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. Colin Weir
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 the 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 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 22 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. Colin Weir
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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.**

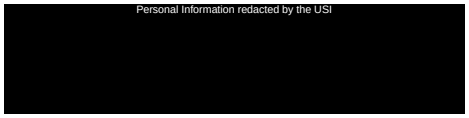
APPLICATION TO VARY OR REVOKE THE NOTICE

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 22 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 Medical Director, Associate Medical Director and Head of Urology Service 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, as Clinical Director, 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 Medical Director(s);
    (iii) the Director(s) of Acute Services;
    (iv) the Assistant Director(s);
    (v) the Associate Medical Director;
    (vi) the Clinical Lead;
    (vii) the Head of Service;
    (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

USI Ref: Notice 22 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Colin Weir

I, Colin Weir, will say as follows:-

[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.

1. I was appointed Consultant in General Surgery to Craigavon Area Hospital Group Trust (later Southern Health and Social Care Trust) in August 1996.

2. I have held several senior roles including Associate Medical Director for Education and Training until 31/7/2018, and Foundation Programme Director until 31/7/2017.

3. I was appointed Clinical Director ('CD') in surgery after competitive interview starting 1/6/2016 and ending 31/1/2022. For clarity, my area of responsibility initially (until December 2018) was urology, ENT, and general surgery in Daisy Hill Hospital. After December 2018, when I returned from a period of sick leave my area of responsibility was switched to General Surgery on the Craigavon

Site and then to both Craigavon and Daisy Hill sites in January 2021, after the retirement of the CD on the Daisy Hill site. Therefore there was overlapping of roles from 1 June 2016 until July 2017 when I was Clinical Director, Foundation Programme Director, and Associate Medical Director for Education and Training; from July 2017 to July 2018 when I was Associate Medical Director for Education and Training and Clinical Director; and from July 2018 to January 2022 when I was Clinical Director only.

4. My direct line manager was Dr C McAllister as Associate Medical Director, who was appointed to the post on a temporary basis in addition to his role as AMD for Anaesthetics. I was directly answerable to him and had weekly meetings with him along with the other Clinical Director (Mr. Haynes). Dr. McAllister's tenure ended in October 2016 and his acting replacement was Mr. Haynes, whom I believe commenced in January 2017. *This date should read "**on 1st October 2017**" as per amendment to statement received on 20/02/2023 (TRU-320007 refers). Annotated by the Urology Services Inquiry.*

5. During my tenure as urology CD, I had sick leave in November 2016 for about 4 weeks [redacted], in late August 2017 for 6 weeks [redacted], and again from late November to February 2018 [redacted]. I had further sick leave from late November 2018 through to February 2019 with some working from home [redacted]

6. Soon after commencing my post as Clinical Director for Surgery and Elective Care with responsibility for urology I was made aware there were outstanding issues in relation to Mr. O'Brien. I was sent a copy of correspondence to him written on 23 March 2016, *[20160615 - E Confidential letter to AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* sent to me on 15 June 2016. This correspondence highlighted outstanding issues namely:

   (i) Untriaged outpatient referral letters;
   (ii) a review backlog of 679 patient;
   (iii) lack of documentation;
   (iv) patients notes kept at Mr. O'Brien's home.

7. I believe this was sent to me because Dr McAllister (acting AMD), in around June or July 2016 (from personal undated handwritten note) had asked me to try and resolve this outstanding issue. More specifically he asked me to try and resolve this with negotiation with Mr. O'Brien and have him agree to an action plan without recourse to formal investigation or procedures

8. I was not aware of these issues in any way prior to being informed by the acting AMD.

9. I was also informed that the Lead Consultant, Mr. Young, was aware of the issues and that he would be approaching Mr. O'Brien in the first instance.

10. I recorded in my handwritten notebook a meeting with My Young on 9.8.2016. I noted “AIDAN-MY will D/W with him”, meaning that, as Lead Consultant, Mr. Young would discuss with Mr. O’Brien issues in relation to some or all the four concerns raised above *[1. personal handwritten notebook, located in S21 22 of 2022 Attachments].*

11. On 22.8.2016 Simon Gibson, the Assistant Director, emailed more senior managers to enquire if any plans or proposals were received in relation to Mr. O'Brien and the concerns above. [20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]

12. Dr McAllister suggested by email on 23.8.2016 that we hold off any further actions until the “dust settles on the process.”[20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]

13. On 31st August Mr. Haynes noted a patient of Mr. O'Brien’s was not triaged. [20160902 - E Urgent for investigation please located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD] The patient was seen by me for leg pain possibly due to a circulation issue, but metastatic disease was noted in keeping with metastatic prostatic

carcinoma. The triage delay was 3.5 months and apparently this would not have changed the outcome but there was a concern regarding delayed triages in general. This was raised with the AMD (Dr C McAllister) on 31st August 2016 and he suggested it be referred to the lead Consultant first (Mr. M Young) and myself second as per email31 August 2016.*[20160916 - E Missing triage located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*

14. I don't know what further action flowed from that exchange of emails, but an email on 15.9.2016 noted a meeting between the Director of Acute Services, Assistant Director and AMD (and sent to the Medical Director), suggesting that myself and the AMD be allowed 3 months to deal with Mr. O'Brien and the outstanding issues.[*20160915 - E Meeting re Mr. O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* There was an oversight committee whose function or membership I had no knowledge of, I was not part of that committee, and any communication or decisions came to me via the acting AMD.

15. I was sent an email on 15.9.2016 from the Head of Service noting over 50 patients with outstanding triage, with the longest wait being 52 days.[*20160916 - E Missing triage located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

16. On 16.9.2016 I emailed an action plan to Dr McAllister in which I noted the need: [*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*

    (i) for a series of face to face meetings with Mr. O'Brien,

    (ii) to ask Mr. O'Brien to implement a plan to clear triage backlog,

    (iii) to have the review backlog validated and change the new to review ratio to reduce that backlog,

    (iv) to ask that all dictation be done at time of clinic or consultation,

(v) to encourage Mr. O'Brien in full engagement of this process and that if he complied with these no further action would be needed other than ongoing monitoring to ensure the same concerns did not recur.

17. There was an email exchange with Mr. O'Brien between 5th and 18th October 2016 to try and meet him to undertake a job plan review. [*20161018 E job plan located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

18. This did not happen and then I was on sick leave [redacted] from approximately 11.11.2016. I also note that Mr. O'Brien was on sick leave from around 17.11.2016.

19. Because of this, there was no activity involving me until I was made aware, via email forwarded to me on 30.11.2016 from the Medical Director, that following SAI investigation in respect of Mr. O'Brien that there remained outstanding issues. [*20161209 - E Confidential located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*

20. I was forwarded an email written by Simon Gibson, Assistant Director to the Medical Director's Office, on 30.12.2016 that, [*20161230 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*] after a meeting, Mr. O'Brien was informed he was being "immediately excluded" to "allow the Trust time to scope the scale of the issues which have been identified". It listed those concerns and included: notes at home, untriaged referrals, undictated clinics, and conclusion of an SAI.

21. I was not party to or involved with these meetings or discussions or involved in or aware of the SAI process.

22. Martina Corrigan (Head of Service) and I met the remainder of the urology consultants on 3.1.2017 to explain Mr. O'Brien's exclusion. [*20170103 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* It was recorded that Mr. O'Brien had at that stage returned notes that he had retained at home.

23. On 9.1.2017 I received a copy of correspondence from Dr Wright to Mr. O'Brien (sent to Mr. O'Brien on 6.1.2017) [*20170109 - E letter to aob 30 Dec located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* This was a formal written notification of immediate exclusion and investigation under the Maintaining High Professional Standards Framework (MHPS). Around this time (but I don't have a precise date or written or email notification or record) I was asked to be the Case Investigator under MHPS, with Dr Ahmed Khan being the Case Manager.

24. This correspondence from the Dr Wright, Medical Director, mentioned, inter *alia,* the lengthy period of time to triage referrals, the large number of untriaged cases (318), an ongoing SAI, a backlog on over 60 undictated clinics, and that some notes had been taken home.

25. Further documents included and sent to me were: terms of reference for investigation into Mr. O'Brien's practice as outlined in paragraph 23 and correspondence from Dr Khan regarding the investigation.

26. On 24.1.2017 I met Mr. O'Brien. I was meeting in my capacity as Case Investigator. Mrs. Siobhan Hynes provided HR support and was at the meeting. Mr. O'Brien was accompanied by his son.

27. This meeting was to review the situation with Mr. O'Brien. On that date the position was 783 GP referrals not triaged and 668 patients with no outcome dictated or recorded. There were 307 sets of patient notes returned from Mr. O'Brien's home, with 88 tracked to Mr. O'Brien's office and 13 sets of notes missing.

28. It was noted that an early initial review had noted that a number of patients awaiting triage had needed upgraded to red flag status or from routine to urgent.

29. Mr. O'Brien was given opportunity to state his case so that we might better understand the current situation and how I could recommend actions that might help resolve things and allow Mr. O'Brien to return to work within restrictions or stipulations on his practice. This was recorded in detail by Siobhan Hynds and written in documentary form *[20170126 - E Preliminary report from case*

investigatoe 26 jan 17 - final located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD] He referred, *inter alia*, to workload pressures, additional operating sessions, inequitable workload compared to his colleagues, and high numbers of hours worked.

30. The documented typed notes written by Siobhan Hynds from the meeting *[20170126 - E Preliminary report from case investigatoe 26 jan 17 - final located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* recorded that Mr. O'Brien stated the exclusion was stressful, was keen to return to work, and would be accepting of working with acceptable time frames for clinics, operating lists, and dictation to be complete at the end of every clinic. He was open to our suggestion of regular monitoring of the above. He stated that being excluded from work was stressful.

31. On 26.1.2017 I was present at an Oversight Committee meeting in relation to Mr. O'Brien which was Chaired by Dr Wright, Medical Director, with HR representatives, Assistant Director, Simon Gibson, Dr Khan, Case Manager, Siobhan Hynds, HR representative and me as Case investigator *[20170126 - E Preliminary report from case investigatoe 26 jan 17 - final located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD].*

32. During this meeting we noted the position (as per para 26 above). There was discussion in which I advocated for Mr. O'Brien in my role as clinical director. From personal knowledge of working with Mr. O'Brien, seeing him operate and operate with him in the elective and emergency situation and having his assistance for me at short notice, I felt as a surgeon he was “good, precise and caring”. I knew from referrals to me from Mr. O'Brien that he had deep knowledge of his patients and his letters were very detailed. The committee asked my view on Mr. O'Brien’s return to work. Based on the above, I proposed and advocated for a return to work with either restricted duties or robust monitoring of Mr. O'Brien’s practice. The committee decided that the operational team would undertake this process. The committee agreed with the

view with strict compliance required in relation to Trust policies in relation to triage, note keeping, storage of medical records and private practice.

