for cancer patients, or they may have been discussed at MDM. Mr O’Brien stated that GPs have access to CAPP and that he personally explains all matters to the patient. Mr O’Brien reported that he didn’t feel letters were that important. He went as far to say that he was frustrated by the obsession regarding dictation of outcomes for every attendance.

Subject: STAFF SHORTAGES

From: Lawson, Pamela

To: Forde, Helen

Sent: 24/03/2014, 09:02:50

Helen

Just want to make you aware of the situation here at the moment.

You know we have lost [redacted] and [redacted]. ENT reception needs covered this week as Linda is off [redacted]. Karen Campbell has to be in STH on Tues and Thurs to cover [redacted]. I have Karen covering ENT today and Wednesday but have to take out of core staffing to cover Tues, Thurs and Fri am. I have Sharon off [redacted] from Ramone OPD and Eileen [redacted] this week so I am sending Barry down to cover Monday am, Tuesday pm, Wednesday am and Thursday and Friday. He has to cover Linda in BBPC on Mon pm, Tues am and Wed pm as she is off [redacted] (Barry has been doing this from 27th February since Linda went [redacted]). This then leaves me down one supervisor. Sean has been off from 28th February [redacted] but is hoping to back on Wednesday.

I am also taking 2 staff out of filing/portering 2 days a week to V3 as we really have to get the weed done here as charts are already on top of bays again because the filing rooms are overflowing.

We have taken on the new breast clinic (which we still haven't been informed about!!) which is 35 patients per week. Mr McCaul is a new ENT consultant and this means extra clinics and arranged admissions every week for him.

We cannot continue like this.

I want to decrease the issue desk a bit so am asking you to agree to my proposal of only getting charts for other sites that are needed for clinics. Secretaries on other sites we will also provide charts for as they send their charts over for clinics to us.

However, CAH secretaries will have to either come down and get their own charts or provide us with the charts required for clinics, in which case I will be able to get Dolores and Barbara on to clinics and issue desk.

Can you let me know asap please

Many thanks
Pamela

Pamela Lawson
Health Records Manager
CAH

[redacted]

Subject: RE: Staff - Health Records

From: Carroll, Anita

To: Forde, Helen

Sent: 14/05/2014, 08:43:06

Helen thanks for this but you know we will not be getting permanent admin we will only get bank however I have been asked to redeploy someone who comes from pharmacy so this may assist

A

From: Forde, Helen

Sent: 14 May 2014 08:39

To: Carroll, Anita

Subject: Staff - Health Records

We are having problems with the staffing in CAH health records

1 WTE agency left

1 WTE porter now

Another member of staff to leave at the end of the month, and 2 more want to reduce their hours due to health reasons – so that would create another 1 WTE vacancy.

Mr McCaul has started and we are having to take that on
SWAH clinics for urology added on

These are some of the figures that shows the activity in CAH per month – this is the total number of charts per month that are pulled and filed in Health Records, so there is a large volume. (And I know you will ask – so yes we are doing comparisons across the sites and moving staff to meet the need – I know you so well now!).

But also I would like to have some permanent members of staff as all of our replacements have been agency and it does leave us vulnerable as they want to have permanent posts.

Many thanks.

Month

Total pulled/filed

Jan-14

39370

Feb-14

34661

Mar-14

36100

Forde, Helen

From: Carroll, Anita [Personal Information redacted by the USI]
Sent: 02 April 2015 13:06
To: Burns, Deborah
Cc: Stinson, Emma M; Forde, Helen
Subject: FW: Scrutiny form for Ward Clerk in CAH to cover [Personal Information redacted by the USI] March 15
Attachments: Scrutiny form form for Ward Clerk in CAH to cover [Personal Information redacted by the USI] March 15.doc

Debbie

Would you be agreeable to this scrutiny form – a full time ward clerk is [Personal Information redacted by the USI] from 3 South and we really need to have this replaced at 0.6 WTE. We have done some work arounds and reduced cover in other areas to make up the short fall in the hours as we can't get the full hours covered as this is a [Personal Information redacted by the USI], but we would need to get cover in for the 0.6 WTE.

Thanks Anita

Forde, Helen

From: Carroll, Anita [Personal Information redacted by the USI]
Sent: 07 September 2015 10:58
To: Forde, Helen
Cc: Lappin, Aideen
Subject: RE: Staffing levels

That's fine Helen and I know it does sound awful will get Aideen to get us some time A

From: Forde, Helen
Sent: 04 September 2015 18:14
To: Carroll, Anita
Subject: Staffing levels

When I come back I'd really like a bit of time with you to go through the staffing levels and confirm what we can do re getting staff made permanent and also about the staffing levels.

