Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Ms. Wendy Clayton
Head of Service ENT & Urology Ophthalmology & Outpatients
Surgical Clinical Director
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

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 25 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:

Ms. Wendy Clayton
Head of Service ENT & Urology Ophthalmology & Outpatients
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

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

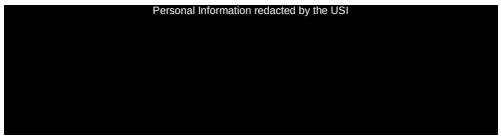
APPLICATION TO VARY OR REVOKE THE NOTICE

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

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

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

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 25 of 2022]

General

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

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

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

Your position(s) within the SHSCT

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

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

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

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

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

Urology services/Urology unit - staffing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Engagement with unit staff

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

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

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

Governance – generally

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concerns regarding the urology unit

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. O'Brien

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Learning

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

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

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

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

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

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

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

NOTE:

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

SCHEDULE
[No 25 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.

1.1 I was employed by Craigavon Area Hospital Group Trust (CAHGT) from 28 November 1994. I transferred to the new Trust, Southern Health and Social Care Trust (SHSCT), in April 2007. At this stage, I was Cancer Services Co-ordinator, Band 5. My main responsibilities and duties included daily administrative co-ordination of cancer services, the co-ordination of the multidisciplinary team meetings, and the line management responsibility for the administrative and clerical staff within Cancer and Clinical Services/Anaesthetics, Theatres and Intensive Care CCS/ATICS.

1.2 In July 2007 to March 2016, I was employed as Operational Support Lead (OSL) for Cancer & Clinical Services (CCS) and Anaesthetists, Theatres and Intensive Care (ATICS), Band 7. I was responsible for the delivery and monitoring of the elective pathways and performance, supporting the Heads of Service and Assistant Director within CCS/ATICS. I also had line management responsibility for the administrative and clerical staff within the division, with Service Administrators reporting directly to myself.

1.3 In April 2016, Acute Services was re-structured, I was transferred side-ways and became the OSL for Surgery and Elective Care (SEC) / ATICS along with my line manager Ronan Carroll. SEC includes General Surgery, Urology, ENT and Trauma & Orthopaedics. I was responsible for the delivery and monitoring of the elective pathways and performance, supporting the Heads of Service and Assistant Director within SEC/ATICS.

1.4 I first became aware of concerns relating to Mr O'Brien as detailed in question 54 between 23 December 2016 and 8 March 2017. My line manager Ronan Carroll, AD for SEC/ATICs, requested that I provide information on charts tracked to Mr O'Brien's office and patients that had been seen privately and who subsequently had surgery in the Trust. I was not given a rationale for this request.

1.5 On 23 December 2016, I undertook an exercise on the number of charts which were tracked to Mr O'Brien's office in relation to 11 clinics which Mr O'Brien had undertaken in South West Acute Hospital (SWAH). There were a total of 183 patient attendances across the 11 clinics, a random sample of these patients was selected to establish the volume of charts tracked to Mr O'Brien's office. The attendances of 98 patients were screened and the exercise demonstrated that 55 charts were tracked to Mr O'Brien's office (56%).

1.6 Also on 23 December 2016, as requested by Mr Carroll, I ran a PAS query to check the number of charts tracked in total to Mr O'Brien's office. This revealed 365 charts were tracked to his office on that date.

1.7 On 13 January 2017, Ronan Carroll requested again that I run a query from PAS on the number of charts tracked to Mr O'Brien – this revealed 35 charts were tracked at that point.

1.8 On the 15 October 2018, when Martina Corrigan was [redacted], I was requested by my line manager Ronan Carroll to update an action plan with 4 concerns in relation to Mr O'Brien; (i) outstanding triage, (ii) notes in Mr O'Brien's office, (iii) dictation backlog, and (iv) private patients having surgery. During this period, I was Interim Head of General Surgery, Endoscopy and Orthodontics.

1.9 The following day, on the 16 October 2018, I sent an update to Ronan Carroll stating that there were 82 charts tracked out specifically to Mr O'Brien and that I had requested an update regarding the typing backlog from Collette McCaul, Service Administrator for Urology. Collette reported directly to Katherine Robinson, Head of Admin and Functional Services.

1.10 On the 17 October 2018, I forwarded an update on the outstanding digital dictation for Mr O'Brien to Ronan Carroll indicating that there were 117 charts waiting on dictation.

1.11 On the 22nd October 2018, following request from Ronan Carroll, I emailed updated information regarding Mr O'Brien's 4 specific concerns (i) outstanding triage, (ii) notes in Mr O'Brien's office, (iii) dictation backlog, and (iv) private patients having surgery. This exercise was completed in conjunction with Brigeen Kelly, Head of Service for Trauma and Orthopaedics.

1.12 On the 26 October 2018, Ronan Carroll emailed myself and Brigeen Kelly, Head of Trauma & Orthopaedics, to advise that he still required monitoring of Mr O'Brien's 4 concerns; (i) outstanding triage, (ii) notes in Mr O'Brien's office, (iii) dictation backlog, and (iv) private patients having surgery, until Martina Corrigan's return on the 5th November 2018.

1.13 On the 26 and 29 October 2018, I emailed Brigeen Kelly an update on how to extract information on the 4 x Mr O'Brien concerns which required to be monitored as I was going on a period of planned leave.

1.14 While I provided this information on the direct request from Ronan Carroll for the action plan, I was not directly involved in any discussions or meetings in relation to Mr O'Brien.

1.15 In October 2020, I was asked to backfill the role as Interim Head of Urology, ENT, Outpatient and Ophthalmology Services, while the current Head of Service, Martina Corrigan, was seconded to undertake a Urology service lookback exercise.

1.16 During my tenure as Interim Head of Urology Services, I operationally managed the service on a day-to-day basis and was not involved in the Urology services lookback review at that time.

1.17 In November 2021, as Interim Head of Urology Services, I became a member of the Urology Lookback Steering Group. Members of this group included; Melanie McClements, Chair of the meeting (Director of Acute Services), Sarah Ward, Maria O'Kane (Chief Executive), Damian Gormley (Deputy Medical Director), Ronan Carroll (AD for SEC/ATICS), and Mark Haynes, (DMD). The remit of this meeting was to determine the volume of patients that remained under the care of AOB between January 2019 and June 2020 (an 18 month period).

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.

2.1 All documents that I am aware of and that are relevant have been referenced in my responses to questions 4-72 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.

4.1 Qualifications:

a. I left Portadown College in June 1993 with 2 A levels;
b. I gained my LCCI Personal Secretary qualification in June 1994;
c. I studied part time while working and achieved my Diploma in June 2000 and Advanced Diploma in Administrative Management in June 2002.

4.2 Occupational History prior to commencing employment with SHSCT:

a. I worked in [redacted] as a Personal Secretary for 6 months from June 1994.

b. I commenced in Craigavon Area Hospital Group Trust (CAHGT) on 28 November 1994; my employment history report was provided by Ciara Rafferty, Senior Human Resource Data Analyst. **20220503 question 5 WC SHSCT employment history. This can be located at Attachment folder S21 25 of 2022- Attachment 1**

c. My positions in CAHGT were:

- from 28 November 1994 - Grade 2 Clerical Officer within Paediatrics and Medical Divisions;
- between 18 July 1999 and 28 October 1999 - I was upgraded to Grade 3 within Medical Division;
- between 29 October 1999 and 29 July 2007 - I was Grade 4, then upgraded to Grade 5 as Cancer Services Co-ordinator;
- April 2007 - I transferred to the Southern Health and Social Care Trust (SHSCT) as a Band 5 Cancer Services Co-ordinator.

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.

5.1 As described in Question 4, I was employed by CAHGT from 28 November 1994 and then moved across to the new Trust – Southern Health and Social Care Trust (SHSCT) - in April 2007. My roles, duties, and responsibilities in SHSCT were as follows:

a. Cancer Services Co-ordinator, Band 5 – from 29 October 1999 to 29 July 2007.

- The daily administrative co-ordination of cancer services.

- The co-ordination of the multidisciplinary.
- Line management responsibility for the administrative and clerical staff.
- Work with the Lead nurse in the implementation of new systems.
- Yes, I felt the job description was an accurate reflection of my duties.

19991029 question 5 Band 5 Cancer Coordinator JD. This can be located at Attachment folder S21 25 of 2022- Attachment 2.

b. Operational Support Lead (OSL) for Cancer & Clinical Services (CCS) and Anaesthetists, Theatres and Intensive Care (ATICS) – Band 7 – 30 July 2007 to 31 March 2016.

- CCS includes Cancer, Diagnostics, Radiology and AHP specialities.
- I was responsible for the delivery and monitoring of the elective pathways and performance, supporting the Heads of Service and Assistant Director within CCS/ATICS.
- I had line management responsibility for the administrative and clerical staff within the division, with Service Administrators reporting directly to myself.
- Yes, I felt the job description was an accurate reflection of my duties.

20170601 question 5b OSL Band 7 – JD. This can be located at Attachment folder S21 25 of 2022- Attachment 3.

c. Operational Support Lead (OSL) Surgery & Elective Care (SEC) and ATICS – Band 7 – I moved horizontally to SEC/ATICS with the Assistant Director (AD) Ronan Carroll in April 2016. I was the Operational Support Lead for SEC/ATICS from 01 April 2016 to 19 November 2017 and then again from 21 January 2019 to 20 October 2019.

- SEC includes General Surgery, Urology, ENT and Trauma & Orthopaedics.
- I was responsible for the delivery and monitoring of the elective pathways and performance, supporting the Heads of Service and Assistant Director within SEC/ATICS.
- I did not receive a new job description when transferred horizontally to this post.
- No new duties or responsibilities came with this role.

20170601 question 5b OSL Band 7 – JD. This can be located at Attachment folder S21 25 of 2022- Attachment 3.

d. Interim Head of Service for General Surgery, Endoscopy, Breast and Orthodontics – Band 8b – 20 November 2017 to 20 January 2019.

- I covered a 14 month period of maternity leave for Amie Nelson, Head of Service for General Surgery, Endoscopy, Breast and Orthodontics.
- I was responsible for the operational performance, governance and strategic development and monitoring of the services.
- I provided leadership and guidance to the division.
- I represented the Trust in regional strategic meetings and I was responsible and accountable for the delegated budget, supporting development of Investment Proposal Templates (business cases).

- Yes, I felt the job description was an accurate reflection of my duties. **20171101 question 5 JD Head of Gen Surgery, Endo, Breast and Orthodontics. This can be located at Attachment folder S21 25 of 2022- Attachment 4.**

e. Interim Head of Service for Trauma & Orthopaedics – Band 8b – 21 October 2019 to October 2020.

- I covered a 13 month period of [redacted] for Brigeen Kelly, Head of Service for Trauma & Orthopaedics.
- My duties and responsibilities in each Head of Service role are the same, i.e., accountable to the AD for SEC/ATICS for performance, governance and finance. My skills were transferable across the surgical specialities.
- This period covered the start of Covid-19 (started March 2020) so the main focus was reform of services to adapt with the environment and challenges we were faced with due to the covid-19 pandemic. In addition, I supported staff at all levels.
- Yes, I felt the job description was an accurate reflection of my duties. **20191001 question 5 JD HOS TO Band 8B. This can be located at Attachment folder S21 25 of 2022- Attachment 5.**

f. Interim Head of Service for ENT, Urology, Outpatients and Ophthalmology – Band 8b – October 2020 to present.

- I was already in an Interim Head of Service role which was coming to the end of its contract when I was requested to transfer horizontally to Interim Head of Service for ENT, Urology, Outpatients and Ophthalmology in October 2020 to release Martina Corrigan for reasons related to the Urology Public Inquiry.
- As in 5 (e) my skills were transferable across to ENT, Urology, Outpatients and Ophthalmology and I was accountable to Ronan Carroll, AD for SEC/ATICS for performance, governance and finance.
- I did not receive a new job description when transferred horizontally to this post.
- No new duties or responsibilities came with this role.

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.

6.1 My line management in each role can be summarised as follows:

a. Administrative Co-ordinator Cancer Services, Band 5 – I reported directly to the Lead Nurse in Cancer Services and I was responsible for the

Administrative and Clerical staff within Cancer Services. This included admin staff from Band 2 to Band 4.

b. Operational Support Lead for Cancer & Clinical Services (CCS) and Anaesthetists, Theatres and Intensive Care (ATICS) – Band 7 – July 2007 to April 2016.

- I reported to Ronan Carroll, Assistant Director for CCS/ATICs and supported HOS. This is illustrated in the Management structure.
- CCS includes Cancer, Diagnostics, Radiology and AHP specialities. **20150901 question 6 CCS.ATICS Management structure. This can be located at Attachment folder S21 25 of 2022- Attachment 6.**
- As OSL in CCS/ATICS, I had 3 Service Administrators reporting directly to me (Gillian Reaney, Angela Muldrew and Lorraine Meredith). The Service Administrators were responsible for the direct Line management responsibility for admin and clerical staff throughout CCS/ATICS.

c. Operational Support Lead Surgery & Elective Care (SEC) and ATICS – Band 7 – April 2016 to November 2017 and then again from January 2019 to October 2019 – I moved horizontally to SEC/ATICS with my Assistant Director (AD) Ronan Carroll.

- I reported to Ronan Carroll, Assistant Director for SEC/ATICS and supported the HOS; Amie Nelson, HOS for General Surgery, Endoscopy and Orthodontics, Brigeen Kelly, HOS for Trauma & Orthopaedics and Martina Corrigan, HOS for Urology, ENT, Outpatients and Ophthalmology. This is illustrated in the Management structure evidence below.
  20160401 question 6 SEC.ATICs organisational structure OSL. This can be located at Attachment folder S21 25 of 2022- Attachment 7.
- As OSL in CCS/ATICS, I had 3 Service Administrators reporting directly to me; Lorraine Meredith for ATICS, Jane Scott for Surgery, Scheduling and Pre-operative assessment and Denise Park for Breast Screening and Symptomatic. The Service Administrators were responsible for the direct Line management responsibility for admin and clerical staff within their specialities. This is illustrated in the management structure.
  20160401 question 6 OSL SEC.ATICs Structure. This can be located at Attachment folder S21 25 of 2022- Attachment 8.

d. Interim Head of Service for General Surgery, Endoscopy and Orthodontics – Band 8b – November 2017 to January 2019.

- I reported to Ronan Carroll, Assistant Director for SEC/ATICS.
- I had responsibility and was accountable for General Surgery, Endoscopy, Orthodonitics and Breast services, this included the overview of all medical staff and nursing staff.

- I had responsibility for the following wards and staff; Daisy Hill hospital (DHH) elective ward, DHH female and male surgery, CAH 4 North and CAH 4 South. There were Lead Nurses aligned to manage the nursing staff; Josie Matthews for DHH and Dorothy Sharpe for CAH.
  20171130 question 6 HOS Gen Surg Endo, orthodontics and Breast. This can be located at Attachment folder S21 25 of 2022- Attachment 9.

e. Interim Head of Service for Trauma & Orthopaedics – Band 8b – September 2019 to October 2020.

- I reported to Ronan Carroll, Assistant Director for SEC/ATICS.
- I had responsibility and was accountable for the Trauma & Orthopaedic service in the Southern Trust, this included the overview of all medical staff and nursing staff.
- I had responsibility for the following wards and staff; Trauma and Orthopaedic wards in CAH along with the Fracture Outpatient Unit in CAH. Sarah Ward, Lead Nurse was aligned to manage the nursing staff.
  20190930 Q6 HOS Trauma and Orthopaedics. This can be located at Attachment folder S21 25 of 2022- Attachment 10.

f. Interim Head of Service for ENT, Urology, Outpatients and Ophthalmology – Band 8b – October 2020 to present.

- I reported to Ronan Carroll, Assistant Director for SEC/ATICS.
  20220401 doc Q6 Management structure SEC/ATICS April 2022. This can be located at Attachment folder S21 25 of 2022- Attachment 11.
- I had responsibility and was accountable for ENT, Urology, Outpatient and Ophthalmology services, this included the overview of all medical staff and nursing staff.
- I have responsibility for the following wards and staff; CAH 3 South and elective wards and all Outpatient Units through the Southern Trust (CAH, DHH, South Tyrone Hospital, Armagh Community Hospital and Banbridge Polyclinic). There are Lead Nurses aligned to manage the nursing staff; Tracey McGuigan for CAH elective ward, Paula McKay for 3 South and Josie Matthews for Outpatient services.
- Illustrated in the Management structure.
  20220401 doc Q6 HOS ENT, Urology, OPD management structure. This can be located at Attachment folder S21 25 of 2022- Attachment 12.

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

7.1 During my tenure as OSL for CCS/ATICs (July 2007 to April 2016) I was responsible for the administration and co-ordination of Cancer Services. The operational governance responsibility sat with the Head of Cancer Services (Fiona Reddick). The OSL role was to support the Head of Cancer Services (Fiona Reddick) as well as the AD for Cancer Services (Ronan Carroll). The Cancer tracker team reported to the Cancer Services Co-ordinator (Angela Muldrew) who then reported to me where responsible for the tracking of the cancer patients on the cancer pathway including escalations to the Head of the speciality service, which would have been Martina Corrigan as Head of Urology Services.

7.2 During my tenure as OSL for SEC/ATICS (April 2016 – 2017 and 2019) I was responsible for the monitoring of the elective performance within SEC, which included Urology, Martina Corrigan was the Head of Urology Services during my tenure. I would have updated performance reports discussing any issues at the HOS meetings chaired by Ronan Carroll.

7.3 As Interim Head of Urology Services it is my responsibility to ensure that the operational and governance of urology services is carried out in conjunction with the Urology medical and nursing staff. Governance is everyone's responsibility however, it is my responsibility to monitor and ensure safe practice. I am accountable to Ronan Carroll, AD for SEC/ATICS

7.4 My roles and responsibility include the following:

a. I am responsible for the operational and strategic management, for example, monitoring of performance; outpatients, cancer and inpatient / day case elective patients waiting and waiting times.
b. Provide leadership to Urology Services and progress service developments with the Urology Team.
c. Work closely with the AD for SEC/ATICS, Consultants and nursing staff within the Urology team.
d. I hold a weekly Urology Departmental Meeting to promote communication and shared learning. These meetings cover on a weekly basis; covid updates, urology public inquiry, performance, Urology CNS update and any other business. The team meeting includes all medical staff, Urology CNS, Lead nurse and once a month the Outpatients Sister and Performance Service Administrator. I have attached examples of notes from the Urology Department meeting which outline discussions and actions:

   20210204 question 7 Urology Departmental Meeting NOTES- This can be located at Attachment folder S21 25 of 2022- Attachment 13a.

   20210520 question 7 Urology Departmental Meeting NOTES- This can be located at Attachment folder S21 25 of 2022- Attachment 13b.

   20210304 question 7 Urology Departmental Meeting NOTES MC and MOK present- This can be located at Attachment folder S21 25 of 2022- Attachment 13c.

20211111 question 7 Urology Department Meeting NOTES- This can be located at Attachment folder S21 25 of 2022- Attachment 13d.

20211111 question 7 Urology Department Meeting NOTES A1- This can be located at Attachment folder S21 25 of 2022- Attachment 13e.

20211111 question 7 Urology Department Meeting NOTES A2- This can be located at Attachment folder S21 25 of 2022- Attachment 13f.

e. All nursing governance issues are escalated to Head of Service T&O and Nursing Governance (Brigeen Kelly).
f. In relation to governance as Interim Head of Service I take the lead on ensuring responses are complete for all complaints.
g. Ensure DATIX incidents in relation to urology are investigated, updated and discussed at the Patient safety meeting is relevant. The Governance team would escalate any DATIX which reaches the threshold of SAI screening.
h. Link with the Chair of the Patient Safety Meeting (PSM), Mr John O'Donoghue, from November 2021 (previously Mr Anthony Glackin).

