Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Mr. Richard Wright
C/O
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Sir,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by the Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 27 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Mr. Richard Wright
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

Issued by the Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th April 2022

Signed 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 27 of 2022]

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 you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

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

Your position(s) within the SHSCT

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

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, Associate Medical Director, the Head of Service, the Clinical Lead, urology consultants or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern

catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected,

can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

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

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

26. What, if any role did you have in staff performance reviews?

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37. Did those systems or processes change over time? If so, how, by whom and why?

38. How did you ensure that you were appraised of any concerns generally within the unit?

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

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

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

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

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you liaised with, involved, and had meetings with the following staff (please name the individual/s who held each role during your tenure):

    (i) The Chief Executive(s);
    (ii) the Director(s) of Acute Services;
    (iii) the Assistant Director(s);
    (iv) the Clinical Director
    (v) the Associate Medical Director;
    (vi) the Head of Service;
    (vii) the Clinical Lead;
    (viii) the consultant urologists.

    When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

    (a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and

detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

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

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

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

(a) properly identified,
(b) their extent and impact assessed,
(c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

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

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding

concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

61. Did any such agreements and systems which were 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?

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were

those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

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

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

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

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text

communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

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

USI Ref: Notice 27 of 2021

Date of Notice:

Witness Statement of: Richard Wright

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

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

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

Roles, Responsibilities and Duties

Timeline of involvement:

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

1.2. I was Medical Director of the Southern Health and Social Care Trust from July 2015. I would have been responsible for professional matters relating to all doctors within the Trust. In this role I would have overseen the appraisal process across the Trust for all doctors. I would have been responsible for the training of doctors at all grades within all units in the Trust. I would have overseen the job planning process for doctors. I also had specific responsibility for Infection Control issues in the Trust. I had, however, no direct operational responsibility for the day to day management of the Urology service. That would have been the remit of the Acute Services Director (Mrs Gishkori). A complete list of my duties and responsibilities is provided in my Medical Director's job description which has been provided.

1.3. I fulfilled the function of the Responsible Officer (RO) for medical registration and revalidation in keeping with General Medical Council Guidance including that of Mr O'Brien.

1.4. Mrs Trouton (Assistant Director) has stated in her 5 June 2017 witness statement to Dr Chada (Case Investigator) as part of the MHPS investigation into Mr O'Brien that I was informed of the triage and other issues in a meeting on 11th January 2016 (see TRU-00797 at para 13). She has stated that, at that time, I advised her to write formally to Mr O'Brien concerning the issues. I cannot recall the details of this meeting. At that time, I would have assumed that the matter had been followed up within the Service Directorate and that I would have been informed had there been any further difficulties. I was not involved in the issues regarding Mr O'Brien again until Mr Haynes spoke to me in Early September 2016.

1.5. Mr Eamon Mackle, Associate Medical Director, and Mrs Heather Trouton (Assistant Director) met with Mr O'Brien, to outline concerns regarding his clinical practice. Mr O'Brien was provided with a letter dated 23 March 2016 detailing these concerns and asking him to respond (apparently in line with what had been discussed between Mrs Trouton and myself in January 2016). I was not privy to the March 2016 meeting or letter at the time. I became aware of them and what had or had not happened in the period since early 2016 at an Oversight Committee meeting in September 2016

(see further below). Please see *2016 9 13 Oversight Group Notes Action Points* ***Bates Reference TRU-00025-TRU-0002.***

1.6. It appears that, during the period April to October 2016, the local management team based within the Acute Services Directorate decided that the issues raised could best be managed informally and without escalation to the Medical Director's office. I was also informed of this approach in September 2016.

1.7. Between the meeting in January 2016 with Mrs Trouton (which I cannot now recall) and September 2016 I had incorrectly assumed that the matter had been dealt with. I was not aware that Mr O'Brien had not addressed the issues satisfactorily until early September 2016 when I was contacted by the Acute Services team. I believe that this was Mr Haynes (previously Clinical Director but now Associate Medical Director) who telephoned me to express concerns over issues that were coming to light regarding Mr O'Brien's administrative practice and patient management. (I have asked Mr Haynes if he recalls this, and he confirmed that he rang me about the issue but, like me, cannot be sure of the exact date). Mr Haynes was newly appointed as Surgical Associate Medical Director and had discovered that the issues previously raised with Mr O'Brien had not been satisfactorily addressed. We agreed that the Acute Services team would commission an informal investigation from Mr Weir (Clinical Director) under the MHPS process and that Mrs Toal (Human Resources Director) and I would immediately schedule a meeting of the Trust Oversight Committee which was the appropriate forum for such matters to be addressed.

1.8. I functioned as the Co-chair of the Oversight Committee which had a responsibility to ensure that professional issues related to a doctor were addressed. On this occasion that was through the Maintaining Higher Professional Standards (MHPS) process. The Medical Director would have been responsible for implementing many of the recommendations of the MHPS report, but with this investigation, I had retired before the recommendations were presented, so that role would have been the responsibility of my successor.

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

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

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

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

light through the SAI and asked Mrs Gishkori to update me further of the implications (e-mail 30th November). I received a response from Mrs Gishkori on 06th December 2016 explaining that not all the patient's notes had been returned but that this process was still ongoing, from the Acute Services Governance team.

1.13. On 22nd December 2016, the Oversight meeting noted that Mr O'Brien was now on Personal Information leave but that an ongoing Serious Adverse Incident investigation (SAI) had identified a poor clinical outcome for a patient of Mr O'Brien's because of a delay in triage. Dr Boyce (Acute Services Governance lead) had also discovered several other relevant patient administration concerns. As a result of this Mr Carroll and Mr Weir were charged with producing an action plan to address the issues raised by the date of the next Oversight meeting on 10th January 2017. At this stage the Oversight team believed they had enough evidence of concern to require formal investigation under MHPS. I contacted the National Clinical Assessment Service (NCAS) on 28th December 2016 by telephone consistent with the MHPS process and arranged to meet Mr O'Brien on Friday 30th December to inform him of the decision. I directly informed the Chief Executive in person of our recommendation and also personally informed Mrs Brownlee (Chair of Trust Board) as she needed to appoint a Non-Executive Director to oversee the MHPS process. A follow up letter was then sent to Mr O'Brien detailing the decision of the immediate exclusion. Mr Wilkinson was appointed as the designated Non-Executive Director (NED).

1.14. I met with Mr O'Brien (accompanied by his wife) along with Lynne Hainey (Human Resources Manager) on 30th December 2016, at which point we explained that we were excluding him from work for a period of four weeks from immediate effect to allow further preliminary inquiries to be undertaken. This was consistent with the MHPS process and in keeping with discussion I had a few days before with NCAS. After this meeting I sent Mr O'Brien a follow up letter on 06th January 2017 reflecting what had been discussed. *This can be located in Relevant to HR, Evidence after 4*

November HR, V Toal no 77, 20170106 Ltr for Dr Wrights signature- to AOB

1.15. On 10th January 2017 a further Oversight meeting was held. *Oversight documentation Mr O'Brien 2016 27 01 10 Oversight group notes* ***Bates Reference TRU-00035-TRU-000036.*** I informed the team that, consistent with MHPS guidelines, Mr John Wilkinson had been appointed as the designated Non-Executive Director. Dr Ahmed Khan (Associate Medical Director Paediatrics) had been appointed Case Manager and Mr Colin Weir (Clinical Director Surgery) had been appointed Case Investigator. Mrs Siobhan Hynds was appointed as the Human Resources lead manager. Mr Carroll was to lead on the implementation plan to resolve the issues arising from untriaged patients' notes being kept at home, undictated outcomes and matters regarding private patients.

1.16. At the Oversight meeting on 26th January 2017 Mr Colin Weir's preliminary report *(this can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170126 - Attachment - Preliminary report from Case Investigator 26 January 2017)* was presented in accordance with MHPS Section II, para 10. Mr Weir briefed the Oversight group on a meeting that he had held with Mr O'Brien on 24th January. Mr O'Brien had been excluded from work on 30th December for a maximum of up to four weeks i.e., 27th January 2017. As Case Manager, Dr Khan considered that, based upon the evidence presented, there was a case to answer as there was significant deviation from good medical practice.

1.17. At that point Mr Weir reflected that there were no concerns in relation to the clinical practice of Mr O'Brien. Mr Khan recommended that Mr O'Brien could return to work subject to the suggested monitoring and support mechanisms being in place. His immediate exclusion was lifted on 27th January 2017. The Oversight team decided that Mrs Gishkori (Director) and Mr Carroll (Assistant Director) would put measures in place to monitor and support Mr O'Brien's return to work. I informed NCAS of these developments by telephone over the next few days. It was agreed that Dr

Khan would inform Mr O'Brien of the decision to let him return to work immediately by telephone to try to reduce his anxiety regarding the process. It was also agreed to seek an updated occupational health assurance that Mr O'Brien was fit to return to work as he was in fact still off work on Personal Information redacted by the USI leave.

1.18. During January and February 2017 Mr O'Brien made representation to Mr Wilkinson (Non-Executive Director) in respect of process and timescale and the Case Investigator. Mr O'Brien wrote to me on 21st February 2017 with a number of suggested changes to the notes of our meeting on 30th December 2016. I amended the notes accordingly and shared an amended copy. In considering these representations the Oversight team decided that in fairness to all involved it would be better if the Case Investigator had no history of working closely with Mr O'Brien. (Mr Weir was his Clinical Director). After discussion with Dr Khan, I asked Dr Neta Chada (Associate Medical Director, Mental Health and Learning Disability) to take on the role.

1.19. In May 2017 I was asked by the governance team to source an expert in Serious Adverse Incidents and Root Cause Analysis regarding ongoing issues related to Mr O'Brien. I recommended Dr Julian Johnston, a former colleague who had recently retired from Belfast HSC Trust. After putting the governance team in touch with him, Dr Johnston accepted the role.

1.20. I understand from now reading the record that Dr Chada's MHPS report was presented to Dr Khan the Case Manager on 12th June 2018. The Case Manager, Dr Ahmed Khan, gave his conclusions and recommendations in an MHPS report dated 28th September 2018. I had left the Trust and retired by this stage and had no knowledge of the conclusions or recommendations until I read the report at Trust Headquarters on 09th May 2022 as part of this inquiry. I was not involved in the decision process regarding the implementation of the recommendations. I note that within this MHPS report Dr Khan concluded that, when Mr O'Brien returned to work in January 2017, "he worked successfully to the action plan during this period."

1.21. I had no direct involvement with this case after February 2018 when I had to take Personal Information redacted by the USI leave Personal Information redacted by the USI. On my return,

Mr Devlin (Chief Executive) asked me to carry out a number of reviews concerning job planning and medical recruitment for him. It was decided that I should not return to my role as Medical Director as I had decided that I would retire from the service in August 2018 to pursue other plans outside of medicine. At this stage, there were clear indicators that Mr O'Brien was complying fully with the support measures around his practice and his performance was satisfactory.

1.22. Following my retirement on 31st August 2018, I was approached by Mrs O'Brien when she telephoned my former secretary and advised that she wanted to meet with me informally. Although I had technically left the Trust, I agreed to meet her in my old office as a compassionate gesture. During that meeting Mrs O'Brien expressed annoyance at the treatment of her husband by the Trust. I explained why it had been necessary to institute the MHPS investigation. I acknowledged the degree of hurt experienced by both Mr and Mrs O'Brien but explained that the action taken was necessary to protect patients and Mr O'Brien as well as the Trust, and that there had been no intention to unnecessarily annoy either of them. Mrs O'Brien was quite upset during the meeting, which ended cordially. I believe we parted on reasonable terms.

1.23. After that meeting in early September 2018, I had no further connection or dealings with Mr O'Brien or the Trust in relation to the matter until this public inquiry commenced.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

Urology Services Inquiry

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

Your position(s) within the SHSCT

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

4.1. My qualifications are:

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

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

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

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

4. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

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

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

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

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

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

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

5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

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

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

6.3. The full list of responsibilities of my role as Medical Director are given in the Job Description but included professional standards of all medical doctors within SHSCT, Medical Education and The Trust's Medical Appraisal Department to include patient data guardian, medical research oversight, infection control, Undergraduate and Postgraduate Medical Education as well as shared corporate responsibility for all matters within the Trust along with the other members of the Executive team.

6. With specific reference to the operation and governance of urology services, please set out your roles and responsibility and lines of management.

7.1. The Service Director (Mrs Gishkori) and Assistant Director for surgery (Mr Ronan Carroll) were the senior team responsible for the delivery of the service and for governance issues therein. Dr Tracey Boyce was the Governance lead within the Acute Services directorate.

7.2. I held a position on the Trust Board and Executive Team and as such shared joint responsibility for all aspects of the service within the SHSCT along with all the other board members and executive team.

7.3. As Medical Director I was responsible for the professional medical standards and behaviour of all doctors within the Trust including Urology. The professional medical lines of accountability ran from me to the Surgical Associate Medical Director (AMD) (Initially Mr Mackle and then Mr Haynes) and then to the two Clinical Directors (Mr Weir and Mr Haynes initially but then there was one vacant post as Mr Haynes assumed the role of AMD).

7.4. I had no direct operational responsibility for any clinical service including Urology. During my tenure between 2015-2018, the role of AMD was sequentially held by Mr Eamon Mackle, briefly by Mr Charles McAllister and then by Mr Mark Haynes.

Urology Services Inquiry

7. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were relevant to the operation and governance of urology services, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, Associate Medical Director, the Head of Service, the Clinical Lead, urology consultants or with any other role which had governance responsibility.

8.1. I was the director who was professionally accountable for a doctor's behaviour but the Acute Services Director (Mrs Gishkori) was responsible for all operational matters including internal governance issues within her Directorate. The Associate Medical Director (initially Mr Mackle and then Mr Haynes) was therefore accountable to both the Acute Services Director for operational and governance issues and to me for professional matters. The same double line of accountability applied to all the medical staff. I had no direct role in overseeing any of the non-medical staff such as Nurses, Allied Health Professions or Administration staff.

8.2. The responsibility for governance issues is shared by all in line management from the clinical frontline to the Trust Board. However, the primary responsibility for the clinical governance issues relating to a doctor's patients' care rests with the consultant looking after the patient. A doctor who is unable to provide a satisfactory service because of resource, team, or other issues has a duty to escalate those issues to their line manager. A doctor must always practice within the guidance of 'Good Medical Practice' as outlined by the General Medical Council. This gives advice regarding not only clinical care but also patient administration and behaviour standards.

8.3. I was accountable for the delivery of the Trust appraisal system with the assistance of two appraisal leads, Dr Joan McGuinness and Dr Damian Scullion. The appraisal administrative lead was Mrs Norma Thompson. The appraisal system usually delivered completed appraisals of 99% each year which is almost unprecedented in the NHS. The two appraisal leads scrutinised the

quality of appraisals against agreed standards particularly concentrating on those doctors approaching revalidation each year.

8.4. Towards the end of my tenure, the Executive Team decided to move the reporting lines of the Governance team to my office from the office of the Chief Executive. This was seen as an interim measure as, just as I was retiring, I understand Mr Devlin, the Chief Executive, was considering a major governance review across the Trust which went ahead shortly after I retired in August 2018.

Urology services/Urology unit - staffing

8. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

9.1. I understand that the regional review of Urology services was undertaken in response to safety concerns in 2009. This predated my involvement in the service by six years. I was not involved in either the review or its implementation nor in the establishment of the Southern Trust team. During my term as Medical Director I was aware that recruitment into Urology has been challenging. I encouraged informal cooperation between Trusts, often supporting specialists from our Trust to share surgical lists in both the South Eastern HSC Trust and Belfast HSC Trust to maximise clinical expertise for the system. As an example of the support offered to the urology team, I encouraged the appointment of an ADEPT clinical management fellow at registrar level as an additional staff member.

9. What, if any, performance indicators were used within the urology unit at its inception?

10.1. I am unaware of which performance indicators were used within the urology service at its inception as I did not join the Trust until many years later.

10.2. During my tenure as Medical Director from 2015-2018, the SHSCT participated in the CHKS comparator programme along with all other medical specialities. The SHSCT was usually placed within the top 40 performing Trusts with the UK. The types of indicators used then were measures which included, for example, infection control, morbidity and mortality measures and Pulmonary Embolism prophylaxis. The Commissioning Board asked for regular updates relating to waiting times and the number of patients' episodes processed. The Morbidity and Mortality (M&M) system had evolved but was well established by 2015. By the time I left post all Consultants were required to participate actively in these reviews in line with regional guidance. The urology team had an active quality improvement programme which my team supported. Indeed, the urology team won the 'Team of the year' award from the Chairman (2016-17).

10. Was the 'Integrated Elective Access Protocol' published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

11.1. I had no knowledge regarding the dissemination of 'Integrated Access Protocols' published in 2008 as this predated my appointment to the Southern HSC Trust by 7 years.