- Pamela was talking to the unions and the discussion came up about the staffing levels – she has 2 people in CAH on long term sick and 1 in BPC (so CAH have to cover some of that post), and 1 in STH along with a maternity as well in STH.
- Kate has now 2 WTE off [Personal Information redacted by the USI] (Brendan [Personal Information redacted by the USI]) and Aidan, and then one person leaving.
- Helen McCaul met with me on Wednesday and Kellie and her both wanted to talk to me about the pressures of the post and the amount of work to do, and that something has to be done. I advised her to talk to John Harty and Kay Donaghue and get some points down where change could make a difference, and how could the team work together to help things. John Harty going to Diane Corrigan to discuss the activity levels of the renal unit soon.
- Irene – concerned about agency staff leaving, and we have to make the decision about getting the secretarial post filled. (panel for the ED coders meeting on Monday 7th so should know the outcome at end of week).
- Sinead – covering wards means only limited sometimes available and some wards have been complaining about the lack of support.

I try and not come to you with staffing issues but things just seem to be really busy and we can't progress with anything, we're just keeping going, and I know the financial situation is grim, but would just like to sit and talk things through in case there's something I'm missing that would help.

Thanks.

Helen Forde
Head of Health Records
Admin Floor, CAH

DDI [Personal Information redacted by the USI] Ext [Personal Information redacted by the USI]
[Personal Information redacted by the USI]

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Additional Services with no funding 2017/2018

Ref	Service	Additionality	Commencing	Patient Numbers Details of additionality	Resources
1	Neurology	New Consultant	Apr-17	82 per month	
2	Paediatrics	ID Clinic Feeding Clinic	Apr-17	16 per month	
3	Leukaemia MDM	Need both CAH and DHH chart instead of one	May-17	5 per month	
4	GMED/RHEU	New Acute Physician with interest in Rheum no funding for Rheum aspect of work	Sep-17	69 per month	
5	GMED/RHEU	Irrelevant Personal Information returning early	Aug-17	30 per month	
6	Rheu	Irrelevant Personal Information to replace Irrelevant Personal Information , but additional clinic on a Friday taking place along with increase in Irrelevant Personal Information by 2 pts	Sep-17	36 per month	
7	ENT	117 patients seen in DHH in Sept as additionality - funding in a "central" pot of money	Sep-17	117 per month	Only Sept so not including in WTE required
8	Dermatology	Irrelevant Personal Information replaced Irrelevant Personal Information and clinic template increased and new DHH clinic being held	Sep-17	88 per month	
9	Bowel	2 clinics per week to start - service improvement and no funding	Nov-17	80 per month	
10	Clinical Decision Unit	All patients are now admitted on PAS to CDU and a chart requested. This is an average of 16 per day.	Jun-17	480 per month	Stopped in Nov so nothing more needed here
11	Cardiology	DCC Cardio review clinic told not additional	TBC	32 per month	
12	Pain	New Consultant Irrelevant Personal Information will have additional Pain clinic in STH	Oct-17	34 per month	
13	Dermatology	New consultant - unfunded Irrelevant Personal Information starting 2/10/17 Increasing Irrelevant Personal Information clinic by 12 weekly RF clinic of 10 weekly Day case list ? Number of patients Pre-assessment clinic 12 weekly	Oct-17	176 per month	
14	Oral Sugery	Not extra but because we use Ulster Pas for these clinics, we have double the admin work.			Not extra
15	Orthop clinics	Not meeting SBA so having 2 review clinics per month to meet SBA - so not additional	Nov-17	20 per month (not additional)	None
16	Anti Coag clinic	Coming back from community to DHH from 1 Nov	Nov-17	160 per month	
17	Breast Clinic	Charts pulled by Rec instead of sec CBRESRS & CBRESHM was originally to be 6 per week	Nov-17	Average 60 per month	
18	Gastro additionality	Additionality for Gastro Dec - March	Dec-18	24 per month	
19	Fracture	Irrelevant Personal Information increasing from 35-40 up to 47 per week - AND 2 NEW CONSULTANTS	Jan-18	208 PER MONTH	
20	Bowel screeing	4 pts per week in STH	Feb-18	16 per month	
21	Fracture Clinics in MIU	2 clinics per week in STH	Jan-18	280 per month	
			Resources required	808 – 160 = 638 per month for registration and full partial booking process doesn't include bowel screen, number 20	638 x 12 / 52 x 40 mins / 37.5 = 2.5 WTE Band 3. This also has an impact on all secretaries so some funding could be allocated to secretaries/audio typists.