20141101 SHSCT Grading Matrix- This can be located at Attachment folder S21 25 of 2022- Attachment 14a

20161101 Procedure for the Reporting and Follow Up of Serious Adverse Incidents- This can be located at Attachment folder S21 25 of 2022- Attachment 14b

i. Work closely with Mark Haynes, Divisional Medical Director (DMD), in relation to job planning for all Urology medical staff, ensuring clinical activity is undertaken against job plans.
j. Work closely with the Urology team to ensure Serious Adverse Incident (SAI) recommendations are progressed and updated on the action plan.
k. Governance also overlaps with Performance monitoring to improve and monitor patient pathways.
l. As Interim Head of Urology Services I meet on a monthly basis with Michael Smyth, Finance Manager for SEC/ATICs, to review the financial position at each month end and to discuss budget allocations, both current and future.
m. Standards & Guidelines – I liaise with the Acute Governance Lead (Chris Warr) and Corporate Governance Lead (Caroline Beattie) to review the guidelines against current provision and action plans against any deficits.
n. Any risks which are not resolved are discussed with the AD for SEC/ATICs and recorded on the risk register. Risks include urology performance waiting times; outpatients, inpatient/day case, planned and review backlog and reduction in elective activity

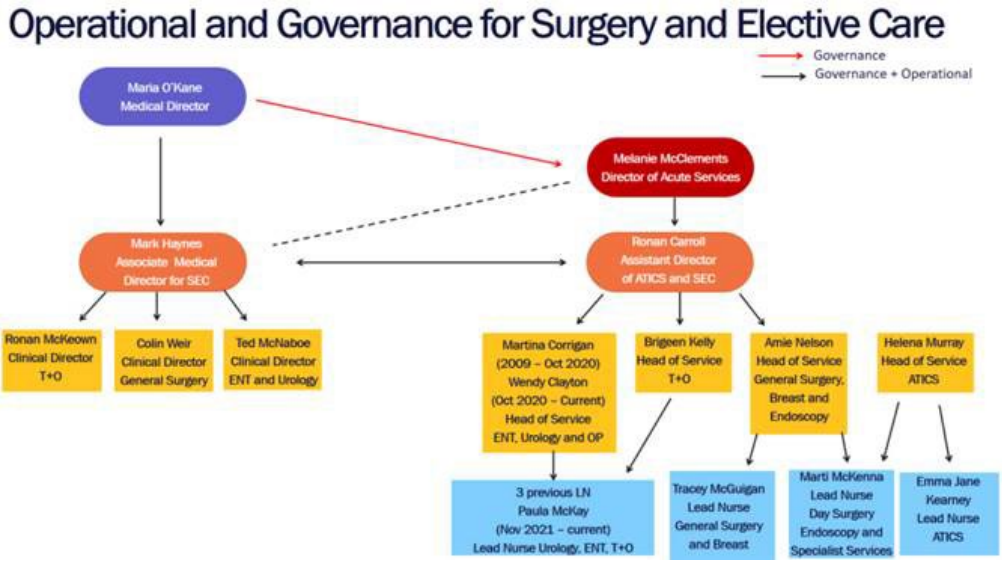
20220301 question 7 SEC risk register- This can be located at Attachment folder S21 25 of 2022- Attachment 15

o. I take part in the Head of Service Acute on call rota. I would be on call approximately twice a month; on weekdays from 5pm to 9am and at weekends from 9am for 24 hours.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and*

***governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, the Medical Director, Associate Medical Director, the Clinical Lead, urology consultants or with any other role which had governance responsibility.**

8.1 I believe the Head of Service role and responsibilities for operation and governance overlap partially with the Assistant Directors, the Clinical Director, the Associate Medical Director (which is now known as Divisional Medical Director (DMD)), the Clinical Lead, and the urology consultants.



Operational Responsibility

8.2 It is the Head of Service responsibility to oversee governance systems ensuring action plans and recommendations are followed through. I do have responsibility to monitor performance, highlight waiting time risks, and ensure clinical activity is undertaken in accordance to job plans.

Governance responsibility

8.3 It is the Head of Service's responsibility to support the medical and nursing staff, ensuring processes are in place to monitor governance. This is a shared responsibility with the AD, CD and AMD, for example:

a. Complaints – ensure complaint responses are investigated and responded to by the relevant staff, e.g., a nursing ward issue complaint would be by the Lead Nurse and Ward Sister; patient care or clinical complaints would be by the medical team; and performance issues would be responded to by myself as Head of Service.
b. Litigation – ensure litigation responses are complete within timeframe; I would receive escalations if deadlines are not met.
c. Oversight of the Corporate Senior Management Team (SMT) audits, these include weekly hand hygiene and commode audits. For April 2022, the ward 3 south achieved 100% for both audits

20220401 question 8 Rolling Commodes Exception Report- This can be located at Attachment folder S21 25 of 2022- Attachment 16a.
20220401 question 8 Rolling HH Exception Report- This can be located at Attachment folder S21 25 of 2022- Attachment 16b.

d. SAI – ensure recommendation action plans from SAIs are discussed at the Urology Departmental meeting. As evidenced in the Urology Team Departmental meeting of the 31 March 2022, Sarah Ward, Head of Clinical Assurance, attended to review and discuss the 11 MDT SAI recommendations.

20220331 question 8 Urology Team Meeting NOTES 31.03.2022- This can be located at Attachment folder S21 25 of 2022- Attachment 17a.
20220331 question 8 Urology Team Meeting NOTES 31.03.2022 A1- This can be located at Attachment folder S21 25 of 2022- Attachment 17b.

e. DATIX – trends and themes monitored and learning shared with medical and nursing staff, for example. 3 South DATIX highlights a deficit in staffing and lack of core staff and Thorndale DATIX highlights medication errors.

20220501 question 7 3South DATIX Web Report- This can be located at Attachment folder S21 25 of 2022- Attachment 18a.
20220501 question 7 Thorndale DATIX Web Report- This can be located at Attachment folder S21 25 of 2022- Attachment 18b.

8.4 It is the medical managers (CD, AMD/DMD) who ensure professional responsibility for the medical staff at all levels. This would include professional responsibility for:

a. appraisals and revalidation;
b. professional issues pertaining to medical staff being escalated to the CD, AMD/DMD.

8.5 Medical staff are managed through the CD and DMDs within the Division. I would, however, meet weekly with the DMD for Urology Services to discuss operational issues of the service.
2022 Q8 1to1 notes Mark and Wendy- This can be located at Attachment folder S21 25 of 2022- Attachment 19.

8.6 Medical staff within the Urology Service attend a monthly Patient Safety Meeting (PSM), with Mr John O'Donoghue as the PSM Chair for Urology. At this meeting, they would discuss and review Morbidity and Mortality (M&M). There is a quarterly combined Anaesthetics and Surgical PSM. I would attend the PSM on an ad-hoc basis, dependent on other commitments.

Evidence added or renamed after 19 01 2022, Acute, SEC, Document No 2M and 39 -*20210817 Q8 Urology patient Safety meeting minutes*

8.7 The below job descriptions outlines the roles and responsibilities for the CD and DMDs

20220301 question 8 CD ENT Urology JD. This can be located at Attachment folder S21 25 of 2022- Attachment 20a.
20210701 question 8 Interim DivMD JD SEC (FINAL)- This can be located at Attachment folder S21 25 of 2022- Attachment 20b.

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.

9.1 I was not involved in the regional review or establishment of the urology unit in March 2009. During this time I was OSL for CCS/ATICS and had no direct or indirect involvement. It was the AD for SEC (Heather Trouton) and Head of Urology Services (Martina Corrigan) who would have been involved.

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

10.1 As per question 9, I was not involved in the inception of the Urology unit.

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?

11.1 During my tenure as Interim Head of Service in Urology, the Integrated Elective Access Protocol (IEAP) has not been circulated to the Urology Consultants. I do not know whether the Urology Consultants are aware of the IEAP document itself as it is an administrative protocol. However, I believe they are aware of the Department targets for Cancer Services as set out in the IEAP (31 and 62 day targets) which are discussed at the Urology departmental meeting with the team. The consultants would also be aware that we are not meeting the outpatient (9 weeks) and inpatient/day case (13 weeks) targets.

11.2 As referenced in the previous paragraph, the IEAP issued on 9th May 2008, and then updated again in June 2020, was primarily an administrative protocol which outlines the rules and guidance for booking and scheduling of elective patients as evidenced below.
20200601 Q11 IEAP June 2020- This can be located at Attachment folder S21 25 of 2022- Attachment 21.
Relevant to Acute, Document Number 6 The IEAP for 2008

11.3 The IEAP set out the regional departmental targets which can be summarised as follows:

a. Outpatients 9 weeks from receipt of first referral appointment.
b. Elective inpatient/daycases 13 weeks from date a patient is added to the waiting list.
c. Cancer targets:

- 14 days – 100% for the 2 week wait breast symptomatic outpatient appointment;
- 31 days – 98% from date decision to treat to first definitive treatment;
- 62 days – 95% date of receipt of referral to first definitive treatment.

d. Diagnostic 9 week wait from receipt of referral.

11.4 In addition to the IEAP, there was a specific document for cancer performance called, 'A guide to cancer waiting times'. This is a regional cancer access standard guide which each Trust would have used when developing the processes and systems for the cancer patient along their 62 and 31 day cancer pathways.
In my role as OSL for CCS I took part in the cancer roadshows which promoted the new cancer standards and pathways and urology would have been included in these roadshows. Each cancer tumour site (including urology) was present at these roadshows and would have received a copy of the guidance.
Relevant to Acute, Document Number 11 A guide to cancer waiting times

11.5 During my tenure as OSL for CCS/ATICs between August 2007 and April 2016 and as OSL for SEC/ATICS between April 2016 and November 2017, we circulated the IEAP to the Admin & Clerical staff. We also provided IEAP awareness training sessions for all Admin & Clerical staff within Surgical (which included Urology), Medical, and Gynae Specialities in 2008 and again in 2015.

a. The OSLs were:
   - Wendy Clayton OSL for CCS/ATICS – 2007 – 2016.
   - Sharon Glenny OSL for Surgery & Elective Care (SEC) 2007-2016.
   - Pauline Matier, OSL for Integrated Maternity & Woman's Health (IMWH) 2007-2009 and replaced by Lisa McAreavey 2009 – 2016.
   - Phyllis Richardson OSL for Medicine & Unscheduled care(MUSC) 2009 – 2016 (retired in 2016); replaced by Lisa McAreavey from 2016.

b. The relevant documents included:
   - IEAP Admin powerpoint presentation October/November 2008;
   - IEAP Admin IPDC powerpoint presentation November 2015;
   - There was an IEAP presentation shared by the Belfast Trust for circulated to Admin Managers for guidance for the administrative and clerical staff.

20081001 Q11 IEAPAdmin powerpoint presentation- This can be located at Attachment folder S21 25 of 2022- Attachment 22a.

20151101 Q11 IEAP Admin IPDC powerpoint presentation- This can be located at Attachment folder S21 25 of 2022- Attachment 22b.

20211201 Q11 IEAP Training presentation- This can be located at Attachment folder S21 25 of 2022- Attachment 22c.

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?

12.1 The IEAP departmental waiting time targets as set out in the IEAP (and summarised below) were monitored by the Trust's Performance Team and also by the OSLs for each specialty. The main point of contact for Acute Services was and remains Lynn Lappin, Head of Performance for the Trust from 2011 (Lesley Leeman, Head of Performance 2007 – 2011).

a. Outpatients 9 weeks from receipt of first referral appointment;
b. Elective inpatient/daycases 13 weeks from date a patient is added to the waiting list;
c. Cancer targets:
   - 14 days – 100% for the 2 week wait breast symptomatic outpatient appointment;
   - 31 days – 98% from date decision to treat to first definitive treatment;
   - 62 days – 95% date of receipt of referral to first definitive treatment.
d. Diagnostic 9 week wait from receipt of referral.

12.2 IEAP (2020) outlines the referral pathway from receipt of GP referral (page 22 'New Referrals' point 2.3.4) and sets out the standards for registration of referral onto PAS and onward to the consultant for triage.

a. All referrals will be prioritised within a maximum of three working days of date;
b. Red flag referrals require daily triage.

12.3 Unfortunately, due to the significant waiting times currently within Urology and other specialties, the DOH waiting time targets are not met and haven't been for a number of years.

12.4 The table below demonstrates the growing waiting times since my tenure as OSL in SEC and subsequently as Interim Head of Urology Services. The data is extracted from the cancer performance report, monthly performance waiting times report, and is discussed at the meetings below:

a. Head of Service Performance meeting.
b. Urology Department Meetings; Urology Performance reports demonstrate the current urology position for the month. They monitor new outpatient waiting list positions for red flag, urgent and routine; trends of referrals; review backlog and inpatient and daycase waiting list positions.
   a. ***20211201 Question 34 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 23a***

b. ***20220301 Question 34 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 23b***

c. Acute SMT Performance meeting; the AD and, recently, the OSL was invited to attend the SMT Performance meetings.
d. Cancer Checkpoint meetings – This meeting is chaired by Barry Conway, AD for CCS.
e. HSCB performance meetings – this meeting is chaired by SPPG (previously known as HSCB) with a number of Southern Trust representatives present; Director for Acute Services, AD for SEC/ATICS and AD for CCS.

20160401 Question 12 FY2016-17 SUSPECT TUMOUR SITE UROLOGICAL CANCER 31 AND 62 DAY COMPLETED WAITS- This can be located at Attachment folder S21 25 of 2022- Attachment 24a
20190401 Question 12 FY2018-19 SUSPECT TUMOUR SITE UROLOGICAL CANCER 31 AND 62 DAY COMPLETED WAITS20220401 Q12 FY2021-22 - This can be located at Attachment folder S21 25 of 2022- Attachment 24b

	IEAP Target	Performance as at 1 April 2016	Performance as at 1 April 2019	Performance as at 1 April 2022
Red flag outpatient 1st appointment (internal target)	14 days	3.5 weeks	5-7 weeks	11 weeks
62 Day Performance (yearend)	95%	80%	54.8%	27.4%
31 Day Performance (yearend)	98%	100%	99.3%	98.15%

12.5 The below tables outline the number of Urology patients, total waiting, and longest wait (in) weeks for Urology (Sourced from Commissioning Plan Direction (CPD) Score Care month end position).

OUT-PATIENT WAITING LIST – UROLOGY – target 9 weeks

Date	Total	>9-Weeks	>52-Weeks	Longest Wait Weeks
@ 31/1/2022	**5530**	**4869**	**3763**	**313**
@ 31/3/2021	4819	4280	3461	269
@ 31/3/2020	4041	3390	2063	217
@ 31/3/2019	3754	2964	1969	167
@ 31/3/2018	2988	2253	1079	114
@ 31/3/2017	2562	1872	195	76

@ 31/3/2016	2714	2040	4	74

IN-PATIENT / DAY CASE WAITING LIST – UROLOGY
Target 13 weeks

Date	Total	>13-Weeks	>52-Weeks	Longest Wait (Weeks)
@ 31/1/2022	**2086**	**1737**	**1263**	**399**
@ 31/3/2021	2063	1728	1407	361
@ 31/3/2020	1700	1437	934	309
@ 31/3/2019	1737	1421	807	269
@ 31/3/2018	1757	1362	692	217
@ 31/3/2017	1495	890	343	165
@ 31/3/2016	970	567	301	120

12.6 As demonstrated in the table at 12.7 below, the monthly referrals into urology show a significant capacity gap with the commissioned activity volumes. This has had an impact on the waiting times and number of patients waiting for an appointment. This is illustrated in the outpatient waiting list table above; which show that, by January 2022, there were 3763 patients waiting over 52 weeks for their first outpatient appointment.

12.7 Acute performance is discussed at the Acute Senior Management Team Meeting where the Performance Head of Service, Lynn Lappin, would have presented all performance risks to Melanie McClements, Director of Acute Services. Ronan Carroll, AD for SEC/ATIC, would be present at this meeting also. In addition, the Trust would have met with the Health and Social Care Board (HSCB, now known as Strategic Planning and Performance Group / SPPG) to discuss performance against the targets.

	Total outpatient referrals	Average monthly outpatients referrals	Commissioned outpatient activity per month	Variance of capacity gap
2016/17	5121	427	299	-128
2017/18	5965	497	299	-198
2018/19	6427	536	299	-237
2019/20	6136	511	299	-212
2020/21	4484	374	299	-75

2021/22	4824	402	299	-103
Average	5492.8	458	299	-159

12.8 As OSL for CCS between August 2007 and April 2016 it was my responsibility to monitor the cancer waiting time targets (which included urology) and, as OSL for SEC/ATICS between April 2016 and November 2017, it was my responsibility to monitor the urology waiting times for outpatients and elective inpatients/daycases.

12.9 In relation to my tenure as OSL for CCS, I developed a Cancer Performance Dashboard which was discussed at a monthly Cancer Performance Meeting. These meetings were developed in April 2012 and chaired by the AD for Cancer Services. The group membership included; Assistant Directors in Surgery, Medicine and Cancer, Surgery and Gynae, Heads of Service in Surgery (which included Mrs Martina Corrigan as Head of Urology Services), Medicine and Cancer, OSLs in Surgery, Medicine and Cancer, and occasionally attended by the Director at that time, Dr Gillian Rankin. The purpose of the meeting was to share the cancer performance for the Trust along with discussion with any operational issues. I have provided as evidence an example of the notes and performance dashboards from 2012 to 2016 which outline the challenges within urology services such as capacity issues:

20121220 Q12 Cancer Perf meeting notes- This can be located at Attachment folder S21 25 of 2022- Attachment 25a
20121101 Q12 Cancer Performance Nov 12 summary- This can be located at Attachment folder S21 25 of 2022- Attachment 25b
20131101 Q12 Cancer Perf meeting notes- This can be located at Attachment folder S21 25 of 2022- Attachment 25c
20131101 Q12 Cancer Performance Nov 13 summary- This can be located at Attachment folder S21 25 of 2022- Attachment 25d
20141218 Q12 Cancer Perf meeting notes- This can be located at Attachment folder S21 25 of 2022- Attachment 25e
20141101 Q12 Cancer Performance Nov 14 summary- This can be located at Attachment folder S21 25 of 2022- Attachment 25f
20151119 Q12 Cancer Perf meeting notes- This can be located at Attachment folder S21 25 of 2022- Attachment 25g

12.10 In relation to my tenure as OSL for SEC (which included Urology), I would have provided a monthly waiting times report to the AD and HOS. This was report was discussed at the Head of Service Performance meetings on the 4th Tuesday of every month.
20160412 Q12 ATICS.SEC Performance Update- This can be located at Attachment folder S21 25 of 2022- Attachment 26

12.11 In relation to my tenure as Interim Head of Urology Services, I developed a monthly Urology Performance report which was discussed at the Urology Departmental Meeting. Waiting time issues were discussed for outpatients, elective

inpatient/daycase and cancer, with potential plans put in place to address non-compliance with waiting time targets, for example:

a. Securing an Independent Sector (IS) provider for Urology new outpatient referrals including a follow up consequences and procedures; and also an IS contract for a small amount of Inpatient Transurethral resection of the prostate (TURP) procedures.
b. Transferring of patients to other Trusts with shorter waiting times, for example, Transpernial biopsies (TP biopsy) and flexible cystoscopy to Lagan Valley Hospital and discussion regarding the transfer for patients requiring percutaneous nephrolitotomy (PCNL) procedure to the South Eastern Trust.
c. Regional capacity waiting time issues are discussed through the Regional Priority Group (RPOG). Mr Ted McNaboe, Divisional Medical Director, and Mark Haynes, Divisional Medical Director, represent the Trust on the group.
d. In addition to the RPOG meetings, I have a good working relationship with the other Trust Service Managers and would communicate directly with the other Trusts in relation to capacity for Urology patients.
e. Capacity and waiting time issues are escalated at a Regional Equalisation meeting. Lynn Lappin, Head of Performance, represents the Trust to formally request help from other Trusts.

20220506 email Q12 TP Bx Regional help RPOG- This can be located at Attachment folder S21 25 of 2022- Attachment 27a

20220506 email Q12 ST urology TURBT Transfer- This can be located at Attachment folder S21 25 of 2022- Attachment 27b

20220506 email Q12 ST urology TURBT Transfer A1- This can be located at Attachment folder S21 25 of 2022- Attachment 27c

20220506 email Q12 PCNL transfer to SET- This can be located at Attachment folder S21 25 of 2022- Attachment 27d

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?

13.1 I was not involved in the Regional Review of Urology Services, Team South Implementation Plan. I had no indirect knowledge or involvement in the Implementation Plan. In 2010 I was OSL for CCS/ATICS and the scope of my post was outside of the Implementation Plan. The Head of Service for Urology, Mrs Martina Corrigan, and the Assistant Director for Surgery and Elective Care, Mrs Heather Trouton, would have led on this plan and hold the knowledge.

II. How was it implemented, reviewed and its effectiveness assessed?

13.2 I refer to my answer at 13.1.

III. What was your role in that process?

13.3 I refer to my answer at 13.1.

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.

13.4 As indicated at 13.1, I was not aware of the Regional Review of Urology Services, Team South Implementation Plan, and had no direct or indirect involvement.

13.5 However, I have sourced a copy of the plan and reviewed it for the purpose of this statement. From reviewing the plan, I can advise the following clinical activity was being undertaken when I took up post as OSL for SEC/ATICS in April 2016, as stated in the plan:

a. Acute elective sessions, in-patient and day case, for Team South were being undertaken at CAH, South Tyrone Hospital (STH), DHH and Erne Hospital;
b. Outpatient clinics, which includes consultant-led, prostate, lower urinary tract systems (LUTS), haematuria and urodynamics were being held in CAH, STH, Armagh Community (ACH), Banbridge Polyclinic (BBPC) and Erne;
c. Daycase flexible cystoscopy sessions were being undertaken;
d. Lithotripsy service was established on CAH site.

13.6 While the sessional commitment in the plan for clinical activity was in place, in relation to the substantial backlog of patients awaiting review at consultant led clinics, the plan has not delivered in reducing the backlog of review patients. The table below outlines the backlog from when I took up post as OSL for SEC/ATICS in April 2016 to April 2022. It has to be noted that the review backlog has not grown in the number of patients waiting, however, it has not significantly reduced either. It should also be noted that the Implementation Plan was based on 5 Urology Consultants and, as at April 2022, the service had 6 Consultants.

	Number of patients on the urology review backlog	**Longest date (patients see by date)**
April 2016	1414	Jan 2013
April 2022	1389	July 2013

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.

14.1 As indicated above, I was not involved in the Regional Review of Urology Services, Team South Implementation Plan direct or indirectly. As also indicated above, I have sourced and reviewed the Implementation Plan for the purpose of my statement. However, I have not seen any governance documents, minutes of meetings in relation to the Implementation Plan.

14.2 It would have been Heather Trouton, AD for SEC, and Martina Corrigan, Head of Urology Service, who were involved in this implementation plan and would have the knowledge of Trust governance documents or minutes of meetings, and/or the Risk Registers in relation to this.