33. Before 3.3.2017 I discussed Mr. O'Brien's return to work schedule with Martina Corrigan, Head of Service, and she emailed him [*20170303 - E Mr O'Brien schedule for next few weeks located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* with a comprehensive working plan commencing 7th March 2017 and included in that a plan for the next 5 weeks at that time.

34. There was a written return to work action plan. I was not involved in writing this but was based on recommendations of the oversight committee. This stated that Mr. O'Brien must, when urologist of the week (once every 6 weeks), do the following: action and triage all referrals for which he is responsible, and red flag referrals to be completed daily. In addition, Mr. O'Brien was not to remove any notes off Trust premises, he was to dictate all clinic letters in all clinics by the end of each and every clinic with an outcome and action plan for every patient attending. Finally, Mr. O'Brien was to adhere to the scheduling policy for private patients.

35. I met Mr. O'Brien with Martina Corrigan, Head of Service, on 9.3.2017*.[20170315 - E meeting with Mr O'Brien and Mr Weir 9 March 2017 located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* I emphasise that this was in my capacity as Clinical Director, not as Case Investigator. Mr. O'Brien wished to restart his clinics in South West Acute Hospital (SWAH). We agreed to that but stipulated patient numbers (8 am, 8 pm) and 1 hour given to dictate at the end of the clinic. I asked him if this was fair and he stated, "nothing about job plans was fair". Mr. O'Brien raised an issue that he did not want to see anymore new patients, citing the longest wait times and largest numbers waiting compared to his peers. Martina Corrigan was able to clarify these numbers in that another consultant, in urology, had a longer wait time, and another consultant had larger numbers waiting. Martina Corrigan and I told Mr. O'Brien that he was to continue to see new patients and that was complied with as far as I knew.

36. We also discussed concerns around review backlogs and that oncology patients were not separate from urgent patients and that was a concern. Martina Corrigan later discussed the need to dictate contemporaneously to ensure patient outcomes were recorded.

37. There was discussion around Mr. O'Brien's work as MDT urology oncology Chair and the additional workload required to do this. It was agreed with the lead consultant, Mr. Young that he could drop his theatre session once a month to allow him time to do this extra work.

38. Mr. O'Brien also raised some health issues during this meeting [redacted] Personal Information redacted by the USI We offered a referral to Occupational Health and I suggested a referral to his GP.

39. On or before 11.4.2017, I was informed that I was no longer lead investigator for Mr. O'Brien's case. My exact date is not certain or documented but I was emailed to invite me to give an account to the new lead investigator, Dr Neta Chada, on 11.4.2017 [ref 20170411]. My recollection is that Dr Richard Wright, Medical Director, received advice from the Trust's legal advisors and was advised there was a conflict of interest in being both a Clinical Director and Case Investigator for the same individual. It was not explained what that conflict of interest was. But I was happy to accept that as undertaking both roles was challenging.

40. On 14.4.2017 I was sent an email from Martina Corrigan to confirm Mr. O'Brien was complying with all four points of the action plan.

41. On 28.4.2017 there was an initial series of emails to which I was not (initially) included, noting that, after review, there were now 5 patients who had cancer. This was an SAI apparently in process for the original patient (as per para 12 above). I was not party to, had no involvement in or communication from, and was not aware of outcomes from any SAI at any time. Email correspondence suggests that there was to be an external reviewer appointed by the Medical Director and that all 5 patients were to be included in this process.

42. I was asked by the Assistant Director for Surgery (Ronan Carroll) to inform Mr. O'Brien of these new cases. Martina Corrigan and I did this on 25.5.2017. I was aware that Mr. O'Brien did not have a copy of the first SAI, but neither did I.

43. On 24.5.2017 I met Dr Chada, lead investigator for Mr. O'Brien's case under MHPS. The account of that is written and does not differ in content or timeline from the above narrative.

44. On 25.5.2017 I forwarded a copy of Mr. O'Brien's job plan to Martina Corrigan as this needed discussion and updating. In turn Martina forwarded it to Mr. O'Brien on the same date. The date of most recent change or update was 10.4.2017 and was awaiting agreement by Mr. O'Brien. It was published using the Zircadian job planning system.

45. On 19.6.2017 I received a long and detailed email from Mr. O'Brien regarding his job plan. This discussed issues with timing, end and start times, times for red flag referrals, times for pre and post op ward rounds, time allowed for chairing MDT, time allocated for patient administration.

46. On 21.6.2017 I was made aware via copy email that Mr. O'Brien had gradually increased the number of patient notes in his office (17).

47. On 23.6.2017 an email was forwarded from Ronan Carroll to me, which had been sent to Ronan Carroll from Martina Corrigan *[20170623 - E MHPS case update on 23 june 2017 located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*], recording that Mr. O'Brien had 85 charts in his office but that he was complying with the other terms of his oversight committee recommendation, namely, timely triage, timely dictation of clinics, and no private patients on operating list.

48. On 11.7.2017 I was copied into an email from Martina Corrigan sent to Ronan Carroll saying that Mr. O'Brien had 30 outstanding paper referrals not yet triaged and he was asked to address these urgently.

49. On 18.7.2017 I was made aware that the theatre manager had raised with Ronan Carroll an issue where, on a Saturday, a patient had urological surgery

on what is the emergency/urgent weekend list. It stated that the patient brought a letter for elective admission. I was forwarded this email and was asked to investigate further. I recommended that we review all urological cases undertaken over that weekend. There were counted: Saturday 15.7.2017 - 5 urology cases; Sunday 16.7.2017 - 6 urology cases; and Monday 17.7.2017 – 4 cases carried over and not done over the weekend.

50. On 28.7.2017, after review of the nature of the cases, I recommended no further action. They all, except for one, appeared to need urgent intervention (nearly all being admitted via the emergency department and the one case that was raised was requested to be done by a locum consultant).

51. There is a then a gap in my knowledge and/or involvement until April 2018 as I had two periods of sick leave from late August 2017 to early October 2017 and then from November 2017 through to March 2018.

52. On 5.4.2018 I emailed Mr. O'Brien as I had been working again on his job plan to try and finalise it. I asked him to check it for accuracy.

53. On 18.10.2018 I was made aware of a series of emails reviewing the position with Mr. O'Brien and compliance with the plan set out in the oversight group. There were 82 charts in Mr. O'Brien's office and 91 clinic letters waiting to be dictated. I immediately emailed Dr Khan and Simon Gibson stating that I had not seen the finding of recent review of Mr. O'Brien's practice but I assumed he was in breach of these given the previous framework. I asked how they would like me to proceed, on the basis that Dr Khan was the Case Manager from previously and Mr Gibson worked in the Medical Director's office. I offered to meet Mr. O'Brien with the Assistant Director. I was not aware of further actions after that.

54. On 21.10.2018 I received from Mr. O'Brien further email correspondence in relation to his job plan, noting "I do appreciate all the work you have put in to it".[*20181023 - E Job plan located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

55. [redacted], and when I returned to work in February/March 2019, my area of responsibility as Clinical Director had changed to general surgery at Craigavon Area Hospital.

[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.

<u>Your position(s) within the SHSCT</u>

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

56. I commenced employment in Craigavon Area Group Trust (later Southern Health and Social Care Trust) on 1st August 1996. Prior to that I was a trainee in general and vascular surgery in Northern Ireland.

57. I qualified from Queen's University, Belfast in 1984. After that I was employed as a junior doctor in the Royal Victoria Hospital, Belfast City Hospital, Royal Belfast Hospital for Sick Children, Ulster Hospital, Coleraine Hospital and undertook a period of research at Queen's University, Belfast from February 1991 to August 1992

[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.

58. I have held the following posts with the following duties and responsibilities:

a. Chair combined surgery and anaesthetic morbidity and mortality meetings 1999-2003

Role: to oversee monthly joint audit meetings, summarise action plans and communicate with all surgical and anaesthesia specialties any learning outcome or action plans from such meetings

b. Chair Surgical Area Audit Group 1998-2001

Role: to oversee joint audit meetings with surgical representatives from (at the time) all three hospitals in the Southern Area, namely Daisy Hill Hospital, South Tyrone Hospital and Craigavon Area Hospital

c. Member Area Medical Audit committee 1998-2001.

Role: represent surgical learning and input to wider medical community

d. Member Craigavon Area Hospital Trust Audit Committee 2001-2003

Role: as previous item

e. Chair CREST wound management implementation group for CAH

Role: to work with wound care specialties in implementing regional guidance (CREST Clinical efficiency support teams) wound management for all patients in the Trust.

f. NCEPOD reporter for CAH Jan 2002-2003

Role: To ensure return of forms for National Confidential Enquiry into Post-Operative Deaths

g. Pre Registration House Officer (PRHO) educational supervisor 1997-2002

Role: I was lead supervisor for all year 1 junior doctors, previously called Pre-registration House Officers (PRHOs). This required: supervision of rotas, ensuring learning opportunities, supervision, guidance and supervision for consultant trainers, approval of pay banding, working with and being accountable to the NI postgraduate training agency.

h. Member Undergraduate and Postgraduate education committees CAH 1998-2017

i. Final MB examiner Queen's University, Belfast 1998-Current.

j. Honorary clinical lecturer in surgery, Queen's University, Belfast, 2006-current

Role: honorary post in recognition of excellence and support and lead role in teaching and training of undergraduate students in surgery at Southern Trust

k. Associate Medical Director, Education and Training Aug 2008-2017 *[2. job description Doc b located in S21 22 of 2022 Attachments]*

Role: Lead role at AMD level with overall responsibility for all post and undergraduate teaching and training at Southern Health and Social Care Trust. Accountable to the Medical Director with monthly face to face meetings. Accountable for the Trust as a provider to the Northern Ireland Medical and Dental Training Agency. The role involved meetings at many levels with other educators, facilitation of deanery inspections and visits, facilitating and responding to GMC inspections, regional meetings with directors of medical education and the post graduate dean, and helping to deal with trainees in difficulty or in need of support

The job description was an accurate reflection of the role and duties

l. Foundation Programme Director 2005-31/7/2017 [3. job description doc c *located in S21 22 of 2022 Attachments*]

Role: Similar to PRHO educational supervisor. This new role was needed with the implementation of the new 2-year foundation programme throughout the UK replacing the one-year pre-registration house officer year. The role was challenging in implementation of significant staffing changes and teaching and rota changes for all departments. It needed new systems of recording outcomes and many meetings to deliver this. On an ongoing basis I was responsible for reporting back to the Medical and Dental Training agency, ensuring standards were met,

appointment of consultants as educational supervisors and dealing with newly appointed doctors in need of additional support.