11.2. During my time at SHSCT between 2015 - 2018, the Trust Executive Team and Trust Board would regularly review performance targets from all the teams including urology. In addition, we were asked to provide monthly updates

to the Commissioning Board both in written form but also via systematic and regular accountability briefings which we would have delivered in person. This process would have been led by the Director of Performance and Planning which would have been Mrs Aldrina Magwood between 2015-2018 when I was in post.

11. How, if at all, did the 'Integrated Elective Access Protocol' (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?"

12.1. I was not employed by the SHSCT in 2010 when the Regional Review of Urology Services was published and therefore as a radiologist working in another Trust, I had no working knowledge of its implementation.

12.2. During my time as Medical Director performance targets were monitored by Mrs Aldrina Magwood (Director of Performance and Planning) and her team. These performance figures would have been reviewed corporately by the Senior Management Team chaired by the Chief Executive and then in turn by the Commissioning Board. Regular accountability reviews would have been held in Linenhall Street (Board Headquarters). These reviews would mostly have centred around access targets including many of the indicators within the Integrated Elective Access Protocol such as new referrals, 'Did Not Attends', waiting times etc.

12.3. During my period as Medical Director (up until February 2018), urology services were generally under considerable pressure in line with most surgical specialties but were not one of the specialties giving most concern. There were major regional issues relating to Emergency Department Services and Breast Surgery in particular. It would have been primarily the responsibility of the Acute Services Director and her team to react to the relevant indicators.

12. The implementation plan, Regional Review of Urology Services, Team South Implementation Plan, published on 14 June 2010, notes that there

was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. **What is your knowledge of and what was your involvement with this plan?**
II. **How was it implemented, reviewed and its effectiveness assessed?**
III. **What was your role in that process?**

Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

13.1. *(I – III inclusive):* The issues regarding implementation of the implementation plan, 'Regional Review of Urology Services', predate my appointment by several years and therefore I cannot meaningfully comment on the governance documents or risk register at the time. I understand that each directorate would have populated its own risk register intermittently, the Senior Management Team would decide which items moved to the Trust corporate register.

13. Were the issues raised by the Implementation Plan reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

14.1. See reply to Question 13.

14. To your knowledge, were the issues noted in the Regional Review of Urology Services, Team South Implementation Plan resolved satisfactorily, or did problems persist following the setting up of the urology unit?

15.1. I did not come into post until 5 years after the implementation plan. My experience of the urology team during my tenure however was that they were generally a progressive and forward-thinking team. The team showed a willingness to engage with other urology teams around the province in progressing new services and addressing waiting list issues. I witnessed multiple examples of good cross-trust co-operation. The frequency of incidents or complaints was comparable to other surgical teams. Generally speaking, they were a team who attempted to resolve issues that arose internally. Their adoption of an ADEPT surgical fellow demonstrated an enthusiasm to progress and reform their service. They were the first and only surgical team in Northern Ireland to embrace a leadership fellow at that time indicating that they were forward thinking and progressive. This was not a failing team by any recognised criteria.

15. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

16.1. My awareness of staffing issues lies mostly with the Medical Staff. Like most clinical specialities, there was a sense within the Southern HSC Trust that our medical manpower was insufficient by 2015 when I arrived.

16.2. Over the intervening years from the publication of the review in 2010 there were several issues at play including the following:-

i. Clinical developments and potential therapies had evolved becoming more effective but also more complex.
ii. Specialist procedures now often required ‘buddy operating’ which required two surgeons rather than one.
iii. Robotic interventions were beginning to evolve which was clearly going to require limited expensive resource to be shared across all the urology teams in Northern Ireland but, possibly, initially on one site only.

iv. There was an appropriate and necessary increase in the level of cooperation between trusts with our surgeons often having to travel to other centres to assist with complex surgical procedures.

v. The referral rate continued to rise.

vi. Job planning on a regular basis highlighted the volume of work undertaken by individual consultants recognising that excessively long hours of working were inappropriate.

vii. New demands on consultants such as regular participation in multidisciplinary meetings (MDMs) and Morbidity and Mortality review meetings inevitably meant there was less time available for direct patient care.

viii. New demands on trainee surgeons rightly meant the focus for them had to be training rather than service delivery.

16.3. These factors all conspired to put ever more pressure on the clinical service. I would have been made aware of the medical staffing issues through the regular one to one meetings I would have had with the Associate Medical Directors and Clinical Directors. These were informal meetings without minutes but occurred every few months. In addition, we had formal Associate Medical Director team meetings each month, but these were focused upon issues which affected all the teams rather than individual directorate issues. Not long after taking up post I made a point of trying to meet each medical team as a group. I met team urology as a group in 2015. They eloquently expressed their frustrations regarding theatre time, and staffing pressures and junior doctor supervision, together with their hopes and aspirations. The mood at the meeting was good natured. They valued the opportunity for direct communication with myself. I made it clear at the meeting that they could arrange to see me individually at any time and was able to update them on progress around professional issues such as job planning and appraisal.

16. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

17.1. Yes; I had some awareness of staffing issues. My awareness of these issues lies mostly with the Medical Staff.

17.2. One consultant left the service and this funded consultant place was not replaced for several months. Consultant urology staffing never reached the threshold required to be put on the corporate risk register during my tenure (2015-2018).

17.3. Of significance, however, was the turnover of surgical team surgeon management posts. One Clinical Director (Mr Brown) retired. Mr Haynes took up the role of Assistant Medical Director for Surgery, after previously being Clinical Director but the residual two Clinical Director for surgery posts proved difficult to fill. Mr Weir was one of the Clinical Directors but was keen to step down as he also fulfilled a demanding role as Associate Medical Director for Postgraduate Medical Education across the whole Trust. Between March 2016 and December 2016 there were three AMDs (Mr Mackle, Dr McAllister and Mr Haynes).

17.4. There was a period when it proved difficult to fill staff grade vacancies and this issue was placed on the Corporate Risk Register (2017). This was partially addressed by the appointment of an ADEPT trainee leadership fellow from NIMDTA (Northern Ireland Medical and Dental Training Authority).

17. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

18.1. In relation to medical staff, I am aware that there were prolonged periods when at least one funded consultant post was unfilled. The Acute Services Director would have worked with the Associate Medical Director to progress these posts, but my understanding is that delays were largely due to the lack of availability of appropriately qualified staff rather than delays in the recruitment process. My role in direct recruitment would have largely been a supportive one: helping to design job plans and supporting the interview process.

18.2. As stated above, the instability in the surgical clinical leadership posts was challenging. One issue that may have contributed was the lack of appropriate training of doctors for clinical leadership roles. As a result, my team, in association with the Trust Human Resources team and with assistance from the HSC Leadership Centre, designed a bespoke training programme for all doctors interested or involved in leadership or management. *This can be located in S21 No 27 of 2022, Attachments, 1. Final Brochure AMD and CD Development Programme January 2017*. This was delivered in 2017/2018 and received positive feedback from those who took part.

18. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

19.1. The unfilled consultant and staff grade posts that were fully funded would have had a significant impact on the delivery of services. It is highly likely that, since the regional Urology review, the complexity of the clinical services and the additional administrative and governance demands placed upon all medical staff would have made delivery of a safe service increasingly challenging. However, during the period that I was involved (2015-2018) these issues would have been similar in most other specialties. The issues around patient triage, clinic notes, private patents and so on identified by the MHPS process were noted to be disproportionately affecting Mr. O'Brien's practice at that time to a level which was unrecognizable when compared to the other consultants.

19. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

20.1. Mr Carroll replaced Mrs Trouton as Acute Services Assistant Director before the first Oversight meeting in 2016. Mr Eamon Mackle stood down as Associate Medical Director (AMD) for surgery in Spring 2016. His role was transiently filled by Dr McAllister who was already AMD for Anaesthetics and

Critical Care and then Mr Haynes was appointed substantively as AMD for Surgery in Autumn 2016. (He was previously one of the two Clinical Directors in Surgery along with Mr Weir). This left a Clinical Director post vacant which proved difficult to fill over the next year. My knowledge relates primarily to medical staff. I have no knowledge of the nursing or administration staffing situation during that time.

20.2. We appointed an ADEPT training fellow in 2017 to urology for a period of two years. The appointment of this ADEPT fellow effectively increased the staffing compliment by one trainee doctor. However, this particular post focused on leadership development for the doctor rather than provision of the clinical service. When Mr Haynes became Associate Medical Director for Surgery he would have had less time available for clinical urological practice as he was coincidentally a Urologist.

20.3. I am aware that Mrs Gishkori (Acute Services Director) reprofiled the roles of her senior management team during this period, however, I would not be aware of the details of this except that Mr. Simon Gibson (Assistant Director) moved from the Acute Services Team to my team in the Medical Director's office to fill a vacancy.

20.4. One other key realignment was the move of Mr. Carroll into the role of Assistant Director responsible for surgical services including Urology. He replaced Mrs. Heather Trouton in that role sometime between March 2016 and September 2016.

20. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

21.1. A few months before I retired, the Senior Management Team moved the direct reporting lines of the central governance team from the Chief Executive

to me as an interim measure pending a more substantial review of governance which I understand happened after I retired in 2019. This did not directly affect the Acute Services or Urology internal reporting lines.

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1. I have no detailed knowledge of the administrative or nursing support within team urology, however in my last few months I conducted a review of all medical leadership roles within the SHSCT for the Chief Executive (from April - August 2018). This identified a widespread issue of a lack of sufficient administrative support time for the clinical leadership teams across all specialities. For instance, the Morbidity and Mortality (M&M) chair would often have to input most of the patient details on the system themselves, using up hours of valuable Consultant time. The review (2018) identified a need for more consistent administrative support across the Trust for doctors in clinical leadership roles.

22.2. In my opinion, having spoken to nearly all the clinical leaders at the time, this lack of administrative support and dedicated time within job plans was a significant reason why some doctors felt unable to accept medical leadership positions. Mrs Gishkori (Acute Services Director) and Mr Carroll (Assistant Director) may be best placed to answer these questions.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff

allocated to particular consultants? How was the administrative workload monitored?

23.1. I have no knowledge of the administrative teamwork patterns within the urology team. The Service Manager (Martina Corrigan) and Assistant Director (Ronan Carroll) would be better placed to answer these questions.

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

24.1. I am unaware of concerns raised by administrative staff.

24.2. However, as Medical Director I would have expected those concerns to have been escalated initially through the directorate line management. In my last year of office (2018), I assumed responsibility as the director accountable for the Trust whistleblowing system. I was not aware of any relevant whistleblowing incidents from the urology team. During my review of job planning for consultants (March -August 2018) medical administration support was raised by many across the Trust especially in relation to supporting clinical leadership roles. I presented this paper to the Chief Executive and Senior Management Team just before I retired. There was no suggestion at that time that the Urology team were significantly different to other surgical teams at that time, however all were under pressure.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

25.1. Mrs Gishkori was the Acute Service Director. Mrs Heather Trouton and Mr Ronan Carroll were the sequential Assistant Directors with responsibility for surgical services. Mrs Martina Corrigan was the urology Head of Service.

25.2. Initially Mr Mackle, Dr McAllister and then Mr Haynes became the surgical Associate Medical Director. Mr Weir was the Clinical Director for surgery for most of the relevant time of my involvement between 2015-2018. Mr Young was the team lead for Urology. I am not aware of the relevant nursing or administrative post holders at that time.

25.3. Mrs Gishkori as the Acute Services Director was the person in charge of the service. She was responsible to the Chief Executive. Mr Carroll and Mrs Trouton reported to Mrs Gishkori. Martina Corrigan, the Head of Service, reported to Mrs Trouton and then Mr Carroll sequentially. The Associate Medical Directors reported to Mrs Gishkori for operational matters and to me as Medical Director for professional issues.

25.4. I had no direct operational responsibility but, as Medical Director, was responsible to the Chief Executive for medical professional issues and infection control matters.

26. "What, if any role did you have in staff performance reviews?

26.1. My role around staff performance review within urology was largely centred around that of individual medical staff, in respect of whom I was responsible for overseeing the staff appraisal system and for ensuring job planning review was updated annually. I had no direct role in reviewing the administrative, nursing, or other staff within the urology team. I would have conducted several annual appraisals for administrative staff working directly to me within the Medical Director's office, but these did not directly involve the urology team. The Medical Director's office team, under the leadership of Mrs Norma Thompson, were responsible for the smooth running of the appraisal

system. From the feedback that I received from many staff and from my own experience, the administration processes, including proactive encouragement and follow-up, worked well within the Trust. It was my experience, having undertaken multiple 1:1 revalidation interviews with Staff grade and Associate Specialty doctors (SAS) and Consultant doctors, that the standard and quality of appraisals for doctors was high.

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

27.1. Like all doctors, I was required to have an annual appraisal to comply with revalidation requirements. Over the period 2015-2018 this was conducted by a Medical Director from another Trust. I revalidated with the GMC successfully in March 2018 just before I retired. For this revalidation I would have had to satisfy the appraiser against specific criteria set by the General Medical Council including 360 degree colleague feedback. This feedback would have included evidence regarding my role as Medical Director as well as Clinical Performance. Objectives would have been agreed with the appraiser under a personal development plan and would have related to ongoing Continuing Professional Development courses. This would have been within the framework of 'Good Medical Practice' as outlined by the General Medical Council. Generally, appraisal would have been broken down under four main categories around Continuing Medical Education, Safety and Quality, Communication with Colleagues and Communication with Patients.

(Example appraisal enclosed and located in S21 No 27 of 2022, Attachments, RW Appraisal.)

Urology Services Inquiry

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

28.1. I met regularly with the Surgical Associate Medical Director as part of our monthly Associate Medical Director (AMD) team meetings. All the other AMDs would also be present. We spent approximately two hours together on a Friday afternoon. These meetings were formally recorded. In addition, approximately once every few months I would have a one-to-one meeting with each AMD. I would have had occasional 1:1 meetings with the Clinical Directors when they were in post. These 1:1 meetings tended to be informal. There were no minutes recorded.

28.2. I met with the full Urology consultant team in 2015 as part of a round of team engagement meetings after I was appointed to the role of Medical Director. I attended both the Craigavon and Daisy Hill Medical Staff meetings monthly to present the Medical Director's report and to answer ad hoc questions from medical staff. I had an open-door approach to all medical staff and would endeavour to see any staff member within a few days if requested. I would systematically meet with all doctors just prior to their revalidation date. In addition, there would be multiple informal opportunities for meetings.

28.3. I piloted an occasional Medical Director's newsletter that I sent by email to all medical staff. As sponsor of the ADEPT leadership fellows within the Trust I would meet regularly with our Urology ADEPT fellow to discuss progress during his attachment. I developed an educational leadership programme for medical staff initially which I helped to deliver and design which provided a useful forum for interaction. My team assisted in the delivery of the Trust Quality

Improvement programme encouraging medical staff as well as other clinical and administrative staff to participate.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

29.1. My engagement with the urology staff was usually through the Associate Medical Director and Clinical Directors as mentioned in the paragraph above. I would not have regularly formally met specifically with non-medical urology staff.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

30.1. The best example of good team working was when the entire Urology team won the Chairman's Trust award for team of the year in 2016/17 based upon a series of criteria and judged by our non-executive directors. The ADEPT leadership fellow within the urology team proved to be most successful engaging with all types of staff to develop a reconfigured lithotripsy service. To secure funding for this the Urology team had to compete with every other speciality across the province. At that time this was the only Surgical ADEPT fellow to be appointed anywhere in Northern Ireland. I had a sense that for the most part the team functioned well. Mr O'Brien was the longest serving member of the team and was held in high regard. However, I sensed that this sometimes meant that team members avoided challenging him directly.

30.2. In my role as Medical Director, I would have witnessed meetings involving variously Mrs Gishkori (Service Director), Mrs Trouton, Mr Carroll (Assistant Directors), Mrs Corrigan (Urology Service Manager), Mr Haynes

(AMD), Mr Weir (CD) and Mr Young (urology team lead). Any encounters I witnessed were professional and often good humoured. I would have described the team dynamic at this level as appropriate, professional, and patient focused. Team members were not afraid to express their views robustly when required. However, I did not have the opportunity to witness how the team worked at a more operational level. I would have described the team dynamics between Mr Haynes, Mr Weir, and myself as strong and professional.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

31.1. As the lead doctor within the Trust, I was the Executive Director who was primarily responsible for the Clinical Governance matters relating to doctors. There is often a blurring of boundaries, so this responsibility would be shared with the relevant service director. In this case that would be Mrs Gishkori. This role was delegated through the line leadership structure to the Associate Medical Director for Surgery, through the two surgical Clinical Directors, then through to the urology team lead and finally to consultants and other medical staff including trainees and SAS (Staff and Associate Specialist) doctors. There was also a shared governance responsibility through the Associate Medical Director Team across the Trust specialities.

31.2. Operational governance issues were the primary responsibility of the Acute Service Director (Mrs Gishkori).

31.3. Minor day to day issues would be expected to be managed by the Clinical Directors with the service managers and Assistant Director but more serious clinical governance issues would have been escalated to the Associate Medical Director and then to the Service Director .