14.3 When I commenced my tenure as OSL for SEC/ATICS in April 2016 acute performance was on the Corporate Risk Register. In April 2016, this Corporate Risk Register was updated by Lynn Lappin, Head of Performance, by way of general acute risks for all specialties which would have included urology. Those risks included in the register were:

a. Reviews beyond clinically indicated timescales;
b. Outpatient (OP) access times;
c. Inpatient / Daycase (IP/DC) access times;
d. Failure to deliver SBA volumes (IP/DC and OP).

20160401 question 14 April 16 performance risk register- This can be located at Attachment folder S21 25 of 2022- Attachment 28

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?

15.1 As indicated, I was not involved in the Regional Review of Urology Services, Team South Implementation Plan.

15.2 However, from my tenures as OSL for CCS/ATICS and SEC/ATICS, I have been aware of ongoing waiting time challenges against the targets set out in the IEAP referred to in question 12. The table below illustrates the upward trajectory of waiting times for the urology elective service:

	Outpatients weeks waiting			**Inpatient / daycase weeks waiting**	
	Red flag	Urgent	Routine	Urgent	Routine
April 2016	3.5	40	74	119	120
April 2022	11	310	313	397	398

15.3 The Inpatient / daycase planned backlogs, which include Urology, have been on the Divisional SEC Risk Register from October 2016, and the access waiting times for outpatients and inpatient / daycases have been on the Divisional Risk Register from April 2019.

	Number of patients on the urology review backlog	Longest date (patients see by date)
April 2016	1414	Jan 2013
April 2022	1389	July 2013

20220401 question 15 SEC.ATICS Div.HOS.Team RR April 2022- This can be located at Attachment folder S21 25 of 2022- Attachment 29.

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?

16.1 I am unable to comment in relation to the unit being adequately resourced from its inception

16.2 During my tenure as OSL for CCS/ATIC (until 2016), I would not have been aware of issues in relation to staffing levels within urology. However, as OSL for SEC/ATICs I would have been aware from Martina Corrigan, Head of Urology Services, discussing staffing issues at the weekly HOS meetings regarding Consultant vacancies.

16.3 It wasn't until my tenure as Interim Head of Urology Services that I was made aware of the exact vacancies in the Urology Consultants workforce.

16.4 The Urology Team are funded for 7.0 whole time equivalents (wte), however, at present there are 3.5 permanent Consultant Urologists and 1 locum Consultant Urologist in post; namely Mr Haynes (part-time in the Southern Trust), Mr Glackin, Mr O'Donoghue and Mr Tyson (each of whom are full-time), and Mr Khan as a Locum Consultant Urologist. Therefore, we have a vacancy gap of 3.5 wte permanent Consultants, of which 1 is backfilled currently with a locum Consultant.

16.5 The current medical staffing complement is not sufficient to meet the demand of the Urology Service. The Consultants would each have on average 2 outpatients' and 3 operating sessions per week. As demonstrated in my answer to question 12 (specifically, the outpatient waiting-list table), the current capacity is in my view insufficient.

16.6 In addition, the Urology Clinical Nurse Specialists (CNS) - Kate O'Neill, Jenny McMahon, Leanne McCourt, Patricia Thompson and Jason Young - support the Urology Consultants to provide a safe service. Since my tenure the CNS team have commenced independent clinics for cancer and benign patients. However, there is no outpatient nursing support to these clinics. The CNS have to run their outpatient session on their own or with a Health Care Assistant (HCA) if available.

16.7 3 South ward continues to have nursing workforce issues with a high number of vacant Band 5 registered nurse (RN) posts; as at May 2022 the position in this regard is as follows:

Band 5 RN

a. Funded – 31 wte
b. Permanent – 12.15wte
c. Bank – 7.74

Deficit = 11.11wte (35%)

The ward relies heavily on locum agency bookings to ensure a safe complement on the ward.

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.

17.1 Since my tenure as Interim Head of Urology Services there have been, and there continue to be, vacancies within the Urology Service. This includes the following.

Consultant Urologists

17.2 As stated above, the Urology service is currently funded for 7.0 whole time equivalents (wte), however, the Trust is still under discussions with SPPG regarding releasing of the funding for the 7th Consultant.

17.3 As also stated above, currently we have 3.5 permanent and 1 locum Consultant Urologist in post.

17.4 The 7th Urology Consultant Investment Proposal Template (IPT) has been agreed by HSCB. However, there have been ongoing discussions regarding the funding. In the interim, the Health & Social Care Board (HSCB, now known as the Strategic Planning & Performance Group / SPPG) agreed £200k non-recurrent funding in 2020/21.

20210101 Q17 Urology 7th Consultant business case- This can be located at Attachment folder S21 25 of 2022- Attachment 30a.

20200601 Q17 Urology Allocation letter Southern Trust- This can be located at Attachment folder S21 25 of 2022- Attachment 30b.

17.5 Since October 2020, there have been 5 attempts to recruit a Consultant Urologist with no success. In February 2022, the advertisement was enhanced to include the BMJ website and again further enhanced in April 2022 to include the Irish Medical Times, BMJ website (which now includes Australia and New Zealand), premium job, promoted job, target emails as well as CV database search.

17.6 Due to failed recruitment, this is leaving the Urology Consultant team vulnerable, with an increased number of 'on-call' and 'Urologist of the Week (UOW)' shifts requiring to be covered. The UOW is currently 1:7 weeks. The impact of the continuing consultant vacancies is that there are UOW shifts left uncovered and these are currently being picked up by the current consultants which then, in turn, has decreased clinical activity for that week, as this requires them to drop their elective workload to cover the unscheduled element with UOW shifts.

17.7 While we await outcome of the current enhanced advertisement we are investigating recruiting a Consultant Urologist on a temporary basis while they work towards being added to the specialist register; this may take up to 2 years to become registered. As this is a new advertising process Medical Human Resources will require approval from the Trust's Senior Management Team (SMT).

17.8 The below table and evidence relating to recruitment efforts has been provided to me by Joanne McMullan, Medical HR Head of Service.

20210301 to 20220503 Q17 Cons urology recruitments- This can be located at Attachment folder S21 25 of 2022- Attachment 31.

NO. OF TIMES ADVERTISED	DATE ADVERTISED	NORMAL ADVERTISING	APPLICATIONS RECEIVED	ENHANCED ADVERTISING
1	March 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	
2	May 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
3	October 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
4	February 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	➢ BMJ website – Top Job
5	April 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	Closing date: 10 May 2022	➢ Irish Medical Times ➢ BMJ website enhancements Top Job Premium job Promoted Job

				Target email to 150 registered candidates CV database search ➢ BMJ website in Australia & New Zealand

17.9 In addition to permanent Urology Consultant Recruitments, we have been periodically trying to recruit Locum Urologists. The below table illustrates the timeline and replacement reasons in respect of Locums from October 2020.

First Name of Doctor filling booking	Surname of Doctor filling booking	Start Date	Expected End Date	Reason for Locum
Shawgi	**Razig Omer**	21/09/2020	30/06/2021	Backfill AOB
Saifeldin	**Elamin**	19/07/2021	02/08/2021	Backlog clearance clinics only
Shawgi	**Omer**	16/08/2021	30/10/2021	Backfill AOB
Nasir	**Khan**	2/11/2021	Still in post	Backfill Con 7

17.10 Due to the ongoing consultant recruitment challenges, and in response to the pressures on the urology service, the Trust recruited additional junior middle grade doctors (clinical fellows) from August 2020.

20210501 Q17 Junior Clinical Fellow Urology- This can be located at Attachment folder S21 25 of 2022- Attachment 32

17.11 In September 2021, there were a number of Physician Associate posts recruited within Acute Services in an attempt to release the workload burden on the wards for the junior doctors and 0.5 whole time equivalent (18 ¾ hours) was allocated to urology.

20210601 Q17 Physicians Associate General Medicine- This can be located at Attachment folder S21 25 of 2022- Attachment 33

Staff nursing vacancy workforce at ward level

17.12 Under my portfolio of management is ward 3 South. The urology emergency patients are currently mainly nursed on 3 South. 3 South is a surgical ward with 36 beds; 18 beds are utilised by ENT and Urology emergency patients and 18 beds are for Medical patients. As mentioned above, there is an ongoing vacancy deficit with the band 5 registered nurses (RN):

Band 5 RN

a. Funded – 31 wte
b. Permanent – 12.15wte
c. Bank – 7.74

Deficit = 11.11wte (35%)

17.13 Mrs Paula McKay, Lead nurse for 3 South, and Mrs Laura White, Ward Manager, meet on a monthly basis and update the below staffing table which is then forwarded onto myself and Ronan Carroll, AD for SEC/ATICS.

	FSL	ACTUAL	DEFICIT	AVAILABLE	LTS	MAT	SEC / CB	Other	BANK	LEAVES	Available + Backfill	% staffing available
Band 7	1.00	1.00	0.00	1.00							1.00	100%
Band 6	4.00	5.07	1.18	4.07		1.00					4.07	102%
Band 5	31.00	19.89	-11.11	19.89					7.74		27.63	64%
Band 3	12.98	12.62	-0.36	8.01					1.05		9.06	70%
Band 2	0.00	0.61	0.00	0.00		0.61					0.00	
TOTALS	48.98	39.19	-10.29	32.97	0.00	1.61	0.00	0.00	8.79	0.00	41.76	85%

17.14 The recruitment of RN and Health Care Assistants (HCAs) continues to problematic. This is due to a number of reasons:

a. There is a recognised regional nursing recruitment shortage.
b. The Southern Trust has tried to alleviate the challenges of the nursing pressures with recruitment drives over the years with some success, however, the gaps are so large that this has never addressed all of the shortfall.
c. There has also been international recruitment of nursing staff.
d. Prior to the Covid-19 pandemic, the Surgical 3 South was split to half surgery and half medicine; this was due to the medical bed pressures. Since the pandemic, 3 South has continuingly changed on a number of occasions from nursing covid only patients, medical patients only, and is now split again between surgical and medical patients. The nursing staff on

this ward in particular have found this challenging and unsettling, leading to some staff handing in their notice.

e. Recruitment and retention remains a challenge on 3 South, in particular for the reasons set out above.
f. In addition, a number of RN and HCA staff have left the Trust for nursing agencies due to pay scale issues.

17.15 At a recent Urology Project Implementation Group ('PIG') meeting on 28th April 2022, there was a presentation on regional Urology capacity review which demonstrated a difference in CNSs recruited in each Trust. Slide 19 of the presentation (evidenced below) illustrates that the Western Trust was funded for 9.8 wte specialist nurses (8.0 Consultants) and the Southern Trust is funded for 5.0 wte specialist nurses (7.0 Consultants) which is not a comparable Consultant: Clinical Nurse Specialist ratio.

20220428 Q17 Urology Demand Capacity Review Slides Emma- This can be located at Attachment folder S21 25 of 2022- Attachment 34

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?**

18.1 Yes, there were times when posts in the unit remained vacant. Examples of this, and of the impact and actions taken in response, are referenced in my answers to questions 16 and 17 above as well as below (including in the current answer and at question 19).

Thorndale Ward Managers Support

18.2 There have been ongoing recruitment issues from 29 July 2021.

18.3 The below timeline for the position of Thorndale Higher Clerical Officer has been provided by the post's direct Line Manager, Matthew McAlinden:

- 29/07/2021 – 1wte Ward Manager Support left for Secondment;
- 09/08/2021 – 0.5wte CNS Admin commenced (Permanent position);
- 13/10/2021 – 1wte Temporary Ward Manager Support Commenced;
- 21/03/2022 – 1wte Temporary Ward Manager Support commenced sick leave;
- 12/4/2022 – 1wte Temporary Ward Manager Support resigned;
- 03/05/2022 – 1wte redeployed Band 5 S/N commenced in Thorndale to cover Admin vacancy until recruitment is secured via the Workforce Appeal

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

19.1 The impact of Urology Consultant vacancies can be summarised as follows:

a. Reduction in clinical activity, which in turn has been a factor in the increased waiting times as demonstrated in my response to Question12.
b. There are ongoing MLA queries and complaints in relation to waiting times due to the length of time patients are waiting.
c. Consultants have to cover Urologist of the Week model more frequently. Consultants should cover on-call 1:7 on a rolling rota. However, due to vacancies there are two locum weeks requiring to be covered by the current complement of consultants. An extract from the monthly urology schedule demonstrates this below. The impact is that, when covering urologist of the week on call, this detracts from daily clinical activity (as already described above).

	CAH	CAH
date	OnCall	Night
23	N (I)	G (I)
24	N (I)	G (I)
25	H (I)	H (I)
26	H (I)	H (I)
27	N (I)	OD (I)
28	N (I)	OD (I)
29	N (I)	H(I)

d. The impact on performance as a result of fewer consultant staff is demonstrated in my answer to Q12.

19.2 The impact of Nursing Vacancies can be summarised as follows:

a. From 15 November 2021, 1.0 (37 ½ hours) whole time equivalent Urology Clinical Nurse Specialist was on sick leave, returning on 16 January 2022. In addition, a second Urology Nurse Clinical Specialist went on sick leave from 20 December 2021, returning 9th May 2022. During this period, this left three Urology Clinical Nurse Specialists to cover the service. This resulted in not all cancer MDM outpatient clinics having a Urology CNS available. If this was the case the clinic was covered by a Band 5 or Band 6 and the Urology CNS would have followed up afterwards with a telephone call to the patient.

b. The high volume of nursing vacancies on 3 South had led to a higher reliance on agency locum nurses to ensure adequate nursing levels on the ward. The Nursing Quality Indicators (NQIs) have demonstrated poor percentage score against certain core aspects of nursing care, e.g., delayed medication, high level of falls and poor compliance with skin bundles. In addition, there has been an increase in DATIX incident reporting each year within the ward. The information in the table below regarding DATIX reports has been provided by Chris Walmsley, Head of Acute Governance.

Year	Total
Apr 20 - Mar 21	321
Apr 21 - Mar 22	376

c. From COVID-19, as previously mentioned, 3 South has been predominantly a medical ward and more recently converted back to half medical, half surgical from April 2022.

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

20.1 Since the commencement of my tenure as Interim Head of Urology Services I have worked with Mr Mark Haynes, Divisional Medical Director (DMD), to review the Urology Consultant job plans. Due to emphasis and focus on governance, the following lead elements have been included in their job plans:

a. Patient Safety lead – Mr O Donoghue 0.485PA;
b. Standards and Guidelines lead – Mr Tyson 0.5PA;
c. Quality Improvement lead - Mr Tyson 0.5PA;
d. Cancer MDM lead – Mr Glackin 1.0PA;
e. Rota Co-ordination lead – Mr Young 0.5PA (retired at the end of May, from which point the Head of Urology Service will undertake this role until Mr Young's replacement is in place).

The relevant job plans have been provided by the medical human resources staffing team as evidenced below:

20211101 to 20220531 Q20 Urology consultant job plans- This can be located at Attachment folder S21 25 of 2022- Attachment 35a
20220601 Q20 Urology consultant job plans- This can be located at Attachment folder S21 25 of 2022- Attachment 35b
20210401 Q20 JP overview AG- This can be located at Attachment folder S21 25 of 2022- Attachment 35c

20210401 Q20 JP overview JOD- This can be located at Attachment folder S21 25 of 2022- Attachment 35d
20211025 Q20 JP overview MT- This can be located at Attachment folder S21 25 of 2022- Attachment 35e
20211101 Q20 JP overview MH- This can be located at Attachment folder S21 25 of 2022- Attachment 35f
20211101 Q20 JP overview MY- This can be located at Attachment folder S21 25 of 2022- Attachment 35g

20.2 Recruitment of a physician associate in September 2021 has impacted positively at ward level by supporting the junior staff in the delivery of patient care, e.g., following up on patient results, preparing discharge letters, and liaising with families.

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?

21.1 My role has changed in relation to governance during my tenures in OSL for CCS/ATICS (2007-2016) and OSL for SEC/SEC to now as Interim Head of Urology Services.

21.2 My governance role as OSL would have been a supportive role to Ronan Carroll, AD, in relation to monitoring performance targets. However, now I am in the Interim Head of Urology Services role I would have operational governance responsibility for the Urology service, working with all the Urology workforce - medical, nursing and administrative - to ensure delivery of a safe service.
I would monitor and assist in the investigation process for complaints, Datix investigation, and SAIs within Urology Services, monitoring for trends and safety concerns within the service area. I would review resource requirements for Urology Services and assist with the financial management of the speciality.

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.

22.1 The Urology Consultant administrative staff are aligned and managed by Anita Carroll, AD for Functional Services, and Katherine Robinson, Head of Service for Admin. As per business cases, each consultant is allocated 0.5 (18 ¾ hours) whole time equivalent (wte) per week.

22.2 In addition to the Urology Consultant clerical staff, there is an Administrative Ward Support, Band 3, x 1.0 whole time equipment (wte) (37.5 hours per week)

supporting the Thorndale Unit. This post was vacant from 21st March 2022, however, a new start commenced on 16 May 2022.

22.3 Included in the IPT of the last 2 Urology Nurse Specialists, a 0.5 (18 ¾ hours) wte Administrative Officer was recruited to support the CNS team on 9th August 2021.

20190918 Q22 LMCW allocation letter for Southern Urology CNS- This can be located at Attachment folder S21 25 of 2022- Attachment 36

22.4 I do not feel that 0.5 wte secretary per consultant is a sufficient level of support for the service. The secretarial team currently have responsibility for scheduling of elective patients, typing of all medical clinical sessions, and all dealing with consultant queries. The April 2022 SEC review backlog report demonstrates outstanding typing and filing. At the Urology departmental meeting on 14 April 2022 the team did request a separate Urology Scheduler. A briefing paper has been developed in support of a dedicated urology scheduler. This paper has been submitted for approval to Ronan Carroll, AD for SEC/ATICS and, if/when the proposal is approved, will be forwarded onto Melanie McClements, Director for Acute Services, for consideration of funding.

20220401 question 22 SEC BACKLOG ALL SPECIALITIES MONTHY TOTAL- This can be located at Attachment folder S21 25 of 2022- Attachment 37a
20220414 Q22 Urology Team Meeting NOTES 14/04/2022- This can be located at Attachment folder S21 25 of 2022- Attachment 37b
20220501 Q22 Urology Scheduling Staff Paper May 22- This can be located at Attachment folder S21 25 of 2022- Attachment 37c

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

23.1 The Urology Consultant administrative staff are aligned and managed by Anita Carroll, AD for Functional Services, and Katherine Robinson, Head of Service for Admin. It is the expectation that administration staff do work collaboratively, for example, to equalise workload or cover if a colleague was off on sickness absence.

23.2 I do receive a monthly SEC backlog report. This report is shared with all Consultant Urologists and any dictation or typing delays are highlighted for action. For example, the April 2022 report demonstrated that Mr Khan had 100 results to be dictated and Mr O'Donoghue had 90 results to be dictated. As Interim Head of Urology Services, I contacted both consultants on 4 April 2022 by telephone. Both consultants advised that they were aware and would be addressing same. Mr Khan, in addition, advised that he would return from annual leave one day early to work on the results backlog. It was the expectation that the results waiting to be dictated would demonstrate an improvement in the end May 2022 SEC review backlog report. In order to ensure the backlog was showing an improving position, I emailed Orla Poland, Surgical Service Administrator on the 18 May 2020 requesting a mid-month backlog report for Mr Khan and Mr O'Donoghue. The end of May 2020 SEC backlog report did show a significant improvement in results waiting to be dictated for both Mr Khan and Mr O'Donoghue.

20220430 Q23 SEC Backlog Urology Monthly total April 22- This can be located at Attachment folder S21 25 of 2022- Attachment 38a
20220518 question 23 email Urology backlog- This can be located at Attachment folder S21 25 of 2022- Attachment 38b

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

24.1 There were no concerns raised with myself nor was I aware of any in relation to the Urology Consultant Secretarial staff. As outlined in question 23 above, the consultant secretarial staff are aligned to Functional Services Division. The secretaries would not be in direct contact with myself, and any queries would likely be through their Line Manager, Orla Poland, who reports to Katherine Robinson.

24.2 However, there was a concern raised to myself from the Urology Clinical Nurse Specialists in relation to their admin supports' competency both by email and also verbally. There was one part time administrative staff member (Catherine Kelly) working alongside the Urology Clinical Nurse Specialist admin support ([redacted]). Catherine, I believe, did raise verbal concern to her line manager Matthew McAlinden.

24.3 In addition, I have also received an email regarding the admin vacancy and concerns raised about typing backlog for CNSs due to their admin supporting going on sick leave from the 21 March 2022. These are both evidenced below.

24.4 To resolve the competency issue, which resulted in a vacancy, I supported Matthew McAlinden, Service Administrator, throughout the Human Resource process and in line with 'Management of the Trust's Disciplinary Procedure'.

24.5 I refer in this regard to:

a. Occupational Health referral form 29/10/2021;
b. Occupational Health Report 16/11/2021;
c. Risk Assessment carried out be RNIB 04/02/2022;
d. Probationary Review 03/03/2022;
e. Agreed Action Plan 14/03/2022;
f. Meeting with [redacted] and Myself regarding an action plan and Performance review 14/03/2022.