The job description was an accurate reflection of the roles and duties

m. Clinical Director in Surgery 1/6/2016-31/1/2022 [4. job description doc d *located in S21 22 of 2022 Attachments*]

Role: To be answerable and work with the Associate Medical Director for Surgery, although during the first approximately 12 months this AMD was a combined role covering anaesthesia and surgery. The role of clinical director was one of two posts for surgery and surgical specialties. This covered general surgery on both Craigavon Area Hospital (CAH) and Daisy Hill Hospital (DHH) sites, orthopaedic surgery, urology, and ENT surgery.

I was, until 2018, responsible for general surgery at DHH, urology and ENT. This included job planning, working with lead consultants from each department, working with the Assistant Director and two Heads of Service. Other roles included helping resolve staffing issues, appointments of new consultants, helping to guide changes in service, signing off travel claims, expenses claims and locum claims.

There were weekly meetings with the acting AMD and other clinical director.

The job description was inaccurate with the statement: “Support the Associate Medical Director in co-ordinating the appraisal of all grades of doctors, including locum tenens, in line with regional guidance”. This was because the appraisal process was organised by a separate team in the Trust, with separately appointed appraisers. However, if a Consultant failed to engage

with the process, for example failed to submit evidence for appraisal or failed to meet or engage with their appraiser within the Trust's timeframe, then this would require a Clinical Director to be informed by the appraisal team and asked to engage with the Consultant on why the appraisal was not happening. For example, an email on 3rd November 2016 *[20161103 - E FOR IMMEDIATE ACTION - OUTSTANDING APPRAISALS located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* from the revalidation support team asks me to explore with a consultant why they had not completed their appraisal.

[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.

59. The following roles had line management:

(i) PRHO educational supervisor 1997-2002

i. I was answerable to the Postgraduate Director of Medical Education who in turn reported to the Medical Director. The role required working with staff from the medical educational centre. I in turn had responsibility overall to all Consultants in their role as educational supervisors to varying numbers of PRHO doctors. As far as I can recall the numbers of PRHOs increased from 18-21 during my tenure.

(ii) Foundation Programme Director (FPD) 2005 - 31/7/2017

i. My direct line manager was the Director of Post graduate education but when this role became Associate Medical Director

for Education and Training, I undertook both roles. As described above, my director line manager was the Medical Director. I worked with 3 medical directors during this time (Dr Paddy Loughran, Dr John Simpson and Dr Richard Wright) and had regular monthly one-one meetings to review progress, actions plans and outstanding issues. I was responsible for overseeing and supporting all educational and clinical supervisors on the Craigavon Site as a Co-Foundation Programme Director was appointed at Daisy Hill Hospital to help work across both sites and better manage local issues relating to these trainees. I had regular meetings at regional level with FPDs from the other 4 Trusts to share ideas and implement new policies from the Northern Ireland Medical and Dental Training Agency and the GMC. I was lead for regular review of the local programme by NIMDTA, so I had dual accountability to the Trust and to the regional agency.

(iii) Associate Medical Director (AMD), Education and Training August 2008-2017

i. As above, namely, my director line manager was the Medical Director. I worked with 3 medical directors during this time and had regular monthly one-one meetings to review progress, actions plans and outstanding issues. I worked with and had the support of another Foundation Programme Director at Daisy Hill Hospital. I had overall responsibility for other educational leads in all specialties throughout the Trust.

(iv) Clinical Director (CD) in Surgery 1/6/2016 - 31/1/2022

i. My line manager was the Associate Medical Director for Surgery and Elective Care (Dr C McAllister). In the initial 12 months, approximately, this was combined with the AMD for Anaesthesia as the post was vacant. I had the support of, and worked with, 2

Heads of Service, Martina Corrigan (Urology and ENT) and Amie Nelson (General Surgery). Ronan Carroll was the Assistant Director for both surgery and anaesthesia services. There were lead consultants I could communicate with to help run the service and deal with issues locally. These lead consultants were, for urology, Michael Young, and for ENT, Ted McNaboe.

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

60. Clinical governance for each specialty was devolved to the Consultant team and their lead Consultant (Mr Michael Young). Thus, the unit would have its own departmental meetings and patient safety meeting, and audit activity. I did not have or undertake specific governance activities for the urology unit other than the investigation of a consultant. There were no team meetings or meetings with respect to governance with me or senior managers. I was answerable to the AMD (Associate Medical Director Dr McAllister until Dec 2016). I liaised with the Head of Service (Martina Corrigan) regularly, often meeting or making contact on a weekly basis. The associate director (Ronan Carroll) would on occasions also contact me. I liaised with the lead consultant (Michael Young). Day to day operational matters were led by the Head of Service and Lead Consultant who, in turn, would have weekly meetings with the urology consultant team. On several occasions I would attend those team meetings if specific issues arose. They had their own regular meetings, multi-disciplinary meetings and attended audit at local and Trust level. Service development was driven by the team. Departmental meetings were attended by the Head of Service very regularly, who supported the team. Any issues were reported back to me. If needed, I would then meet the Lead Consultant or team.

[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 Medical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.**

61. My role would be best described as week to week rather than day to day responsibility. But there were times when frequent involvement either by email, telephone, or meeting may have been needed multiple times during a day or the course of a week. My role was largely confined to interaction with the AMD, Head of Service, and Lead Consultant for urology. I had occasional contact with the Assistant Director and rarely with the Director of Acute Services in relation to operational and governance matters. My role was therefore a local one, dealing with recurring operational matters. Larger areas of concern and strategic decision-making were not in my remit, I believe. For day to day and week to week operational and governance matters, I would not have had contact with the Medical Director. I was aware that issues were discussed at a more senior level, namely with the MD, AMD, and Director of Acute Services. The AMD, if he felt it was relevant, would then bring those issues to me.

62. Thus at unit level the Consultant body, lead Consultant (Mr Young) and Head of Service (Martina Corrigan), would set direction of the unit, undertake and direct audit and education and the bulk of day to day and month to month governance. The team would be present at joint anaesthesia and surgery audit meetings (every 3 months), where I would be present. The Director of Acute Services would be responsible for responding to patient complaints and chairing an acute governance committee.

<u>Urology services/Urology unit - staffing</u>

[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.

63. I had no involvement at any time in any role in the establishment of the Southern Trust urology unit in the Southern Trust area

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

64. I am not aware of the relevant performance indicators as I was not involved in any way or at any time in the development of the unit or 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?

65. No; my role started in 2016 and I was not aware of the Integrated Elective Access Protocol in detail but was aware of targets for red flag pathways, routine referrals, triage and times to first appointment. Also, I was aware of leave notification being a minimum of 6 weeks. I was aware of partial booking systems to reduce numbers of non-attending patients.

[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?

66. I was aware of targets as in 64 above. Oversight and monitoring would have been done by the operational team and Head of Service (Martina Corrigan). I was not responsible for actioning nor was I asked to action or involved in actioning any failure to meet targets. Actions, I understand, would have been the responsibility of the Head of Service and the Assistant Director (Ronan Carroll).

[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.

67. In respect of this issue, and adopting the numbering of the Question, I respond as follows:

I. None;
II. I have no knowledge of this;
III. None;
IV. I cannot answer this as I had no data from or involvement in this.

[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.

68. None of this was in my remit and I was not made aware of any issues raised by the Implementation plan during my tenure.

[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?

69. As above, I was not involved in this plan as it predated my appointment.

[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?

70. During my tenure as CD, the unit was understaffed for consultant numbers and would have benefited from more specialty doctors and Consultant posts. I don't know if the unit was adequately resourced in a material rather than human way, such as specialized equipment for treatment or investigation on an in or out-patient basis.

[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.

71. I was appointed in 2016 and became aware that not all Consultant posts were filled, and that the unit relied on locums to fill vacant Consultant posts from 2016 onwards (and that it had done so prior to that time as well). Despite this, though, there was Consultant expansion from the unit's early days and staffing was improved from its inception.

[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?

72. There were 6 Consultant posts during my time as Clinical Director. During this time one post would have been filled by a locum. This would likely have increased workload on the remaining 5 substantive members of the Consultant team in urology. This position was the case when I became Clinical Director. There was a shortage of trainees available to fill substantive posts and, on occasions, other posts in the same specialty would become available in other units, for example, Belfast Trust, which some trainees might have considered more attractive for a variety of reasons such as travel to work, working environment and sub specialty interest. The vacancy would have been readvertised on multiple occasions (I cannot say, and do not have details of, when). I continued to approve and sign off locum appointments to fill rota gaps.

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

73. The provision of services would have been maintained. Patients were triaged by all members of the team and put onto red flag or urgent pathways. Having a locum would not have affected that, indeed it would have helped maintain throughput of patients through red flag and cancer pathways. However, there

was a great backlog of routine cases, for example in March 2017 a review showed patient waiting times on a Consultant first appointment between 62-162 weeks [*20170315 - E meeting with Mr O'Brien and Mr Weir 9 March 2017 located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

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

74. During my tenure there were 6 posts, with 5 filled and one vacant but filled by a locum. There was no Consultant expansion during this time. The roles and duties of the team were unchanged as far as I can recall. I am not aware of other appointments such as specialist nurses.

[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?

75. No; my governance role as CD did not change (as I outlined in paragraphs 59, 60 and 61 above).

[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.

76. Martina Corrigan, Head of Service at that time, had a sound understanding of support staff around the team. It would be best to ask her this question. I did not have any detailed knowledge of this issue.

[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?

77. I cannot answer this question. It would not be in the remit of a clinical director, unless an issue concerning support staff had a direct consequence on clinical activity. I was not aware of any such issue.

[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.

78. I was not aware at any time of any concerns raised by administrative support staff. As mentioned in the previous answer, it would not ordinarily be in the remit of a clinical director to hear those concerns unless it impacted on clinical activity, such as clinical numbers or availability of notes or return or results. In any case, that would normally be a matter for the clinicians, Head of Service and Assistant Director.

[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.

79. The chain would have been Consultants, then Lead Consultant, then Clinical Director. However, the administrative and operational side would have been led by the Head of Service (Martina Corrigan) and Assistant Director (Ronan

Carroll). 'Day to day running' is a somewhat vague or broad term in this respect: does it mean clinical matters, administrative matters, or both? It would in my view be better to describe it as follows: the Lead Consultant had 'on the ground', clinical, day to day ownership with the help of the Head of Service, with their roles being distinct and yet overlapping in the clinical area. For example, the Lead Consultant would deal with issues with cancelled theatre lists or scheduling of lists. The Head of Service would work with Clinicians and Nurses on scheduling, cancellations of lists, rotas, and weekly allocations. There was overlap of these roles.

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

80. None. Performance review would have happened as part of the cycle of annual appraisal and each Consultant would have had their own nominated appraiser. This quite rightly is completely separate from clinical supervision of the team.

[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.