31.4. Professional issues should have been escalated via the AMD to me.

31.5. Inevitably, issues relating to clinical governance were often of an operational nature which involved close working with the Acute Services Director. A good example would be that of Clostridium Difficile infection. Where an outbreak occurred the infection control team from my office would work closely with operational acute services staff to contain the infection. (C. Diff rates in SHSCT were consistently the lowest in the province during 2015-18).

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

32.1. Ultimately it was myself and the Acute Services Director who shared responsibility for the Clinical Governance arrangements. The Acute Services governance lead was Dr Tracey Boyce (lead pharmacist). I believe the governance manager reporting to her was Trudi Reid at the time. The Associate Medical Directors and Clinical Directors carried a degree of oversight, especially in relation to the management of issues raised through SAIs. I would meet regularly with the Associate Medical Directors and with Mrs. Gishkori. Senior Management Team would receive regular directorate reports related to Governance but these were rarely focused on Urology alone. Regular governance reports were presented by each operational director to the Senior Management Team and also to the Governance subcommittee of the Trust Board. Clinical Governance issues were a standing item on each weekly Senior Management Team Agenda. Multiple clinical indicators were constantly monitored across all specialties as guided by Department of Health. These were regularly published in quality reports and shared at our performance review meetings with the Commissioning Board.

32.2. One of the most powerful indicators of how a clinical governance system is performing within a trust is to review the monthly mortality and

morbidity figures. During my period (2015-2018) these always compared favourably against peer comparators. We participated in the national CHKS governance indicator peer comparator system and were usually placed within the top 40 performing Trusts within the UK. At SMT and Trust Board level it would have been unusual to have drilled down into individual specialties. This would have been expected to be done within the directorates by their internal governance teams, but Senior Management Team would have expected any outlying indicators to be highlighted to them by the relevant director.

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

33.1. I expected to be fully briefed on professional governance issues on a regular basis by the AMD and Clinical Directors as outlined above in answer to Question 28. If a new issue arose, I expected them to contact me immediately rather than wait until the next meeting. In addition to these normal lines of communications, other useful information was gleaned from the regularly measured performance indicators such as infection control, morbidity, and mortality rates, Venous Thromboembolism (VTE) prophylaxis, etc.

33.2. Within the Acute Directorate there was a clinical governance team who would support all staff and gather information reporting to the Acute Service Director. Clinical Governance issues were reported by all directorates to the executive team and then to the governance sub-committee of Trust Board and ultimately to the full Trust Board. Throughout the relevant period of my tenure, 2015-2018, measurable clinical governance outcomes were often better than most peers, usually resulting in the SHSCT being ranked in the top 40 best performing hospitals in the NHS out of 200 peers under the CHKS peer comparator system. Other useful indicators included information gleaned through the junior medical staff GMC anonymous surveys and GMC and NIMDTA inspections. These objective external inspections indicated good compliance with training requirements and gave no indication of clinical governance concerns in urology.

33.3. In my experience these surveys were often the first place where issues within a unit that was struggling would be identified. Junior doctors move around different departments in their training so are quick to identify variations from expected practice. In 2016 the Trust was rated as within the top 10% training Trusts within the United Kingdom by a General Medical Council (GMC) survey of foundation doctors. Regular review of complaints and incidents provided a wealth of information and were analysed systematically by the Acute Services and central Trust governance teams.

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

34.1. Performance metrics were gathered by the Service Manager and reported via the Assistant Director to the Service Director. Central collation was gathered by the performance and planning team under the direction of Mrs Magwood (Director of Performance and Planning). Regular updates around performance were provided to and reviewed by the Executive Team, Trust Board, and the Commissioning Board.

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

35.1. See my answers to questions 32-34 above.

35.2. In addition to this, the central governance team brought forward regular reports to the executive team governance subcommittee of the Trust Board. These would include most of the performance indicators discussed above including complaints review and review of incidents. These meetings and reports, which I was involved in, identified central themes and issues and looked at trends. Inevitably, the detailed drilling down of individual incidents and complaints

was carried out within the Acute Services governance team which I would not have been part of.

35.3. As stated in answer to Question 34, performance and quality indicators were collected centrally and shared with the Trust Senior Management Team and Trust Board. Clinical indicators such as infection rates, VenoThrombo Embolism prophylaxis, readmission rates, etc. were presented in regular quality reports and compared to peer groups through the CHKS system. GMC (General Medical Council) inspections, Northern Ireland Medical and Dental Training Agency (NIMDTA) inspections were also useful sources of information. The Staff surveys conducted by Human Resources proved a rich source of additional material together collated data from complaints and incidents. In 2017 we piloted a new approach to learning from complaints with the London School of Economics which yielded much useful information rather than simply looking at response times information.

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

36.1. Issues of concern were normally brought to me via the Service Director or Associate Medical Director. However, I also held regular meetings with the Clinical Director and had an open-door policy of availability to all Consultant staff. Concerns could be raised via the GMC or NIMDTA inspections of junior staff and anonymously via the GMC junior staff surveys. Mr Simon Gibson, my Assistant Director, regularly met with FY1 and FY2 doctors to address issues they detected. They were a useful source of intelligence. We instituted a new whistleblowing policy in 2017/18 which provided alternative opportunities for raising issues

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

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

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

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

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37. Did those systems or processes change over time? If so, how, by whom and why?

37.1. Once Mr Haynes was appointed as Associate Medical Director in Autumn 2016, I had confidence that professional issues were being appropriately escalated to me. Prior to that it now seems clear that such issues were not being appropriately highlighted. The turnover of Associate Medical Directors and Assistant Directors in the months preceding this was not helpful for continuity of approach.

37.2. Mrs Gishkori (Acute Service Director) met with me on a regular basis to discuss issues within her directorate. Some of these issues were related to concerns within the urology team but we also took the opportunity to share many positive developments. In addition, there were structured opportunities at each of the weekly Senior Management team meetings to share concerns and also at the monthly Trust Board meetings in either the open or confidential sessions.

38. How did you ensure that you were appraised of any concerns generally within the unit?

38.1. The Acute Services Director or the Associate Medical Director would have informed me directly regarding professional governance concerns in our regular 1:1 meetings or on an ad hoc basis when required. For operational matters the Acute Services Director (Mrs Gishkori) would speak at Senior Management Team each week on any relevant issues bringing reports when appropriate through her governance team. Governance data was collected centrally by, and produced in annual governance reports to, the governance sub-committee of Trust Board. I would have received reports from inspecting agencies such as NIMDTA, GMC and RQIA which could on occasions raise concerns.

38.2. I don’t believe any significant concerns were raised in relation to Urology at the time. I had an open door policy for any Doctor to meet with me personally should they have concerns. The Clinical Director (Mr Weir) would have

met with me regularly for 1:1 sessions in which he was encouraged to share concerns.

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

39.1. Governance reports were received regularly by Senior Management Team from all the directorates including Acute. They measured a plethora of agreed criteria such as incident reporting, complaints and also relevant clinical indicators such as Mortality etc. At SMT these were often presented as overall directorate figures and not routinely broken down by individual surgical unit. When measured against peer groups the figures often suggested that the Acute Directorate was performing well against peers. There was considerable turn over in senior medical leadership staff during the period from Spring 2016 -2017 and I am aware that such a turnover always carries risk with it. The Senior Management Team were aware that the governance reporting processes were in need of review and I understand there was such a review carried out in 2018 after my retirement, partly because there was dissatisfaction with the efficiency of the reporting mechanisms.

39.2. As well as the routine reporting of clinical indicators there are many other means of identifying governance concerns. We would regularly have been subjected to outside inspections from RQIA (Regulation and Quality Improvement Authority) GMC (General Medical Council) and NIMDTA (Northern Ireland Medical and Dental Training Agency) across all our specialties. None of these were suggesting a localised problem within urology over the time period 2015 - August 2018, as far as I can recall.

39.3. The central Governance team would have reviewed Incidents and Complaints, both of which can prove useful sources of intelligence. I did not ask

for specific drilling down into the Urology data, however, it would have been expected for any significant variance from expected norms to have been highlighted in the regular reports produced.

39.4. In retrospect I believe the issues of concern that related to Mr O'Brien had been managed for too long exclusively within the directorate on an informal basis. Once it became clear that the measures put in place were not proving as effective as they might have been I would have expected that this would have been shared more forcibly at an earlier stage.

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

40.1. The concerns were discussed in detail at the Oversight Committee meetings, the minutes of which are provided. As these were issues affecting predominantly the Acute Services Directorate, any governance concerns would normally be escalated through the Directorate governance pathway in the first instance. The Corporate Risk Register reveals some concerns around staff grade medical recruitment. Although there were temporary consultant vacancies they did not reach the threshold to be placed on the Corporate Risk Register during my time (July 2015 until February 2018).

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

41.1. Patient data collection would have been the responsibility of the Acute Services Directorate operational team. As Medical Director I would not normally be involved at this level and therefore am not the best placed person to answer this question. Over the time period of my involvement (July 2015 - February

2018) data gleaned by the Head of Service (Mrs Corrigan) and her team highlighted the difficulties around patient triage. The Datix IR1 incident reporting system was in place across the Trust. It seems that it is through this mechanism the incident (Patient 10 which subsequently became was upgraded to the first SAI (Serious Adverse Incident) was identified.

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

42.1. The Acute Services Governance Manager, Dr Tracey Boyce, or the central Governance Lead at the time, Margaret Marshall, may be in a better position to comment on this. I have no detailed knowledge of the data collection systems within urology at the time. My involvement ceased in February 2018 when I went initially on Personal Information leave and then retired. However, I note that the central data governance team in the Trust won the UK award for best data governance team within the UK among 200 trusts from the CHKS peer comparator system 2017.

42.2. In my opinion, and with hindsight, it seems there was significant data available regarding many of the key issues. As I see the issue, the main factor was a reluctance to formally address the issues identified, rather than a lack of data.

42.3. Incident reporting moved from a paper-based system to an online system (Datix). This allowed for more timely collection of statistics and analysis but was dependent to some degree upon access to input terminals and appropriate training to use the system.

42.4. During this period the central governance team were piloting a new system of understanding complaints data with the London School of Economics. This eventually provided much more useful information around relevant themes rather than simple response time information.

Urology Services Inquiry

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

43.1. Individual performance objectives for Consultants would have been agreed through the appraisal process with the consultant's appraiser on an annual basis. These would normally be agreed in the knowledge of what would reasonably be expected form peers working in a similar environment. Team objectives would have been shared by the specialty lead at urology team meetings. I would have expected the appraisal would have included a discussion on relevant access targets and included reference to any relevant patient administration issues. In keeping with national best practice at the time, we did not impose performance objectives on any given consultant but rather encouraged a meaningful discussion between appraiser and appraisee to work towards continually improving performance in a supportive manner.

43.2. Relevant clinical indicators were measured across all surgical specialties and included regionally agreed parameters such as VT prophylaxis, infection control and mortality. These measures were determined by the Department of Health NI to ensure consistency of reporting across all Trusts within Northern Ireland. The Trust performed well in these areas during the time period when I was involved, from 2015 to early 2018. Performance targets regarding urology were monitored internally by the Directorate and externally by the Commissioning Board. The relevant Clinical performance indicators were published in the annual Trust quality reports and as part of the CHKS peer comparator report. Performance waiting time figures would have been held by the Trust Planning and Performance Directorate and by the Commissioning Board. Individual performance figures would have been reviewed at annual appraisal where it was the individual consultant's responsibility to ensure the relevant performance figures to their practice were available for review and discussion

with their appraiser. I would have expected the appraisers to have actively looked for such performance data at the time of appraisal such as complications during surgery, returns to theatre, morbidity, and mortality review. They would also have been expected to look for evidence of good practice regarding patient administration.

43.3. All of this would have been in line with best recommended practice for consultant appraisals. In my own opinion, the system is too dependent on the view of an individual appraiser and consultant. I believe there should be more direct guidance from the Department of Health over speciality specific indicators, possibly in association with the Royal Colleges. To date, the emphasis has always been on local consensus among teams. It would be very difficult for an individual Trust to move forward in this direction unless it was part of a regional or national plan. Introducing such a change would, however, bring the benefit of making peer comparison across the United Kingdom much simpler. For some specialities, agreeing the correct indicators would be problematic because of the lack of easily measured indicators, but for others (including many of the surgical specialities like Urology) this ought to be relatively straightforward, e.g., return to theatre data, mortality, wound infection, late diagnosis of tumour recurrence, etc. It is vitally important that any such change would be introduced regionally and nationally, otherwise there would be a postcode lottery of performance data which would not be helpful for patients nor indeed for recruiting or retaining staff.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

44.1. The cycle of Appraisal was, I believe, managed effectively with almost 100% appraisal returns made each year for medical staff. From a process perspective, this worked well when compared to peer comparators. Having worked in other trusts (Belfast 2005-2015; South Eastern 1993-2005) I believed there was a good level of administrative support in place for the doctors concerned. My sense was that system of appraisal was more efficient and reliable than was usually the case in the UK. I had been involved as the Northern Ireland representative on a national assessment of appraisal across all four UK

nations (2015) and that experience led me to conclude that the process of appraisal was well managed in SHSCT.

44.2. The quality of appraisal was reviewed regularly and systematically by our two consultants and one Associate Specialist appraisal lead who would check appraisal folders against agreed criteria in preparation form revalidation. Once all the documentation was in order, I met consultants just before their five yearly revalidation date before making the appropriate recommendation to the GMC. I note that Mr O'Brien's most recent revalidation date pre-dated my period as Responsible Officer and Medical Director

44.3. During my tenure, we implemented a goal that a doctor should not be appraised by the same appraiser for more than three years in succession to encourage a degree of appropriate challenge. Whilst we had moved significantly to implement this by 2018, we had not yet reached the stage where this was universally applied due to the limited available number of appropriately trained appraisers.

44.4. Job planning had been challenging. Not every doctor received an updated job plan every year as was recommended. This was, in part, due to the restricted amount of time allocated to Clinical Directors and Associate Medical Directors to carry out the function of job planner. In April 2018 I began a major review of job planning within the Trust in which I held regular meetings with the relevant leads to improve the process. We did achieve significant improvement across the Trust but job planning within surgery proved challenging due to vacancies and high turn around within the clinical leadership team.

44.5. Many changes to the online 'Zircadian' job planning system were introduced in a bid to streamline the system. However, suffice to say we still had not reached the point where every consultant had a refreshed job plan signed off each year. The period that the Clinical Director posts were vacant within the surgical team was a factor in the team's relatively poor performance in this area. In early 2018 I made a bid to the Senior Management Team for two Deputy

Medical Director posts, one of which would have assumed responsibility for Job Planning to give a renewed focus on this. Unfortunately, this was unsuccessful at that time mostly because of financial constraints. I am pleased that this progressed further after I retired but regret that this measure was not implemented earlier.

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1. Concerns could be raised through a number of channels. If an incident occurred, the Datix Reporting system was the preferred route for reporting. Such incidents would have been reviewed regularly by the Acute Service Directorate Governance teams. Dr Tracey Boyce was head of Acute Governance (Lead Pharmacist). For medical staff there would have been opportunities at urology team meetings. Concerns could be raised through the Clinical Director (Mr Weir) or Head of Service (Mrs Corrigan) and then to the Associate Medical Director (initially Mr Mackle) and/or Assistant Director (Mrs Trouton and then Mr Carroll) and Acute Services Director (Mrs Gishkori). As Medical Director, I would have expected significant concerns to be escalated to me via the Associate Medical Director and/or the Acute Services Director. These were recorded formally within the Oversight team meetings which have been provided. The GMC and NIMDTA and RQIA performed regular inspections which highlighted areas of concern and also good practice.

45.2. Junior medical staff could respond to anonymous GMC surveys which were regularly sent to them. Simon Gibson (Assistant Director, Medical Director's office) would meet regularly with junior doctors in small groups to listen to their issues. The Datix reporting system was widely implemented with ALL staff

encouraged to report concerns through this computer terminal based system. This had the advantage of being quick and trackable. Often, the best way to raise concerns would be through normal departmental team meetings with the Clinical Director and/or Head of Service. Such meetings would usually be minuted.

45.3. For those staff who felt uncomfortable with this there was the option of a clear whistleblowing system which offered significant anonymity and protection to the complainant if appropriate.

45.4. In my experience (which was almost exclusively in relation to medical staff), significant concerns were most frequently and effectively raised through the Clinical Director. Usually, they were able to address most issues raised locally, but if this was not possible then the Clinical Director could escalate via their Associate Medical Director. They in turn could escalate concerns directly to the relevant Service Director or to me as Medical Director or to both of us. Relevant documentation would include the Datix records (IR1s) which can be provided by the central governance team. One example would be the Emergency Department service in Daisy Hill Hospital in 2017. Concerns were brought to me by one of the consultants via their Clinical Director and Associate Medical Director over staffing issues and possible safety implications. I discussed these with the Chief Executive and formally escalated these to the Senior Management Team. The concerns were so significant that the Acting Chief Executive (Stephen McNally) and I took these directly to the Permanent Secretary (Mr Pengelly) and Chief Medical Officer (Sir Michael McBride). This resulted in a major programme of reform and resource known as the ‘Daisy Hill Pathfinder Project’ which looked at the whole acute service pathway for Daisy Hill.