20150401 Q24 Disciplinary Procedure- This can be located at Attachment folder S21 25 of 2022- Attachment 39a
20220328 Q24 email Typing backlog LMcC- This can be located at Attachment folder S21 25 of 2022- Attachment 39b
20211029 Q29 [redacted] Occupational Health referral form- This can be located at Attachment folder S21 25 of 2022- Attachment 39c
20211116 Q24 [redacted] OH report- This can be located at Attachment folder S21 25 of 2022- Attachment 39d
20220204 Q24 AtW Asessment [redacted] This can be located at Attachment folder S21 25 of 2022- Attachment 39e
20220303 Q24 [redacted] Probationary review- This can be located at Attachment folder S21 25 of 2022- Attachment 39f
20220314 Q24 [redacted] Action plan signed- This can be located at Attachment folder S21 25 of 2022- Attachment 39g
20220314 Q24 Staff meeting with [redacted] - This can be located at Attachment folder S21 25 of 2022- Attachment 39h

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.

25.1 Since my tenure in October 2020, I have overall responsibility for the operational day to day running of the Urology Service, being accountable to Ronan Carroll, AD for SEC/ATICS.

25.2 The Thorndale Unit is operationally managed on a day to day basis by:

a. Josephine Matthews, Lead Nurse for Outpatients (who reports directly to me)
b. Joanna Percival, Outpatient Manager (who reports to Josephine Matthews), and Dolores Campbell, Clinical Outpatient Sister (who reports to Joanna Percival).

25.3 The Admin staff for the Urology Clinical Nurse Specialist and Thorndale Unit report directly to Matthew McAlinden, Service Administrator.

25.4 The Medical team report along the medical management lines. Mr Michael Young was the Lead urology consultant until his retirement at the end of May 2022 (this post is now vacant) for operational services, for example, rota or oncall issues, however, any professional issues would have been be reported to Mr Ted McNaboe, Clinical Director until December 2021 (the post is now vacant), and to Mr Mark Haynes, SEC Associated Medical Director (AMD). From December 2021, Mr Haynes became Divisional Medical Director (DMD) for Urology QI Improvement and Mr McNaboe became Surgical DMD. There is no Lead Urology Consultant or Clinical Lead at present, therefore, the medical team report to Mr McNaboe and Mr Haynes as DMD.

25.5 The Urology CNSs (Kate O'Neill, Jenny McMahon, Leanne McCourt, Patricia Thompson and Jason Young) report to the Paula McKay (previously Sarah Ward), Lead Nurse for Urology.

25.6 South ward is managed by Laura While, Ward Sister. Laura reports directly to Paula McKay (previously Sarah Ward), Lead Nurse for Urology.

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

26.1 During my tenure as Interim Head of Urology Services, I have not been responsible for staff performance reviews.

26.2 The Medical team within urology have their staff performance appraisal undertaken by their medical professional line management.

26.3 The Lead Nurses for my areas have their staff performance reviewed by Mrs Brigeen Kelly, Head of Service for SEC Nursing Governance.

26.4 The Urology Clinical Nurse Specialists have their staff performance reviewed by Mrs Paula McKay, Lead Nurse for SEC. Paula commenced on 1 November 2021 (Mrs Sarah Ward was the Lead Nurse prior to Paula).

26.5 The Admin staff aligned to the Urology CNS and Thorndale have their staff performance reviewed by Mr Matthew McAlinden, Service Administrator. Matthew

McAlinden reports directly to, and would have his performance reviewed by, Jane Scott, OSL for SEC/ATICS.

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

27.1 From my tenure as Interim Head of Urology Services in October 2020, there was no performance review undertaken in 2019/20 due to Covid-19 pandemic pressures. I had a performance appraisal for the period April 2021 to March 2022 by my Line Manager, Ronan Carroll and I have just had a recent performance review on the 1st June 2022.

27.2 The annual PDP identifies learning needs, date of corporate training undertaken, and key objectives going into 2021/22 which include:

a. Continue to lead and support the ENT, Urology, OPD and Ophthalmology services, meeting regularly and promoting their service;
b. Ensure job plans are updated for consultants and CNSs;
c. Set up CNS outpatient clinics;
d. Stabilise nursing workforce in 3 South;
e. Monitoring of elective access targets and KPIs – OPD and IPDC;
f. Maintain and boost admin staff morale.

20190529 question 27 KSF 19.20 signed - This can be located at Attachment folder S21 25 of 2022- Attachment 40a
20210914 question 27 KSF Flow Chart- This can be located at Attachment folder S21 25 of 2022- Attachment 40b

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

28.1 As Interim Head of Service for ENT, Urology, Outpatients and Ophthalmology, I would have regular engagement with the Urology team staff, both medical and nursing; I would estimate that this occupies approximately 40% of my working week. Examples of how I engage are set out below.

28.2 I chair **weekly Urology Departmental Meetings**. I have a set agenda plus additional items for discussion as they arise. The set agenda includes; Covid, Public Inquiry, Performance, Governance, CNS Update, and Any Other Business. Membership of this meeting includes:

- All Urology Consultants (Mr Young, Mr O'Donoghue, Mr Khan, Mr Haynes, Mr Glackin and Mr Tyson);
- Junior Medical Team (Laura McAuley – Specialty Doctor, Saba Hasinain – Speciality Doctor, Conor McCann – Registrar, Kishan Tailor – Registrar, Susie Cull – Clinical Fellow, Fiona Griffin – Clinical Fellow);
- All Urology CNS (Kate O'Neill, Jenny McMahon, Leanne McCourt, Patricia Thompson and Jason Young);
- Lead Nurse – Paula McKay;
- Outpatient Manager added from March 2022 (Jo Pervical).

28.3 I attend the **monthly Urology Nurse-led review meeting** chaired by Mary Haughey, Macmillan Cancer Service Improvement Lead, along with the Urology CNSs.
20210923 Q28 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41a
20211028 Q28 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41b
20211202 Q28 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41c
20220127 Q28 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41d
20220222 Q28 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41e
20220421 Q28 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41f

28.4 I have **informal daily face to face conversations** with Paula McKay, Lead Nurse for Surgical (which includes Urology), and Josephine Matthews, Outpatients Lead Nurse.

28.5 I have also started **formal 1 to 1 meetings** with Paula McKay from March 2022.

20220328 Q28 1to1 Paula McKay LN- This can be located at Attachment folder S21 25 of 2022- Attachment 42a
20220328 Q28 1to1 Paula McKay LN A1- This can be located at Attachment folder S21 25 of 2022- Attachment 42b

28.6 In terms of **ward engagement**, I engage with the ward through the Ward Manager, primarily in relation patient flow and Infection control issues.

28.7 **Informal conversations take place on an ad hoc basis** with all consultants, junior staff and nursing staff as required.

28.8 I have **information conversations with all members of the Urology medical team** from Consultants to Clinical Fellow/SHO level. The team know they can approach me at any stage in relation to any issues, for example, sick leave, rota

issues, and staff levels. This is in addition to the weekly Urology Departmental meetings.

28.9 I attend every Tuesday morning at the **weekly Head of Service meetings** with AD and other SEC and ATICS Heads of Service. These meetings are themed each week: Week 1 – Governance, Week 2 – Ad hoc, Week 3 – Finance and Human Resource, and Week 4 – Performance.

28.10 I attend **monthly 1:1 Meetings with the AD for SEC/ATICS** (Ronan Carroll), who is my Direct Line Manager. At these meetings I would advise Ronan Carroll of any concerns, operational issues, new service developments or workforce issues.
20220328 Q28 1 to 1 3S Paula McKay LN- This can be located at Attachment folder S21 25 of 2022- Attachment 42a
20220513 Q28 1 to1 3S Paula McKay LN- This can be located at Attachment folder S21 25 of 2022- Attachment 43a

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

29.1 Please see my response to Question 28 above in addition to what is set out below.

29.2 Scheduled Meetings:

a. Weekly Urology Department Meetings are scheduled weekly and last approximately 1 hour 30 minutes.
Evidence was previously been uploaded in first section 21

b. Urology CNS meetings are scheduled monthly and last 1 hour. A sample of notes of the meetings are evidenced in question 28.
20210923 Q29 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41a
20211028 Q29 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41b
20211102 Q29 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41c
20220127 Q29 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41d
20220222 Q29 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41e
20220421 Q29 Notes from Nurse led review meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 41f

c. Weekly SEC/ATICS meetings with AD and other HOS are scheduled weekly and last approximately 2 hours.
Evidence was previously been uploaded in first section 21

d. 1 to 1 with Lead Nurse for Surgery meetings are scheduled monthly and last approximately 1 hour.
20220328 Q29 1 to 1 3S Paula McKay LN- This can be located at Attachment folder S21 25 of 2022- Attachment 42-43a
20220513 Q29 1 to1 3S Paula McKay LN- This can be located at Attachment folder S21 25 of 2022- Attachment 42-43b

e. Finance meetings with SEC Finance manager (Michael Smyth) are scheduled monthly and last approximately 1 hour.
20211001 question 29 HOS SUMMARY REPORT 2122 M07 - OCTOBER 21 SEC-ATICS CA6840 ENT UROL OPHTHAL OUTPAT-
20211101 question 29 HOS SUMMARY REPORT 2122 M08 NOVEMBER 21 SEC-ATICS CA6840 ENT UROL OPHTHAL OUTPAT
20211201 question 29 HOS SUMMARY REPORT 2122 M09 DECEMBER 21 SEC-ATICS CA6840 ENT UROL OPHTHAL OUTPAT
20220101 question 29 HOS SUMMARY REPORT 2122 M10 JANUARY 2022 SEC-ATICS CA6840 ENT UROL OPHTHAL OUTPAT- This can be located at Attachment folder S21 25 of 2022- Attachment 44

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

30.1 Yes, it is my opinion that the urology team work well together, for example:

a. Cover locum consultant week – to date I have had no gaps in the oncall rota as the Urology Consultants have backfilled these vacant sessions to ensure the service is covered.
b. During Covid-19, and in particular when staff members contract Covid-19, the medical colleagues will backfill oncall or theatre sessions to ensure minimal disruption to the service.
c. There is good attendance by all disciplines of staff at the weekly Urology Departmental Meeting which demonstrates, to me, the willingness for team working.
d. Junior medical staff help each other, in the event of short notice sickness absence, to cover clinics or oncall.
e. There has been progression in service development since my tenure began in relation to stone treatment, lower urinary tract systems (LUTS) service, and Nurse-led clinics. It is with team work between the medical and professional staff that these service developments have progressed. The Urology stone team were nominated for the British Medical Journal (BMJ) awards in 2021 for the service development project 'STONES, **s**tone meetings, **t**imely **c**ommunication, **o**utcomes, **n**ew stone referrals, and **e**vidence based care, savings).

20210401 question 30 HSJ Value Award Presentation- This can be located at Attachment folder S21 25 of 2022- Attachment 45a

20210701 Question 30 Nurse Led Clinic Flow Chart- This can be located at Attachment folder S21 25 of 2022- Attachment 45b

Governance – generally

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

31.1 As Interim Head of Urology Services, it is my responsibility to ensure process and systems are robust in clinical governance.

31.2 Below are some examples of my governance role with the medical team for learning purposes:

a. Complaints/ Ombudsman – The Complaints Team would forward all urology complaints to myself and I would ensure the relevant Consultant receives this complaint for investigation and response. I would prompt the Consultant for responses and support required in the investigation. During my tenure from October 2020 to May 2022 there have been 25 urology

related complaints; this can be broken down to 19 recorded under urology clinic, 1 recorded under Thorndale, and 5 recorded under 3 South.

20220425 question 31 email letter to MO'K re [Personal Information redacted by the USI] - This can be located at Attachment folder S21 25 of 2022- Attachment 46a
20201001 to 20220501 question 31 Urology complaints- This can be located at Attachment folder S21 25 of 2022- Attachment 46b

I would facilitate family meetings with the Urology Consultants, if required. These meetings are to address any concerns or issues the patient or family may have had with the care while inpatient in the Trust.

20220316 question 31 [Personal Information] family meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 47

b. DATIX incident reporting – I monitor the number of incident reports through DATIX and forward on any DATIX that requires discussion the Patient Safety Lead, Mr O'Donoghue, for discussion at the Patient Safety Meeting (PSM). I also escalate any DATIXs that reach the threshold for SAI Screening.

20220503 Question 31 Email Datix Web Feedback Message W153756- This can be located at Attachment folder S21 25 of 2022- Attachment 48a
20220428 question 31 email Datix Web Feedback message W153756- This can be located at Attachment folder S21 25 of 2022- Attachment 48b
20220201 question 31 email Datix Web Feedback message W143600- This can be located at Attachment folder S21 25 of 2022- Attachment 48c

c. Serious Adverse Incident (SAI) recommendations – It is my responsibility to ensure that any action plans and recommendations are discussed with the Urology Consultants. From my tenure in October 2020, there are currently 3 SAI cases opened and 1 completed SAI in 2021.
20211101 question 31 Notification Form [Personal Information] - This can be located at Attachment folder S21 25 of 2022- Attachment 49a
20210831 question 31 Notification Form [Personal Information] - This can be located at Attachment folder S21 25 of 2022- Attachment 49b
20210603 question 31 Notification to HSCB 3.6.2021- This can be located at Attachment folder S21 25 of 2022- Attachment 49c

The outstanding SAI recommendations would be discussed at the PMS and Departmental meetings if actions or updating of recommendation is required.

2 outstanding SAI recommendations from October 2020 are

i. Patient [Personal Information] recommendation: ureteric stent change/removal patients do not have ureteric stents in place for longer than required. This recommendation is not possible at present due to backlog of planned surgery. The planned surgical backlog is on the risk register.

20220330 question 31 SAI recommendation pt [redacted]- This can be located at Attachment folder S21 25 of 2022- Attachment 50

ii. Patient [redacted] recommendation: During medical handovers at 08:00 night staff should highlight to day staff all bloods which have been taken and the results are pending in order that these can be followed up. This recommendation was discussed at PSM 13 October 2021.
20211007 question 31 email action plan [redacted] final report to review team and M.M- This can be located at Attachment folder S21 25 of 2022- Attachment 51a
20211007 question 31 email action plan [redacted] final report to review team and M.M A1- This can be located at Attachment folder S21 25 of 2022- Attachment 51b
20211007 question 31 email action plan [redacted] final report to review team and M.M A2- This can be located at Attachment folder S21 25 of 2022- Attachment 51c

d. Risk Registers – Along with the other SEC/ATICs Heads of Service (Amie Nelson, Helena Murray and Brigeen Kelly), I would update the risk register and add on risks as they arise on behalf of a speciality.
20220301 Excel Question 7 March 22 Divisional Risk Register- This can be located at Attachment folder S21 25 of 2022- Attachment 15
20220401 Question 48b SEC.ATICS Div.HOS.Team RR April 2022- This can be located at Attachment folder S21 25 of 2022- Attachment 52a
20220401 Question 48b Directorate RR April 2022- This can be located at Attachment folder S21 25 of 2022- Attachment 52b

e. I review the administration reports, such as the SEC backlog report, and action and discuss directly with the consultants if required.
20220504 question 31 email outstanding results- This can be located at Attachment folder S21 25 of 2022- Attachment 53

f. Urology rota – from May 2022 I have the responsibility for compiling the monthly Urology clinical rota; this is to ensure there is adequate medical cover for oncall, theatres, and outpatients. Dr Laura McAuley, Speciality Doctor, will support myself in this task.

There would be weeks within the team month that would require Locum Oncall cover. It is my responsibility to ensure this backfill to ensure the appropriate grade of staff and experience of staff is available for each of the service areas to ensure safe patient care.

31.3 I report directly to Ronan Carroll, AD for SEC/ATICs, to whom I am accountable in relation to governance. We have a monthly Head of Service Governance meeting where we discuss Nursing Quality Indicators (NQIs), Complaints, SAI recommendations, DATIX incident reporting, Medication incidents, and risk registers. Evidenced below are examples of a Governance Head of Service agenda.

In addition, I would liaise with the Head of Service for Acute Governance (Chris Wamsley) in relation to governance concerns.
20220308 Question 31 HOS Governance agenda and documents- This can be located at Attachment folder S21 25 of 2022- Attachment 54a
20220308 Question 31 HOS Governance agenda and documents A1- This can be located at Attachment folder S21 25 of 2022- Attachment 54b
20220308 Question 31 HOS Governance agenda and documents A2- This can be located at Attachment folder S21 25 of 2022- Attachment 54c
20220308 Question 31 HOS Governance agenda and documents A3- This can be located at Attachment folder S21 25 of 2022- Attachment 54d
20220308 Question 31 HOS Governance agenda and documents A4- This can be located at Attachment folder S21 25 of 2022- Attachment 54e
20220308 Question 31 HOS Governance agenda and documents A5- This can be located at Attachment folder S21 25 of 2022- Attachment 54f

31.4 The Urology Consultants and junior medical staff report directly to Mr Mark Haynes, Associate Medical Director (in the absence of a Clinical Director).
Mr Michael Young, Urology Service Lead, was my first point of contact of operational daily duties until his retirement on 27 May 2022; now I liaise directly with Mr Mark Haynes for all operational and clinical concerns.

31.5 Ted McNaboe came into post as Divisional Medical Director (DMD). The Trust's Medical revalidation team are also responsible for supervision and annual appraisals.
20160101 to 20200101 question 31 urology appraisals- This can be located at Attachment folder S21 25 of 2022- Attachment 55

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

32.1 On a day to day basis it is myself, as Interim Head of Urology Services, who has responsibility to oversee the clinical governance arrangements for Urology (previously it was Martina Corrigan), and I remain accountable to Ronan Carroll, AD for SEC/ATICS.

32.2 However, from a professional point of view the responsibility is as follows. Clinical governance responsibility lay with the Clinical Lead (Mr Young, until retirement on 27 May 2022 - this post is now vacant), to Clinical Director (this post is now vacant, Ted McNaboe until December 2021), to Divisional Medical Director (Mark Haynes) until December 2021, now Ted McNaboe and Mark Haynes as DMD for Urology Service Improvement), and ultimately up to the Medical Director (previously Maria O'Kane, covered on a 2 monthly basis by Aishling Diamond until June 2022).

Medical Director Cover

Covering Medical Director	Start Date (Inclusive)	End Date (Inclusive)
Dr Aisling Diamond	Tuesday, 3rd May 2022	Sunday, 3rd July 2022
Dr Damian Gormley	Monday, 4th July 2022	Sunday, 4th September 2022
Dr Damian Scullion	Monday, 5th September 2022	Sunday, 6th November 2022

32.3 Any medical concerns are raised through their Medical structure, i.e., from Clinical Lead to Clinical Director to Divisional Medical Director and escalated to Ronan Carroll, AD for SEC/ATICS, and myself, as Interim Head of Urology Services, as necessary.

32.4 If any issues arise these can be recorded through DATIX incidents forms, complaints and SAIs. However, I am aware of concerns being raised through professional lines such as revalidation, which would not be recorded on DATIX. As outlined in question 31 I would review these reports and ensure that the appropriate actions are being taken forward.

32.5 To provide assurance for governance, as a team the ATIC/SEC AD (Ronan Carroll) and ATIC/SEC Head of Service (Wendy Clayton, Amie Nelson, Helena Murray and Brigeen Kelly) would review the Clinical Governance reports prepared by the Acute Governance team at the monthly Governance Head of Service meeting. In addition, in March 2022 I added Clinical Governance as a standing agenda item to the Urology Departmental Meeting. This is evidenced in agenda item 7.
20220331 Question 32 Urology Team Meeting AGENDA - This can be located at Attachment folder S21 25 of 2022- Attachments 56 a-d.

32.6 The medical team would hold a monthly Speciality Patient Safety Meeting (PSM) chaired by Mr John O'Donoghue, Consultant Urologist. At this meeting the team discuss mortality and morbidity (M&M) within the urology service. There is a Combined Anaesthetic and Surgical M&M meeting once a quarter in place of the Speciality PSM meetings. I attend the Speciality PSM meeting when possible; this is not every month as I am also Head of Service for ENT, Outpatients, and Ophthalmology services.

20220401 Question 32 Urology PSM Minutes- This can be located at Attachment folder S21 25 of 2022- Attachments 57 a-h
20220401 Question 32 Urology PSM Minutes A1
20220401 Question 32 Urology PSM Minutes A2
20220401 Question 32 Urology PSM Minutes A3
20220401 Question 32 Urology PSM Minutes A4
20220401 Question 32 Urology PSM Minutes A5
20220401 Question 32 Urology PSM Minutes A6
20220401 Question 32 Urology PSM Minutes A7

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

33.1 As mentioned in Questions 30-32, clinical governance is overseen, monitored, and assured through many avenues. These avenues also provide some oversight and assurance in respect of the quality of urology services provided by the Trust.

33.2 In addition to the acute clinical governance reports, regular PSM meetings, and HOS governance meetings, clinical governance is achieved through measuring the performance of the urology service. Examples of measuring performance are set out below.

Performance
33.3 Over the years, the assurance has been given by measuring the commissioned activity against the actual activity undertaken, review backlog, and waiting times.

33.4 As illustrated in my response to Question 12, during my tenure as OSL for CCS/ATICS (between 2007 and 2016) I would have monitored the cancer performance. Then during my tenure as OSL for SEC/ATICS (between 2016 and 2017, and again in 2019) I would have monitored the Urology performance on behalf of the Head of Urology Services (Martina Corrigan) and AD for SEC/ATICS (Ronan Carroll).