Subject: Chart tracking

From: Forde, Helen

Personal Information redacted by the USI

To: Lawson, Pamela

Personal Information redacted by the USI

, Watters, Kate

Personal Information redacted by the USI

Sent: 20/11/2017, 08:42:19

Could we take a four week period and keep a tally of charts which haven't been tracked and where time has been wasted looking for a chart which hasn't been tracked. Something like below – but it you want to add in more columns work again – it's just so we get a picture of what happened with the chart. Thanks.

Could this start today and run to 15 th Dec and then you let me have your collated version 20th Dec.

Would you use EXCEL and then we can filter by specialty to see if there's a pattern with some specialties. Thanks for this.

Site	Number	Name	speciality	Tracked to	Found in or not found	Time taken to look		

Helen Forde

Head of Health Records

Admin Floor, CAH

Personal Information redacted by the USI

and senior management challenge that, at that time, was not forthcoming in regard to referral triage management and notes at home in particular.

497. I do not think there was a failure to engage fully with the problems of the Urology service from an Acute perspective. I think there could have been a much more constructive interest in recurring concerns from the senior management team level including the Chief Executive with associated support.

[51] Do you consider that mistakes were made by you or others in handling the concerns identified? If yes, please explain. What could have been done differently?

498. I have reflected much on the handling of the concerns raised and noted in this statement.

499. When I read the emails of that time from myself and others, I can see a frustration regarding the lack of capacity across the board, a frustration with the practice of Mr O'Brien regarding delays in triage, leaving patient notes at home, and his often dismissive attitude to core systems and processes (which were often regionally directed and locally agreed). I also see a relatively small number of clinicians and managers working extremely hard to manage many services, elective and unscheduled care flow across 2 acute hospitals, under-funding, and staffing constraints.

500. I also see a consultant who struggled to adjust to the use of technology and to working in a multidisciplinary team who were there to support his practice (to allow his expertise to focus on the aspects of care that only he could do, leaving other aspects of care that could be done by others to those others). I believe that he genuinely struggled to adjust to the volume of patients needing to be managed. I think that, while other consultants adjusted their practice to meet time slots at clinics etc., Mr O'Brien was just unable or unwilling to adjust.

501. On reflection, I believe the Head of Urology and ENT, myself and the Associate Medical Director handled the concerns to the best of our ability at

10.7 Standard Operating Procedures (SOPs) – SOPs were in place as a guide to the staff in how to perform their day to day tasks. *Please see 27. SOP FOR CHECKLIST FOR E-DISCHARGES ON WARD 211115*

10.8 There were other performance indicators or monitoring that could have been used, however, due to staffing levels these were not used/carried out. Health Records is a support service for the Directorates. The Trusts were issued with instructions that they had to improve waiting times for inpatient and outpatients as per the IEAP. These were strictly managed, with Trusts having to report on each individual patient who breached their waiting time. Every Trust was under immense pressure to ensure that all patients were seen in the appropriate timeframe. This meant that clinics would have been set up at short notice to make sure patients did not breach their timeframe. Although this was good for the patient it put great strain on all staff, including the Health Records staff who had to get charts at short notice for newly arranged clinics – and make sure the charts were in the right hospital for the clinic. The Health Records Department in Craigavon Area Hospital is spread over 8 libraries on the Craigavon Area Hospital site, and if the chart has been pulled for a clinic, an admission or a query it can be in any location on the site, as well as any location on any of the other Acute sites. Therefore staff plan their work, and prepare several clinics at one time so ensuring that they maximise their time and plan their journeys to each of the libraries and wards for locating the charts. This method of having clinics at short notice prevented the staff in planning their workload as they would have to make their journey for just one chart due to the timeframe they were working to. This made the service much more inefficient, but it met the demand of the short notice clinic. Working practices like this, and also staffing levels did not provide the Health Records service with the ability to carry out more monitoring. One of the monitoring tools that could have been used was looking at all of the charts tracked out to individual offices/locations and checking to see if they were actually where they were tracked out to. (Tracking refers to a function on PAS in which you enter in the hospital number of the chart and you can record that the chart has been sent to a particular office, clinic, ward so when you