81. I had an annual appraisal (documents are supplied for 2016, 2017, and 2018). I was appraised in order by Dr Wright (Medical Director), Mr Mackle (Consultant Surgeon), and Mr. Murugan (Associate Specialist). The appraisal focused on my clinical work and role in education and training. Personal development plans reflected this. There was recognition of my role as clinical director in 2018. However, my role was not reviewed as part of the appraisal process, and I did not have separate performance review of my role as clinical director. I had no framework or guidance on the role of clinical director, but I did have a detailed

job description which highlighted key responsibilities, professional leadership role, leading the medical team and general responsibilities.

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.

82. I had meetings with the Lead Consultant, Mr. Young, on an ad hoc basis and meetings with the whole team if significant developments or concerns arose. I met Mr Young to discuss issues in relation to Mr. O'Brien and regarding payments for urology on call work *[20161005 E Urology oncall located in 20161005 E Urology oncall].* This only happened on one or two occasions. I had regular meetings (at least 3 times a month) with the Head of Service to appraise me of any issues relevant to my Clinical Director role. For example, we discussed waiting times for patients, staffing issues and locum appointments. I also met all the Consultants to discuss job plans. I estimate that, on average, urology unit work would occupy an hour a week.

[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.

83. I was not involved in scheduled meetings or minuted scheduled meetings working on an ad hoc basis but had regular contact with the Head of Service. For example, there would have been email correspondence, almost entirely

from the Head of Service, but much of the work with the Head of Service was done when she either phoned me or I regularly called into her office (at least once a week). These meetings could be brief (15 minutes) to discuss, e.g., a rota issue or longer (an hour) to discuss, e.g., ongoing issues with one consultant.

[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.

84. Operational managers in Surgery and Elective Care worked well, with regular meetings with the Head of Service (who was superb in role) and all the consultants, including the Lead Consultant (as a Medical Manager). There was good flow of information back and forward between them and to me if required. I was copied into email correspondence on matters of significance by the Head of Service (Martina Corrigan) and by the Assistant Director (Ronan Carroll).

Governance – generally

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

85. As explained in my responses to Questions 5-8 above, clinical governance was at the local, team level; the urological consultant team as a whole had their own regular meetings and MDM discussions. They took part in the joint audit surgical/anaesthesia meetings which I also attended. I had no concerns raised with me other than with one consultant (Mr. O'Brien). Apart from this one individual I had no significant governance concerns raised. I had regular contact with the Head of Service who would have advised me of any governance issues.

[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?

86. The Lead Consultant would have had team responsibility and another consultant chaired the MDM. As explained above, the main elements of clinical governance (that is: quality assurance, education, clinic audit, research and development) were all organized by the specialty team of consultants under the direction of the lead consultant (Mr Young). I was fully aware that the events and activities were taking place and participated in joint audit meetings that encompassed all surgical specialties. I was therefore able to witness case presentations and morbidity and mortality reports by the urology team at such meetings. My oversight role was to be informed or appraised of patient safety matters that arose out of audit of activity or patient safety meetings. The significant governance concern arose out of an audit of activity of Mr. O'Brien. It was clear there was the potential for a clinical effectiveness issue and on this I had frequent updates.

[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?

87. Quality of service roles and supervision in urology would have been shared between the Lead Consultant, Head of Service, Assistant Director, AMD, and Director of Acute 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?

88. Answer is as per question 33.

[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?

89. I was appraised regularly by the Head of Service. If any issues of concern were raised in the department I would have been informed rapidly by the Head of Service. I would have access to waiting list figures for routine, urgent and red flag outpatients and surgery cases via the Head of Service. I was very confident that this line of communication was robust. For example, I investigated the perceived misuse of emergency theatre time by one consultant [*20170728 - E charts in office located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*].

90. I had frequent updates by email from the Head of Service (Martina Corrigan) on, for example, wait times for discharge letters by all consultants [*20181018- E Return to work action plan February 2017 Final 3aa located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*, with follow up face to face discussion with the Head of Service. Other examples (as previously mentioned) include rota gaps and wait times for first appointments for routine cases.

91. Patient safety concerns were always either in respect of waiting times or the practice of one consultant (Mr. O'Brien), for which I met the Head of Service on many occasions.

[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?

92. Areas of concern could be brought to me via any of the Consultant team, the Lead Consultant and the Head of Service. Patient concerns would be raised through Trust complaints mechanisms, with oversight by the Director Acute Services. Concerns and complaints were directed to the consultant concerned with the support of the operational team and responses returned by the Director of Acute Services. If a concern required Clinical Director input, then that was an option, but I don't recall ever needing to be involved in such a concern other than an internal one. The systems were robust, open, clear, and timely

93. Patient complaints were managed via the Director of Acute Services and responses elicited from clinicians involved, and written response was from, I recall, the Director of Acute Service. I was not involved in this process.

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

94. I am not aware of them changing.

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

95. I ensured that I was appraised of any concerns by regular meetings with the Head of Service who worked very closely with the whole unit and its clinicians.

[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?

96. I have explained (e.g., at Questions 5 to 8 above) that my role in clinical governance was limited other than a main issue with Mr. O'Brien.

97. Within approximately 2 weeks of commencing appointment as Clinical Director I was made aware of an ongoing unresolved governance issue with one of the consultants in the unit (Mr. O'Brien). This was during regular weekly meetings with the Associate Medical Director (Dr McAllister). The issues raised were of Mr. O'Brien's failure to triage patients in a timely manner, that there was a review backlog of oupatients, and that because there was a backlog of dictated letters there were no outcomes recorded in many cases. Also, there were a significant number of NHS/HSC notes belonging to the Trust that Mr. O'Brien kept at home. At this stage I was not informed of precise numbers, how long this had been occurring, what previous action plans and meetings had occurred to address this, or any other significant briefing. I consider it a failure of good governance to ask a newly appointed Clinical Director with no previous experience to resolve, informally, a longstanding and complex problem with only a weekly meeting with my line manager.

[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.

98. I was not aware of concerns in governance meeting minutes and I have no record of such documents or any other type of governance documentation. I had no involvement or written communication regarding the Risk Register.

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

99. The only data relevant to my role would be waiting list data for outpatient appointment and for surgery. There may be other local audit data specific to the unit but I'm not aware what those were.

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

100. Other than above response I can't answer as I was not aware of any other data systems. There were other systems such as DATIX but I did not use this. I don't recall a DATIX event specific to urology. Broadly, from what I did see of the systems they worked in that staff could identify concerns and in that sense they were efficacious. I was not aware of system changes over time or my tenure.

[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.

101. During my tenure I was not involved in setting, nor was I aware of, performance objectives other than red flag pathways (that is treatment to commence for a proven cancer within 62 days of red flag referral from GP). Job planning would not have demanded performance objectives. As the service was

understaffed and wait times were long and the team was working at full capacity it would have been inappropriate to demand changes in performance.

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

102. My role included job planning for all the urology consultants. My role was not to undertake appraisal as this was a separate process. In theory, a consultant who did not engage or submit an annual appraisal could be referred to me for follow up, but this was never required during my tenure. Job planning review was a two-way process with meetings with each consultant. We would agree rotas, annualised activities and other roles. Then either I, in some cases, or the consultant, in others, would use a commercial system (Zircadian) that the Trust purchased to support the process. This allowed each party to agree or disagree the job plan. In one case (Mr. O'Brien) this was complex and repetitive and required many hours work by me to achieve an agreed job plan. However, the system and process is robust, fair, and open to regular review. My only criticism as a user is that the Zircadian system is at times very complex and more time consuming than it needs to be to use.

[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.

103. Governance concerns could be raised through Head of Service, Assistant Director, AMD and the Director of Acute Services or myself. An Acute Governance Committee would oversee the process, chaired by the Director of Acute Services, and met on a monthly basis. Those processes were outside my remit and can be addressed and explained by others. During my tenure, and in relation to urology, there were no governance concerns I can recall other than one (of a series) of concerns which relates to this Inquiry. In this case, Mr. O'Brien was the subject of ongoing concerns as described in answer to Question 39 above. In this first instance the process was entirely informal with an action plan drawn up me [*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*] . However, this was overtaken by the intervention the Medical Director (Dr Wright) and a more formal process followed with investigation under the MHPS framework and in line with the Trust's implementation of that. Subsequently, there was monitoring of Mr. O'Brien's performance against set targets on triage, undictated letters, booking of patients in date order and priority, and ensuring no patient notes were at Mr. O'Brien's home. The process involved other members of the management team having the same information shared including the Head of Service and Assistant Director. It is important for me to record that I was not primarily responsible for this process and had very limited experience of the process other than in the case of Mr. O'Brien.

[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.

104. I had some support from the medical hierarchy, with weekly meetings with the acting AMD for Surgery (Dr McAllister) at least approximately to December 2016, when he was removed from the post. At times, it was

*This date should read "**to October 2016**" as per amendment to statement received on 20/02/2023 (TRU-320007 refers). Annotated by the Urology Services Inquiry.*

challenging because, not long after my appointment, I was made aware of the issues in urology pertaining to one consultant, Mr. O'Brien. Initially, I was asked to manage the situation on an informal basis. However, in retrospect I had not realised the enormity of the problem nor the previous attempts to resolve it. None of this was communicated to me. Other than the meeting above, and until a formal investigation commenced in January 2017, I did not feel there were enough more formal meetings, or minuted meetings, or opportunity to gain advice, or communicate a complex and challenging case with the management team (that is, the Director Acute Services, Esther Gishkori, Medical Director, Dr Richard Wright, Assistant Director Surgery, Ronan Carroll, and Associate Medical Director, Dr McAllister, in post for a short time). There were no meetings until the MHPS investigation with more senior hierarchy that I can recall. There were some emails around this [*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]. I must state, however, that the Head of Service Martina Corrigan was invaluable, with clear communication and she helped me to manage some of the complexities of the issues with Mr. O'Brien.

<u>Concerns regarding the urology unit</u>

[47] The Inquiry is keen to understand how, if at all, you, as Clinical Director, 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 Medical Director(s);**

iii. **the Director(s) of Acute Services;**

iv. **the Assistant Director(s);**

v. **the Associate Medical Director;**

vi. **the Clinical Lead;**

vii. **the Head of Service;**

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.