33.5 I would have generated reports for the AD and HOS for discussion at the HOS meetings and with their consultants.

33.6 Currently, as Interim Head of Urology Services, I produce a monthly performance report for the consultants and AD (Ronan Carroll). This report monitors all aspects of the performance: outpatients and inpatient/daycase waiting times and volumes of patients on waiting lists. The trends, challenges, and possible solutions are discussed each month at the Urology Departmental meeting.
20211201 question 33 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 58a

20220301 question 33 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 58b
20220201 question 33 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 58c

OUT-PATIENT WAITING LIST – UROLOGY – target 9 weeks

Date	Total	>9-Weeks	>52-Weeks	Longest Wait Weeks
@ 31/1/2022	**5530**	**4869**	**3763**	**313**
@ 31/3/2021	4819	4280	3461	269
@ 31/3/2020	4041	3390	2063	217
@ 31/3/2019	3754	2964	1969	167
@ 31/3/2018	2988	2253	1079	114
@ 31/3/2017	2562	1872	195	76
@ 31/3/2016	2714	2040	4	74

IN-PATIENT / DAY CASE WAITING LIST – UROLOGY Target 13 weeks

Date	Total	>13-Weeks	>52-Weeks	Longest Wait (Weeks)
@ 31/1/2022	**2086**	**1737**	**1263**	**399**
@ 31/3/2021	2063	1728	1407	361
@ 31/3/2020	1700	1437	934	309
@ 31/3/2019	1737	1421	807	269
@ 31/3/2018	1757	1362	692	217
@ 31/3/2017	1495	890	343	165
@ 31/3/2016	970	567	301	120

33.7 Unfortunately, the waiting times far exceed the departmental targets set out in the IEAP i.e., 9 weeks for outpatients, 13 weeks for inpatient/daycases, 95% for 62 day cancer pathway, and 98% for 31 day cancer pathways.

33.8 Over the years there have been a small number of waiting list initiatives (WLI), sessions undertaken as illustrated in the table below (provided by the OSL for SEC/ATICS - Jane Scott). The limited number of WLI sessions are due to several factors which include:

a. Pension contributions which does not make it financially attractive for consultants to undertake WLI;
b. Consultants who are not on an 11PA contract are not eligible to access the enhanced payment rates for WLI sessions;
c. The willingness from a consultant - not many consultants wish to undertake WLI and it is voluntary, not compulsory;
d. In relation to elective WLI, there is an ongoing workforce issue with theatre registered nurse and health care assistants which makes it challenging to staff an additional theatre session; along with bed pressure.

In house additionality activity undertaken from 2016/17 to 2021/22

	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Virtual Reviews	0	0	9	102	8	83
Face to Face Reviews	132	41	62	113	8	30
Virtual News			0	18	0	0
Mega Clinic (Pre Assessment)	0	0	0	0	0	36
Face to Face New	128	0	48	141	0	0
Elective Daycase stones	7	0	5	3	0	0
Elective InpatientsP	12	0	0	0	0	0
Consultant led Validation	0	140	0	0	0	0

Outpatient Review Backlog (RBL)

33.9 The urology RBL is monitored on a monthly basis at operational level by the OSL and at corporate level through the CPD scorecard and risks highlighted. The RBL reports identify patients who have been waiting longer than their required date, e.g., a patient was due to be seen by August 2021 ('see by' date) but is still on the review backlog report waiting on an appointment in April 2022.

OUT-PATIENT REVIEW BACKLOG - UROLOGY

Date	Total	Urgent	Routine
@ 31/1/2022	1503	743	760
@ 31/3/2021	2295	945	1350
@ 31/3/2020	2832	1182	1650
@ 31/3/2019	2711	1175	1536
@ 31/3/2018	2228	846	1382
@ 31/3/2017	1636	462	1174
@ 31/3/2016	2021	607	1414

33.10 In recent years, and since the start of the Covid-19 pandemic in March 2020, the Trust has had a significant reduction in theatre capacity. This is associated with the Trust's response to the pandemic and the redeployment of the theatre nursing workforce associated with the CaNNI ICU requirements. Due to reduction in theatres, the Federation of Surgical Speciality Association (FSSA) developed a regional clinical priority for the scheduling of patients. The FSSA guidance is evidenced below. Only patients that were categorised as priority 2 (which included a mixture of proven cancers, clinically suspect cancer and benign disease) were added to a Priority 2 waiting list for their surgery as a clinical priority. The remaining patients remained on the elective waiting list. This regional surgical prioritisation modernisation was led clinically by the Urology AMD (Mark Haynes), who is now the Urology Service Improvement DMD. Due to demand, it was only Priority 2 patients that were being considered for surgery with available capacity given to 2a and 2b patients regionally.

33.11 As mentioned in Question 12, the RPOG oversaw the clinical prioritisation of patients and streamlining waiting times regionally.

20220128 Question 33 FSSA prioritisation_master_28_01_22- This can be located at Attachment folder S21 25 of 2022- Attachment 59a
20201105 question 33 email Surgical prioritisation- This can be located at Attachment folder S21 25 of 2022- Attachment 59b

Nursing Assurance
33.12 The Lead Nurse for SEC (Paula McKay, previously Sarah Ward) would have provided myself as Interim Head of Urology Services with nursing assurance by focusing on the following nursing elements:

a. Monthly NQIs (Nursing Quality Indicators) focused on key elements of care standards on the ward. Action plans are devised monthly for elements that require improvement as evidenced in the report from July 2020 to March 2022. If the ward did not achieve 90% or above on the NQI audit, then this was recorded on the action plan. A common recurrent theme on the action is:
    i. Lying and standing blood pressure;
    ii. Urinalysis.
    20200701 to 20220301 question 33 QI QIP 3 South- This can be located at Attachment folder S21 25 of 2022- Attachment 60
b. Nursing Observation Audit Tool (NOAT) monthly audits focus on documentation standards. An action plan would have been devised for improvement and this is included in the NQI audit action plan above.
c. Spot checks - the Lead Nurse (Paula McKay, previously Sarah Ward) and the Ward Sister for 3 South (Laura White) would complete weekly walkabouts and a monthly "big" walkabout based on the Regulation and Quality Improvement Authority (RQIA) audit tool, to ensure ward environment/estates, Infection Prevention Control, Documentation. Any

deficits from this are fed into a ward based action plan that involves all staff to improve on areas required.
20210504 question 33 Monthly Ward Assurance Audit- This can be located at Attachment folder S21 25 of 2022- Attachment 61

d. Measures Board meetings - these meetings are weekly at ward level. The meeting is to provide feedback to all staff on areas such as complaints, DATIX, and audit results. This is discussed with the team present and also displayed on the staff notice board.
e. Datix - 3 South DATIX incident reports are completed with the Ward Sister and added to the measures board for discussion with entire team for learning.
f. Complaints - 3 South complaints are completed by the Lead Nurse and the Ward sister and shared with the team. Paula McKay (Lead Nurse) would discuss this with myself at the monthly 1:1 meetings.
g. Safety Brief - the safety briefs are competed twice daily at each shift change over. The purpose of the meeting is to identify risks, e.g., falls and pressure risk patients, high risk medications, infection control, and resus status. The Safety Brief also included staffing cover and gaps and actions taken to spread risk on ward.
h. Monthly 1 to 1 between the Lead Nurse and ward sister - the 1 to 1 detailed review of staffing, training, complaints, Datix, governance, audits, sickness, KSF/ Probations/ Revalidation and future planning etc.
i. Monthly staffing meeting with Head of Urology Services - vacancies, sickness, maternity leaves, and bank/ agency block bookings are reviewed with ward sister. The staffing template is updated was monthly and shared with the AD.

20210113 Question 33 email Urgent 3South staffing- This can be located at Attachment folder S21 25 of 2022- Attachment 62

j. Training Matrix - managed by the clinical educator with the ward sister. A constant review and highlight of deficits. Individual staff are targeted and supported to avail of training.

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

34.1 The Head of Performance (Lynn Lappin) would have monitored the Trust's performance however it was the OSLs and Head of Service who would have operationally managed the performance element of the service, being accountable to the AD (Ronan Carroll).

34.2 In my role as OSL for CCS/ATICS (2007-2016) and SEC/ATICS (2016-2017 and 2019), I had a pivotal role in the overseeing metrics in urology, liaising closely with the Head of Urology Services (Martina Corrigan during in tenure as OSL for SEC/ATICS).

34.3 There are a number of monitoring performance reports on the Trust's SharePoint website which are developed by the Information Team, led by Lesley-

Anne Reid, and the Performance Team, led by Lynn Lappin. The OSL would have used these reports, for example, outpatient referrals, outpatient and inpatient/daycase activity reports, cancer performance reports, and in particular the trajectory reports, to bring informed discussion regarding capacity, demand, and challenges that may arise to the AD and Head of Cancer Services.

34.5 The Trust regionally continues to monitor activity via the Service Delivery Plan (SDP) process which is led by the SPPG on behalf of the Minister. The Trust's SDP plan for 2021/2022, Actual Versus Projected, was presented to SMT on 17 May 2022 as per attached document.
20220516 questions 34 SMT Infographic 21.22- This can be located at Attachment folder S21 25 of 2022- Attachment 63

Cancer Performance (target 95% for the 62 day target and 985 for the 31 day target)
34.6 It was my responsibility during my tenure as OSL for CCS/ATICS (2007-2016) to develop the Cancer Performance Dashboard, which included performance of all cancer tumour site specialties. The purpose of this dashboard was to:

a. Monitor the deviation from the cancer access targets so that the HOS can take corrective action where they can;
b. To highlight issues with referral trends, for example, if there was an increase in red flag referrals that would impact on the ability to see suspect cancer patients within the cancer pathway to see the patients in the timescale.

34.7 Breach reports provide a retrospective look at how patients have progressed on pathways and highlight any ongoing concerns in delays in treatments. A sample of these reports are highlighted in Question 12 above. These reports were discussed at the Monthly Cancer Performance Meetings (sample of meetings are also highlighted in Question 12) and provided a meaningful open discussion regarding challenges with the service, with the AD for CCS/ATICS (Ronan Carroll) and the Head of Cancer Services (Alison Porter and then replaced by Fiona Reddick in June 2012).

	Cancer 62 day % performance	Cancer 31 day % performance
2016/17	80	100
2017/18	58	99.4
2018/19	54.8	99.3
2019/20	42.6	98.7
2020/21	32.3	94.2
2021/22	27.4	98.15

Urology Performance

34.8 During my tenure as OSL for SEC/ATICS and Interim Head of Urology Services, I would have produced a number of reports.

34.9 As OSL for SEC/ATICS, I would have monitored outpatient and inpatient/daycase waiting times, outpatient review backlogs, and referral trends for the Head of Urology Services and AD for SEC/ATICS. These monthly reports would have been discussed at the Head of Service Performance Meetings and any variances discussed.
Relevant to Acute, Document 13 SEC and ATICS Performance meetings

34.10 In addition, the Head of Performance (Lynn Lappin) would have attended the Director of Acute Services SMT Meetings to present Acute Services performance reports highlighting any issues of concerns.

20160321 Question 34 SEC PERFORMANCE UPDATE WC 21.03.16- This can be located at Attachment folder S21 25 of 2022- Attachment 64a
20170328 Question 34 ATICS.SEC PERFORMANCE UPDATE WC- This can be located at Attachment folder S21 25 of 2022- Attachment 64b
20191030 Question 34 SHSCT Delivery of Core (OP) Traj v Actual - October 2019- This can be located at Attachment folder S21 25 of 2022- Attachment 64c
20191030 Question 34 SHSCT Delivery of Core (IPDC) Traj v Actual - October 2019- This can be located at Attachment folder S21 25 of 2022- Attachment 64d
20220401 Question 34 Referral trends Performance Dashboard
Include RBL reports- This can be located at Attachment folder S21 25 of 2022- Attachment 64e

34.11 Since my tenure as Interim Head of Urology Services, I produced a Urology monthly specialty performance report and presented it at the Urology Departmental Meetings once a month. At these meetings we discussed the risks and possible options such as transfer long waiting red flag TP biopsy patients to other hospitals such as Lagan Valley Hospital, South Eastern Trust.
20211201 Question 34 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 23a
20220301 Question 34 Urology Performance Report- This can be located at Attachment folder S21 25 of 2022- Attachment 23b
20211216 Question 34 Urology Team Meeting NOTES 16.12.2021- This can be located at Attachment folder S21 25 of 2022- Attachment 65a

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

35.1 As outlined in Questions 33 and 34, as Interim of Urology Services there are a number of systems in place to provide assurance that standards are met. These include:

a. DATIX screening meetings – at these meetings a team would screen DATIX incidents to collectively agree if a further investigation is required to identify learning.
b. Complaints – these are escalated weekly to Ronan Carroll, AD for SEC/ATIC, and all Surgical HOS. This report allows the team to monitor open complaints and escalate any outstanding investigations still to be undertaken with the relevant staff member.
20220401 question 35 SEC outstanding complaints- This can be located at Attachment folder S21 25 of 2022- Attachment 66
c. Review of performance metrics and dashboards at HOS meetings, SMT, Regional Board meetings.
d. Nursing NQI key performance indicators are monitored and actions taken appropriately.

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

36.1 Issues of concerns are brought to my attention in the first instance through Performance and Governance meetings and also through reviewing reports and taking appropriate action.

36.2 **Internal Concerns** can be brought to my attention in a number of ways, such as:

a. **DATIX incident reporting** – Staff would complete a DATIX incident reporting form, this is reviewed and investigated by the lead investigator. The identity of the lead investigator is dependent on the incident, for example, a Nursing issue would be investigated by the Lead Nurse, and performance related DATIXs by the Head of Service or Consultant. As Interim Head of Urology Services, I would escalate DATIX incidents which I feel require discussion at the Urology Patient Safety Meetings (PSM) to the Urology PSM Chair (Mr John O'Donoghue from 1 November 2021; previously chaired by Mr Anthony Glackin).
20220428 Question 36 Email DATIX feedback to JOD- This can be located at Attachment folder S21 25 of 2022- Attachment 67a
20210505 Question 36 Email Datix Incident Report W133594- This can be located at Attachment folder S21 25 of 2022- Attachment 67b
20210505 Question 36 email Datix Incident Report W133594 A1- This can be located at Attachment folder S21 25 of 2022- Attachment 67c

b. **Screening Process** - At these meetings a team would screen DATIX incidents to collectively agree if a further investigation is required to identify learning and proceed to a Serious Adverse Incident (SAI). The Acute Governance Team would provide the AD for SEC/ATIC with a report of all SAIs and this would have been discussed at the Governance Head of Service meetings. As Interim Head of Urology Services, there were operational recommendations that I would have followed up with the

Urology Consultants; this was done mainly at the Urology Department Meeting

c. **Department meetings** – Governance performance issues and concerns are raised and discussed at the Urology Department meetings and Performance Head of Service meetings. These meetings are used to collectively share learning and provide solutions and suggestions for improvements.

   The Urology Department meeting notes of the 31 March 2022, under agenda item 'Governance', highlights that at this meeting Sarah Ward, Head of Clinical Assurance for Public Inquiry, attended and presented the Multi-disciplinary SAI recommendations to the team. In addition, outstanding SAIs and complaints were discussed and actioned appropriately.
   20220331 Question 36 Urology Team Meeting NOTES 31.03.2022- This can be located at Attachment folder S21 25 of 2022- Attachment 68a
   20220331 Question 36 Urology Team Meeting NOTES 31.03.2022 A1- This can be located at Attachment folder S21 25 of 2022- Attachment 68b

d. **Governance Head of Service meetings** – At these meetings the AD for SEC/ATIC (Ronan Carroll) systematically goes through the Patient Safety Report which is generated by the Acute Governance Team. The Heads of Service (Wendy Clayton, Amie Nelson, Helena Murray and Brigeen Kelly) along with the Lead Nurses (Emmajane Kearney, Marti McKenna, Tracey McGuigan, Josie Matthews and Paula McKay) would be challenged or praised by the AD for ATICS/SEC if the performance within our service did or did not meet the recommended target or if there had been an increase or decrease on the previous month's performance.
   20211101 Question 36 Acute Governance Report Nov21- This can be located at Attachment folder S21 25 of 2022- Attachment 69

e. **Performance** – Any issues or concerns in relation to Performance are raised at the Performance Head of Service Meeting, then escalated by the AD for SEC/ATICS further onto the Acute SMT for Performance and also at the SPPG (previously known as HSCB) Performance meetings by the Assistant Director for Performance (Lesley Leeman). In addition, and as outlined in my answer to Question 12, performance issues are raised and possible solutions discussed at the Urology Departmental meetings.
   20211026 Question 36 Performance Head of Service Minutes- This can be located at Attachment folder S21 25 of 2022- Attachment 70

36.3 **External Concerns** can be brought to my attention in various ways including:

a. **Complaints and Re-opened complaints** – All urology-related complaints are sent to myself from the Complaints Department. By way of recent

example, there have been 27 complaints raised in relation to Urology from October 2021 to 10 May 2022. I would forward the complaint on to the relevant staff for investigation and response, ensuring the complaint is finalised and forwarded back to the Complaints Department for onward approval by the Director of Acute Services. I attach an example of an Acute Governance current complaints record which is circulated to all relevant staff in ATIC/SEC for action and escalation. This report is discussed at the Governance Head of Service meetings.

20220404 Question 36 Email Rcarroll Governance Complaint Record- This can be located at Attachment folder S21 25 of 2022- Attachment 71a

20220404 Question 36 Email Rcarroll Governance Complaint Record A1- This can be located at Attachment folder S21 25 of 2022- Attachment 71b

20220501 Question 36 Urology Complaints from Oct 2021- This can be located at Attachment folder S21 25 of 2022- Attachment 71c

If patients are not satisfied with the complaint response, they are entitled to forward the complaint on to the Ombudsman for further investigation.

b. **MLA queries** – There are approximately 6 MLA queries per month. These queries are investigated by myself and are responded to accordingly. The main issue for MLA queries is, understandably, in relation to long waiting times for a urology outpatient or elective appointment date.

c. **Care Opinion** – 'Care Opinion' is a platform in which patients, carers and relatives can share their experiences of UK health and care services, good or bad. Depending on the content of the story, it is shared with many disciplines and responses are required from each, i.e., Nursing in relation to patient care, communication, compassion, etc.; Catering if food is commented on; Domestic Supervisor if cleanliness is commented on; and so on. These stories are uploaded alongside the original story on the care opinion platform.

36.4 My opinion on the efficacy of the governance systems is as follows. The processes currently in place are primarily reactive rather than proactive, for example, focusing post-incident, through DATIX and screening and complaints, to address governance concerns. Governance processes are limited by staffing / workforce issues, and this is reinforced by the lack of clinical audit undertaken to monitor and ensure safe practice and that checks and balances are in place for patient safety, for example, clinical audits on complication rates, extended length of stay, re-admission rates, etc.

36.5 In respect of improvements, in January 2022, a Cancer MDT Administrator (Angela Muldrew) was appointed to support the MDT clinical teams, which includes Urology. A function of the Cancer MDT Administrator role is to oversee and manage the MDT outcomes audit. A pilot audit of the Urology Multi-disciplinary Meeting

(MDM) outcomes was completed in January 2022. The pilot demonstrated that all MDM outcomes were actioned appropriately.
20220131 Question 36 Urology MDM Outcome Audit - Jan 2022- This can be located at Attachment folder S21 25 of 2022- Attachment 72

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

37.1 Since my tenure as Interim Head of Urology Services commenced in October 2020, there have been the following systems or process change:

a. Job planning – the Urology Consultants' job plans were changed in November/December 2021 to include Clinical Lead roles as follows:

   i. Patient Safety Lead – Mr O Donoghue 0.485PA
   ii. Standards and Guidelines Lead – Mr Tyson 0.5PA
   iii. Quality Improvement Lead - Mr Tyson 0.5PA
   iv. Cancer MDM Lead – Mr Glackin 1.0PA
   v. Rota Co-ordination Lead – Mr Young 0.5PA (retired at the end of May 2022 – the Interim Head of Urology Service will undertake this role until a replacement consultant is in place).

   Mr Mark Haynes, AMD/DMD for Urology, implemented these changes to strengthen governance within Urology.

b. Due to Covid-19 and the closure of HSCB (now SPPG) the Trust's performance monitoring has changed from service level activity (SBA) to the monitoring of Service Delivery Plans, i.e., performance rebuild plans.

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

38.1 I ensure that I am appraised of any concerns within Urology by having a strong professional working relationship with the Urology team, AD in SEC/ATICS, and my colleagues in other specialities.

38.2 I am also appraised of concerns by reviewing the Acute Governance and Performance Reports at the meetings outlined in my detailed answers to Questions 32 to 36 above, for example, DATIX reports, Complaints, SAIs, NQIs, and so on. Any concerns which I have would be raised with my AD for SEC/ATICS (Ronan Carroll), either on an informal basis or during my 1:1 monthly meetings (see further my evidence at Question 25).

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

39.1 I ensure governance systems are adequate by monitoring the reports generated for acute governance and performance and discussing the findings as outlined in detail in response to Questions 31 – 34 above and by having regular governance meetings with the SEC/ATIC management team (AD and Heads of Service for SEC/ATICS) and the Urology team. Any medical professional issues would be investigated through the DMD.

39.2 With the exception of the Urology Consultant workforce issue and performance concerns (both of which have been mentioned at various points above – e.g., at Questions 12, 16, 17 and 19), there have been no additional concerns raised to me during my tenure.

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

40.1 By the commencement of my tenure in October 2020, I was aware that concerns had been escalated and problems identified and a specialised team were put in place to commence a Urology 'look back' exercise.