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

46.1. As Medical Director my immediate line manager was the Chief Executive. This role was sequentially held by Paula Clarke, Kieran Donaghy, Francis Rice, Stephen McNally, and ultimately Shane Devlin.

46.2. I found all of them to be individually supportive, however, the rapid turnover of chief executives during the relevant time period was not helpful in forming close working relationships. During the relevant period, Mr Mackle stood down from his role as AMD and after that I supported Mr Haynes formally and informally as he took on the AMD role.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you liaised with, involved, and had meetings with the following staff (please name the individual/s who held each role during your tenure):

1. **(i) The Chief Executive(s);**
2. **(ii) the Director(s) of Acute Services;**
3. **(iii) the Assistant Director(s);**
4. **(iv) the Clinical Director**
5. **(v) the Associate Medical Director;**
6. **(vi) the Head of Service;**
7. **(vii) the Clinical Lead;**
8. **(viii) the consultant urologists.**

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on

matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

(i) I had regular, formal, 1:1 meetings with the various Chief Executives over the three-year period from 2015-2018. My office and the Chief Executive's office were co-located on the same corridor so there were plentiful opportunities for less formal engagement. We formally met as part of Senior Management Team (SMT) on a weekly basis. The Chief Executive role was quite fluid during my tenure changing from Paula Clarke ,Kieran Donaghy, Francis Rice, Stephen McNally and then Shane Devlin. Francis Rice was the Chief Executive in post when I became aware of issues related to Mr O'Brien. He then went on Personal information leave, so I liaised with Stephen McNally and then Shane Devlin.

(ii) The Director of Acute Services (Mrs Gishkori) and I had intermittent 1:1 meetings around matters of mutual interest. In addition, we met weekly at Senior Management Team meetings and Trust Board on a monthly basis. There would be many other meetings on a given week where we would both be present. Mrs Gishkori would have attended most of the Oversight Committee meetings between October 2016 to January 2017 regarding Mr O'Brien but also many of the other Oversight meetings prior to this in relation to other unrelated cases. We would occasionally have met informally for coffee in the Canteen. Our discussions regarding the urology issues were mostly centred around the Oversight Committee meetings

(iii) I had no formal, direct, 1:1 meetings with the Assistant Directors of Surgery but would have engaged with them frequently most weeks at various meetings of common interest. They would occasionally have deputised for Mrs Gishkori (e.g., Mr Carroll attended the first relevant Oversight Committee meeting in September 2016). They would have met with me

regularly regarding other governance issues such as the Daisy Hill Pathfinder Project.

(iv) I would have regular 1:1 meetings with all my Clinical Directors when in post. I would have also engaged with them at medical staff meetings. Both Daisy Hill and Craigavon Hospitals held monthly Medical Staff Meetings which most of the CDs and I would have attended.

(v) I met with my Associate Medical Directors as a team monthly in a formal recorded meeting. These were usually held for 2 hours on a Friday afternoon. In addition, I held regular 1:1 meetings with all my Associate Medical Directors. The AMDs and I would have attended most medical staff meetings held monthly in Daisy Hill and Craigavon. There would be multiple other opportunities during a given week to engage at a variety of other meetings (e.g., Drug and Therapeutics committee meetings). In addition, I encouraged them to contact me directly by email or telephone regarding any issue of concern. The Urology issue was discussed mostly at the Oversight Committee meetings which Mr Haynes was often invited to when Mr O'Brien was being discussed. Mr Haynes would contact me from time to time by telephone to ask for advice about many matters including Urology.

(vi) I would meet service heads only intermittently as I had no direct line management responsibility for them.

(vii) (and (viii)) I would only meet the Clinical lead occasionally. I would have expected him to relay messages via the Clinical Director and AMD. The same applies for the consultant urologists. However, I communicated regularly to all medical staff with email newsletters regarding issues affecting medics and made it clear that I encouraged an open-door policy for any of them to contact me if required with a concern. I met with all Consultant and SAS (Staff -grade and Associate Specialist) staff prior to each of their revalidation dates.

Urology Services Inquiry

48. "Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

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

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain."

48.1.

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

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

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

(d) See (c).

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

(f) See (e).

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

(h) See (g).

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

(a) properly identified,

(b) their extent and impact assessed,

(c) and the potential risk to patients properly considered?

49.1. The whole purpose of the MHPS process that the Oversight team initiated was to identify the extent and nature of any deficiencies. I was not in post when this report was completed but on recent reading of the conclusions, they seem appropriate in my opinion. The interim measures put in place by the directorate team with monitoring arrangements seemed to initially work well for as long as my period of responsibility continued until February 2018. Reports were provided by the Head of Service (Martina Corrigan) to the Acute Services Director (Esther Gishkori) to indicate same.

49.2. I was not involved in the Serious Adverse Incident (SAI) Root Cause Analysis review apart from recommending Dr Johnston as an appropriate advisor and chair. I did not see the conclusions until I was compiling this report as I had left the Trust before it reported. I understand now that the Acute Services team were aware of many of the issues for some period of time and had attempted to address them. I believe that once it became apparent the remedial measures put in place were not successful, the issues should have been escalated earlier.

49.3. I am conscious that there were several changes in clinical leadership roles within Acute Services over the relevant time period, 2016 - February 2018, especially in relation to the Associate Medical Director role and Assistant Director, which may have impaired the free flow of information between Acute Services and myself over the months March 2016 - September 2018. It is my opinion that the remedial action informally taken, up to September 2016, was ineffective. The potential implications for patient safety were not fully appreciated until Mr Haynes became Associate Medical Director (I believe this was in September 2018). He was coincidentally a Urologist which would have given him a good insight into the significance of Mr O'Brien's poor administration practice. Mr O'Brien's variation from best practice should never have been tolerated once identified. If the Service Directorate were unable to deal with the issues satisfactorily the matter should have been escalated formally to me much sooner.

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

50.1. My main direct level of support was to the Associate Medical Director Mr Haynes and Clinical Director Mr Weir which I did informally on a 1:1 basis between 2015-February 2018. The Associate Medical Director and Clinical Director for the service would in turn be responsible for offering support to their respective teams. I am unaware of what was in place before or after this time period. The support mechanisms for the Consultant staff would normally be delegated through the Associate Medical Director and Clinical Director.

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

51.1. Yes. There was a Trust-wide quality improvement (QI) programme which was available to all clinical staff with Quality Improvement (QI) expertise and training for relevant QI qualifications. I sponsored an ADEPT clinical leadership fellow specifically in the Urology service who led on an important QI project regarding lithotripsy. We were the only Trust in all of Northern Ireland to invest and support a surgical trainee as an ADEPT fellow. There was an annual Quality Improvement Trust Conference which showcased achievements and best practice. The Urology team won the Chairman's award for Innovation in 2016/17 receiving a cash injection into the unit as a prize.

<u>Mr. O'Brien</u>

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly

basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

52.1. I was Mr O'Brien's Medical Director and Responsible Officer from July 2015 until February 2018.

52.2. As such I had a responsibility to ensure that he performed his medical duties in accordance with the Good Medical Practice requirements of the GMC. I had an obligation to ensure he undertook an annual appraisal. I, along with the Acute Services Director, undertook to ensure the environment in which he worked was safe appropriate for the duties we required of him. I was responsible for infection control standards within the Trust. I had a responsibility to develop medical staffing and recruitment. I had not knowingly met Mr O'Brien until I came to the Trust in July 2015.

52.3. Until the start of the MHPS inquiry I believe that I encountered him less than half a dozen times. For example:

i. I met him while delivering a training session regarding the management of private patients that we required all our consultants to attend.
ii. I recall meeting him on one of the surgical wards as I was walking through when I asked him to comply with infection control standards and remove his jacket.
iii. I met the entire team of urologists in 2015 for an hour when he was present.
iv. I believe we both were invited guests at the Trust Chair's birthday celebrations at a large private function in a hotel, but I do not recall encountering him directly on that occasion [redacted] Irrelevant Information Redacted by the USI
v. I had an email exchange regarding the implementation of new policies and corresponded with him regarding a report for the Trust legal team and a few other email exchanges regarding reviewing investigation results.
vi. I met formally with him, accompanied by his wife, in Trust Headquarters on 30th January 2016. Lynne Hainey was present from Human Resources. This was in relation to initiating the formal MHPS process.

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

53.1. My role in job planning was in overseeing and improving the job planning system. I chaired the Associate Medical Directors' Job planning task group which agreed overall principles in 2017/18. Usually, an individual's job planning meeting would have been with their Associate Medical Director or Clinical Director. The Surgical team had some of the lowest levels of job planning updates within the Trust largely due to unfilled Clinical Director posts and sick leave. During 2017/18 this was being actively addressed but somewhat hampered by temporarily unfilled posts in the medical management chain. There was a regular focus on improving this situation among the Associate Medical Director team.

53.2. In 2018 on my return from Personal Information leave I held several rounds of support meetings with the all the Clinical Directors specifically to improve the level of timely job planning. This was partially but not completely successful with the surgical team proving the most challenging area to improve. I had no direct role in Mr O'Brien's job planning. That would have fallen to the Clinical Director or Associate Medical Director. I was aware that Mr Weir had met with him to discuss an updated job plan but that there were a few unresolved issues which prevented full sign off. I discussed Mr O'Brien's job plan with him at our meeting on 30th January 2017, at which he indicated that it was appropriate for the work he was asked to carry out.

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

54.1. I was alerted to some concerns regarding Mr O'Brien at a meeting with Mrs Trouton in January 2016. At that stage we agreed that in the first instance Mrs Trouton would write to Mr O'Brien outlining the nature of the concerns and instructing

him to amend his practice to come into line with his colleagues and the principles of 'Good medical Practice.'

54.2. I incorrectly assumed that issue had been resolved until Mr Haynes raised the full extent of the unresolved issues with me in early September 2016. Mr Haynes described the issues to me by phone in early September 2016. The issues were outlined in Mr Weir's report *located in Relevant to HR, Reference No 1, MHPS Investigation, MHPS Investigation, AOB SCREENING REPORT MHPS* and were discussed at the Oversight meeting which was held in September 2016. I saw this report at that Oversight meeting on 13th September 2016 which was minuted. As indicated above, I cannot recall the detail of the initial meeting with Mrs Trouton in January 2016 other than her witness statement to the MHPS investigation.

54.3. The governance reports that had been presented to the senior management team had not identified any alarming trends.

54.4. Having now read the SAI reports and Case Manager's MHPS report (for the first time within the last few weeks) it is apparent the issues were in existence for many years prior to me coming into post as Medical Director in 2015 but I did not appreciate the full extent of this before this. At the first relevant oversight meeting in September 2016 we were informed of the March 2016 letter from Mrs Trouton and Mr Mackle to Mr O'Brien. I had incorrectly assumed that the problems identified extended over a few months or possibly up to a year before March 2016.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

55.1. Mrs Trouton (Assistant Director) recalls a meeting with me in January 2016 in which she informed me of ongoing issues with Mr O'Brien's practice. I cannot recall the detail of this meeting but she states that we agreed that she should

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

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

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

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

55.5. In addition to this:

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

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

iii. On 15th September 2016 I had an Email communication with Mrs Gishkori (Acute Services Director).

iv. In January/February 2017 there were informal conversations with Mrs Vivienne Toal (HR Director) regarding the appointment of a Case Investigator.

v. Mr O'Brien wrote to me in February 2017 regarding some issues he had with the MHPS process to which I then replied.

vi. I emailed Dr Khan, the Case Manager, on 21st February 2017 referring to a discussion I had with trust legal advisors after Mr O'Brien had expressed concerns to Mr Wilkinson about the role of Mr Weir as Case Investigator.

vii. I met with Mr Devlin (the new Chief Executive from 2018) just after his appointment as Chief Executive to brief him on doctors of concern, at which meeting I informed him that Mr O'Brien was the subject of an ongoing MHPS process.

viii. I had a brief conversation with Dr Chada (Case Investigator) to ask how the investigation was progressing in the spring of 2017, to which she responded that progress was slower than she had hoped as there were difficulties in agreeing interview dates.

ix. I believe I also asked Dr Khan (Case Manager) how the investigation was progressing in spring 2017 when I met him for one of our regular AMD 1:1 meetings. This would not have been the focus of our discussions

x. I met with Mrs O'Brien at her request just after I retired at Trust Headquarters in early September 2018.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

56.1. Initially the issues raised by Mrs Trouton appeared easily remedied and we agreed that a letter be sent to Mr O'Brien outlining the issues and asking him to amend his practice. I cannot recall the details of this meeting but assumed (incorrectly with hindsight) that the issues had been addressed.

56.2. After hearing from Mr Haynes of the nature of the concerns in early September 2016, I spoke with Mrs Toal (Human Resources Director) and Mr Gibson (Assistant Director) to arrange an Oversight meeting on 13th September 2016 to discuss the way forward. At that meeting initial findings of concern were shared with the team by Mr Carroll (Assistant Director) from Acute Services.

56.3. Oversight team meetings then followed on:

- 12th October 2016
- 22nd December 2016
- 10th January 2017
- 26th January 2017

56.4. A series of Oversight meetings followed until on December 22nd the preliminary findings of a Serious Adverse Incident (Patient 10 were shared. The Oversight team decided to implement an investigation into the concerns under the 'Maintaining Higher Professional Standards' Framework. A Case Investigator and Case Manager were appointed and a Non- Executive Director. Mr O'Brien was initially excluded from work for a period of four weeks but then encouraged to return with a number of restrictions and support measures in place. When I was in post, monitoring arrangements indicated that Mr O'Brien was complying with the risk mitigation measures in place to ensure patient safety. I responded to Mr O'Brien's concern regarding Mr Weir as Case Manager by asking Dr Chada to assume that role in February 2017. Regarding any concerns Mr O'Brien had in relation to his patients, I indicated that the Directorate were putting plans in place to cover his absence from work at the meeting with him on 30th January 2017.

56.5. I had retired before the outcome of the MHPS process was known.

56.6. The direct action described above is captured in the Oversight team minutes and in the minutes of the meeting with Mr O'Brien on 30th January 2017 and

in the subsequent response to him in March 2017. An email documenting the change of Case Investigator decision was sent from me to Dr Khan on 21st February 2017.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this? If none, please explain.

If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

57.1. Yes; the issue was considered.

57.2. I was reassured by Mr Weir's assessment that the issues raised were largely administrative and that no patient safety issues had arisen. The Acute Services Directorate had put a number of measures in place to triage patients appropriately and address the other administrative concerns raised. We believed in 2017 that the support measures put in place around Mr O'Brien were sufficient to ensure safe working practices as the investigation continued. This recovery plan was instituted by the Acute Services Directorate team as they were responsible for delivering the clinical urology service and had the relevant expertise at hand. They monitored these support measures weekly and reported monthly to the Case Manager. Upon Mr O'Brien's immediate return to work, initial updates were provided to the Oversight team. The primary responsibility for establishing and maintaining mitigating and support measures in place lay with the Acute Services team under the leadership of Mrs Gishkori (Acute Services Director) and assisted by Mr Carroll (Surgical Assistant Director) and Mrs Corrigan (Head of Service).

57.3. As a consequence of an investigation carried out by an incident raised by one of the urology team it became clear there were some further patients that may have had a delay in treatment which could potentially have affected their

outcomes. In response to this, a further Serious Adverse incident review was instituted. I was asked to advise on an external chair and suggested Dr Julian Johnston a former colleague from Belfast HSC Trust who had considerable experience in risk management. This investigation did not conclude until after I had retired.

57.4. The primary responsibility for carrying out a risk assessment would be with the Operational Service Director and her team, however, with hindsight I regret not being more proactive in asking to see evidence of same. I accepted the assurances given to me by the Acute Services team.

58.If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

58.1. With regard to the concerns raised by Mr. O'Brien, the oversight team appointed Dr Chada as the new Case Manager instead of Mr. Weir in February 2017. Mr. O'Brien expressed concerns regarding the management of his patients at our meeting on 30th January 2017. These concerns were already shared by the Oversight team and the senior management team in Acute Services. The Acute Services team already had a plan in place to manage his patients as Mr. O'Brien had been on Personal Information leave for some time. It was partly through this process of other urology Consultants reviewing his patients that many of the issues of poor patient administration on Mr. O'Brien's part were identified.

59.What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

59.1. This would primarily have been the responsibility of the Acute Services Senior Management Team. When Mr. O'Brien was planned to return to work the Acute Services Management Team brought a return to work plan to the Oversight team. Subsequent to his return, they would have monitored those arrangements weekly and reported to Dr Khan, the Case Manager.

59.2. The Return to Work plan and Monitoring arrangements required strict compliance around the triaging of referrals, contemporaneous note keeping, storage of medical records, and private practice.