Mr Epanomeritakos	96
Mr Weir	0
Mr McCaigue	61
Mr Neill	1
Mr Young	26

Helen Forde
Head of Health Records
Admin Floor, CAH

Personal Information redacted by the USI

Mobile :

Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 19 July 2017 16:41
To: Carroll, Anita; Forde, Helen
Subject: RE: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE
Importance: High

These are mostly GS , what about his peers

Mr Haynes Mr Glackin & Mr O Donaghue

Ronan Carroll

Assistant Director Acute Services

ATICs/Surgery & Elective Care

Personal information redacted by the USI

From: Carroll, Anita
Sent: 19 July 2017 16:35
To: Forde, Helen
Cc: Carroll, Ronan
Subject: Re: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

Thanks Helen

Ronan do you need more

Sent from my BlackBerry 10 smartphone.

From: Forde, Helen
Sent: Wednesday, 19 July 2017 16:29
To: Carroll, Anita
Subject: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

Mr Mackle	o
Mr Hewitt	o

Personal Information redacted by the USI

Mobile : Personal Information redacted by the USI

From: Carroll, Anita
Sent: 20 July 2017 08:25
To: Forde, Helen
Subject: Re: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

Why so different do any secretaries have tracking codes or is it only doctors

Sent from my BlackBerry 10 smartphone.

From: Forde, Helen
Sent: Wednesday, 19 July 2017 16:48
To: Carroll, Ronan; Carroll, Anita
Subject: RE: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

There you go.

Mr Glackin	34
Mr O'Donaghue	6
Mr Haynes	0

Helen Forde
Head of Health Records
Admin Floor, CAH

Personal Information redacted by the USI

Subject: RE: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

From: Forde, Helen

To: Carroll, Anita

Sent: 20/07/2017, 09:10:24

Message

HAYNES SEC = 87

AOB SEC = 154

Helen Forde

Head of Health Records

Admin Floor, CAH

Personal information redacted by the USI

Mobile :

Personal information redacted by the USI

From: Carroll, Anita

Sent: 20 July 2017 08:59

To: Forde, Helen

Subject: RE: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

For example if you look at mr Haynes how many are with his sec and for AOB how many with sec ?

From: Forde, Helen

Sent: 20 July 2017 08:50

To: Carroll, Anita

Subject: RE: EXAMPLE OF CHARTS TRACKED OUT TO CONSULTANTS OFFICE

Majority of charts are in the secretaries' offices and they have their own tracking code and then the consultant has his/her own tracking code for their office.

Helen Forde

Head of Health Records

Admin Floor, CAH

Subject: Charts tracked to Consultants.xlsx
From: Forde, Helen
To: Carroll, Anita
Sent: 09/10/2017, 16:07:17

Message

Charts tracked to Consultants.xlsx

	A	B	C	D
1	BASE	SURNAME	CODE	NUMBER
2	DHH	Wilkinson	Personal Information redacted by the USI	0
3	DHH	McArdle		25
4	DHH	Kadhim		51
5	DHH	boyd		4
6	DHH	Masih		0
7	DHH	Lewis		23
8	DHH	Acheson		24
9	DHH	Gudyma		39
10	DHH	Thompson		0
11	DHH	Hilliman		31
12	DHH	Jones		0
13	DHH	McCrory		0
14	DHH	McCaul		34
15	DHH	Donnelly		0
16	DHH	Duffin		46
17	DHH	Ahmed		11
18	CAH	Young		27
19	CAH	O'Brien		36
20	CAH	Mackle		1
21	CAH	Mannos		
22	CAH	Hewitt		
23	CAH	Lewis		
24	CAH	Murphy P		46
25	CAH	Liggett		
26	CAH	Mallon		0
27	CAH	McCaffrey P		0
28	CAH	McConaghy		1

35. 20150127 Aob and charts at home

40. 20150304 MR AOB

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

35.1 Improvement could come in the way of having confirmation that the concern is raised and an outcome of the discussion provided, and to see a change in practice with the concern being resolved. I feel that concerns should be raised in a more formal platform with formal feedback being received regarding the concern rather than verbal conversations.

35.2 In hindsight I feel I should have been much more formal in my approach to this concern, detailing every conversation, asking for follow up, requesting a formal meeting to discuss when things did not change.

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

36.1 I had a good working relationship with the Head of Service, Martina Corrigan and due to the close proximity of our offices our interaction tended to be informal.

36.2 I had no working relationship issues with other staff in urology. I did not have contact with urology staff with the exception of Martina Corrigan, and I was not aware of any working relationship issues with urology staff and other Trust staff.