40.2 In relation to my tenure, from October 2020 onwards any concerns identified are captured in the following documents:

a. Complaints / DATIX reports;
b. SAI recommendations, for example, bloods to be handed over at ward level the next morning and stent replacements;
20210921 question 40 email Wendy follow up C Wamsley- This can be located at Attachment folder S21 25 of 2022- Attachment 73a
20201124 question 40 email attachment Final Report to review team MM 24.11.2020 A1 – This can be located at Attachment folder S21 25 of 2022- Attachment 73b
c. Risk registers – Urology performance targets for outpatients, cancer, elective and planned are all on the Divisional Risk Register along with other surgical specialties; ***20220301 Question 40 March 22 Divisional Risk Register- This can be located at Attachment folder S21 25 of 2022- Attachment 74***
d. Performance challenges and concerns are raised with SPPG (previously HSCB) by the Director of Acute Services, along with the Assistant Director (Lesley Leeman) and Head of Performance (Lynn Lappin) on behalf of Acute Services;
e. After discussion with Chris Wamsley, Head of Acute Clinical Governance, the Urology Consultant vacancy will be added to the Corporate Risk

Register. This risk will be incorporated with other specialty clinical workforce issues.

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

41.1 There are a number of systems for collecting patient data. They are:

a. The Patient Administrative System (PAS) – This is used for recording all patient episodes and attendance while in the Trust, for example, all GP outpatient referrals, emergency admissions, or outpatient and inpatient / daycase episodes. In addition to these episodes, there is handwritten documentation in the patient's hospital notes.

b. The Northern Ireland Electronic Care Record (NIECR) – This is an overarching computer system that takes existing information from a number of different electronic records, e.g., PAS and laboratory and radiology results, from across the Trusts and gives clinical staff important access to information about a patient's medical condition.

c. When investigating patients' complaints and MLA queries PAS and hospital notes are used. These systems would identify any issues with patient care or waiting times. It is the responsibility of the clinician to ensure a clinical note is recorded in the patient record at the time of consultation, e.g., out-patient, ward round, etc.

d. CaPPS - Suspect (62 days) and confirmed (31 days) Cancer Patient pathways are recorded on a Regional Cancer Patient Pathway System referred to as CaPPS. The Cancer team have an escalation process to identify delays in the patient's pathway. The Cancer Service Administrator (Sinead Lee, previously Vicki Graham and Angela Muldrew) would email the OSL and Head of Urology Service with urology cancer escalations due to capacity issues. The Head of Urology Service would try and resolve this delay if possible.

Relevant to Acute, Document Number 11 The Cancer Pathway Escalation Policy Final August 2019
20220216 question 41 email urology escalation- This can be located at Attachment folder S21 25 of 2022- Attachment 75a
20220407 question 41 email Urology escalation- This can be located at Attachment folder S21 25 of 2022- Attachment 75b

e. Information from PAS and CAPPS can be extracted from Business Objects XI (known as 'BOXI'). BOXI is a decision support tool to aid performance management, planning reporting, and analysis of activity. Regular reports from BOXI include activity reports, number of referrals, and waiting lists of patients. The data helps to identify concerns, for

example, number of patients on a waiting list, the longest patient waiting in weeks for their appointment, number of referrals highlighting trends, peaks and troughs.

f. The urology consultants use 'e-triage' for GP referrals which is an electronic system used to manage the triage of referrals to the service via Clinical Commissioning Groups (CCG).

The Urology service went live on e-triage on 24 March 2017. The CAH Urology Haematuria referral pathway was added on 9 July 2020. This has made the identification of any patients going outside of guidelines for triage easier to identify directly to the consultant team dealing with the triage, unfortunately, this is not escalated to the Head of Urology Service directly from CCG.

The Referral and Booking Centre (RBC) and the Cancer Team have a missing triage report which is emailed to the OSL for onward escalation.
20201201 question 41 TRIAGE PROCESS DEC 20- This can be located at Attachment folder S21 25 of 2022- Attachment 76a
20210209 question 41 email missing triage- This can be located at Attachment folder S21 25 of 2022- Attachment 76b
20220202 question 41 email missing triage A1- This can be located at Attachment folder S21 25 of 2022- Attachment 76c
20220202 question 41 email missing triage- This can be located at Attachment folder S21 25 of 2022- Attachment 76d
20201119 question 41 email missing triage report- This can be located at Attachment folder S21 25 of 2022- Attachment 76e
20160218 question 41 email urology referrals not back from triage- This can be located at Attachment folder S21 25 of 2022- Attachment 76f
20160310 question 41 email Triage- This can be located at Attachment folder S21 25 of 2022- Attachment 76g
20151120 question 41 email missing urology RF referral from triage- This can be located at Attachment folder S21 25 of 2022- Attachment 76h

g. SEC Backlog report – this is a manual report developed by the admin secretarial staff within Functional Service. This report would collect data, for example, on results waiting to be dictated by the consultant, letters to be typed, etc. This report is reliant on the secretarial staff updating the report and would have highlighted any concerns if there was a backlog in dictation.

h. DATIX is used to record clinical incidents on the wards and throughout the Trust. The severity of incident is coded from a matrix. Any catastrophic incidents are sent to the screening panel to ascertain if an SAI should be undertaken.

i. Radiology Information System (RIS) and Northern Ireland Picture Archiving and Communication Systems (NIPACS) – these are radiology referral and reporting systems for radiological examinations. These systems are used by the clinical staff to request radiological imaging. There is a radiology policy for escalation of any unexpected findings back to the referring clinician, but this is not escalated to the Head of Urology Services.

20210423 Question 41 Reporting and Communicating of Critical Urgent Significant Unexpected Radiological Findings- This can be located at Attachment folder S21 25 of 2022- Attachment 77

j. Theatre Management System – This captures start and finish times of surgical operating times, from the point when a patient enters theatre to recovery.

41.2 I have no knowledge of whether any of these systems assisted in identifying concerns regarding Mr O'Brien. In relation to potentially identifying concerns, PAS, BOXI, SEC backlog report, and DATIX are the main systems used in relation to hospital attendances and clinical activity:

a. PAS – this can assist in:

   i. Identifying private patients being added to the National Health Service (NHS) and date of surgery;
   ii. Case note tracking, which identifies where a chart is located, e.g., a report can be generated to identify how many charts are in an office.

b. BOXI – this can assist in:

   i. Identifying referrals which have not been triaged;
   ii. Identifying the number of red flag referrals, list of patients on each tumour site; and days waiting on their pathway.

c. SEC backlog report – although this report is manual it is still used to identify letters or results to be dictated and typing backlogs.

d. DATIX would identify medical and nursing concerns, e.g., medication errors, nursing deficits on the ward, and so on.

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

42.1 The current systems are reliant on accuracy of data entry and there will always therefore be an element of exposure to the risk of human error. They are also reliant on the clinical staff completing note-taking in hospital charts, dictation, and ensuring all radiology and laboratory examinations are requested and reviewed.

42.2 Systems such as PAS outpatient module do lack high level decision making reports, for example, where an outpatient referral is received for Urology there is no easy method of coding the referral for the specific reason of referral, e.g., prostate, haematuria or bladder. The referrals are on one waiting list and a comment is typed in the free text field stating which specific area of urology the patient is being referred for, requiring a manual sift of reports if you are looking for this body part specifically.

42.3 PAS holds episodic patient information but does not hold clinical details, for example, a patient's date of admission, discharge, speciality and consultant is recorded on PAS but this system does not hold a clinical note on consultations etc. Clinical information, both medical and nursing, are hand written and only accessible in the hospital notes.

42.4 I believe that the DATIX incident report system does enable trends of incidents to be identified.

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

43.1 Key Performance objectives are set by the Minister of Health for the delivery of out-patient, elective and diagnostic service. Within the urology service there is a recognised capacity gap which has led to waiting times for all these areas increasing and patients being treated outside the Department of Health targets as outlined in the IEAP. This was further compounded by the Covid-19 pandemic (from March 2020 onwards). The Department of Health targets have not changed since 2008, however, the monitoring of the performance has varied over the years. Each specialty is monitored against the commissioned clinical activity as agreed by SPPG (previously HSCB) against actual activity known as Service Baseline Agreement (SBA). SBA was the term used from 2012/13 until 2017, following 2017 the term was changed to 'trajectory'. Post covid, the Trust has been measured against their rebuild plans only.

43.2 Within the Urology Consultant job plans each consultant has clear clinical sessions to be delivered as outlined in their job plan and to be achieved over the year. Since updating the Urology Consultant job plans in November/December 2021, I have been monitoring the clinical sessions undertaken by each consultant, taking annual leave into consideration.
20211101 question 43 Cons activity from Nov 21- This can be located at Attachment folder S21 25 of 2022- Attachment 78

43.3 In my opinion, the performance objectives were clear and the consultant medical staff are aware of the number of clinical sessions they require to undertake each year; this is outlined and agreed with the consultants in their job plans. The performance activity for Urology services is monitored and discussed at a number of Performance meetings, as outlined in my response to Question 12 above.

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

44.1 Since my tenure began, I have supported the Divisional Medical Director, Mr Mark Haynes, to complete all medical job plans. These were signed off in November/ December 2021.

44.2 We achieved the objective of the cycle of job planning and do not feel it would be beneficial to review job plans any more frequently than once a year, unless specifically requested by the medical staff themselves if their circumstances changed. Current job plans are evidenced in my answer to Question 20.

44.3 I did not have any job planning and appraisal role prior to being HOS.

20160101 to 20200101 Question 44 Urology Appraisals- This can be located at Attachment folder S21 25 of 2022- Attachment 79

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

45.1 As OSL for CCS/ATICS and SEC/ATICS, I received escalations from the red flag team (Angela Muldrew or Vicki Graham) in relation to delayed triaged or delays in cancer pathways. Specifically in respect of urology, I would have contacted Martina Corrigan, Head of Urology Services, and Ronan Carroll, Assistant Director, for action as appropriate. Following my escalation, I understand that Martina Corrigan would have contacted the Consultant directly, either by email or face to face, to address the issue, and I have included some examples of my involvement in this process below.

20140912 question 45 missing referrals- This can be located at Attachment folder S21 25 of 2022- Attachment 80a
20150203 question 45 missing urology referrals- This can be located at Attachment folder S21 25 of 2022- Attachment 80b
Relevant to Acute, Wendy Clayton Q77, 20150125 question 45 email WC urology red flag referrals still missing
20160217 question 45 urology referrals not back from triage- This can be located at Attachment folder S21 25 of 2022- Attachment 80c
Relevant to Acute, Wendy Clayton Q77, 20150526 question 45 outstanding referrals

45.2 When the original urology governance concerns were raised I was OSL for SEC/ATICS (2016-2017 and 2019) had no input to the process, procedures or personnel involved.

45.3 I commenced my tenure as Interim Head of Urology Services in October 2020. At this stage the issues regarding Mr O'Brien had been already identified and a specialised urology 'lookback' team was set up to review the service. I was employed as the Operational Head of Urology Services, which is separate from the 'lookback' exercise currently being undertaken.

45.4 As Interim Head of Urology Services, if I became aware of patient safety issues the process would involve the following steps:

a. Gaining an understanding of the issue, e.g.,-

   i. Backlog in results dictation would be discussed directly with the consultant;
   20220504 question 45 outstanding results- This can be located at Attachment folder S21 25 of 2022- Attachment 53

   ii. Patient safety issue following receipt of a DATIX would be forwarded to Mr John O'Donaghue (Chair of Urology PSM) for adding to the agenda and discussion noted in the PMS notes as evidenced in PSM notes April 22 agenda item no.8;
   20220512 question 45 DATIX feedback- This can be located at Attachment folder S21 25 of 2022- Attachment 81a
   20220412 question 45 PSM minutes April 2022 item no.8- This can be located at Attachment folder S21 25 of 2022- Attachment 81b

b. Ensuring completion of relevant documents if not already completed, e.g., DATIX for onward screening to SAI if warranted; following 'Procedure for the reporting and follow up of Serious Adverse Incidents' November 2016;

c. (If the incident resulted in an SAI) discussing the action plan with the medical team at the Urology Departmental meeting;

d. Monitoring the implementation of the plan and feeding back/discussing the learning at departmental meetings.

20210609 question 45 email IR1 [redacted]- This can be located at Attachment folder S21 25 of 2022- Attachment 82a
20210921 question 45 email action plan [redacted]- This can be located at Attachment folder S21 25 of 2022- Attachment 82b
20210921 question 45 email action plan [redacted] A1- This can be located at Attachment folder S21 25 of 2022- Attachment 82c
20210921 question 45 email action plan [redacted] A2- This can be located at Attachment folder S21 25 of 2022- Attachment 82d

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

46.1 Yes, I do feel supported by both Ted McNaboe, Surgical DMD, and Mark Haynes, Urology Service Improvement DMD (previously Surgical AMD until 1 December 2021). I also feel I have the support of all the Urology Consultants. I meet weekly with both DMDs (if they are not consultant of the week) to discuss job planning, operational workforce issues, and service development. Some examples of communications between myself as HOS and the DMD are listed below:

20220422 Question 46 1to1 notes Mark and Wendy- This can be located at Attachment folder S21 25 of 2022- Attachment 83a
20211211 Question 46 Email Emergency Admission of Patients on WL for Elective Surgery- This can be located at Attachment folder S21 25 of 2022- Attachment 83b
20220228 Question 46 Email ST Urology TURBT- This can be located at Attachment folder S21 25 of 2022- Attachment 83c
20220303 Question 46 Email 3fivetwo Contract- This can be located at Attachment folder S21 25 of 2022- Attachment 83d
20220425 Question 46 Email Job Plan MY- This can be located at Attachment folder S21 25 of 2022- Attachment 83e

46.2 I would also have a strong working relationship with all Medical staff within the Urology Department. I am in daily contact with the consultants, both verbally and via email, in respect of any requests, issues or guidance they require. The evidence submitted below comprises some examples of the consultants working together and supporting the team and service development.
20211103 question 46 email Mr Khan off until 22.11.21- This can be located at Attachment folder S21 25 of 2022- Attachment 84a
20220513 question 46 email TP biopsy 352 contract- This can be located at Attachment folder S21 25 of 2022- Attachment 84b

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

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

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

47.1 In my response to Questions 47 – 51 I will refer to general Urology service issues and in my responses to Questions 52 – 65 I will give specific answers relating to Mr O'Brien issues.

47.2 As described earlier, of potential relevance to urology I have held 3 posts from 2007 onwards:

a. OSL for CCS/ATICS from 2007 – 2016; during this tenure I monitored cancer performance including urology;
b. OSL for SEC/ATICS from 2016 – 2017 and then again in 2019; during this tenure I monitored urology performance;
c. Interim Head of Urology Services from October 2020 to present.

(i) Chief Executive
47.3 I have not had direct contact with any Chief Executive in relation to escalation of matters of concern regarding urology governance issues during any of my roles save that I have been a member of the Urology Lookback Steering Group from November 2021, which Maria O'Kane, Chief Executive from April 2022 (previously Medical Director), attends. I did not have contact with any other Chief Executives.
20220509 question 47i Lookback Steering Group Minutes 9.5.22- This can be located at Attachment folder S21 25 of 2022- Attachment 85a
20220411 question 47i Lookback Steering Group Minutes- This can be located at Attachment folder S21 25 of 2022- Attachment 85b

(ii) Medical Director

47.4 I have not had direct contact with any of the Medical Directors in relation to governance generally, or specifically in respect of the escalation of matters of concern regarding urology governance issues, during any of my roles.

47.5 As outlined in 47.3, I became a member of the Urology Lookback Steering Group from November 2021 which the current Chief Executive (Maria O'Kane) attended in her previous role as Medical Director.

20211111 question 47ii Lookback Steering Group Minutes- This can be located at Attachment folder S21 25 of 2022- Attachment 86a

20211206 question 47ii Lookback Steering Group Minutes- This can be located at Attachment folder S21 25 of 2022- Attachment 86b

(iii) Director(s) of Acute Services

47.6 During all my tenures as OSL and HOS, the Directors of Acute Services have been Gillian Rankin, Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements. I would have had a good working relationship with all the Directors, having had regular face to face contact in relation to performance issues that arose, which included the speciality Urology.

47.7 When Ronan Carroll, AD for SEC/ATIC, is on leave the HOS would attend governance meetings on his behalf which the Director of Acute Services would have chaired. These meetings would have included Acute SMT performance and governance meetings, Acute Standard & Guidelines Meetings and AD Huddle.

(iv) Assistant Director(s)

47.8 Ronan Carroll, Assistant Director for SEC/ATICs, has remained my line manager from 2007 throughout my tenures as OSL and HOS.

47.9 I communicate with Ronan Carroll on a daily basis with regards to general governance issues such as finance, governance and performance. Now that I am Interim Head of Urology, ENT, Outpatients, and Ophthalmology, the communication would be more specific to Urology governance issues, e.g., workforce and performance. These issues are discussed at HOS meetings, 1:1 meetings (see my 1:1 evidence at Question 21), by email, and through 'Zoom' and face to face conversations.

47.10 During my OSL roles I would have emailed cancer escalations in relation to capacity issues, missing triage, and performance and included the AD into the emails for awareness.

47.11 As Interim Head of Urology, examples of communications to Ronan Carroll include in respect of workforce issues due to vacant Consultant Urology posts, 3 south nursing, performance, waiting times issues and complaints.

20080520 question 47iv Email Escalation of cancer patients- This can be located at Attachment folder S21 25 of 2022- Attachment 87a

20170106 question 47 iv email TURP audit- This can be located at Attachment folder S21 25 of 2022- Attachment 87b

Relevant to Acute, Wendy Clayton Q77, 20181019 question 47 iv email AOB update

20220513 question 47 iv urology scheduler- This can be located at Attachment folder S21 25 of 2022- Attachment 87c

20220513 question 47 iv urology scheduler A1- This can be located at Attachment folder S21 25 of 2022- Attachment 87d

20220513 question 47 iv Consultant urologist CAH URGENT- This can be located at Attachment folder S21 25 of 2022- Attachment 87e

20220506 question 47 iv TP Bx regional help RPPG- This can be located at Attachment folder S21 25 of 2022- Attachment 87f

20220408 question 47 iv New complaint for investigation Personal Information redacted by the USI **This can be located at Attachment folder S21 25 of 2022- Attachment 87g**

20210604 question 47iv ward available DHH to service UB lists- This can be located at Attachment folder S21 25 of 2022- Attachment 87h

20210811 question 47iv Personal Information redacted by the USI **This can be located at Attachment folder S21 25 of 2022- Attachment 87i**

20210903 question 47iv new regulations for close contact - This can be located at Attachment folder S21 25 of 2022- Attachment 87j

(v) Clinical Director

47.12 During my tenure as OSL for SEC/ATICS and during part of my tenure as Interim Head of Urology Services, Mr Ted McNaboe was CD for Urology and ENT, until he was appointed as Surgical DMD in December 2021. The CD post has remained vacant from December 2021.

47.13 In relation both to general governance issues and specific urology issues, I would have had minimal contact with Mr McNaboe as CD as I communicated directly with Mr Mark Haynes as Associate Medical Director (now DMD for Urology Quality Improvement) on any issues relating to Urology.

47.14Mr Ted McNaboe is the Trust's representative on the RPOG meeting and I would have provided Urology elective information to Mr McNaboe for this meeting, example attached:

20210204 question 47v RPOG Urology- This can be located at Attachment folder S21 25 of 2022- Attachment 88a

20210204 question 47v RPOG Urology A1- This can be located at Attachment folder S21 25 of 2022- Attachment 88b

20220303 question 47v Urology RPOG elective priority spreadsheet June 21- This can be located at Attachment folder S21 25 of 2022- Attachment 88c

20220303 question 47v Urology RPOG elective priority spreadsheet June 21 A1- This can be located at Attachment folder S21 25 of 2022- Attachment 88d

(vi) Associate Medical Director

47.15 I would not have had regular contact with the AMD (now known as DMD) during my tenures as OSL. However, I now have regular weekly contact with both SEC DMD (Mr Ted McNaboe, previously Mr Mark Haynes) and the newly appointed Urology Quality Improvement DMD (Mr Mark Haynes) in relation to urology governance issues.

47.16 The communication is primarily verbal, face to face and on the phone, discussing daily issues such as operational capacity issues, complaints, service improvement, and workforce. 1:1 notes with the Urology Service Improvement DMD are evidenced in Question 46.

20220503 question 47vi TP biopsy transfer to LVH- This can be located at Attachment folder S21 25 of 2022- Attachment 89a

20220503 question 47vi New complaint for investigation Personal Information redacted by the USI **- This can be located at Attachment folder S21 25 of 2022- Attachment 89b**

20220504 question 47vi Stones- This can be located at Attachment folder S21 25 of 2022- Attachment 89c

20220505 question 47vi Bx Regional help – RPOG- This can be located at Attachment folder S21 25 of 2022- Attachment 89d

20220407 question 47vi Urology service improvement- This can be located at Attachment folder S21 25 of 2022- Attachment 89e

20220407 question 47vi Urology service improvement A1- This can be located at Attachment folder S21 25 of 2022- Attachment 89f

20220407 question 47vi Urology service improvement A2- This can be located at Attachment folder S21 25 of 2022- Attachment 89g

(vii) Clinical Lead

47.17 I would not have had contact with the Clinical Lead during my tenures as OSL in relation to governance or urology issues. During my tenure as Interim Head of Urology Services, I would have weekly contact with the Urology Clinical Lead (Mr Michael Young). This communication was primarily regarding Urology clinical rota and workforce issues and was verbal - on the phone or face to face. The Clinical Lead would attend the weekly Urology Department Meeting. Mr Young's attendance was noted in the minutes of this meeting.