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

60.1. The Oversight Committee on 26th January 2017instructed Mrs Gishkori (Acute Services Director) and her team to put a manageable return to work plan in place and to monitor its implementation on a weekly basis. This was to facilitate Mr O'Brien's return to work on 28th January 2017. The results of the monitoring process would be shared with Dr Khan the appointed Case Manager. Mrs Corrigan (Head of Service) and Mr Carroll (Assistant Director) would lead operationally on ensuring the data was acquired to evidence compliance.

60.2. With regard to concerns raised by Mr O'Brien, the Acute Services team were actively monitoring Mr O'Brien's patient administration by means of weekly monitoring through the 'return to work' plan, developed in January/February 2017. This was monitored weekly and the results shared with the Acute Services Director and also the MHPS Case Manager, Dr Khan. Mr Carroll had met with the other members of the Consultant urology team to galvanise their assistance in addressing the issues of concern. This happened in early January 2017, and ended with a workable plan to address the unresolved issues.

Urology Services Inquiry

61.Did any such agreements and systems which were 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?

61.1. The interim measures put in place by Acute Services were actively monitored by the Acute Services team until I went on Personal information redacted by USI leave in February 2018. Monitoring indicators demonstrated good compliance during this period indicating that these measures were effective at that time. I have no knowledge of what happened after that period.

61.2. With hindsight a formal monitoring arrangement should have been put in place of the issues raised as soon as they were recognised to ensure that they were being addressed.

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

62.1. Yes. Mr O'Brien expressed concern for his patients at the time that I met him with Lynne Hainey on 30th December 2016 explaining the need for the MHPS process and informing him of his temporary exclusion from work.

62.2. At that time, he had not returned formally from a period of extended Personal Information redacted by USI leave. I explained to him that the Acute Services Directorate had been instituting a plan to deal with his patients during his period of Personal Information leave and that this would continue until he returned to work. The details of these arrangements would be known by the Acute Services Operational team who would be better placed to answer this. His clinical reviews would have been distributed among the other urology Consultants. Mr Carroll (Assistant Director) had met the Urologists as a team

in early January 2017 to agree how this would work and how they would be remunerated for the extra work required achieve this.

62.3. However, before Mr O'Brien returned to work, a specific return to work plan was developed, primarily by Mr Carroll (Assistant Director) to address the known patient administration issues. This was monitored on a weekly basis with Mrs Corrigan (Head of Service) taking the lead on this.

63.Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?
(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?
If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

63.1. Yes:

(a) I was the lead director along with the Director of Human Resources (Mrs Toal) to initiate the MHPS process part of the Oversight team in response to concerns brought to us by the Acute Services Director.

(b) I discussed these with an NCAS representative and informed the Trust Chief Executive and Trust Chair of our decision.

(c) The decision to commence a formal MHPS investigation was based on my advice to the Oversight Committee and the Chief Executive. The main concerns related to untriaged referrals and clinical notes with regard to outpatient attendances but are described in detail in the Oversight meeting minutes and in the Case Manager's MHPS report.

(d) See (c).

63.2. Therefore, I raised concerns to the Chief Executive directly in person between the Oversight meeting of 22nd December 2016 and my call to NCAS on 28th December (the exact date of which is uncertain). The action taken was to ask for an appointed, designated Non-Executive Director to be identified. We informed the Chief Executive of the nature of the concerns and the actions we were instituting i.e., immediate exclusion and launching of an MHPS investigation in consultation with NCAS. The Oversight group had asked the Acute Services team to produce a plan to mitigate the effects of the concerns identified.

63.3. I also met briefly with Mrs Brownlee, the Trust chair to inform her of our decision.

64.What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1. My involvement spanned from January 2016 to February 2018. The Oversight Team, which included the Director of Human Resources, and I offered various avenues of support to Mr O'Brien both verbally at the time of my face-to-face interview on 30th December 2016 and in a follow up letter.

64.2. This included access to staff 'care call'. Mr O'Brien was encouraged to bring a supporting friend or colleague to all meetings related to the process. This was an option he did avail of, bringing Mrs O'Brien with him to our first meeting on 30th January 2017. I understand that, during the MHPS process, he brought further family members with him to interview.

64.3. Before his return to work we specifically ensured that the occupational health team were content that Mr O'Brien was fit to perform clinical duties. The Acute Services Director and Assistant Director and Service Manager offered professional support when appropriate. In addition, as part of the MHPS process, Mr O'Brien was able to contact Mr Wilkinson (designated Non-Executive Director) directly with any

ongoing concerns. I am aware that Mr Young, his colleague and Urology team lead, had a strong track record of supporting him. I understand that Mr O'Brien was a personal friend of the Trust Chair, Mrs Brownlee, but I am not sure what direct support, if any, that she may have offered.

65.How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

65.1. Mr O'Brien raised some concerns about how his patients were to be cared for during his four-week period of exclusion in January 2017 and subsequent restrictions on his practice. The Acute Service directorate developed a plan in place to care for those patients within the urology team. Access times and medical staffing issues were generally on the corporate risk register and reviewed frequently, but there were no specific issues related to consultant urology between September 2016 and 2018. It would have been normal practice for the director of the relevant Service to bring such issues forward through their governance team. The Acute Services Director would be able to comment in detail on their own service risk register.

65.2. During the time period of my own involvement, I don't have any recollection of the concerns regarding Mr O'Brien being placed on the risk register, nor can I find evidence of same. It would not have been normal practice for issues that were the subject of an ongoing investigation to be placed on the risk register before a determination had been reached unless there were immediate safety concerns raised. We were being given assurances from the informal investigation by Mr Weir initially and eventually by the Case Manager, Dr Khan, that there were no immediate safety concerns. We were also reassured by the Acute Service Director (Mrs Gishkori) and her team that, during the investigation, Mr O'Brien was fully compliant with his return to work plan.

65.3. It is possible that the matters were discussed in confidential sessions of the Trust Board but I have no definite recollection of same.

65.4. I am always reluctant to raise such cases in a public forum prior to a determination being made to allow the case investigation to proceed in a confidential and unbiased manner.

65.5. I cannot meaningfully comment on events after February 2018 as I was no longer acting as Medical Director at that stage and not part of the ongoing process.

Learning

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

66.1. I have no knowledge of governance concerns which may have arisen after I left the Trust in 2018 apart from what was reported in the press. At the time I retired in 2018 there was an ongoing MHPS investigation which had not yet reported and there were modifications to Mr O'Brien's practice in place to ensure patient safety. There was evidence at that time that those measures were effective at ensuring patient safety.

66.2. I now appreciate that the concerns raised were known in the service directorate for much longer than I initially appreciated

66.3. I have reflected upon the findings of the Serious Adverse Incident Root Cause Analysis reviews that reported in 2020, two years after I had left the Trust. In relation to SAI Personal information redacted by USI, I concur with Dr Johnston's learning points and recommendations which largely centre around communication between teams and particularly when involving teams from other trusts. Referral by conventional letter is no longer appropriate. Electronic means of referral is much easier to track and respond to and quicker to action. Since 2016 there have already been huge improvements in this area with the consolidation of the electronic care record and

development of the 'encompass' programme. Clearly, there is a need for the Trust to develop written guidelines for discharge letters and other email correspondence between clinicians.

66.4. I regret that this was not put in place sooner. However, I note that the GMC has clear guidance around such matters to which all doctors must work. These were in place long before 2016.

66.5. With regard to SAI Personal information redacted by USI, I concur with the recommendations and guidance. A clearer and more robust process for triage of urology referrals should be developed and monitored with clear escalation policies, where variation exists, ultimately to Medical Director and Chief Executive levels if necessary. Electronic referral from GPS in my opinion would facilitate this and should be considered as part of the Encompass development project. I regret that there was not a clearer specific escalation policy in place at the time of this incident.

66.6. With regard to review S Personal information redacted by USI I concur with all the recommendations, many of which overlap with Personal information redacted by USI. With regard to recommendation 10, I strongly endorse this. We had worked hard to develop an open and transparent culture of discussing concerns amongst the medical staff, which for the most part appeared to work well as evidenced by our response to the Emergency Department and Breast Surgery issues which occurred over a similar time period.

66.7. The delays in triage adversely were important considerations for the outcome of several patients who presented between 2015-2016. Had these been highlighted to me I would have convened an Oversight meeting sooner and initiated the formal MHPS process sooner, insisting on a recovery plan.

66.8. A clear unambiguous escalation policy to Medical Director level would have facilitated earlier resolution of these issues, as if I had known that they had been unresolved, a formal process would have started much earlier.

66.9. Further work needs to be done to ensure that doctors and other staff feel comfortable about escalating concerns, even about close colleagues, where patient safety may potentially be at risk.

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

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

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

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

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

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

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

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

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

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

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

issues are not so easily separated. One solution would be to have a medically qualified person in sole charge to make the reporting lines clear and simple.

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

68.1. Performance issues affecting doctors should be considered by the Oversight Committee from the outset when they become apparent. The Service Director and Associate Medical Director need to highlight such issues at an early stage.

68.2. The Trust needs to continue to build trust and expertise and capacity to address performance issues with doctors and needs to be seen to address them promptly, effectively and without prejudice.

68.3. Adequate time in job plans and adequate expert administrative support needs to be given to MHPS Case Investigators and Case Managers to allow them to complete their tasks in a timely manner.

69.Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

69.1. In retrospect there were many attempts within the Acute Directorate made to engage with the issues but unfortunately these proved to be less than completely effective. I would expect that similar issues arising again with any member of medical staff would be considered by the Oversight team at the outset and not managed within the Directorate alone.

69.2. The Operational Directorate senior management team should have escalated the persistent variation from best practice earlier. When Mr Haynes took on the role of interim Associate Medical Director the issues were escalated appropriately.

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

70.1. Yes; mistakes were made.

70.2. I did appreciate the full implications of Mr O'Brien's variation from good practice when I was first informed of them in January 2016. I did not keep a minute of the meeting. I incorrectly assumed that the matter would be rapidly resolved and did not proactively check that this was the case.

70.3. The issues around Mr O'Brien's practice should have been escalated to the Oversight committee much earlier. Once it was apparent that informal measures to address the issues had not worked, a formal process should have been considered earlier. I do, however, believe that, once I was notified of the nature of the unresolved concerns around Mr O'Brien's practice, I called a meeting of the Oversight meeting and initiating the steps outlined above. I am convinced that using the MHPS process was appropriate given the gravity of the concerns. I believe that, given the time for the MHPS process to conclude, more time within job plans and administrative support needs to be given to those undertaking such reviews to try and reach a conclusion as quickly as is possible. There could be better guidance developed within the MHPS process to ensure the subject of an investigation responds in a timely manner to requests for interview and written responses.

70.4. I believe that I made a mistake in not more proactively looking for assurances of good practice of medical staff from the Service Director. I was too reliant on the Service directorates 'filtering' issues before bringing them formally to me.

70.5. I should have been more proactive in advising the Trust Chair to ensure that board members' training in MHPS was up to date and appropriate.

70.6. I don't believe the governance arrangements were utilised early enough in this instance. The triage issues in particular were known for too long before formal escalation to myself.

70.7. Within the governance arrangements that were already in place it would have been appropriate and expected that ongoing unresolved issues should have been escalated to me as Medical Director.

70.8. If I was in this situation again I would have brought the issues discovered to Senior Management Team and to the confidential session of Trust Board.

70.9. I would have insisted on regular updated reports of compliance with the return to work plan and restrictions around Mr O'Brien's practice to be considered during the MHPS investigation.

70.10. The role of appropriately trained senior medical staff is crucial so an ongoing training programme for managing concerns regarding doctors' practices needs to be strengthened further The Oversight committee (of which I was joint chair) needs to find a means of tracking progress of MHPS investigations more systematically without unduly interfering in what must be an impartial process. I was not in post after February 2018 so cannot meaningfully comment on what happened after that in this specific case.

70.11. I believe the management structure did not support good governance arrangements. The Associate Medical Directors had to report to the Acute Services Director for operational and many governance issues and to me for professional issues. A more streamlined reporting pathway would have been simpler and clearer.

This could have been achieved if there was a medical lead to the Service Directorate.

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

71.1. No; they were not fit for purpose. By 2018, it was generally accepted by members of the Executive Team that the Trust internal governance arrangements needed review. It is self-evident that the governance arrangements did not appropriately identify and remedy the issues described in the MHPS report. I am aware that, at the time, I was leaving the Trust in 2018, Mr Devlin (Chief Executive) was about to conduct a review of governance arrangements, however, I have no knowledge of the outcome of that process.

71.2. In relation to reporting lines, see my earlier answers including those to Questions 67 and 70.

71.3. I believe that, in hindsight, I was too reliant on issues of concern being escalated to me from the directorates at their initiation. If I was in post again, I would put in place a system of proactively inspecting professional governance arrangements directorate by directorate to identify issues at an earlier stage.

71.4. I believe that, in my time as Medical Director, we managed to completely reform the team dynamics of the senior medical leadership team at AMD and Clinical Director level, building trust and confidence, however, much more needed to be done to embed a culture of trust.

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

Urology Services Inquiry

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

Statement of Truth

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

Signed [redacted] Personal Information redacted by the USI

Date: 16th June 2022_____

Section 21 Notice Number 27 of 2022

Attachments

Attachment	Document Name
1.	Final Brochure AMD and CD Development Programme January 2017‘
2.	RW Appraisal

Southern Health and Social Care Trust

Quality Care - for you, with you

Medical Director's Office

Trust Development Programme for Associate Medical Directors and Clinical Directors - 2017

January 2017

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Message from the Medical Director

Dear Colleagues

It is with great pleasure that I announce the launch of our Trust Development Programme for Associate Medical Directors and Clinical Directors.

This programme is the product of several months planning with colleagues from within my own office and also the Trust's Education, Learning and Development Team. A short-life working group was established, the remit of which was to review the role descriptors of both AMDs and CDs and, as a result, a series of key subject areas were identified. These subjects cover many of the domains proposed in the 'Framework for Generic Professional Capabilities' in the Association of Medical Royal College's and the General Medical Council's public consultation document (click here) each of which have specific themes and required outcomes (see figure 1 below).

Figure 1: Proposed Framework for Generic Professional Capabilities

Further, the GMC's Core Guidance "Leadership and Management for all Doctors" (GMC, 2012 click here) states that being a good doctor means more than simply being a good clinician. In their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer. This guidance sets out the wider management and leadership responsibilities of doctors in the workplace including:

- Responsibilities relating to employment issues
- Teaching and training
- Planning, using and managing resources
- Raising and acting on concerns
- Helping to develop and improve services

The subjects within this development programme also encompass the domains of the NHS Healthcare Leadership Model which is contained within page 12 of this brochure.

I very much hope you enjoy the programme which consists of four modules being held over four full days, one day per month. Each of the days will be held twice to ensure that all AMDs and CDs can attend all four days. Dates and booking arrangements are on page 11.

I look forward to seeing you during the programme.

Dr Richard Wright
Medical Director

Module 1: Taking Your Service Forward

Quality Improvement

AIMS/OBJECTIVES:

- Understand Quality Improvement Models and how they are applicable to the AMD / CD role.
- Understand how to complete Quality Improvement Projects and be aware of the tools available to assist.

DESIRED OUTCOMES:

- By the end of this session, participants will feel confident in fostering an ethos of continuous improvement and reflection.

Developing Business Cases / Service Improvement Plans

AIMS/OBJECTIVES:

- Understand the principles of developing a Business Case / Service Improvement Plan.
- Understand how to work with colleagues when taking forward implementation plans.

DESIRED OUTCOMES:

- By the end of this session participants will be able to contribute effectively to the development and implementation of business cases / service improvement plans through evidence-based decision-making.

Overview of Budget Management

AIMS/OBJECTIVES:

- To provide participants with an overview of financial / budgetary management and common terminology.

DESIRED OUTCOMES:

- By the end of this session participants will be more confident in understanding and managing budgets, including their legal requirements and responsibilities.

HEALTHCARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 1: TAKING YOUR SERVICE FORWARD

Inspiring Shared Purpose

- Valuing a service ethos.
- Curious about how to improve services and patient care.
- Behaving in a way that reflects the principles and values of the NHS.

Influencing For Results

- Deciding how to have a positive impact on other people.
- Building relationships to recognise other people's passions and concerns.
- Using interpersonal and organisational understanding to persuade and build collaboration.

Evaluating Information

- Seeking out varied information.
- Using information to generate new ideas and make effective plans for improvement or change.
- Making evidence-based decisions that respect different perspectives and meet the needs of all service users

Module 2: Delivering Quality Care

Information Governance

AIMS/OBJECTIVES:

- To provide an overview of legal, statutory and personal responsibilities in relation to all aspects of Information Governance.

DESIRED OUTCOMES:

- By the end of this session, participants will be fully aware of their own and the Trust's responsibilities in relation to Information Governance and the legal implications of non-compliance.

Clinical and Social Care Governance / Safety, Risk and Improvement

AIMS/OBJECTIVES:

- Participants will have the opportunity to consider a range of information and consider how this information informs CSCG priorities within their area of responsibility.