105. In relation to governance concerns in general in the urology unit or patient safety concerns, I reply as follows:

i. I had no meetings with the Chief Executive.

ii. I had no meetings with the Medical Director (Dr Richard Wright) in my role as Clinical Director until a formal investigation was instigated and I was asked to be case investigator for a series of concerns in the practice or Mr. O'Brien (set out at para 6 above).

iii. I had perhaps one or two meetings with the Director of Acute Services (Esther Gishkori), but I have no written record of that and am recalling as best I can from memory. As far as I can remember, this would have been in relation to clinical concern or governance issue in relation to urology, which related to Mr. O'Brien's practice (again, as set out at para 6).

iv. I would have had occasional meetings with the Assistant Director, usually during the course of meetings with Heads of Service, and there would have been un-minuted meetings in relation to concerns regarding clinical performance of an individual consultant, which was Mr. O'Brien (again, as set out at para 6). The Assistant Director would and did contact me from time to time by phone or email if issues arose. This was one of many different pathways between the clinician and operational managers.

v. When I was first appointed, there was an acting AMD, Dr McAllister. This role was combined with surgery and anaethesia services. There were regular weekly meetings with the AMD and the other Clinical Director (whose role was general surgery and orthpaedic surgery). Sometimes a Head of Service was in attendance. These meetings were not minuted, but action plans were agreed between us. I was made aware of issues

in relation to urology probably 2 weeks after commencing my role as Clinical Director (see paras 6,7, and 8 above). I recorded that the Lead Consultant in the first instance was to deal with the urology governance issue. Later, I was asked to approach the consultant in urology (Mr. O'Brien) where the governance issues existed. These issues I now know had been active for some time but I was not aware of previous actions or initiatives at that time. I was asked to approach issues on an informal basis and later come up with action plans.
This all happened with the AMD in August 2016, followed by meetings with myself and the Head of Service in September. Also, there were to be meetings between the Assistant Director, Head of Service and Mr. O'Brien. The AMD had oversight of an action plan agreed with Mr. O'Brien. There was a series of emails in relation to that.[*20160921- E meeting re Mr O'Brien located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

vi. I had several face to face meetings with the Clinical Lead (Mr Young) in relation to job planning and the clinical governance issues in relation to Mr. O'Brien. Much of the interaction was via the Head of Service and there were no other issues or concerns that needed more frequent or other face to face interactions.

vii. I had very frequent and regular contact with the Head of Service. This was always timely and we often met or interacted on a weekly or even a daily basis, as well as there being numerous email correspondence between us. The Head of Service was my most important, useful and vital contact in the whole team as she interacted with all the clinicians and clinical and operational managers. She had a deep knowledge of the urology team and its working systems. My role would have been even more challenging without her help. She had full awareness of any

governance issues and these could and would have been made available to me and discussed.

viii. During my tenure I had individual face to face meetings with the urologists to discuss job plans or any live or governance issues. There were no such issues except in relation to Mr. O'Brien. There was email contact between the individuals to discuss job plans.

[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:-

(i) 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.

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

(iii) 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.

(iv) 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?

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

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

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

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

106.

(i) The main issues raised which were ongoing and pre-dated my appointment were workload and on call rotas, access to enough theatre time, and the challenge of unbalanced endoscopy vs. open surgery. Also, some urology was undertaken at Daisy Hill Hospital by another consultant with a specialty doctor but that doctor needed mentoring and could not undertake clinics independently. The consultant at Daisy Hill was to retire and that created a gap in capacity for urology activity there, for example, cystoscopy. A vacant post required a job plan. I recorded ad hoc meetings with the Lead Consultant but more often and nearly always with the Head of Service. These ongoing issues were the shared responsibility of the Lead Consultant (Mr Young), Head of Service (Martina Corrigan), Assistant Director (Ronan Carroll), and myself. There may have been other meetings to discuss these issues within the Department or between the Consultants and Head of Service. I would absolutely not have had primary responsibility for resolving these issues. There were no minuted meetings of which I have any record.

(ii) I don't recall being involved in or being aware of any risk impact assessment for these issues.

(iii) There were no immediate patient safety concerns with these issues other than the challenges that the wider NHS experienced of gradually increasing patient numbers and waiting lists. The use of the unsupervised specialty doctor at Daisy Hill was to be discussed with the Clinical Lead.

(iv) The department used locums to cover consultant gaps and vacant nights on the rota were covered on a locum basis. There was a plan for the urology specialty doctor to be mentored on the Craigavon site but I have no record of how that progressed. My recollection is that the Lead Consultant, Mr Young, would have been primarily responsible for that. I helped to write and sign off a job plan in urology for a new Consultant post (5 consultants in post and 1 vacant).

(v) Regular meetings with the Head of Service, acting AMD, and occasional contact from the Lead Consultant meant that these concerns were monitored.

(vi) These issues were not resolved or reliant on assurances. They were ongoing issues with gradual increase in waiting lists and need to have another Consultant in post-that did not happen in my tenure.

(vii) They were not successful in my tenure as I had 2 periods of sick leave and, after the second extended period in 2018, I returned to a different Clinical Director role which did not involve urology. The plans to undertake lists in Daisy Hill Hospital to help with capacity, I believe, were progressing but then the Covid 19 pandemic disrupted all plans.

(viii) I can't answer as I did not have input from or to urology after late 2018.

[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?

107.

a. Yes; they were properly identified. As I outlined in my response to Question 48 above, there were ongoing issues being identified and addressed by the Consultant body, Lead Consultant, Head of Service, myself and Assistant Director. I was made aware of issues of concern via the Associate Medical Director in weekly meetings and by frequent meetings with the Head of Service, Martina Corrigan. In the absence of the Associate Medical Director, I could be contacted, for example, in relation to missing appraisals [*20161103 - E FOR IMMEDIATE ACTION - OUTSTANDING APPRAISALS located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]*
b. Impact would have been reviewed by the team namely Lead Consultant Mr Young, Head of Service Martina Corrigan and the Assistant Director, Ronan Carroll. This included reports of waiting times for clinic appointments, triage times, and waiting lists for treatment or surgery.

c. The reports of waiting times and lists were under constant review for patient safety reasons. And to ensure red flag targets were being met or not. Waiting list initiatives were funded to reduce the waiting lists for outpatient appointments on the basis of patient risk.

[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).

108. Working with Head of Service and Assistant Director we listened to concerns around workload, job plans, locums and service delivery. Beyond those areas I don't recall the need for "support". Support for clinicians, for

example occupational health referrals, would be made by the operational team usually and after discussion with me, but there were no examples of this (other than in respect of Mr O'Brien – see further my answer to Question 1 para 37).

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

109. I was not involved in offering or providing any such support and am unaware of whether it was offered or provided by others.

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)?

110. I was Clinical Director which included an oversight role for the whole urology team of 5 Consultants and a locum Consultant. There was a Lead Consultant (Michael Young) who provided day to day oversight of the team. That Lead Consultant would communicate with me and I with him if issues arose. Specifically, I was responsible for job planning for the whole team on an individual basis and therefore for Mr. O'Brien. I was responsible for discussing any action plans as directed by the Associate Director or AMD. I was responsible for Mr. O'Brien undertaking the requirements of his job plan and engaging with quality improvement and, if he did not undertake annual appraisal, to ask to him to do so. I met Mr. O'Brien in my Clinical Director role between June 2016 and December 2018 perhaps 5 or 6 times. There was a period between late December 2016 and February 2017 when I was lead

investigator (under MHPS) for issues of concern, meaning that this was the focus of any meetings that I had with Mr O'Brien. I also had 3 periods of sick leave during this time: late August 2017 for 6 weeks, November 2017 to February 2018, and from the start of November 2018 to early March 2019. Mr O'Brien contacted me for long telephone discussions on at least one occasion when I was off duty (on a Sunday), so he clearly had the ability to contact me at all times.

[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.

111. I was the job planner for Mr. O'Brien. I had meetings and email correspondence with him. I used the ZIrcadian software system deployed by the Trust to facilitate the process. In Mr. O'Brien's case I entered all the figures, clinics, lists, rota and on call arrangements. I entered SPA (Supporting Professional Activity) figures, MDM figures and any annualized activities. It was a complex process. I undertook this writing onto Zircadian and review and back and forth emails on his behalf, more than any other Consultant that I job planned.

112. On 5th October 2016 I started email discussions with Mr O'Brien (6 emails between us) [*20161018 E job plan located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* regarding job plans and also had a telephone discussion. There was a record on the Zircadian system that tracks dates and times of sign off that it was completely written and waiting doctor agreement (that is from Mr. O'Brien) on 10th October 2016. This job plan was then cancelled and a further written job plan on Zircadian was published on 7th November, but this too was cancelled in February 2017, rewritten in April 2017 and cancelled again in August 2017.*[20170525 - E AOB job plan located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*]

113. There was a further review of job planning in April 2018 but the start date retrospectively was to be February 2017.

114. There was a lengthy email from Mr. O'Brien in September 2018 regarding changes he wished to make in his job plan

115. There was further email correspondence in October and December 2018 Personal Information redacted by the USI regarding job planning, but I was unable to respond and then my responsibility for urology stopped.

116. By the commencement of my sick leave in Mid-October 2018 through to December 2018, the job plan was not finalised, resolved or signed off on the Zircadian system. During Personal Information redacted by the USI sick leave, I did respond to an email from Mr. O'Brien [ref 20181205] in relation to job planning but, by then, I was becoming quite unable to work in any capacity. I ceased my urology CD role before I returned to work in March 2019, with an approximate end date of 30 December 2018.

[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.

117. I was appointed to Clinical Director on 1 June 2016 and occupied that role until 31 January 2022. However, my urology responsibilities stopped in December 2018.

118. Around June 2016, the Acting AMD for surgery (Dr McAllister) made me aware, during our weekly Clinical Directors meeting, of issues with Mr. O'Brien,

namely, that there were issues with charts, triage and clinics. I have written in a witness statement dated 24th May 2017 [*20170607- E Witness Statement located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD*] (as part of the MHPS process) that I was told (by Dr McAllister) these concerns were not "a really serious problem". I was only made aware that these issues predated my appointment as Clinical Director and attempts had been made to address them by the previous AMD for Surgery (Mr Mackle) and Assistant Director (Heather Troughton). I was not made aware of any correspondence or previous action plans or the duration of said concerns. Since I was in post only a matter of 2 weeks, and since Dr McAllister was being directed by the Director of Acute Service and Medical Director, I had no reason to question previous initiatives, correspondence, actions, and meetings largely because I was inexperienced as a Clinical Director. It was not made clear to me the depth and degree of issues regarding Mr. O'Brien.

*This should read **"Trouton"** as per amendment to statement received 20/02/2023 (TRU-320007 refers). Annotated by the Urology Services Inquiry.*

119. It became clear by August 2016, as emails were forwarded to me that included a letter written on 23rd March 2016 by Mr Mackle, Associate Medical Director, and Heather Trouton, Assistant Director, *[20160823 - E Confidential AOB located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD]* that the concerns were as follows: triage of referrals had not been done, there was a dictation backlog, no outcome was recorded on some out-patients, and notes were missing from records (being in the possession of Mr. O'Brien at home).

[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.