20211007 question 47vii urology team meeting notes 7.10.2021- This can be located at Attachment folder S21 25 of 2022- Attachment 90a

20220113 question 47vii urology team department notes 13.1.2022- This can be located at Attachment folder S21 25 of 2022- Attachment 90b

(viii) Consultant Urologists

47.18 I would have had minimal contact with the Urology consultants during my tenure as OSL. The only contact I would have had would have been in relation to cancer performance escalations.

47.19 As Interim Head of Urology Services, I have regular contact with all the consultants; this is verbal and written (in emails) in relation to complaints, performance issues, work force, and service improvement. In addition, there is a weekly departmental team meeting.

47.20 I have provided examples of emails in relation to general urology governance:

20211103 question 47viii Mr Khan off until 22.11.21- This can be located at Attachment folder S21 25 of 2022- Attachment 91a
20220120 question 47viii important rota request- This can be located at Attachment folder S21 25 of 2022- Attachment 91b
20220127 question 47viii advert for consultant urologist- This can be located at Attachment folder S21 25 of 2022- Attachment 91c
20220520 question 47viii complaint received from website feedback form- This can be located at Attachment folder S21 25 of 2022- Attachment 91d
20211028 question 47viii 352 urology outpatients, diagnostics and surgical services- This can be located at Attachment folder S21 25 of 2022- Attachment 91e
20201231 question 47viii MI 12830- This can be located at Attachment folder S21 25 of 2022- Attachment 91f
20201019 question 47viii enquiry response required- This can be located at Attachment folder S21 25 of 2022- Attachment 91g

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.

48.1 During my tenure as OSL for CCS and SEC, the main problems which I encountered in relation to Urology were the performance targets as outlined in the IEAP.

48.2 As OSL for CCS, the main urology concerns were triage and waiting times for the patients on their cancer pathway. As OSL, I would have raised these concerns

at the monthly Cancer Performance meetings as evidenced in Question 12 above. This meeting was attended by the AD, HOS and OSL for each Surgical and Medical specialty. In addition the Cancer Services Co-ordinator (Angela Muldrew from August 2008 to October 2014, then Vicki Graham) and I would have escalated missing triage to the relevant HOS for action with the appropriate consultant.

48.3 As OSL for SEC, the urology concerns remained performance for urology cancer and elective services (outpatients, inpatient/daycases) as outlined in Questions 12 and 33 above. By the time Ronan Carroll and I transferred to SEC in 2016, the waiting time targets were not achieved as outlined in the IEAP, outpatients was 74 weeks (target 9 weeks) and inpatient /daycases was 120 weeks (target 13 weeks). Acute performance concerns, which included urology, were added to the Trusts Acute Divisional Risk Register as follows:

a. November 2010 Risk Register – Cancer delays ID 2071 and ID897;
b. March 2016 Risk Register – all performance risks.

48.4 The table below demonstrates the change in waiting times from April 2016 to April 2022 for the urology specialty for both out-patients and elective waiting lists.

	Outpatients weeks waiting			**Inpatient / daycase weeks waiting**	
	Red flag	Urgent	Routine	Urgent	Routine
April 2016	3.5	40	74	119	120
April 2022	11	310	313	397	398

48.5 From my tenure as Interim Head of Urology Services from October 2020, the 2 main issues that have been brought to me have been: (i) Consultant Urology vacancies; and (ii) Performance capacity and demand (both during the verbal handover from the previous post-holder, Martina Corrigan).

(i) Consultant Urologist Vacancies

48.6 In relation to Consultant Urology recruitment please refer to my detailed answers above, in particular to Questions 17 and 19.

20220512 Question 48 URGENT Consultant Urologist Recruitment- This can be located at Attachment folder S21 25 of 2022- Attachment 92a
20220513 Question 48 Email Consultant Urologist CAH – Urgent- This can be located at Attachment folder S21 25 of 2022- Attachment 92b

(ii) Performance Capacity and Demand

48.7 As mentioned in my response to Question 12 above, performance continues to be a significant concern for Urology services. Performance issues, including urology performance issues, remain today on the Divisional Risk Register as well as being discussed at regional monthly meetings including the HOS meeting, Directors Performance SMT, and SPPG (previously known as HSCB) performance meetings. There were never any formal minutes of the SPPG performance meetings, however, Lynn Lappin (Head of Performance) kept notes which are evidenced below. Present

at the SPPG performance meetings included: SPPG representatives; Cara Anderson, Director of Performance; David McCormick, AD of Performance; and Trust representatives from each Acute Division (Melanie McClements, Director of Acute Services and ADs) along with the AD and HOS for Performance (Lesley Leeman and Lynn Lappin). The HOS or OSL were in attendance if specifically requested or in place of the AD.

20200923 question 48a Actions Issues Register - HSCB SHSCT Service Issues and Performance Meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 93a
20180523 question 48a Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 93b
20180523 question 48 Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting A1- This can be located at Attachment folder S21 25 of 2022- Attachment 93c
20180523 question 48 Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting A2- This can be located at Attachment folder S21 25 of 2022- Attachment 93d
20160921 Q48 Internal Prep Notes - HSCB SHSCT Service Issues and Performance Meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 93e
20160624 Q48 Internal Prep and Action Notes - HSCB SHSCT Service Issues and Performance Meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 93f
20160921 Qu 48 Internal Prep Notes - HSCB SHSCT Service Issues and Performance Meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 93e
20170530 Q48 Internal Prep Notes - HSCB SHSCT Services Issues and Performance Meeting- This can be located at Attachment folder S21 25 of 2022- Attachment 93h
20170530 Q48 Internal Prep Notes - HSCB SHSCT Services Issues and Performance Meeting A1- This can be located at Attachment folder S21 25 of 2022- Attachment 93i

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

48.8 Acute performance, including urology performance, is on the Divisional Risk Register along with other specialities in relation to long waiting times for outpatients, inpatients / daycases, planned surveillance patients, and review backlog.

48.9 Cancer performance is on the Directorate Risk Register due to cancer pathway capacity issues in Urology and other tumour sites.

20220401 Question 48b SEC.ATICS Div.HOS.Team RR April 2022- This can be located at Attachment folder S21 25 of 2022- Attachment 52a
20220401 Question 48b Directorate RR April 2022- This can be located at Attachment folder S21 25 of 2022- Attachment 52b

48.10 Performance is monitored on a monthly basis and issues and challenges highlighted.

48.11 Review backlog reports are generated by Jane Scott, OSL for SEC/ATICS, and I also include review backlog in the consultants' monthly urology performance reports. There has been a significant reduction of 141 review patients between January 2022 and March 2022. The review backlog report (summary illustrated in the table below, showing the improvement in numbers of patients waiting) has previous consultants on the report such as Messrs O'Brien, Jacob, Solt and Fel, as they were the original doctors treating the patients and, given the ongoing recruitment challenges, there has been no permanent replacement to move these patients across to another named consultant for the management of their care. These patients are still receiving care.

Review outpatient backlog update (as at 23rd March 2022)

	Jan-22		Feb-22		Mar-22	
	Total	Longest Date	Total	Longest Date	Total	Longest Date
Glackin	73	May-20	95	May-19	88	May-20
O' Donoghue	405	Mar-17	394	Mar-17	373	Mar-17
Young	500	Dec-16	475	Dec-16	478	Dec-16
Haynes	121	Feb-19	123	Feb-19	120	Feb-19
Omer	69	Mar-18				
Khan	15	May-21	149	Jul-17	62	Jul-17
O' Brien	288	Jul-13	234	Jul-13	187	Jul-13
Tyson	43	May-19			81	Sep-18
Jacob	4	Jul-17				

Solt	10	Oct-19	10	Oct-19		
Fel	4	Dec-20	3	Jan-21		
Mr Brown			2	Apr-17	2	Apr-17
Total	**1532**		**1485**		**1391**	

48.12 The validation team, under the line management of Jane Scott, OSL for SEC/ATICS, has commenced urology inpatient elective admin waiting list validation. In the report of 6 May 2022 this led to 6% of urgent patients (36 patients) and 4% of routine patients (9 patients) being removed from the waiting list.
20220506 question 48b WEEKLY ACHIEVEMENTS - VALIDATION TEAM as at 06052022- This can be located at Attachment folder S21 25 of 2022 Attachment 95

(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.

48.13 Yes, I do consider that there may be potential harm to patients from the above concerns, particularly due to the long waiting times for out-patients, elective treatment and planned treatment.

48.14 The following steps in particular were undertaken to mitigate the risk of harm to patients:

a. It is recognised that potential harm may come to patients, therefore, performance was added to the Acute and Divisional Risk Registers.
b. Sourcing independent sector providers to reduce waiting time - In January 2022, we commenced a new outpatient referral contract with '3fivetwo healthcare', an independent sector provider (ISP). This contract was commenced in quarter 4 (January to March) of 2021/22 and was for 800 new urology outpatient referrals, as well as dealing with 'wash through' consequences (which means that the patient will stay with the ISP for the remainder of their treatment pathway or until the ISP can no longer provide care within the limitations of the contract).
c. In 2022/23 the Southern Trust led on the Urology new outpatient pathway contract for the region. In quarter one (April – June 2022) we received non-recurrent funding for 1200 new outpatient referrals for the region. The Southern Trust had approximately two thirds of this volume (approx. 800 referrals). It is estimated that waiting time will be significantly reduced from 313 weeks to approx. 52 weeks for urgent referrals.
d. Regional support to equalise waiting times through the RPOG meetings (Mr Ted McNaboe is the Trust Representative on this). From these meetings, we have been able to transfer long waiting urology cancer and urology stone patients waiting on surgery to the South Eastern Trust.

20220106 Question 48c _Final Contract Award Letter_BJ- This can be located at Attachment folder S21 25 of 2022 Attachment 96

(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?

48.15 The Head of Performance (Lesley Leeman, replaced by Lynn Lappin in 2011) monitored the Trust's performance against the agreed currency of activity. From 2012/13 the Trust's performance was monitored against the Service Baseline Agreement (SBA); then from 2017 this was changed to 'trajectories'; and now 'rebuild plans' since the COVID pandemic.

48.16 It was the responsibility of the OSL to operationally monitor performance within their specialty areas and escalate waiting time concerns to the AD and relevant HOS:

a. As OSL for CCS/ATICS I would have escalated the cancer performance waiting times through the monthly cancer performance meetings and email escalations including missing triage;
b. As OSL for SEC/ATICS I circulated the surgical (which included urology) performance waiting times to the AD and HOS, as well as being discussed at monthly HOS performance meetings.
20191030 Question 48d SHSCT Delivery of Core (OP) Traj v Actual - October 2019- This can be located at Attachment folder S21 25 of 2022 Attachment 97a
20191030 Question 48d SHSCT Delivery of Core (IPDC) Traj v Actual - October 2019- This can be located at Attachment folder S21 25 of 2022 Attachment 97b

48.17 To address the performance concerns within urology, in house additionally, independent sector provision, and validation was undertaken. Unfortunately, this did not have a significant impact on the waiting times for the reasons already outlined in my response to Question 12.

(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?

48.18 During my tenure as OSL in CCS/ATIC and SEC/ATICs there was ongoing rigorous performance monitoring by the Performance Team led by Lynn Lappin and the OSL. The monthly performance reports developed by the OSL, performance and information teams were shared with the Acute Senior Managers at a number of meetings including HOS meetings and Acute SMT performance meetings. The reports were used to identify any deviations and a plan agreed to escalate risk to SPPG (previously HSCB) and action taken.

48.19 The same process is still being used during my tenure as Interim Head of Urology. I review the performance reports, discuss with the consultants at the monthly performance Urology department meeting, and actions are agreed and undertaken. I am assured that the systems are working by monitoring the reports to identify trends to ensure the information provided is accurate.

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

48.20 Both as OSL and Interim Head of Urology I would have given assurances to the AD for CCS/ATICS up to 2016 and, from then, to the AD for SEC/ATICS, that the processes were in place to monitor performance.

48.21 With the knowledge and expertise in relation to performance I would have identified any trends and/or inconsistences in the performance reports developed and discussed at the monthly HOS and Urology department meetings.

48.22 The monthly performance reports which outlined outpatient and inpatient/daycase waiting times, volumes of patients waiting, and review backlog, were shared and discussed in a number of forums. Trends and risks were identified and escalated to the HSCB by the Senior Management Team, which included the Director for Performance, Director for Acute Services and, on occasions, the Assistant Director for SEC/ATICS.

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

48.23 The main issues, as described above, were performance and workforce.

48.24 The performance reports which are presented on a monthly basis, did not rectify the waiting list problems, but were successful in highlighting when the service was facing significant challenges in terms of meeting predicted capacity, e.g. if a consultant went off on sick leave then the service would have lost the predicted capacity. This loss of capacity would have been reflected in the performance reports. Unfortunately, there is no easy solution to the capacity and demand issue and demand for the service continues to grow and outweigh the commissioned level of capacity. SPPG have non-recurrently commissioned the Trust to source independent sector capacity for urology (e.g., in 3fivetwo Healthcare and Hermitage Private Hospital as part of Regional Contracts). There are minimal in-house additional sessions undertaken as these sessions are optional and also because of the challenges outlined in my response to Question 12.

48.25 The Referral and Booking Centre have a process in place where they forward missing triage reports for each specialty; these reports are forwarded to the OSL for onward escalation and action. As Interim Head of Urology Services I have received triage escalations from the red flag team (Sinead Lee); these escalations are forwarded to the consultant for immediate attention and action.

48.26 During my tenure as OSL there was a cancer escalation policy to highlight delays in suspect and confirmed cancer pathways. This policy states what the key trigger points of escalation are and who the responsible officer is for undertaking action in the onward escalation.

20190801 Question 41 Cancer Pathway Escalation Policy Final August 2019 updated- This can be located at Attachment folder S21 25 of 2022 Attachment 98

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

48.27 On a monthly basis SBA, trajectories, and (now) rebuild plans were used to monitor the predicted performance activity as outlined in my answers to Questions 4-8 and 12.

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

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

49.1 I would answer as follows in respect of urology:

a. I believe performance and workforce issues of concern were appropriately identified through the Trust's Senior Management Team, albeit, there continues to be a capacity and demand gap as well as an ongoing inability to recruit to consultant posts.

b. Performance is impact assessed by the monitoring of out-patient and elective activity against the agreed rebuild plans.

c. There is a clinical priority for scheduling of patients as outlined in my response to Question 12. This ensures patients are taken in clinical priority and chronologically scheduled for all specialties, including urology.

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

50.1 During my tenure as OSL for CCS/ATIC and SEC/ATIC I am not aware of any support given to the Urology team in relation to workforce or performance. It would have been Ronan Carroll, AD for SEC/ATICs, and Martina Corrigan, Head of Urology Services, who would have engaged with the Urology team and provided support.

50.2 During my tenure as Interim Head of Urology Services there was support given to the Urology Team at the following Departmental meetings:

a. 21 October 2021 – Maria O'Kane as Medical Director attended the meeting;
b. 16 December 2021 – Maria O'Kane as Medical Director attended the meeting;
c. 24 March 2022 – Jane McKimm, Director of Public Inquiry, and Melanie McClements, Director for Acute Services, attended the meeting;
d. 7 April 2022 – the General Medical Council representative and Nursing and Midwifery Council representative attended the meeting.

50.3 The medical staff would have been supported by the CD and DMD (previously known as AMD) as outlined in Question 25.

50.4 Paula McKay, Lead Nurse (previously Sarah Ward), would have supported the Urology CNS team and 3 South nursing staff.

50.5 In my role as Interim Head of Urology Service, I continue to operationally and managerially support the urology team and have an open door policy. In terms of the ongoing recruitment issues, I continue to explore with Medical Human Resources every option available to me to bring stability to the workforce, as demonstrated in my response to Question 17.

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

51.1 I am unaware of any quality improvement initiatives prior to October 2020. However, since my tenure there has been quality improvement support for 2 projects:

a. Urology Pathway Process Mapping – the QI team lead in the new referral process mapping exercise in January 2022.
b. Female Lower Urinary Tract Symptom (LUTS) service development – this QI project commenced May 2022; the aim is to equalise the wait for female patients across Urology and Gynae specialties on both Craigavon and Daisy Hill Hospital sites.

20220126 question 50 Urology Pathway Process map QI FINAL- This can be located at Attachment folder S21 25 of 2022 Attachment 99a
20220126 question 50 Urology Pathway Process map QI FINAL worksheet 2- This can be located at Attachment folder S21 25 of 2022 Attachment 99b
20220404 question 50 Combined urogynae approach to female LUTS.pp- This can be located at Attachment folder S21 25 of 2022 Attachment 99c

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)?

52.1 Mr O'Brien retired in June 2020 and I commenced my tenure as Interim Head of Urology Services in October 2020. I therefore had no contact with Mr O'Brien in my current role.

52.2 During my tenure as OSL for CCS/ATICS (2007 – 2016), I had minimal direct contact with Mr O'Brien or any of the Urology Consultants. The cancer escalations would have been emailed to Martina Corrigan as Head of Urology Services by the CCS OSL (Wendy Clayton to 2016, and then Sharon Glenny) or the Cancer Services Co-ordinator (Angela Muldrew from August 2008 to October 2014, and then Vicki Graham from October 2014 to August 2020, and now Sinead Lee from August 2020 to present).

52.3 During my tenure as OSL for SEC/ATICS (2016-17 and 2019), again I would have had minimal contact with Mr O'Brien or the Urology consultants in relation to performance or cancer escalations. All communication would have been through Martina Corrigan, Head of Urology Services.

52.4 I have evidenced examples of escalation emails below.

20160316 question 52 email urology escalation- This can be located at Attachment folder S21 25 of 2022 Attachment 100a
20160823 question 52 email urology escalation- This can be located at Attachment folder S21 25 of 2022 Attachment 100b
20170906 question 52 email urology escalation [Personal Information redacted by the USI] **- This can be located at Attachment folder S21 25 of 2022 Attachment 100c**
20170922 question 52 email urology escalation- This can be located at Attachment folder S21 25 of 2022 Attachment 100d

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

53.1 Mr O'Brien had retired before my tenure commenced as Interim Head of Urology Services, therefore, I had no role or involvement in the formulation or agreement of Mr O'Brien's job planning.

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

54.1 I have provided below a timeline of the requests which came from my line manager Ronan Carroll, AD for SEC/ATICs, in relation to Mr O'Brien during the period when I was OSL for SEC/ATICS (2016-17 and 2019). I was not advised as to the reasons for the request or the issues surrounding Mr O'Brien nor did I attend any meetings as they were confidential.

a. 23 December 2016 – Ronan Carroll requested that I undertook an exercise on the number of charts which were tracked to Mr O'Brien's office in relation to 11 clinics which Mr O'Brien had undertaken in South West Acute Hospital (SWAH). There were a total of 183 patient attendances across the 11 clinics and a random sample of these patients were selected to establish the volume of charts tracked to Mr O'Brien's office. The attendances of 98 patients were screened and the exercise demonstrated that 55 charts were tracked to Mr O'Brien's office (56%).

b. Also on 23 December 2016 - As requested by Mr Carroll, I ran a PAS query to check the number of charts tracked in total to Mr O'Brien's office and this revealed 365 charts were tracked to his office on that date.

c. 13 January 2017 – Ronan Carroll requested again that I run a query from PAS on the number of charts tracked to Mr O'Brien and this revealed 35 charts were tracked at that point.

   20170113 question 54 email audit of charts AOB- This can be located at Attachment folder S21 25 of 2022 Attachment 101
   Relevant to Acute, Wendy Clayton Q77, 20170116 question 54 email outstanding charts for AOB A1

d. 16 January 2017 – I was copied into an email from Martina Corrigan, Head of Urology, to Ronan Carroll, AD, in relation to missing charts tracked out to Mr O'Brien. This did not require any action from me and none was taken.
   20170116 question 54 email outstanding charts for AOB- This can be located at Attachment folder S21 25 of 2022 Attachment 102

e. 8 March 2017 – I was requested by my line manager Ronan Carroll to audit patients that had surgery under the care of Mr O'Brien in 2016 and also had a '[redacted]' letter on NIECR (which indicated that patient had been seen privately) and did not wait long for surgery in the Southern Trust. There were

830 patients who had surgery in 2016 under the care of Mr O'Brien and there were 11 patients with the '[redacted]' letter on NIECR.
Relevant to Acute, Wendy Clayton Q77, 20170308 question 54 AOB all surgery 2016

54.2 In addition to the above, and as Martina Corrigan was on [redacted] between June and November 2018, I was requested by my line manager, Ronan Carroll, to update an action plan in relation to Mr O'Brien. During this period, I was Interim Head of General Surgery, Endoscopy and Orthodontics. A timeline is provided below and evidenced in emails:

a. 15 October 2018 - Ronan Carroll requested that I update the position regarding the notes checked out to Mr O'Brien and the outstanding digital dictation in Martina Corrigan's absence [redacted].

b. 16 October 2018 - I sent an update to Ronan Carroll stating that there were 82 charts tracked out specifically to Mr O'Brien and that I had requested an update regarding the typing backlog from Collette McCaul, Service Administrator for Urology.

c. 17 October 2018 - I forwarded an update on the outstanding digital dictation for Mr O'Brien to Ronan Carroll, indicating that there were 117 charts waiting on dictation.

d. 18 October 2018 - I was copied into an email in which Ronan Carroll provided an update to Simon Gibson, Colin Weir, Ahmed Khan and Mark Haynes in relation to the timeline from June 2018 to October 2018 for both dictation backlog as well as an update from Martina Corrigan in relation to 4 specific concerns.

e. 22nd October 2018 - I emailed Ronan Carroll regarding an update in respect of the 4 specific concerns completed in conjunction with Brigeen Kelly, Head of Service for Trauma and Orthopaedics, as we were unable to locate the specific action plan. The 4 concerns were triage of referrals, charts tracked to Mr O'Brien's office, undictated letters, and private patients being listed for surgery.