DESIRED OUTCOMES:

- By the end of the session, participants will be fully aware of their own and the organisations responsibilities in relation to Clinical and Social Care Governance.
- Participants will have an opportunity to review and update their areas of responsibility and present CSCG priorities/work plan.

HEALTH CARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 2: DELIVERING QUALITY CARE:-

Evaluating Information

- Seeking out varied information.
- Using information to generate new ideas and make effective plans for improvement or change.
- Making evidence-based decisions that respect different perspectives and meet the needs of all service users.

Inspiring Shared Purpose

- Valuing a service ethos.
- Curious about how to improve services and patient care.
- Behaving in a way that reflects the principles and values of the NHS.

Module 3: Leading Your Team (Day 1)

Job Planning

AIMS/OBJECTIVES:

- To equip participants with the knowledge and skills to effectively manage medical job planning and appraisal within their specialty/division.
- To ensure effective development and delivery of education and research within the specialty / division.

DESIRED OUTCOMES:

- By the end of this session participants will be able to develop effective and accurate job plans to meet the needs of both medical staff and the Trust.

Managing Doctors in Training / Medical Education

AIMS/OBJECTIVES:

- To understand the structure of Medical Education and Training for doctors in training.
- To manage the interfaces and boundaries between the Trust and NIMDTA.
- To be clear on the roles and responsibilities of all medical staff who train junior doctors.
- To be able to implement and monitor Modernising Medical Careers and EWTD for junior doctors.

DESIRED OUTCOMES:

- By the end of this session participants will have acquired the necessary skills and knowledge to be able them to effectively manage doctors in training.

Management of Sickness Absenteeism

AIMS/OBJECTIVES:

- To understand the Trust's Sickness Absenteeism Policy and Procedures and your responsibilities as a manager.
- To understand the role of Occupational Health vis-à-vis sickness absence management.

DESIRED OUTCOMES:

- By the end of this session participants will understand the Trust's Sickness Absenteeism processes and will be aware of their responsibilities when managing staff absences.

Raising and Acting on Concerns / Maintaining High Professional Standards / Disciplinary Procedures

AIMS/OBJECTIVES:

- To be able to manage potential underperformance of medical staff within your specialty / division.
- To be able to take necessary action to address underperformance or unacceptable behaviour.
- To be able to identify and take appropriate action for doctors in difficulty.

DESIRED OUTCOMES:

- By the end of this session participants will have the necessary skills to enable them to identify and act upon concerns at an early stage. They will be aware of MHPS and Disciplinary processes and their involvement in these as well as the protocol to follow for doctors in difficulty.

HEALTHCARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 3: LEADING YOUR TEAM (DAY 1)

Leading With Care

- Having the essential personal qualities for leaders in health and social care.
- Understanding the unique qualities and needs of a team.
- Providing a caring, safe environment to enable everyone to do their jobs effectively.

Developing Capability

- Building capability to enable people to meet future challenges.
- Using a range of experiences as a vehicle for individual and organisational learning.
- Acting as a role model for personal development.

Holding to Account

- Agreeing clear performance goals and quality indicators.
- Supporting individuals and teams to take responsibility for results.
- Providing balanced feedback.

Module 3: Leading Your Team (Day 2)

Teamwork / Engaging and Empowering Staff / Effective Induction

AIMS/OBJECTIVES:

- To be able to understand the principles of effective team working.
- To promote inclusivity, respect and build capability within the team to meet future challenges.
- Have an understanding of the five 'Fundamentals of Civility'.

DESIRED OUTCOMES:

- By the end of this session participants will have the necessary skills to facilitate all individuals within the team to work towards a common goal and to fully promote engagement.

Conflict Management

AIMS/OBJECTIVES:

- To understand various approaches and techniques when managing conflict.

DESIRED OUTCOMES:

- By the end of this session participants will have acquired the necessary skills to confidently address areas / incidents of conflict.

Negotiation and Communication Skills

AIMS/OBJECTIVES:

- To effectively foster multi-disciplinary / inter-divisional team working and promote good working relationships.
- To further develop the above on a specialty / division, Trust, regional and national level.

DESIRED OUTCOMES:

- By the end of this session participants will have the skills to actively promote and develop good working relationships and networks on a local, regional and national level.

HEALTHCARE LEADERSHIP MODEL DIMENSIONS COVERED BY MODULE 3: LEADING YOUR TEAM (DAY 2)

Sharing the Vision

- Communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting.

Engaging The Team

- Involving individuals and demonstrating that their contributions and ideas are valued and important for delivering outcomes and continuous improvements to the service.

Developing Capability

- Building capability to enable people to meet future challenges.
- Using a range of experiences as a vehicle for individual and organisational learning.
- Acting as a role model for personal development.

Influencing For Results

- Deciding how to have a positive impact on other people.
- Building relationships to recognise other people's passions and concerns.
- Using interpersonal and organisational understanding to persuade and build collaboration.

Connecting Our Service

- Understanding how health and social care services fit together and how different people, teams or organisations interconnect and interact.

Module Dates

Module	First Date Module Being Held	Second Date Module Being Held
Module 1: Taking Your Service Forward	Monday 27th February 2017	Tuesday 14th March 2017
Module 2: Delivering Quality Care	Wednesday 22nd March 2017	Monday 10th April 2017
Module 3: Leading Your Team (Day 1)	Friday 28th April 2017	Thursday 18th May 2017
Module 3: Leading Your Team (Day 2)	Tuesday 23rd May 2017	Wednesday 7th June 2017

- **All Modules will take place in the Seagoe Parish Centre, Portadown and will run from 9.30 am sharp to 4.30 pm. Please ensure you arrive at the venue no later than 9.15 am each day.**

- **It is expected that all Associate Medical Directors and Clinical Directors will attend each of the four modules on either one of the dates.**

- **Please email** [redacted] **with your chosen date for each of the four modules no later than Friday 13th January 2016.**

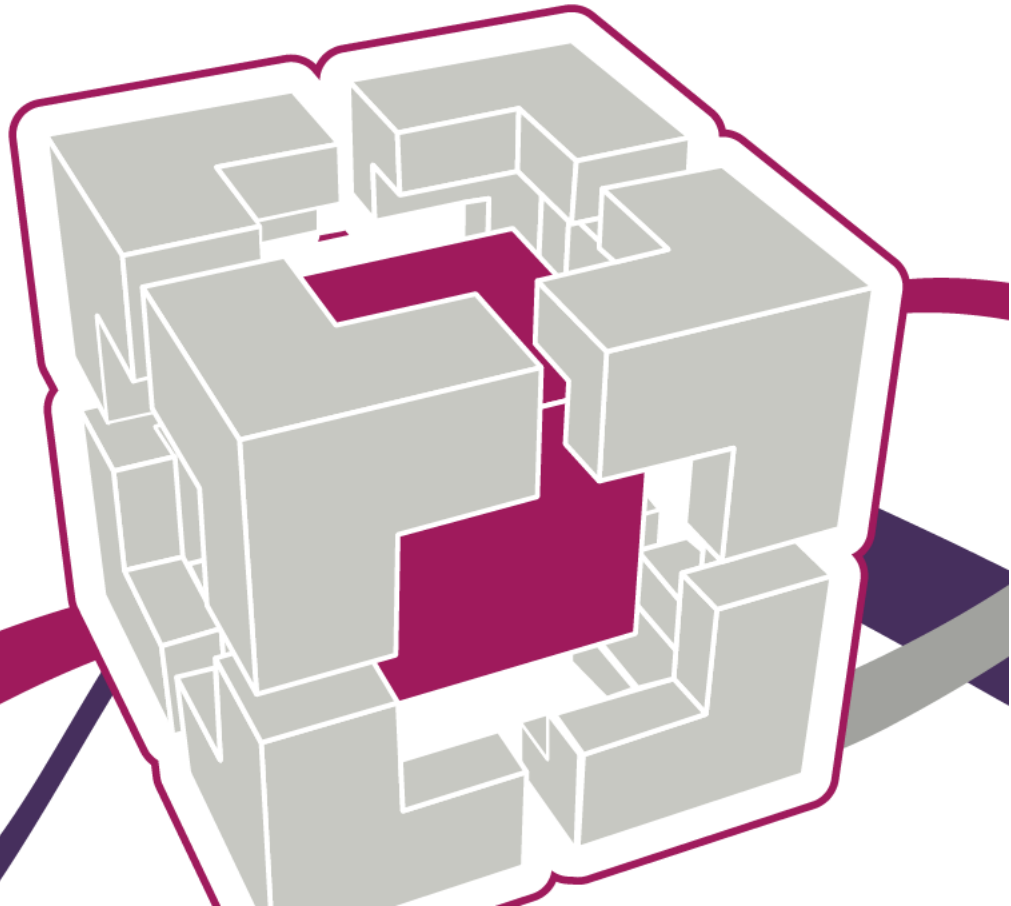
NHS Healthcare Leadership Model

NHS
Leadership Academy

Version 1.0

Healthcare Leadership Model

The nine dimensions of leadership behaviour



www.leadershipacademy.nhs.uk

Publisher: NHS Leadership Academy, No. 3 The Embankment, Sovereign Street, Leeds, West Yorkshire, LS1 4BJ, England.

NHS Leadership Academy (2013), *The Healthcare Leadership Model*, version 1.0, Leeds: NHS Leadership Academy.

Introduction

Who the model is for

The Healthcare Leadership Model is to help those who work in health and care to become better leaders. It is useful for everyone – whether you have formal leadership responsibility or not, if you work in a clinical or other service setting, and if you work with a team of five people or 5,000. It describes the things you can see leaders doing at work and is organised in a way that helps everyone to see how they can develop as a leader. It applies equally to the whole variety of roles and care settings that exist within health and care.

We want to help you understand how your leadership behaviours affect the culture and climate you, your colleagues, and teams work in. Whether you work directly with patients and service users or not, you will realise what you do and how you behave will affect the experiences of patients and service users of your organisation, the quality of care provided, and the reputation of the organisation itself. The nature and effect of a positive leadership style can be summed up as:

Figure 1 : The nature and effect of a positive leadership style

The structure of the model

The Healthcare Leadership Model is made up of nine 'leadership dimensions', each of which has its own page in this document. There is a brief description of what the dimension is about and why it is important, and a section that says 'what it is not' to provide further clarity.

For each dimension, leadership behaviours are shown on a four-part scale which ranges from 'essential' through 'proficient' and 'strong' to 'exemplary'. Although the complexity and sophistication of the behaviours increase as we move up the scale, the scale is not tied to particular job roles or levels. So people in junior roles may find themselves to be within the 'strong' or 'exemplary' parts of the scale, and senior staff may find themselves in the 'essential' or 'proficient' parts. Similarly, you may find where you judge yourself to be may vary depending on the dimension itself. For example, you may be mostly 'strong' in a few dimensions, 'exemplary' in one, and 'essential' or 'proficient' in others. This may be appropriate depending on your job role, or it may show that there are areas that need some development or that are a particular strength.

Within these scales, the leadership behaviours themselves are presented as a series of questions. The questions are short descriptions of what the leadership dimension looks like at each part of the scale. These are the questions that guide leaders' thoughts and result in effective leadership behaviour. They are written in the 'first person' (Do I . . . ?), but are not meant to be answered with a simple 'yes' or 'no'. Instead, they should help you explore your intentions and motivations, and see where your strengths and areas for development may lie. You may also want to think about what evidence you could provide to support your answers.

Research[1] has shown that all nine dimensions of the model are important in an individual's leadership role. However, the type of job you have, the needs of the people you work with, and the context of your role within your organisation will all affect which dimensions are most important for you to use and develop.

The importance of personal qualities

'…the most important element… comes from a combination of emotional expressiveness, self-confidence, self-determination and freedom from internal conflict'[2]

The way that we manage ourselves is a central part of being an effective leader. It is vital to recognise that personal qualities like self-awareness, self-confidence, self-control, self-knowledge, personal reflection, resilience and determination are the foundation of how we behave. Being aware of your strengths and limitations in these areas will have a

[1] Please see Appendix 1 for more information on the research behind the Healthcare Leadership Model.
[2] Bass, B.M (1992), in M. Syrett and C. Hogg (Editors), Frontiers of Leadership. Oxford: Blackwell.

Figure 2 : The impact of personal qualities on the experience of care

direct effect on how you behave and interact with others, and they with you. Without this awareness, it will be much more difficult (if not impossible) to behave in the way research has shown that good leaders do. This, in turn, will have a direct impact on your colleagues, any team you work in, and the overall culture and climate within the team as well as within the organisation. Whether you work directly with patients and service users or not, this can affect the care experience they have. Working positively on these personal qualities will lead to a focus on care and high-quality services for patients and service users, their carers and their families (see Figure 2).

While personal qualities have not been separately highlighted in the Healthcare Leadership Model, you will find them throughout the various dimensions. It is important to realise that areas identified for development within the model may be as much about how you manage yourself as about how you manage your behaviour and relate to other people.

How to use this document

The document illustrates the leadership behaviours expected for all staff in healthcare, so you can use it to help you think about your own leadership behaviours. It will also help you carry out appraisals, and to write documents such as personal and professional development plans, recruitment criteria and processes, educational standards and curricula and training programme materials and criteria.

However, for personal use we are also developing other tools that will more directly help you apply the Healthcare Leadership Model. For example, a self-assessment tool and a 360-degree feedback tool are in development and will have a greater focus on helping individuals to assess their leadership behaviours and more fully understand their leadership development. Please visit www.leadershipacademy.nhs.uk/leadershipmodel for up-to-date information on these tools, as well as other supporting materials.

We would be very interested to hear from anyone using the Healthcare Leadership Model in their work and are planning to collect examples of best practice so that we can share these more widely. If you are interested in sharing how you are using the model, please contact us at leadershipmodel@leadershipacademy.nhs.uk.

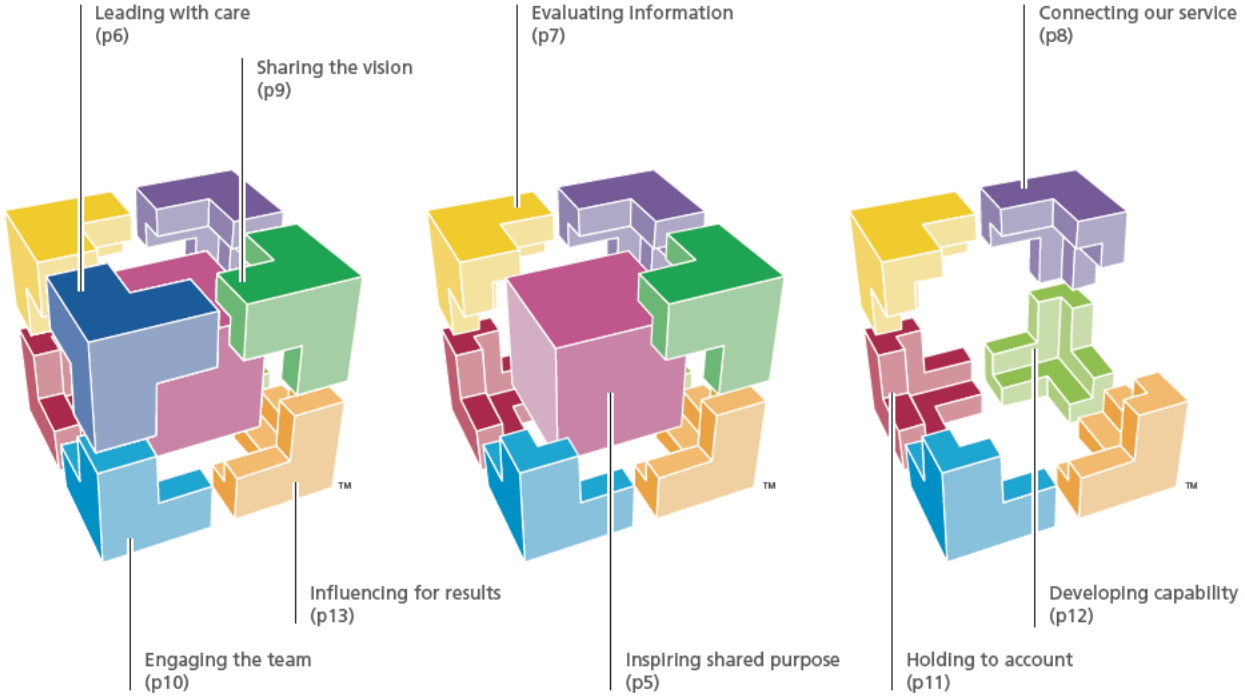
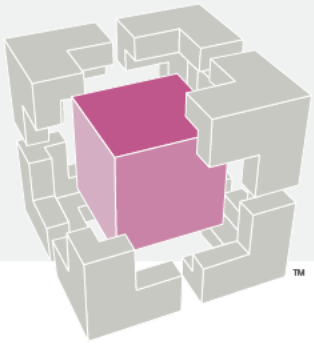


Figure 3 : The nine dimensions of the Healthcare Leadership Model



Inspiring shared purpose

What is it?