120. In or close to June 2016, initial mention of concerns about Mr O'Brien were explained to me by Dr McAllister. Also present at that time was Mr Mark Haynes, Consultant Urologist, in his role as Clinical Director for other specialties in surgery. I was made aware there was an issue with triage, missing charts and clinics. It was asked that I make any initial approaches to Mr. O'Brien informal and try to get Mr. O'Brien to agree to an action plan and timescale.

121. I was told that Mr Young, the Lead Consultant in urology, was aware of the issues and that he would be approaching Mr. O'Brien in the first instance. I recorded the following in my personal notebook on 9 August 2016: "Aidan-MY will D/W him", meaning Mr Young will discuss with Mr O'Brien.

122. After this I wrote an email proposal to Dr McAllister on 16th September 2016. I made a number of recommendations, which all involved an action plan with Mr. O'Brien though a series of face to face meetings. These actions included an initial face to face meeting with Mr. O'Brien, Dr McAllister, and myself explaining the need and timescale to clear the triage backlog. The meetings were to be documented and reported back to Dr McAllister with support as requested by me. Dr McAllister replied that this was the best approach.

123. However, this process never started as it was overtaken by the Medical Director's decision to undertake a formal investigation under MHPS and exclusion of Mr. O'Brien on 30 December 2016. I was then asked to be the Case investigator for this, with Dr Ahmed Khan as the Case manager.

124. I met with Mr. O'Brien and Mrs. Siobhan Hynds (Head of Employee Relations) on 24th Jan 2017 and published a report on 26th Jan 2017. This meeting was to explain the process under MHPS. During that meeting we recorded the issues of concern being initially as follows:

(i) From June 2015, 318 GP referrals not triaged in line with agreed process for such referrals;
(ii) A backlog of over 60 clinics with undictated letters, extending over 18 months and therefore no outcome or action plan;
(iii) That some patient notes were at Mr. O'Brien's home.

125. During the period of exclusion from 30th December 2016 to 24th January 2017, there were:
(i) 783 GP referrals not triaged;
(ii) 668 patients with no outcome dictated;
(iii) 307 notes returned from Mr. O'Brien's home, with 13 notes being missing;
(iv) (a new fourth concern that) 9 private patients had NHS treatment in a shorter timeframe than other patients.

126. There was a Case conference on 26th January 2017 which I attended. It was chaired by Vivienne Toal (Head of HR); also present was Dr Richard Wright (Medical Director), Anne McVey (Assistant Director of Acute Services), Dr Khan (MHPS Case Manager), Simon Gibson (Assistant Director), Siobhan Hynds, and myself.

127. The meeting had my investigation presented and the group confirmed that there was unacceptable practice in relation to delayed outcomes being dictated. The meeting agreed there was a "case to answer" and a formal investigation was required. I noted at the meeting I had no concerns identified in relation to Mr. O'Brien's clinical practice (meaning aspects of his practice, e.g., operating skills, decision making, and so on). I was of the view that Mr. O'Brien should be allowed to return to work during this investigation with close monitoring of his activity. The committee agreed and they also agreed that the operational team would decide what this monitoring would be.

128. I met Mr. O'Brien with the Head of Service on 9th March 2017 to discuss return to work plans for Mr. O'Brien. We agreed actions such as: return to work at South West Acute Hospital, patient numbers at clinics, time for dictation at clinics, clearing the backlog of administration and results.

129. Mr. O'Brien said he no longer wanted to see new patients on the basis of having the most or longest waiting times-which was shown to be incorrect, with other urologists having either longer wait times or more patients waiting.

130. Other actions included separating out oncology patients from urgent patients from the review list.

131. Mr. O'Brien also raised some health concerns Personal Information redacted by the USI [redacted] and was offered an occupational health appointment, but I recommended Mr. O'Brien discuss things with his GP.

132. I was then removed from this process and subsequently interviewed by Dr Neta Chada as the new case investigator on 24th May 2017. The contents of that report have been covered in answering questions above.

133. I met Mr. O'Brien on 25th May 2017 with Martina Corrigan (Head of Service) to advise him that he would be subject to a Serious Adverse Incident investigation (SAI). This was because 5 patients of Mr. O'Brien's, following review by another Consultant, had a cancer diagnosis. I was not involved in these case reviews or the further SAI process at all. I understood the medical director was to appoint and external reviewer for this process.

134. I can find no other record of formal or other meetings other than the job plan meetings discussed above.

135. There were email discussions in July 2017 as concerns were raised that a large number of patients (11) had urgent urological surgery by Mr. O'Brien during the course of weekend. In my view these cases were (except for one) appropriate for urgent pathways of surgical care.

136. On 19th July 2017 I was copied into email correspondence from Head of Service to the Assistant Director highlighting 75 charts in Mr. O'Brien's office.

137. On 18th October 2018 I wrote to Dr Khan and others to ask for urgent consideration as Mr. O'Brien had accumulated a large backlog of undictated letters (91) and had a large number of charts in his office (82). In particular, as I was no longer aware of outcomes of case review, I needed that team to make decisions on Mr. O'Brien

[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.

138. I was directed during all of the above processes. Firstly, I was directed by the AMD to engage on an informal basis in August / September 2016 with Mr. O'Brien. That led to an action plan which didn't ultimately happen as the Trust overtook the process with investigation under MHPS.

139. As described above, investigations were carried out by a Case Manager with me as Case investigator. I recommended at a case review on 26 January 2017 (described in my answer to Question 55 above) an action plan that allowed Mr. O'Brien to return to clinical work. At that meeting the three members of the Oversight Committee (Dr Wright, MD, Ms. Toal, Director of HR, and Anne McVey, Assistant Director obo Director Acute Services) agreed that there should be a review whether Mr. O'Brien had a comparable workload to his peers, that an up to date job plan be discussed, and that Mr. O'Brien comply with Trust policies in relation to triage, contemporaneous note taking, storage of medical records, and issues around his private practice.

[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.

140. The process of responsibility for patient safety was taken on by everyone involved. This was not my primary role to risk assess this or to mitigate this. These decisions were made by the Director of Acute Services, AMD Surgery, Medical Director, and Medical Director's office. I was directed to engage both informally and formally with Mr. O'Brien at the behest of the above, either directly or indirectly via line management routes, to achieve changes to Mr. O'Brien's behavior in the interests of patient safety. It was clearly evident to all and to Mr. O'Brien that these were all patient safety matters. To not deal with them or to fail to explore solutions by whatever means would have been to put patients at risk. Mitigations were put in place by the Oversight Group chaired by the Medical Director. These mitigations have already been summarised at para 33 of my response to Question 1 above but included a requirement that,

when urologist of the week, Mr. O'Brien action and triage all referrals for which he was responsible, with red flag referrals to be completed daily. In addition, he was not remove any notes off Trust premises, he was to dictate all clinic letters in all clinics by end of each and every clinic with an outcome and action plan for every patient attending. Finally, he was to adhere to the scheduling policy for private patients.

[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.

141. These are described already and actions against the four areas of concern highlighted already (this relates to 2017). As also highlighted already, I became concerned once more in October 2018, when outstanding numbers of dictations and charts in the office accumulated again. Once this was highlighted to me, I emailed Dr Khan on 18 October 2018 11:33 (26 minutes after receiving the email in relation to these matters from the acting Head of Service). This was escalated to the Assistant Director for the Medical Director's office and Dr Khan. I don't know what further action, sanctions or mitigations flowed from that, because I suddenly had to take sick leave in October which more or less extended into March 2019. However, I was still in email contact with Mr. O'Brien about his job planning on 31 October 2018 and 5 December 2018.

[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?

142. There was regular review by the operational team of triages outstanding, charts in office, dictations completed (or not completed), and utilization of theatre operating time for patients by clinical priority. This was frequent and was, in my opinion, excellent.

[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?

143. As stated in response to Question 59, there were frequent reviews of numbers across four domains, which review was fair, accurate, frequent and timely, and which helped to highlight the later recurrence of the patterns raised initially in 2016/2017. This reemergence of issues was highlighted in October 2018 to me and I forwarded my concerns to the Medical Director's office.

[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?

144. The initial agreement in January 2017 and action plan was, in my opinion, a good one. It allowed Mr. O'Brien to return to work and he accepted the action plan and he accepted engagement in the job planning process. Regular monitoring by the operational team initially showed resolution of all the concerns. However, the job planning process was protracted, and highly complex; for example, see the following email from Mr. O'Brien *[20180920 - E JOB PLAN located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD].*

145. Although monitoring was being undertaken, and support was being provided (especially by the Head of Service, Martina Corrigan), Mr. O'Brien

reverted to previous behaviour. A response to this should have been actioned sooner and there should have been further exploration with Mr. O'Brien. Perhaps Mr. O'Brien's working practices and speed of working were different from the norm but that should, to a degree, have been accepted. Mr. O'Brien could have been offered reduced clinic numbers and reduced other responsibilities. For instance, he stated "he no longer felt it was fair to continue to see new patients" [*20170315 - E meeting with Mr O'Brien and Mr Weir 9 March 2017 located in Relevant to PIT – Evidence Added or Renamed after 19 01 2022 – Evidence No 77- No 77 Colin Weir CD],* on 9th March 2017 (recorded in minutes of meeting with myself and Martina Corrigan, section 3) and if that had happened then he would not have needed to triage (new) patients-one of the areas of concern. Myself and Martina Corrigan's opinion at that time was that Mr. O'Brien was very capable of seeing new patients, he was already undertaking clinics with a mix of new and review patients. However, in retrospect, occupational health assessments might have helped inform the monitoring and decision around workload better. A wider issue of supporting Consultants as they move to late middle age and towards retirement with reduced clinical and on call activity should also have and be considered by the Trust.

[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

146. Concerns were raised by Mr. O'Brien during the course of the investigation under the terms of MHPS. In the report of that meeting with me (meeting on 24th January 2017, and report 26th January 2017), Mr. O'Brien raised his own concerns of increased workload. He felt he had significantly more operating sessions than peers in his job plan and that he notified Trust managers that he did not have capacity to triage GP referrals. He stated that he was using his SPA (supporting professional activity - which should be free

of time involving patient activity) to undertake clinical work, namely surgical procedures and reviews of patients. He stated he was working high numbers of hours each week.

147. Those factors were considered by the team managing the whole process. Mr. O'Brien had asked to return to work within an agreed framework and he agreed to that. In addition, he agreed to engage with me in the job planning process as outlined above in this statement.

148. Oversight of this was between the Medical Director, the Oversight Committee, and Directorate of Surgery and Elective Care.

149. Mr. O'Brien stated, in a minuted meeting on 9th March 2017, that he felt he could not continue to see new patients because he had the longest waiting times. However, this was found not to be the case, as one other consultant had more patients waiting to be seen (267 vs 257 for Mr. O'Brien) and one other consultant had a longer wait time (162 weeks vs 152 for Mr. O'Brien).