- Valuing a service ethos
- Curious about how to improve services and patient care
- Behaving in a way that reflects the principles and values of the NHS

Why is it important?

Leaders create a shared purpose for diverse individuals doing different work, inspiring them to believe in shared values so that they deliver benefits for patients, their families and the community

What is it not?

- Turning a blind eye
- Using values to push a personal or 'tribal' agenda
- Hiding behind values to avoid doing your best
- Self-righteousness
- Misplaced tenacity
- Shying away from doing what you know is right

Essential

Staying true to NHS principles and values

Do I act as a role model for belief in and commitment to the service?

Do I focus on how what I do contributes to and affects patient care or other service users?

Do I enable colleagues to see the wider meaning in what they do?

Proficient

Holding to principles and values under pressure

Do I behave consistently and make sure that others do so even when we are under pressure?

Do I inspire others in tough times by helping them to focus on the value of their contribution?

Do I actively promote values of service in line with NHS principles?

Strong

Taking personal risks to stand up for the shared purpose

Do I have the self-confidence to question the way things are done in my area of work?

Do I have the resilience to keep challenging others in the face of opposition, or when I have suffered a setback?

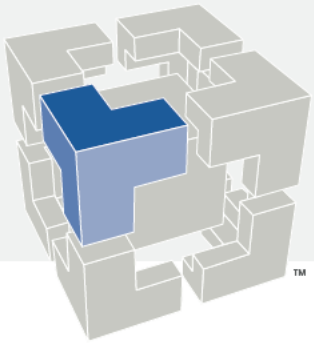
Do I support my team or colleagues when they challenge the way things are done?

Exemplary

Making courageous challenges for the benefit of the service

Do I have the courage to challenge beyond my remit even when it may involve considerable personal risk?

Do I take the initiative and responsibility to put things right outside my remit if I see others fearing to act?



Leading with care

What is it?

- Having the essential personal qualities for leaders in health and social care
- Understanding the unique qualities and needs of a team
- Providing a caring, safe environment to enable everyone to do their jobs effectively

Why is it important?

Leaders understand the underlying emotions that affect their team, and care for team members as individuals, helping them to manage unsettling feelings so they can focus their energy on delivering a great service that results in care for patients and other service users

What is it not?

- Making excuses for poor performance
- Avoiding responsibility for the wellbeing of colleagues in your team
- Failing to understand the impact of your own emotions or behaviour on colleagues
- Taking responsibility away from others

Essential

Caring for the team

Do I notice negative or unsettling emotions in the team and act to put the situation right?

Do my actions demonstrate that the health and wellbeing of my team are important to me?

Do I carry out genuine acts of kindness for my team?

Proficient

Recognising underlying reasons for behaviour

Do I understand the underlying reasons for my behaviour and recognise how it affects my team?

Can I 'read' others, and act with appropriate empathy, especially when they are different from me?

Do I help my colleagues to make the connection between the way they feel and the quality of the service they provide?

Strong

Providing opportunities for mutual support

Do I care for my own physical and mental wellbeing so that I create a positive atmosphere for the team and service users?

Do I help create the conditions that help my team provide mutual care and support?

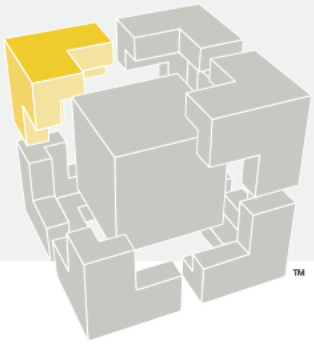
Do I pay close attention to what motivates individuals in my team so that I can channel their energy so they deliver for service users?

Exemplary

Spreading a caring environment beyond my own area

Do I take positive action to make sure other leaders are taking responsibility for the emotional wellbeing of their teams?

Do I share responsibility for colleagues' emotional wellbeing even when I may be junior to them?



Evaluating information

What is it?

- Seeking out varied information
- using information to generate new ideas and make effective plans for improvement or change
- making evidence-based decisions that respect different perspectives and meet the needs of all service users

Why is it important?

Leaders are open and alert to information, investigating what is happening now so that they can think in an informed way about how to develop proposals for improvement

What is it not?

- Failing to look beyond the obvious
- Collecting data without using it
- Thinking only about your own measures or experience
- Reluctance to look for better ways of doing things
- Ignoring problems by ignoring data
- Using research as a weapon

Essential

Gathering data

Do I collect feedback from service users?

Do I collect and record the essential data for my area of work accurately and on time?

Am I regularly thinking about ways to do my job more effectively?

Can I see patterns that help me to do things better, more efficiently or with less waste?

Proficient

Scanning widely

Do I look outside my area of work for information and ideas that could bring about continuous improvement?

Do I establish ongoing methods for measuring performance to gain a detailed understanding of what is happening?

Do I spot future opportunities and risks, and test resulting plans with external stakeholders to improve them?

Strong

Thinking creatively

Do I conduct thorough analyses of data over time and compare outcomes and trends to relevant benchmarks?

Do I see the relevance of seemingly unrelated ideas which could be made useful in my area of work?

Do I creatively apply fresh approaches to improve current ways of working?

Exemplary

Developing new concepts

Do I develop strategies based on new concepts, insights, or perceptive analysis?

Do I create improved pathways, systems or processes through insights that are not obvious to others?

Do I carry out, or encourage, research to understand the root causes of issues?

Connecting our service

What is it?

Understanding how health and social care services fit together and how different people, teams or organisations interconnect and interact

Why is it important?

Leaders understand how things are done in different teams and organisations; they recognise the implications of different structures, goals, values and cultures so that they can make links, share risks and collaborate effectively

What is it not?

- Being rigid in your approach
- Thinking about only your part of the organisation
- Believing only your view is the right one
- Thinking politics is a dirty word
- Failing to engage with other parts of the system
- Focusing solely on the depth of your area at the expense of the broader service

Essential

Recognising how my area of work relates to other parts of the system

Do I understand the formal structure of my area of work and how it fits with other teams?

Do I keep up to date with changes in the system to maintain efficiency?

Do I hand over effectively to others and take responsibility for continuity of service provision?

Proficient

Understanding the culture and politics across my organisation

Do I understand the informal 'chain of command' and unwritten rules of how things get done?

Do I know what I need to do and who to go to so that well-judged decisions are made in my organisation?

Do I understand how financial and other pressures influence the way people react in my organisation?

Strong

Adapting to different standards and approaches outside my organisation

Am I connected to stakeholders in a way that helps me to understand their unspoken needs and agendas?

Am I flexible in my approach so I can work effectively with people in organisations that have different standards and approaches from mine?

Do I act flexibly to overcome obstacles?

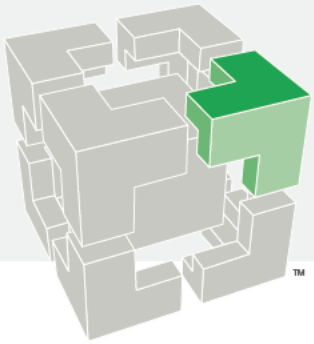
Exemplary

Working strategically across the system

Do I build strategic relationships to make links across the broader system?

Do I understand how complex connections across the health economy affect the efficiency of the system?

Do I understand which issues affect decisions across the system so that I can anticipate how other stakeholders will react?



Sharing the vision

What is it?

Communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting

Why is it important?

Leaders convey a vivid and attractive picture of what everyone is working towards in a clear, consistent and honest way, so that they inspire hope and help others to see how their work fits in

What is it not?

- Saying one thing and doing another
- Talking about the vision but not working to achieve it
- Being inconsistent in what you say
- Avoiding the difficult messages

Essential

Communicating to create credibility and trust

Am I visible and available to my team?

Do I communicate honestly, appropriately and at the right time with people at all levels?

Am I helping other people appreciate how their work contributes to the aims of the team and the organisation?

Do I break things down and explain clearly?

Proficient

Creating clear direction

Do I help people to see the vision as achievable by describing the 'journey' we need to take?

Do I use stories and examples to bring the vision to life?

Do I clearly describe the purpose of the job, the team and the organisation and how they will be different in the future?

Strong

Making long-term goals desirable

Do I encourage others to become 'ambassadors' for the vision and generate excitement about long-term aims?

Do I find ways to make a vivid picture of future success emotionally compelling?

Do I establish ongoing communication strategies to deal with the more complex and difficult issues?

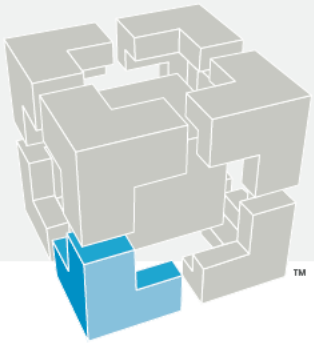
Exemplary

Inspiring confidence for the future

Do I display confidence and integrity under robust and public criticism?

Do I describe future changes in a way that inspires hope, and reassures staff, patients and the public?

Do I explain controversial and complex plans in a way that different groups can hear, understand and accept?



Engaging the team

What is it?

Involving individuals and demonstrating that their contributions and ideas are valued and important for delivering outcomes and continuous improvements to the service

Why is it important?

Leaders promote teamwork and a feeling of pride by valuing individuals' contributions and ideas; this creates an atmosphere of staff engagement where desirable behaviour, such as mutual respect, compassionate care and attention to detail, are reinforced by all team members

What is it not?

- Building plans without consultation
- Autocratic leadership
- Failing to value diversity
- Springing ideas on others without discussion

Essential

Involving the team

Do I recognise and actively appreciate each person's unique perspectives and experience?

Do I listen attentively to my team and value their suggestions?

Do I ask for contributions from my team to raise their engagement?

Proficient

Fostering creative participation

Do I ask for feedback from my team on things that are working well and things we could improve?

Do I shape future plans together with my team?

Do I encourage my team to identify problems and solve them?

Strong

Co-operating to raise the game

Do I enable my team to feed off each other's ideas, even if there is a risk the ideas might not work?

Do I encourage team members to get to know each other's pressures and priorities so that they can co-operate to provide a seamless service when resources are stretched?

Do I offer support and resources to other teams in my organisation?

Exemplary

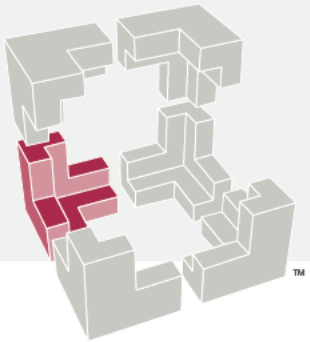
Stretching the team for excellence and innovation

Do I stretch my team so that they deliver a fully 'joined-up' service, and so give the best value they can?

Do I support other leaders to build success within and beyond my organisation?

Do I create a common purpose to unite my team and enable them to work seamlessly together to deliver?

Do I encourage my team to deliver on the shared purpose, as much as on their individual targets?



Holding to account

What is it?

- Agreeing clear performance goals and quality indicators
- Supporting individuals and teams to take responsibility for results
- Providing balanced feedback

Why is it important?

Leaders create clarity about their expectations and what success looks like in order to focus people's energy, give them the freedom to self-manage within the demands of their job, and deliver improving standards of care and service delivery

What is it not?

- Setting unclear targets
- Tolerating mediocrity
- Making erratic and changeable demands
- Giving unbalanced feedback (too much praise or too little)
- Making excuses for poor or variable performance
- Reluctance to change

Essential

Setting clear expectations

Do I take personal responsibility for my own performance?

Do I specify and prioritise what is expected of individuals and the team?

Do I make tasks meaningful and link them to organisational goals?

Do I make sure individual and team goals are SMART[1]?

Proficient

Managing and supporting performance

Do I challenge ways of thinking and encourage people to use data to support their business planning and decision making?

Do I set clear standards for behaviour as well as for achieving tasks?

Do I give balanced feedback and support to improve performance?

Do I act quickly to manage poor performance?

Strong

Challenging for continuous improvement

Do I constantly look out for opportunities to celebrate and reward high standards?

Do I actively link feedback to the overall vision for success?

Do I notice and challenge mediocrity, encouraging people to stop coasting and stretch themselves for the best results they can attain?

Exemplary

Creating a mindset for innovative change

Do I encourage a climate of high expectations in which everyone looks for ways for service delivery to be even better?

Do I share stories and symbols of success that create pride in achievement?

Do I champion a mindset of high ambition for individuals, the team and the organisation?

[1] SMART stands for Specific, Measurable, Achievable, Relevant, Timed

Developing capability

What is it?

- Building capability to enable people to meet future challenges
- Using a range of experiences as a vehicle for individual and organisational learning
- Acting as a role model for personal development

Why is it important?

Leaders champion learning and capability development so that they and others gain the skills, knowledge and experience they need to meet the future needs of the service, develop their own potential, and learn from both success and failure

What is it not?

- Focusing on development for short-term task accomplishment
- Supporting only technical learning at the expense of other forms of growth and development
- Developing yourself mainly for your own benefit
- Developing only the 'best' people

Essential

Providing opportunities for people development

Do I often look for opportunities to develop myself and learn things outside my comfort zone?

Do I understand the importance and impact of people development?

Do I build people development into my planning for my team?

Proficient

Taking multiple steps to develop team members

Do I explore and understand the strengths and development needs of individuals in my team?

Do I provide development opportunities for other people through experience and formal training?

Do I look for and provide regular positive and developmental feedback for my team to help them focus on the right areas to develop professionally?

Strong

Building longer-term capability

Do I explore the career aspirations of colleagues in my team and shape development activities to support them?

Do I provide long-term mentoring or coaching?

Do I spot high-potential colleagues or capability gaps in my team and focus development efforts to build on or deal with the situation?

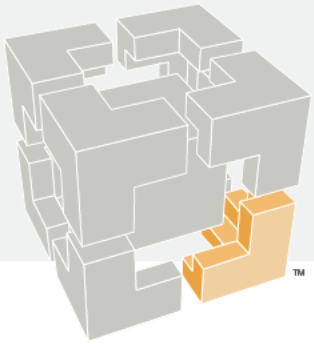
Exemplary

Creating systems for succession to all key roles

Do I create the conditions in which others take responsibility for their development and learn from each other?

Do I take a strategic approach to people development based on the future needs of the NHS?

Do I share in broad organisational development and succession planning beyond my area of work?



Influencing for results

What is it?

- Deciding how to have a positive impact on other people
- Building relationships to recognise other people's passions and concerns
- Using interpersonal and organisational understanding to persuade and build collaboration

Why is it important?

Leaders are sensitive to the concerns and needs of different individuals, groups and organisations, and use this to build networks of influence and plan how to reach agreement about priorities, allocation of resources or approaches to service delivery

What is it not?

- Being insular
- Pushing your agenda without regard to other views
- Only using one influencing style
- Being discourteous or dismissive

Essential

Engaging with others to convince or persuade

Am I respectful in all circumstances?

Do I listen to different views?

Do I share issues and information to help other people understand my thinking?

Do I develop and present well-reasoned arguments?

Do I avoid jargon and express myself clearly?

Proficient

Adapting my approach to connect with diverse groups

Do I adapt my communication to the needs and concerns of different groups?

Do I use stories, symbols and other memorable approaches to increase my impact?

Do I check that others have understood me?

Do I create formal and informal two-way communication channels so I can be more persuasive?

Strong

Developing collaborative agendas and consensus

Do I use 'networks of influence' to develop consensus and buy-in?

Do I create shared agendas with key stakeholders?

Do I use indirect influence and partnerships across organisations to build wide support for my ideas?

Do I give and take?

Exemplary

Building sustainable commitments

Do I contribute calmly and productively to debates arising from strongly-held beliefs, even when my own emotions have been excited?

Do I build enough support for the idea or initiative to take on a life of its own?

Do I act as an ambassador for my organisation to gain reputational influence by sharing experiences and best practice nationally and internationally?

Appendix I How the Healthcare Leadership Model has been developed

The Healthcare Leadership Model has been developed by the NHS Leadership Academy, working with the Hay Group and colleagues from the Open University. It is an evidence-based research model that reflects:

- the values of the NHS
- what we know about effective leadership
- what we have learned from the Leadership Framework (2011)
- what our patients and communities are now asking from us as leaders

This appendix explains how the model was developed and gives more information on how the research was carried out.

1 Secondary Research (March – April 2013)

The aim of the secondary research was to:

- understand what existing research has already said about leadership more generally, and
- help identify what then needs to be different for healthcare, for the NHS, and for the NHS in the current environment.

John Storey and Richard Holti of the Open University, working with Hay Group, carried out a review of current literature and research on leadership models and behaviours, including international as well as private-sector learning. You can see Holti and Storey's paper at www.leadershipacademy.nhs.uk/leadershipmodel

The Hay Group then developed Storey and Holti's findings into a draft behavioural model. As part of this stage, Hay Group drew on the following:

- their own knowledge of leadership in the NHS and elsewhere
- comparison of research data with health system competency models in Hay Group's competency database
- analysis of NHS leaders' assessment data
- analysis of the differences in behaviours between line managers and senior individual professionals

2 Primary Research (April – June 2013)

The aim of the primary research stage was to identify sample leadership behaviours at different levels of intensity and sophistication using the draft model created from the secondary research. This stage consisted of two sets of interviews:

- strategic interviews with people who have extensive experience of leaders in the NHS
- interviews with leaders across the NHS at a variety of levels to gather detailed examples of how they lead and how this delivers results

The sample of interviewees for both sets of interviews was selected by the NHS Leadership Academy working with their Local Delivery Partners (LDPs). The strategic interviews were carried out by staff in the NHS. Hay Group assessors carried out the interviews with leaders, using a focused interview technique. Hay Group then coded all the interviews against the draft leadership model, and carried out a thematic analysis.

3 Drafting (June 2013)

The aim of the drafting stage was to take everything we had learned from the previous two stages to create a more refined draft. The format we used was a 'concept formation' workshop, attended by the NHS Leadership Academy and Hay Group. Here we brought the various data points together to produce a 'working draft' of the leadership model. The data points included:

- the themes from Holti & Storey's research paper
- data sets from both sets of interviews
- data with health system competency models in the Hay Group competency database, and
- thematic analysis of NHS leaders' assessment data

In particular, we used evidence from the interviews to produce the leadership behaviour descriptions you see in the model.

4 Testing (June – August 2013)

The aim of the testing stage was to check with the intended audience of the model (staff in healthcare) that it would be relevant and user-friendly across various roles and contexts. This stage consisted of a number of focus groups, conducted by the NHS Leadership Academy and LDPs, involving a cross-section of staff at various levels working in various contexts. Additional stakeholders, such as colleagues in clinical professional bodies and those working in education, were also invited to provide feedback on the draft model.

The NHS Leadership Academy then analysed and themed the feedback from the focus groups. The feedback was overwhelmingly positive, and improvement points (largely relating to the most accessible language for the model) were acted upon in an updated version of the draft model. This then went through a plain English review, with relevant amendments made.

5 Finishing (August – October 2013)

The final stage was to finalise 'version 1/version 2013' of the Healthcare Leadership Model. This stage consisted of colleagues from Hay Group incorporating the final feedback into a final version of the model, which was signed off by the NHS Leadership Academy. The Academy then worked with designers to produce relevant graphics and finalise the design of this document.

Appendix II Limitations of the Healthcare Leadership Model

A note on the limitations of the Healthcare Leadership Model and plans to keep the model refreshed

The Healthcare Leadership Model (2013) is, as was intended, an evidence-based model which was created using the process described in Appendix I.

In a different economic climate, the NHS Leadership Academy may have chosen to invest more heavily in a wider number of staff interviews to create the first version of the model. However, we have taken the view that the most cost-effective and productive path to take was to interview a small sample of leaders (49 in total) in 2013, and to use this data with the secondary research to create 'version 1' of the model.

The intention therefore is not that this model is 'set in stone' and will still be appropriate for healthcare staff in 2023. Instead, the intention is to make ongoing updates to the model, to make sure it remains as relevant to staff in two or five years' time, as it is to them today. The process of updating the model will be likely to follow a shortened version of the process described in Appendix I, probably taking into account any major new pieces of secondary research and by conducting future sets of interviews and focus groups.

This more flexible and innovative approach will result in future versions being available over the next few years. You could describe this as being similar to the software updates on a smartphone: people can get all the benefits of being able to update their software, while keeping a 'core' product that remains recognisable, rather than having a 'static' product which quickly becomes out of date. In the same way, we intend the Healthcare Leadership Model to adapt and be regularly updated to provide healthcare staff with the most relevant leadership support today and in the future.

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

APPRAISAL DOCUMENTS

CONTENTS

Form 1	Background Details
Form 2	Current Medical Activities
Form 3	Supporting Information for Appraisal & Summary of Appraisal Discussion
Form 4	Personal Development Plan
Form 5	Health & Probity Statements
Form 6	Sign Off -
Form 7	Revalidation Progress
Appendix 1	Education and Training Competencies Available for Medical Staff
Appendix 2	Appraiser Feedback Form
Appendix 3	Appraisee Feedback form
Appendix 4	Aide Memoire and Quality Assurance Audit Tool

FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information – click here to navigate to the relevant guidance in Appendix 4 of these forms.*

1.1	Full name	Robert Edward Richard Wright
1.2	GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3	Main employer	Southern Health and Social Care Trust
1.4	Main place of work	Trust HQ, Craigavon Hospital
1.5	Other employers/ places of work	N/A
1.6	Date of primary medical qualification	1985
1.7	GMC registration number and type	Personal Information redacted by the USI
1.8	Start date of first substantive appointment in HSC as a trained doctor	August 1985
1.8	GMC Registration date and specialties	August 1986 appointed Consultant December 1993
1.9	Title of current post and date appointed	Medical Director Consultant Radiologist 01/07/2015
1.10	For any specialist registration / qualification outside UK, please give date and specialty	N/A
1.11	Please list any other specialties or sub-specialties in which you are registered	N/A
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	28th March 2013
1.14	Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	BHSCT 2005- June 2015 AMD /Radiologist NIMDTA Jan 2014-July 2015 Head of School Diagnostics

2016

ANY ADDITIONAL INFORMATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

Click here to navigate to the relevant guidance in Appendix 4.

2.1 Please give a short description of your work, including the different types of activity you undertake	January –June 2015 AMD and Consultant Radiologist BHSCT July 2015-present Medical Director. Radiologist SHSCT No Clinical Radiology after January 2016
2.2 List your main sub-specialist skills and commitments / special interests	Medical Leadership /Management Previously Paediatric Radiology Ultrasound but no longer applicable
2.3 Please give details of any emergency, on-call and out of hours responsibilities	On call as Trust Director on a 1:9 rota. No Clinical on call
2.4 Please give details of out-patient work if applicable	Not applicable
2.5 Details of any other clinical work	n/a
2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	n/a
2.7 List any non-clinical work that you undertake which relates to teaching	Until July 2015 I was HOS of Diagnostics at NIMDTA with responsibility for Histopathology and Radiology. I taught occasionally on the regional trainee management development program and occasionally to trainee radiologists re plain film interpretation. Since moving to Southern I regularly speak to Postgrad meeting and leadership development programmes

2.7.1 List any non-clinical work that you undertake which relates to management	Medical Director Responsibility for professional issues within the Southern Health and Social Care Trust. Medical Education .Corporate responsibility for Governance, Whistleblowing, Infection control,
2.7.2 List any non-clinical work that you undertake which relates to research	I have responsibility for the development and governance of all research within SHSCT but do not carry out any myself
2.7.3 List any work you undertake for regional, national or international organisations.	Until July 2015, I was Royal College of Radiologist Revalidation Advisor, Advisory Editor and Referee. I was until2016 the RCR representative on the National Emergency Laparotomy Audit
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	N/A

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

My week is virtually completely taken up by my role as Medical Director with Trust-wide roles which include responsibility for Job planning, Appraisal, Trust Governance, Infection Control Data Protection, Whistleblowing, Health Promotion, Litigation, Doctors in Difficulty, Morbidity and Mortality, Audit ,Education at undergraduate, postgraduate SAS and Consultant grade, Research, Standards and Guidelines, quality improvement etc.
I have now ceased my limited clinical work since January 2016.
I work largely on Craigavon site but try to spend at least one day/week at Daisy Hill. I work 1-2 Pas a week from home using online access whenever practical and possible as agreed informally with the then Acting Chief Executive and Director of Human resources. I have a 10.5 PA job plan with a management allowance.

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

In my role as infection control lead the lack of single en-suite room availability means that optimal isolation of infective patients is sometimes not achieved. Despite this we maintain the lowest Hospital Acquired Infection rates in the province.
Several of the Associate Medical Director posts have been unfilled for a variety of reasons which has led to some fragmentation of the AMD team.
Since my appointment as Medical Director in July 2015 there have been 5 different Chief Executives in various acting positions.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 1 - Knowledge, Skills and Performance

Attribute: 1.1 Maintain your professional performance
Attribute: 1.2 Apply knowledge and experience to practice
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

		List of Supporting Information	Applicable Date
1	✓	CPD record - 121 CME points 2016	2016
2		CPD reflection	2016
3	✓	MPS indemnity	2016
4	✓	Southern HSCTrust job contract	2015
5	✓	GMC registration	2016
6	✓	GMC Survey result	2015-16
7	✓	2015 appraisal	2015
8	✓	2016 CHKS Data Quality award	2016
9	✓	Memo to doctors re communication of results	2016
10	✓	Development programme for CDs	2016/17
11	✓	Example of regular MD communication to Medical Staff	2016
12	✓	Evidence of Information Governance training	2016/17
13	✓	Reflection re record keeping, example of ECR team meeting	2016
14	✓	Talk re 'the Medical Directors Role' Doctors behavior, Keep safe, keep well etc	2016

Discussion

Appraisal folder contains multiple evidence of Knowledge, skills + performance.
Discussed the MD Annual report. Excellent appraisal + revalidation
Best in class performance in HCAIs. Good NIMDTA reviews
No longer balancing clinical work + Managerial portfolio.
Research occurs particularly Cardiology + leads 5 PhD students
CPD diary included + included Acumen programme + external certificates
Mandatory training programme included. 2 CHKS awards → data quality → top 40 hospitals.

Actions Agreed

Big challenges with PY1 rotas given ↑ gaps.
Discussed strengths + weakness of Acumen programme and reflected on CPD. Best training HYDRA gold command training by met police - covered MI/ press + multi agency + cross jurisdiction working. No radiology CPD as this does not reflect the current job plan.
Continue good professional performance re Medical Appraisal, revalidation etc.
Consider NCAS retraining

CLICK HERE for further guidance about completing Form 3 and HERE for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients
Attribute: 2.2 Respond to risks to safety
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1	Implementation of Southern M&M system and regional system	2016
2	Trust Audit conference. From Audit to Quality Improvement' sponsor and speaker	2015-16
3	Quality improvement conference/SAS conference re patient safety	2015-16
4	Enhanced Disclosure Certificate	2015
5	National Emergency Laparotomy Audit RCR Representative	2014-16
6	Infection Prevention &Control regional comparators	2016/17
7	NCAS Case investigator training evaluation	2015-16
8	Action plan re Daisy Hill ED	2016/17
9	Regional pathway for intussusception reduction	2016
10	'Umbrella' participation in national GMC review of revalidation	2015-16
11	Evaluation of Trust Medical leadership Development programme	2015-16
12	M&M Monitoring Group Meeting	2015-16
13	CHKS top 40 hospitals award	2016
14	Letter from cardiologist re my health	2017

Discussion

All doctors aligned to M+M Note the conference from audit to QI exploring new models 4 delivery to align audit + QI.
Evidence includes HCAI perfomance + annual quality report with mortality rate, SHIMI perfomance Vs HSMR discussed - not an outlier. own letter re health issues included for reference
Acted promptly + escalated appropriately when safety concens flagged in DHH ED. Now much better staffed ED + trainees supported. Largest challenge + now & above much safer system.
Pathways no paeds pathway included — Work across multiple organisations to agree flows + pathways.

Actions Agreed

(1) Pathfinder ongoing re population health model for locality of Newry. Ongoing [redacted] engagement within the trust + outwith the organisation. Meeting incidents etc. "Friends + family test improved".

(2) Will need to audit outcomes of pathway + user experience

(3) Explore options for promoting shared learning + balance from QI + Audit.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

		List of Supporting Information	Applicable Date
1	✓	Example of direct email letter to medical staff	2016
2	✓	SMT Medical Directors report example	2016
3	✓	Medical Directors office team structure	2016
4		'Hole in wall gang' campaign re visiting and healthcare acquired infection	2016
5	✓	Medical directors regional team minutes	2016
6		AMD team minutes	2016
7		Infection control team minutes	2016
8	✓	Medical Mentoring scheme introduction to Southern Trust	2015-16
9	✓	NHS Leadership Academy 360 feedback and reflection	2015-16
10	✓	Robertson Cooper i-resilience report and reflection	2015-16
11		Leadership Impact report and reflection	2015-16
12	✓	LNC team minutes	2017
13	✓	Example of participation in Medical Leaders Forum	2015-16
14	✓	Minutes and outcome of Southern HSCT AMD team building and development programme	2016

Discussion

Numerous documents in appraisal folder demonstrating team working + partnership.
Mentoring programme in place for new Consultants – Mentors do voluntarily + update variable.
AMD developmental programme + CDS – in process of reappointment of posts and should assist with ongoing development.
Bereavement work ongoing – regional audit demonstrated good practice. Rotate palliative care team through hospice via 1:3 each month.
A number of 360's from Acumen programme with self reflection

Actions Agreed

(1) Continue with the medical leadership structure
(2) With appointment of new CEx the exec team will need to be further developed to function as a team given the changes in CEx (5 in 2 years)
(3) Different model of orthopaedic paediatric services to be explored.
(4) Ongoing involvement in DHH pathfinder

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients
Attribute:4.2 Treat patients and colleagues fairly and without discrimination
Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	Thank You letters	2016
2	NHS Leadership 360 feedback	2015-16
3	NHS Leadership 360 Reflection	2015-16
4	London School of Economics Complaints evaluation project	2016/17
5	Enhanced disclosure certificate	2015
6	Death Certification regional project team minutes	2015-16
7	Colleague 360 feedback	2016
8	Statement re Complaints from SHSCT	2016
9	Complaints review program SHSCT	2015-16
10	Engagement with PPI representation SHSCT	2016
11	Bereavement Committee minutes	2016
12		

Discussion

Evidence in folder has many examples of trust. Signed probity + Health forms.
Enhanced disclosure certificate + fraud awareness training. Attended Safeguarding etc.
No individual complaints + excellent 360 Colleague feedback → lowest score but still > 4.5. Interestingly this may reflect the ~~role~~ very demanding role rather than richard.

Actions Agreed

(1) Reflect on colleague feedback + potential to improve time management.

(2) Complete Mandatory training

(3) Continue to maintain health + attend check ups regularly.

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other developmen activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
Explore opportunity for Coaching	Via Acumen/leadership centre	Yes 2016
Mandatory training	In house courses	Partial 2016
Finish Acumen Programme	Via leadership centre	Complete 2016/17
Attend a radiology conference	RCR UK	No longer relevant

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here

Personal Information redacted by USI

Personal Information redacted by the USI

Richard Wright

GMC Personal Information

10/8/2017

Received from Richard Wright on 16/06/22. Annotated by the Urology Services Inquiry.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**
Update 360 colleague feedback	Leadership Centre platform	December 2017
FMLM conference	UK conference	October 2017
Outstanding Mandatory training modules	In house	Spring 2018
Development of in house Leadership development program.	In association with HR and HSC leadership Centre	Dec 2017

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here

FORM 5- HEALTH AND PROBITY STATEMENTS

HEALTH DECLARATION

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

Professional Obligations
The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: Personal information redacted by USI Date: 10/8/17.

Name in Capitals:

NB: Additional Health and Probity forms are on the Southern Docs website – click here

Regulatory and Voluntary Proceedings *[Please check relevant box by clicking on it and then sign below]*

☑ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

☐ If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: Personal information redacted by USI Date: 10/8/17.

Name in Capitals

PROBITY DECLARATION

Professional obligations

I accept the professi[redacted]ohs 56 to 76 of *Good Medical Practice (2006)*.

Signature: [redacted] Date: 10/08/17

Name in Capitals: [redacted]

Convictions, findings against you and disciplinary action *[Please check relevant box by clicking on it and then sign below]*

☑ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

☐ If I have been subject to any of the above, I have discussed this with my appraiser.

Signature: [redacted] : 10/8/17

Name in Capitals: [redacted]

INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click here

Signature: [redacted] Date: 10/8/17

Name in Capitals: [redacted]

FORM 7- REVALIDATION PROGRESS

Ensure these sections are fully completed to indicate where the appraisee is in their 5 Year Revalidation Cycle.

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	**Action Required**	**Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	**Action Required**	**Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	**Action Required**	**Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2017 has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: [redacted] Name of Appraiser: [redacted]

GMC Number: [redacted] Date: 10/8/2017

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Please ensure the section below is fully completed.

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years	2017	[redacted]	11/8/2017
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Appendix 1 Education and Training Competencies Available for Medical Staff

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 6 - SIGN OFF

Please ensure this section is fully completed, signed and dated by both Appraisee and Appraiser.

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			✓
Quality improvement activity			✓
Significant events review			✓
Review of complaints and compliments			✓
Feedback from colleagues	Year undertaken OR Planned Year:	2017	✓
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	N/A.	N/A

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	✓
Ensure the previous year's Personal Development Plan has been reviewed.	✓
Forward required Forms according to the organisation's appraisal policy.	✓

APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

APPRAISEE

Signature of Appraisee: [redacted] Date: 10/8/17.

APPRAISER

Signature of Appraiser: [redacted] Date: 10/8/2017

GMC Number: [redacted]

CO-APPRAISER (if applicable)

Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____

GMC Number: _____ Organisation: _____