150. As mentioned in my answer to Question 61, Mr. O'Brien expressed a desire for no new patients. However, Mr. O'Brien would take longer to see equivalent numbers of patients from his peers. The workloads presented to each consultant in the urology team, i.e., triage, waiting list times and numbers of outpatients were equivalent. They were all, however, substantial. This was the case in the wider NHS/HSC setting for other specialties and was not unique to urology.

[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?

151. I did not raise the concerns at any time. The concerns predated my appointment. They were referred to me to help deal with the concerns, firstly on informal basis and then under MHPS as Case investigator. Subsequently, as two further concerns were raised with me, I determined next steps.

152. In the first instance, and as described above, there was a concern regarding numbers of emergency patients undertaken by Mr. O'Brien during the course of a weekend. I reviewed the cases and found only one case of potentially dubious merit, with the others in my view being cases of merit of urgent undertaking in patients' best interests. I forwarded my views to the Assistant Director.

153. The second set of concerns was a recurrence of a lack of timely referral triage and a dictation backlog. However, these were raised from the acting Head of Service to the Assistant director. I was copied into this on 18th October 2018 and immediately raised this as a concern to Dr Khan and Simon Gibson on the same day. I was not copied into further action or correspondence but I was due to undergo a period of sick leave [redacted].

[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.

154. My support role was to ensure Mr. O'Brien had a fair job plan that reflected his workload. I recorded with him a recommendation to seek the services of his GP in relation to health concerns he raised. The Oversight committee would have had the main role in recommendation or directing support.

[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.

155. I don't have any recollection of risk register documents or Trust governance documents that I was involved with or discussed with me. There may have been discussions at governance meetings but I was not in attendance at these.

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.

156. No.

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

157. I believe the urology service was very busy and stretched. But that did not explain the behavior of one Consultant which, in retrospect and at the time, was outside acceptable practice. The issue was the difference of opinion of a single Consultant versus their peers, the Trust, and its Acute Services Directorate. I believe a change in AMD and CD did not help to sustain an approach with good briefing of previous initiatives. The Directorate should have employed external review and had an experienced team to provide ongoing oversight. It should not have been the appointed task of a newly appointed Clinical Director (me) in the first few weeks of that appointment to undertake a completely informal attempt to resolve a previous longstanding issue that previous senior managers had failed to resolve. In my view it was a mistake to be appointed to be lead Case Investigator under MHPS, therefore creating a conflict of roles, viz, Case Investigator vs. Clinical Director for the same consultant (Mr. O'Brien). However, this mistake was later rectified and a new Case Investigator appointed.

158. There was too much separation between clinical and operational management and there should have been regular team meetings of all concerned. These should have been minuted.

159. However, despite multiple meetings across MHPS, job planning, and frequent review within a set framework, the consultant reverted to the same pattern of behaviour. It is hard to know how to change this when considerable effort was made to avoid this; maybe an acceptance that the consultant could not cope with the workload but this also required the individual to accept changes in their practice commensurate with safe working.

[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?

160. In retrospect, a much closer working relationship between senior operational and clinical managers was needed as well as better oversight by having all individuals involved, not just by frequent email. Governance at the unit level would need better support with a governance lead appointed or someone with governance responsibility.

[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.

161. The engagement was frequent, and clearly identified. I believe a large number of individuals were involved in attempts to resolve the issues in the unit (as detailed in various answers above). I believe reasonable attempts were made to resolve the issues in the best interests of patients both informally and formally and with close monitoring.

[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?

162. I have outlined areas in answer to Questions 67, 68, and 69 above. If I had more experience in the role, I believe that I would have demanded much more briefing, backup and meetings with a wider team. I would have refused to become a case investigator while being Clinical Director for the same individual.

163. I believe that intervention to suspend Mr. O'Brien sooner in 2018 or even 2017, when charts began to reaccumulate in Mr. O'Brien's office, would have been appropriate. But a regular review by an oversight group would have actioned this sooner.

164. It was probably a mistake to allow Mr. O'Brien to return to the pattern of working he wanted. For instance, the clinic at SWAH was costly of time and productivity.

165. I tried to advocate for Mr. O'Brien during my investigation when he wanted to return to work. That was not a mistake nor a matter of regret on my part but I believe that, in order to be balanced and fair, it needs to be stated.

[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?

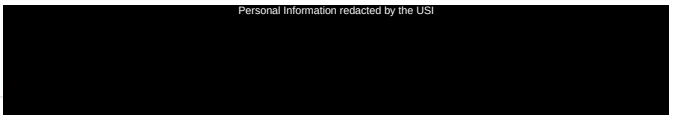
166. I believe I have answered this already. I did not raise governance concerns.

[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?

167. No.

Statement of Truth

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

Signed: _____ 

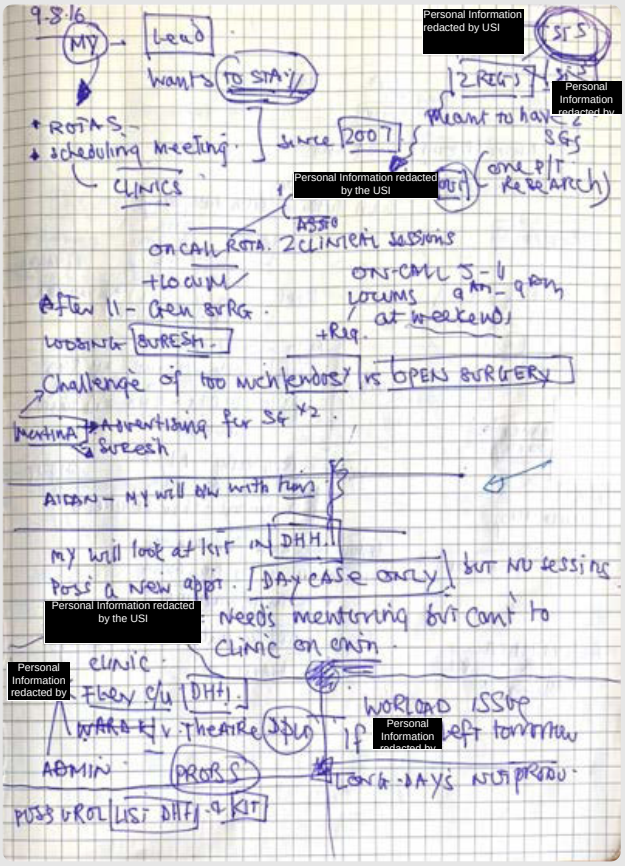
Date: _____21/6/2022_____

S21 22 of 2022

Attachments

Attachment	Name
1	personal handwritten notebook
2	job description Doc b
3	job description doc c
4	job description doc d

Scanned Documents



NORTHERN IRELAND MEDICAL AND DENTAL TRAINING AGENCY

Job Description (Draft)

Title of Post:	Foundation Training Programme Director (FTPD)
Purpose:	The Foundation Training Programme Director is responsible for the overall management and quality assurance of a Foundation Programme, which consists of 20 – 40 placements designed for foundation training across a health economy (Acute, Mental Health and Primary Care Trusts). S/he will work with the local lead educators to ensure that each placement of the programme meets the Deanery standard for training and that each trainee is able to access a comprehensive range of experiences which will enable them to gain the competencies necessary for full registration and completion of Foundation Training.
Accountable to:	Jointly to the Postgraduate Dean and to the Chief Executive of the Trust
Reports to:	The Director of Postgraduate Medical Education (DME)/Clinical Tutor (CT) of the Trust holding F1/2 contracts [or Medical Director if FTPD is also DME]
Appointment Procedure:	Appointed in joint agreement with the Medical Director and Postgraduate Dean
Tenure:	3 years (with review after 12 months)

Key Responsibilities of Post:

1. To deliver a high quality Foundation Training Programme

a. Work with the Foundation Board to ensure that the training programme meets the requirements with Deanery educational contracts for foundation training and the ten principles described in 'Modernising Medical Careers – The Next Steps'

b. Work with local lead educators (Clinical Tutor, Course Organiser, College Tutors) to ensure that each placement in the programme provides high quality experience and meets the educational aims for the programme and those specified for the placement.

c. Ensure that all educational and clinical supervisors have received appropriate training (including equality and diversity training) for their role as educators and assessors.

d. Ensure that all educational supervisors are familiar with the Deanery and national documentation to be completed prior to registration, completion of foundation training and for revalidation.

e. Provide annual reports to the Foundation School so that they can be confident that the programme is meeting the expected standard.

f. When required, produce materials about the programme to ensure effective recruitment to the Schools and to F2 placements.

2 To organise and ensure delivery of a high quality interactive generic professional programme for all Foundation Trainees and to enable the attendance of foundation trainees in the programme.

a. In conjunction with the Associate Dean and other foundation programme directors, determine a local

model for delivery of generic professional training to a minimal equivalent of 3 hours/week (required in deans' educational contracts) for F1 trainees (which may be delivered weekly or as full day equivalents, e.g. 2 hours /week is equivalent to 6 days of training/annum).

b. In conjunction with the Associate Dean and other foundation programme directors, determine a local model for delivery of generic professional training to a minimal equivalent of 10 days/annum for F2 trainees.

c. In conjunction with the Associate Dean and other foundation programme directors, determine what aspects of the specific and generic competencies are best taught in a peer group setting and arrange a suitable programme.

d. To consider the possibility of creating such programmes in whole or in part to be delivered in an interprofessional context.

e. To ensure that the F1 and F2 local generic syllabuses conform at a minimum to the syllabuses and are delivered appropriately in year 1 and in year 2.

f. Work with local lead educators and Trust HR Departments to ensure that Trusts are familiar with the timetable for Foundation Training and that foundation trainees have clinical duties arranged to enable them to regularly attend their generic training.

g. To define the educational aims of each session, consider the most effective educational method and most effective facilitator thereby producing a trainee centred interactive educational programme

h. To evaluate each session and the overall programme giving feedback and producing reports as appropriate.

3. To work with the local trusts to ensure effective development of educational supervisors for Foundation Trainees.

a. To maintain databases of educational supervisors including their potential to contribute to the generic professional programme and their preparation for their role.

b. To devise an effective method of selection and reselection of educational and clinical supervisors in conjunction with Director of Medical Education/Clinical Tutor, local HR Departments and the Deanery.

4. To contribute to the overall development of the Deanery

a. To attend development programmes for clinical educators and maintain skills in medical education.

b. To lead development projects by mutual agreement and share the results.

5. To work with other Tutors within the Health Economy to ensure Foundation training benefits from a co-ordinated approach

6. To assist with the selection and placement of F1 and F2 trainee into foundation programmes.

73808040 Southern Health and Social Services Trust

Associate Medical Director – Medical Education and Training

JOB DESCRIPTION

Responsible to:
Medical Director

Accountable to:
Medical Director

Hours:
Salaried part time position

Job Summary

The Associate Medical Director Medical Education and Training will provide leadership in the delivery of undergraduate and postgraduate medical education in the Southern Trust, working closely with other members of the Medical Directorate. The post holder will work closely with Associate Medical Directors, educational supervisors and post-graduate tutors with regard to the development, delivery and quality assurance of medical education in line with appropriate standards as defined by the Foundation Programme and the Post Graduate Medical Education and Training Board (PMETB). The post holder will provide leadership and management of the implementation of the PMETB Quality Assurance Framework (QAF) and quality assurance processes associated with the Northern Ireland Medical and Dental Agency (NIMDTA). The post holder will ensure excellent communication between the medical education function of the Trust and the Associate Medical Director of Research.

The post holder will play a lead role in the development of the Southern Trust Multi-disciplinary Learning and Development Strategy.

KEY RESULT AREAS

Strategy Development

- Contribute to strategy development as part of the Medical Directorate Management Team.
- Advise the Management Team of the Directorate on priorities and pressures and contribute to the development of the Annual Directorate Management Plan and the Trust Delivery Plan.
- Play a lead role in the development, implementation and monitoring of a Trust-wide Multi-disciplinary Learning and Development Strategy which embraces the principles of continuing professional development and life-long learning, and which reflects the changing needs of the workforce.
- Develop a robust education governance framework that can be readily integrated into the Trust's Integrated Governance Strategy and Assurance Framework.

- Play a lead role in the development, implementation and monitoring of educational governance arrangements in line with the Trust integrated governance strategy.

Service Delivery

- Function as a member of the Directorate Management Team with responsibility to contribute to strategic development and operational excellence in respect of medical education.
- Establish appropriate systems, policies, procedures and management arrangements for education governance within the Trust.
- Support the clinical and social care governance functions of the Trust.
- Work with partners in supporting regional medical education and training.
- Represent the Southern Trust in discussions with external bodies in relation to matters arising in relation to medical education and training.
- Monitor and ensure compliance with education and training agreements and contracts with external bodies at undergraduate and postgraduate level.
- In conjunction with the Senior Manager, Medical Education and Research & Co-Director of Medical Education, manage the medical education resources of the Directorate to deliver undergraduate and postgraduate medical education.
- In conjunction with other Directorate staff develop, implement and monitor budgetary arrangements for medical education within the Southern Trust.
- Provide leadership to innovative approaches to the delivery of medical education in line with the wider HPSS modernisation and reform agenda.
- Provide leadership in the effective implementation and monitoring of New Deal, European Working Time Directive (EWTD) and Modernising Medical Careers (MMC).
- Work closely with the Senior Manager, Medical Education and Research and other appropriate service directorates to ensure the effective and efficient management of postgraduate medical exams, ensuring appropriate standards are met.
- Work with the Senior Manager for Medical Education and Research to secure the provision of high quality education and training facilities.
- In conjunction with the Senior Manager, Medical Education and Research develop, implement and monitor appropriate processes to support the introduction of the PMETB Quality Assurance Framework and the quality assurance processes of NIMDTA in the delivery of medical education.
- In liaison with the Senior Manager Medical Education and Research and appropriate Associate Medical Directors facilitate Deanery, College and PMETB visits and subsequent action plans.
- Support the work of educational supervisors/postgraduate tutors to realise their potential, developing systems to assist in quality assurance, securing funding, securing intellectual property and clinical training resources and transferring new educational techniques and technologies.
- In conjunction with the Senior Manager, Medical Education and Research, work with the staff of the Medical Education Centre, Craigavon Hospital, to establish a high-quality facility to support clinical and skills education and training to meet the needs of the Southern Trust workforce.
- Support the delivery of Trust-wide training programmes including those associated with the Southern Trust Patient/Client Safety Programme.

- In conjunction with the Senior Manager Medical Education and Research and Associate Medical Directors manage the development and delivery of a Trust-wide induction programme for junior doctors.
- Represent the Southern Trust in the design of systems and process for:
  - Brokering arrangements between external bodies and sponsors and program directors for educational programmes and packages;
  - Supporting educational information management and ICT needs;
  - Advising clinical educators on program design and quality assurance; and
  - Designing novel multi-professional assisted learning software packages.

Quality and Information Management

- Work with Directorates and the Effectiveness and Evaluation function of the Trust to ensure that the programme of multi-disciplinary audit supports Trust education and training needs.
- Support the effective implementation of Trust educational policies and procedures.
- Support the Senior Manager, Medical Education and Research in the collation and analysis of medical education and training information, and quality assure informative and meaningful reports for appropriate Trust committees, including the Governance Committee and Trust Board.
- Support the provision of integrated information in respect of multi-disciplinary education and training to support the management of integrated governance within the Southern HSC Trust.

Corporate Responsibilities

- Attend governance meetings as required to provide high quality support and information concerning those areas for which he/she is responsible.
- Provide leadership to the Southern Trust's Undergraduate and Postgraduate Committees.
- Develop and maintain working relationships with senior colleagues to ensure achievement of directorate and corporate objectives.
- Contribute to the Trust's overall corporate governance processes to assure safe and effective care for patients and clients and compliance with public sector values and code of conduct.
- Maintain good staff relationships and morale amongst the staff reporting to him/her.
- Where appropriate, review the organisation and establishment levels and ensure that they are consistent with achieving objectives, recommending change where appropriate.
- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- Take such action as necessary in disciplinary matters in accordance with procedures laid down by the Trust.

- Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for which he/she has responsibility.

General Responsibilities

- At all times provide a caring service and ensure that those whom they come into contact with are treated in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy through the course of their employment.
- Ensure ongoing confidence of the public in service provision.
- Comply with the HPSS Code of Conduct.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director Medical Education and Training works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Medical Director.

April 2008

Personal Specification

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and:

Knowledge, skills and experience required:

- Hold a medical or dental qualification, GMC registration and specialist accreditation.
- Have at least 2 years experience of managing people
- Demonstrate evidence of successful education leadership.
- Demonstrate evidence of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.
- Have an up to date, working knowledge of education governance as applied to health and social care in Northern Ireland.
- Have excellent communication skills, both orally and in writing.
- Be prepared to undertake clinical management development.

Shortlisting

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to the post and the extent to which they satisfy each criterion specified.

Southern Health and Social Care Trust

Quality Care - for you, with you

Ref No: 73816020

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Clinical Director – Surgery & Elective care (2 posts)

BASE: Craigavon Area Hospital / Daisy Hill Hospital

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Services

OPERATIONALLY RESPONSIBLE TO: Associate Medical Director – Surgery and Elective care

ACCOUNTABLE TO: Chief Executive

HOURS: Salaried Part-time position

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of Surgical Services in the Southern Health and Social Care Trust.

There are 2 posts available;
He/She will:

- Participate as a member of the Surgery and Elective Care Divisional Team;
- Be responsible for medical operational issues within Surgery across the Trust.
- Provide professional advice to the Associate Medical Director and Divisional team on professional medical issues of the Division.
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY RESPONSIBILITIES

Setting Direction:

- To support the Trust in the development of a high quality, responsive scheduled and unscheduled care services, ensuring that regional and local targets are achieved.
- To advise the Management Team of Divisional priorities and pressures across the Division.

- Provide leadership and direction to consultants and other medical staff within the specialty.

Service Delivery:

- To function as a member of the Divisional management team with responsibility for medical operational and professional issues within Surgery and Elective care.
- Work with the Associate Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the Division.
- Work with the Divisional Team to use the resources of the Division to deliver, in both quality and quantity, the activity and targets agreed for the Division.
- Work with the Surgery and Elective care Divisional team to deliver efficient, effective services within the agreed financial budgets and to provide advice and guidance on the costs and benefits of planned developments.
- Work with the Surgery and Elective Care Divisional Team in supporting the modernisation of related services.
- To support the Trust in planning a response to major incidents and outbreaks.

Quality, Communication and information management

- Provide clinical leadership to ensure the implementation of patient safety initiatives.
- Support the Associate Medical Director to ensure a programme of multi-professional clinical audit is implemented within the Division that supports the Southern Trust integrated governance strategy and support the development of benchmarking activities within the Division.
- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the specialty.

Professional Leadership

- Support the Associate Medical Director to ensure the highest standards of clinical effectiveness and medical practice in the Division, including the consideration / implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines, SAI recommendations and Regional and National Reports
- To place Patient Safety at the centre of specialty activity

Medical Education and Research

- Work with the Associate Medical Director to support the development and delivery of Education and Research within the specialty, ensuring the appropriate Governance arrangements are in place

Leading the Medical Team

- Support the Associate Medical Director in the implementation of the consultant contract within the specialty, ensuring the contract supports modernisation, quality improvement and achievement of access targets.
- Support the Associate Medical Director in the effective implementation and monitoring of modernising medical careers (MMC) and EWTD for junior doctors.
- Support the Associate Medical Director in co-ordinating the appraisal of all grades of doctors, including locum tenens, in line with regional guidance.
- Where required, take part in the recruitment process for new doctors or ensure that other colleagues do so effectively.
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- Work with the Associate Medical Director to ensure a system of induction is in place for all doctors within the specialty.
- Work with the Associate Medical Director to develop and lead a team of Specialty/Site Leads to assist the Trust in the redesign, modernisation and improvement of service delivery.
- Support the Associate Medical Director in the appraisal of all grades of designated doctors, including locum tenens, in line with regional guidance.
- Ensure that doctors within the specialty comply with arrangements for the assessment of fitness for clinical work.
- Work with the Associate Medical Director and Assistant Director of Surgery and Elective Care to ensure the equitable and fair management of annual, discretionary and study leave process which meets the needs of the service and the development needs of the medical workforce within the Trust.

Collaborative Working

- Actively promote the development of clinical and professional networks between the Trust hospital sites.
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated.
- Support the development of effective multi-professional team working and communication across both acute hospital sites

General Responsibilities

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.

- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS code of conduct.

Responsibility Allowance

- Responsibility Allowance: **£7,525 per annum** (This is a pensionable allowance)

- Dedicated time within job plans between 0.25 PA and up to a maximum of **1 PA per week.** This time allocation will be timetabled into the job plan as additional HPSS responsibilities and will be proportionate to the demands of the role, size of the division etc.

- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE: Clinical Director – Surgery and Elective Care (2 posts)

DIRECTORATE: Acute Services

Ref No: 73816020 **January 2016**

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*

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

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

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration and specialist accreditation (CCT)
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be required to meet with Dr Richard Wright, Medical Director to allow him to further discuss the role of Clinical Directors in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Dr Wright directly on 07702090486 as soon as possible.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are short-listed for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from *http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/*

The successful candidate will be appointed for a period of 1 year subject to satisfactory performance.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

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