Relevant to Acute, Wendy Clayton Q77, 20181019 email AOB update-
Relevant to Acute, Wendy Clayton Q77, 20181022 email WC return to work action plan feb 17 Final

f. 26 October 2018 - Ronan Carroll emailed myself and Brigeen Kelly, Head of Trauma & Orthopaedics, to advise that he still required monitoring of Mr O'Brien's 4 concerns (listed above) until Martina Corrigan's return to work on the 5th November 2018.

g. 26 and 29 October 2018 - I emailed Brigeen Kelly an update on how to extract information on the 4 Mr O'Brien concerns which required to be monitored as I was going on a period of planned leave.

Relevant to Acute, Wendy Clayton Q77, 20181029 question 54 email AOB notes and dictation

54.3 I have searched my archive emails and there are no further emails in relation to these updates that I can find and I do not recall being asked for any further information in relation to Mr O'Brien. I later took up post as Interim Head of Urology Services in October 2020, and by this time Mr O'Brien had retired.

54.4 The next time I had any conversation in relation to Mr O'Brien was in October 2020, when I was asked by my line manager Ronan Carroll to cover the role as Interim Head of Urology Services while Martina Corrigan was seconded to a role specifically in relation to Urology lookback. The Interim Head of Urology Services role was specifically to manage the day to day operational service to permit the lookback to carry on outside of the operational day to day management of the service.

54.5 I was then asked by Sarah Ward in November 2021 to be a member of the Urology Lookback Steering Group as Interim Head of Urology Services.

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

55.1 As outlined in Question 54, I was first asked to provide information on Mr O'Brien from my line manager, Ronan Carroll, in December 2016/January 2017 and again in October 2018.

55.2 I was aware there were issues given the information I provided, but I was not part of any direct discussions or involved in any further investigations as this was kept confidential from me in my role as OSL for SEC/ATICS.

55.3 As Interim Head of Urology Services, I became a member of the Urology Lookback Steering Group from November 2021. Members of this group included: Sarah Ward, Maria O'Kane (Chief Executive), Damian Gormley (Deputy Medical Director), Melanie McClements (Director of Acute Services), Ronan Carroll (AD for SEC/ATICS), and Mark Haynes (DMD). The remit of this meeting was to determine the total number of patients that were under the care of Mr O'Brien between January 2019 and June 2020 (an 18-month period) and who required to be reviewed as they remained on Mr O'Brien's review backlog waiting list or on an elective waiting list. Also at this meeting, we were given an update on the Structured Clinical Record Review (SCRR) patients that had been screened internally and also a communication update regarding letters to patients.
20220509 question 47i Lookback Steering Group Minutes 9.5.22- This can be located at Attachment folder S21 25 of 2022 Attachment 85a
20220411 question 47i Lookback Steering Group Minutes- This can be located at Attachment folder S21 25 of 2022 Attachment 85b

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

56.1 The actions, which I undertook, are time-lined in my response to Question 54. I was not provided with a 'rationale' for them as the issues surrounding Mr O'Brien were kept confidential, and I was advised by my line manager, Ronan Carroll, that I was to undertake the exercise and feed back my findings. No further information was shared with myself.

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

57.1 I was generally aware of concerns regarding the issues within urology as outlined in Question 54 and the 4 concerns in relation to Mr O'Brien; outstanding triage, notes in Mr O'Brien's office, dictation backlog, and private patients having surgery.

57.2 On request of my line manager, Ronan Carroll, over the period December 2016/January 2017 and again in October 2018, I monitored the 4 concerns and fed back the results.

57.3 This was the only exercise I undertook under the direction of my line manager, Mr Ronan Carroll. I do consider that the concerns raised may have impacted on patient care and safety due to Mr O'Brien's administrative processes, e.g., potential delay in diagnosis and treatment due to referral letters not being triaged and letters left undictated. The risk assessment and any actions that should have been taken as a response would have been the responsibility of the Head of Urology Services, Martina Corrigan, and the AD for SEC/ATICS, Ronan Carroll.

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

57.4 I carried out the exercises as requested by Ronan Carroll (and as detailed in Question 54) and relayed the information back.

57.5 The findings of the exercise demonstrated that the following charts were tracked to Mr O'Brien's office:

a. 23 December 2016 there were 365 charts tracked;
b. 13 January 2017 there were 35 charts tracked;
c. 16 October 2018 there were 82 charts tracked.

57.6 The actions required to mitigate against this were the responsibility of the Head of Urology Services, Martina Corrigan, and the AD for SEC/ATICS, Ronan Carroll.

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

58.1 There was no agreed way forward between myself and Mr O'Brien. I am aware from Ronan Carroll's emails to myself in October 2018 that Mr O'Brien was being monitored against an action plan in relation to 4 concerns; outstanding triage, notes in Mr O'Brien's office, dictation backlog, and private patients having surgery.

58.2 Once Martina Corrigan returned [redacted] in November 2018, I had no further communication in relation to Mr O'Brien's 4 concerns as this information was kept confidential from me.

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

59.1 While I was generally aware of concerns regarding the issues within urology which resulted in a look back, I was not familiar with the detail or told directly or involved in the investigation. However, I was requested by Ronan Carroll, AD for SEC/ATIC to update an action plan in Martina Corrigan's absence in October 2018 as outlined in Question 54.

59.2 I am not aware of any other metrics used in monitoring and assessing the effectiveness of Mr O'Brien's administrative processes.

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

60.1 On request by Ronan Carroll, AD for SEC/ATICS, I monitored the following 4 O'Brien concerns during Martina Corrigan's absence in October 2018.

60.2 I am familiar and experienced with using the Trust's information systems so I was confident in my ability to gather and extract the information correctly in relation to the concerns.

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

61.1 I do feel, from my little involvement in monitoring the 4 concerns, that there was an improvement, in particular in the charts tracked to Mr O'Brien's of outlined below:

a. 23 December 2016 there were 365 charts tracked;
b. 13 January 2017 there were 35 charts tracked;
c. 16 October 2018 there were 82 charts tracked.

61.2 I am unable to comment on the other concerns; outstanding triage, dictation backlog, and private patients having surgery as I did not have previous data to perform a comparison.

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

62.1 During my tenure as OSL for CCS/ATICS and SEC/ATICS, Mr O'Brien did not raise any concerns directly with me. I became Interim Head of Urology Services in October 2020, and Mr O'Brien had retired in June 2020.

62.2 If Mr O'Brien raised any concerns, it would likely have been to Martina Corrigan, Head of Urology Services, or to his Medical management line Mr Young, Clinical Lead, or Mr Haynes, AMD (now known as DMD).

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?

(a)
63.1 During my tenure as OSL for CCS/ATICS and SEC/ATICS (and just as I would have done in respect of other clinicians at various times), I would have escalated untriaged red flag referrals and undictated charts by Mr O'Brien to Martina Corrigan, Head of Urology Services, and Ronan Carroll, AD, as evidenced in Questions 45 and 52.

(b)
63.2 The escalations were emailed to Ronan Carroll, AD for SEC/ATICS, and Martina Corrigan, Head of Urology Services, as part of the cancer escalation process. In addition to emailing cancer escalation and untriaged red flag referrals, these issues would have been discussed at the monthly cancer performance meetings (urology was discussed along with all other cancer tumour sites).

20190801 Question 41 Cancer Pathway Escalation Policy Final August 2019 updated- This can be located at Attachment folder S21 25 of 2022 Attachment 98
20220216 question 41 email urology escalation- This can be located at Attachment folder S21 25 of 2022 Attachment 75a
20220407 question 41 email Urology escalation- This can be located at Attachment folder S21 25 of 2022 Attachment 75b

(c)
63.3 In relation to urology, the action would have been raised to Martina Corrigan, Head of Urology Services, for her to take appropriate action with the Consultant, and also with Ronan Carroll, Assistant Director for SEC/ATICS, for information.

(d)
63.4 The matter would have been dealt with by Martina Corrigan and I would not have been made aware of what the outcome was.

63.5 I did not raise any other concerns in relation to Mr O'Brien's conduct or performance.

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other

Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1 I supported Ronan Carroll, AD for SEC/ATICS, during Martina Corrigan's [redacted] period from June to November 2018, to monitor Mr O'Brien's action plan. This was limited support and only at the direction of Ronan Carroll.

64.2 I would have engaged with Katherine Robinson, Head of Admin Services, to obtain information specifically on Mr O'Brien's action plan concerns during the above period; namely outstanding triage and dictation backlog. I did not engage with any other Trust staff.

64.3 I did not provide any support directly to Mr O'Brien.

64.4 During my tenure as Interim Head of Urology Services, support was given to the Urology team during our Urology Department meetings, as set out at Question 50 above.

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

65.1 I am aware of Acute performance issues (which includes urology) have been and are on the Divisional Risk Register, as detailed in Question 7. This includes risks to elective outpatient and inpatient/daycase waiting times, planned inpatient/daycase backlog, and review outpatient backlog.

65.2 I am not aware of any other concerns reflected in Trust governance documents.

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

66.1 I am now aware of the following governance concerns:

a. There was an Independent Review, led by Dr Dermot Hughes, which resulted in 11 SAI MDT recommendations which focused on Urology. These recommendations are being progressed through a Task and Finish Group led by Sarah Ward, Head of Clinical Assurance for the Public Inquiry. I am not part of this group but I believe there is representation from each Cancer MDT. From the recommendations, as outlined in Question 36, in January 2022 a Cancer MDT Administrator (Angela Muldrew) was appointed to support the MDT clinical teams, which includes Urology. A function of the Cancer MDT Administrator role is to oversee and manage the MDT outcomes audit. I was not aware of any MDT

failings during my tenure as OSL for CCS/ATICS. At this time (as far as I am aware) there was no audit or checking mechanism in place to ensure that the agreed MDM outcomes actually took place and no concerns were raised directly to me indicating that these outcomes were not completed in line with the agreed pathway. It would be my view that the Clinician responsible for the patient's care is the responsible officer for ensuring that the agreed action at MDM is taken forward and, where a plan deviates from the original agreed plan, this should be discussed back at the MDM. Following the Dermot Hughes review, and the learning from that which brought about the recruitment of the Cancer MDT Administrator, there will be a greater focus on audit of MDT outcomes which should identify any deviation from agreed actions for patients on all cancer pathways, including urology.

20220401 question 66 MDT SAI recommendations work plan SW- This can be located at Attachment folder S21 25 of 2022 Attachment 103

b. Being part of the Urology Lookback Steering Group meeting from November 2021, I am now aware in more detail of the extent of the issues within Mr O'Brien's administrative processes. The purpose of this group is to progress the Urology Lookback Exercise, plan going forward in line with Lookback guidance evidenced below, maximise capacity to see patients, and inform agenda/communication on regional meetings.
20210701 question 66 Regional guidance DOH Implementing a lookback review process- This can be located at Attachment folder S21 25 of 2022 Attachment 104

c. From the Urology Lookback Steering Group, I am aware that Sarah Ward has completed a DATIX for 77 patients who were identified originally as meeting the threshold for a Structured Clinical Record Review (SCRR) as part of the lookback exercise.
20211220 question 66 notes from urology lookback steering group mtg- This can be located at Attachment folder S21 25 of 2022 Attachment 105

66.2 I do not feel, as OSL, I should have been aware of any further concerns as these were being managed by Martina Corrigan, Head of Urology Services, and Ronan Carroll, AD for SEC/ATIC, and were being kept confidential while an investigation was ongoing.

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

67.1 During my tenure as OSL for SEC/ATICS from 2016 and as Interim Head of Urology Services from October 2020, I would consider workforce issues, i.e., vacancies in consultant urology posts and increased demand into the urology service having an impact on performance waiting times for both patients waiting to be seen in outpatients and inpatient/daycase settings. This places the team under significant pressure as it was under-resourced to deal with the demand.

67.2 Due to the medical vacancies, I feel that the primary focus for the consultants has been on direct patient care, i.e., consultants' priority was undertaking clinical sessions such as outpatients and surgery. I feel the medical staff were not provided with the time or the opportunity to undertake clinical audits to provide assurances that systems and processes were fit for purpose, e.g. clinical audits on outcomes against guidelines.

67.3 Also on reflection, I feel consideration needs to be given to the question of whether the consultants have sufficient administrative time to deal with the volume of enhanced triaging required to complete this task within their job plans. I am aware that triaging has been on the Urology consultant job plan from September 2019 as a 6-hour allocation during the Urologist of the Week sessions and, in November 2021, this was increased to 6 hours and 45 minutes. This equates to a consultant having to triage 16-17 referrals per hour. It has been my experience that the consultants have differing speeds when completing enhanced triaged and completing the weekly enhanced triage can be challenging and time-consuming within allocated consultant job planning time.

67.4 At present, there is an email escalation process for untriaged referrals from the Referral & Booking Centre and the red flag teams in place, however, the triaging backlogs are not evident from SEC Backlog Reports. I feel that, with this addition to the report, it may have highlighted the issue with Mr O'Brien's untriaged referrals sooner.

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

68.1 On reflection from a governance prospective, the learning is not holding Mr O'Brien accountable for his admin processes in relation to missing triage and dictation. It would appear that, even with the action plan in place, Mr O'Brien was able to continue his practice and I feel that Mr O'Brien was personally accountable for not disclosing his backlog of triage and undictated clinic letters. While there was short-term sustained improvement while Mr O'Brien was being monitored on the action plan, I believe his behaviour and habits returned once the monitoring was relaxed for the period of Martina Corrigan's Personal Information redacted by the USI absence.

68.2 I also feel it is reasonable and entirely right and appropriate for the administrative staff to escalate concerns through their management line (functional services), e.g., in respect of undictated letters following clinic, consultants being behind in their results dictation, and so on, which I do not feel was clear to me during my tenures. It should have be made clear to administrative staff that this is the sort of issue that they should have escalated.

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

69.1 Having been made aware of the 4 concerns in relation to Mr O'Brien - (i) outstanding triage, (ii) notes in Mr O'Brien's office, (iii) dictation backlog, and (iv) private patients having surgery - I do feel that the secretarial staff within the service would have been aware of the delays and these concerns should be been escalated sooner with their line manager. The secretarial line management responsibility lies with Mrs Katherine Robinson, Head of Admin Services, and Mrs Anita Carroll, Assistant Director of Function Support Services. However, ultimately it is the consultant's responsibility to raise any backlog in the admin of their practice with the Head of Service or Clinical Director.

69.2 I am not aware of the full detail of the investigation or engagement with staff to comment if there was a failure in this process.

69.3 I do recognise from my tenures as OSL and Interim Head of Urology Services that there continue to be performance and workforce issues within the urology service. I do not feel that there was a failure to engage fully with these particular problems as there has been ongoing recruitment of permanent and locum consultants as well as continuous monitoring of performance. These issues have also been escalated through the Trust's SMT to SPPG (previously HSCB).

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been

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

70.1 On reflection, and while (during my OSL tenures) I was following my accountable lines of management and the processes that were in place at the time for escalation for all tumour sites including urology, I now feel that the escalation process itself has failed somewhat as it now appears that patients were not then onward escalated beyond Head of Service and Assistant Director level; as OSL I would not have been aware of, or party to, such onward escalations. It was the responsibility of the Head of Service, Mrs Martina Corrigan, to escalate further if there were ongoing issues and trends which needed resolved in her service.

70.2 During my tenure as Interim Head of General Surgery, Martina Corrigan was on Personal Information redacted by the USI between June and November 2018. Brigeen Kelly, Head of Trauma and Orthopaedic Services, and I were covering Martina Corrigan's day to day operational duties such as rota and clinic queries only. We were only made aware that an action plan was to be updated for Mr O'Brien when Ronan Carroll AD for SEC/ATICs requested that we update the plan in respect of the 4 concerns. We provided Ronan Carroll with this information which he then used to update the action plan.

70.3 As I am unaware of all the details in relation to Mr O'Brien's investigation or the people involved in the investigation, I am unable to comment on whether others made mistakes or could have done things differently/better.
.

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

71.1 On reflection, I do not feel the governance arrangements were fully robust or fit for purpose. The checks and mechanisms in place to highlight that Mr O'Brien had a backlog in his administration, or that letters were not dictated following consultations, were not adequate enough to identify the problem over a sustained period.

71.2 In order for governance arrangements to be fit for purpose, I feel there needs to be more auditing of practices and processes to ensure that the systems are robust, e.g., a sampling audit of 15 patients were reviewed at an outpatient clinic and 15 patients had dictation carried out at this clinic and that the actions from the clinic were taken appropriately.

71.3 I also feel that more and more responsibility has been added onto the Head of Service role to monitor and ensure governance recommendations and action plans are followed through and actioned. The HOS is operationally responsible for performance, finance, and governance within a number of specialities. As mentioned in Questions 5 and 28, along with Urology I am also responsible for ENT,

Outpatients, and Ophthalmology services. I am aware the AD for SEC/ATICs has requested a dedicated Governance Support for the HOS going forward and additional specific support is needed to ensure complaints, MLA letters, and Ombudsman reports are investigated and learning shared.

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?

72.1 On the basis of the information available to me at present, I do not wish to add anything further.

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

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 08/07/2022

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Southern Health & Social Care Trust CONFIDENTIAL

Wendy Clayton SHSCT Employment History

Prepared by/HR Contact: Ciara Rafferty, Senior HR Data Analyst

Prepared for: Wendy Clayton, Acting Head of Service for ENT, Urology, Ophthalmology & Outpatients

Ref: ad/2022/176

Date: 3 May 2022

Employment History from July 2007 onwards (as per HRPTS)

Pers.No.	Last name	First name	Date Appointed to HSC Org	Date Commenced Post	Date Left Post	Contract Type	Work Contract	Position	Job	Organizational Unit	Cost Centre Code	Cost Centre
Personal Information	Clayton	Wendy Marilyn	28/11/1994	30/07/2007	31/03/2016	Permanent	Permanent	Operational Support Lead	2A17 ADMIN & CLERICAL (7) X007	Cancer & Clinical Services Admin	C0370A	CAH CANCER & CLINICAL ADMIN
				01/04/2016	19/11/2017	Permanent	Permanent	Operational Support Lead	2A17 ADMIN & CLERICAL (7) X007	Surgery & Elective Division Admin	C0369A	CAH AD SURG&ELEC CARE ADMIN
				20/11/2017	20/01/2019	Permanent	Second Internal	HOS-General Surgery	2A1B ADMIN & CLERICAL (8B) X009	General Surgery/Orthodontics	C0T175	PCL GEN SURGERY/ORTHODONTICS
				21/01/2019	20/10/2019	Permanent	Permanent	Operational Support Lead	2A17 ADMIN & CLERICAL (7) X007	Surgery & Elective Division Admin	C0369A	CAH AD SURG&ELEC CARE ADMIN
				21/10/2019	15/10/2020	Permanent	Second Internal	HOS-Surgery & Elective	5B5B NURSE MANAGER (8B) X009	Trauma & Orthopaedics	C0T185	PCL T&O/OPHTHALMOLOGY
				16/10/2021		Permanent	Second Internal	HOS-Urology & Ent	2A1B ADMIN & CLERICAL (8B) X009	PCL ENT/Urology/Outpatients	C0T186	PCL ENT/UROLOGY

Employment History prior to July 2007 (as per HRMS)

Fac/Bk/Sta	Surname	Forename1	Date Appointed to Trust	Hist. Grade Effective Start Date	Hist. Grade Effective End Date	Employment Status Description	Hist. Grade Description	Cost Centre Code	Cost Centre Description (as at Jan 2014)	Hist. Location of Post
Personal Information redacted by the USI	CLAYTON	WENDY MARILYN	28/11/1994	28/11/1994	30/11/1995	Temporary	GRADE 2	32334A	CAH MED REC PAED (MED)	CRAIGAVON AREA HOSPITAL
				01/12/1995	18/05/1997	Temporary	GRADE 2	32335A	CAH MED REC MEDICINE	CRAIGAVON AREA HOSPITAL
				19/05/1997	08/10/1997	Permanent	GRADE 2	32334A	CAH MED REC PAED (MED)	CRAIGAVON AREA HOSPITAL
					18/07/1999	Permanent	GRADE 2	32335A	CAH MED REC MEDICINE	CRAIGAVON AREA HOSPITAL
				09/10/1997	10/04/1998		PERSONAL SECRETARY GRADE 3	32335A	CAH MED REC MEDICINE	CRAIGAVON AREA HOSPITAL
				11/04/1998	24/01/1999	Permanent	GRADE 2	32335A	CAH MED REC MEDICINE	CRAIGAVON AREA HOSPITAL
				25/01/1999	18/07/1999		GRADE 3	32335A	CAH MED REC MEDICINE	CRAIGAVON AREA HOSPITAL
				19/07/1999	28/10/1999	Permanent	GRADE 3	32326W	PAEDIATRIC OUTPATIENTS CAH	CRAIGAVON AREA HOSPITAL
				29/10/1999	31/07/2004	Permanent	GRADE 4	32324A	CAH MED RECORDS - CANCER SERVIC	CRAIGAVON AREA HOSPITAL
					28/02/2006	Permanent	GRADE 4	32324A	CAH MED RECORDS - CANCER SERVIC	CRAIGAVON AREA HOSPITAL
				01/08/2004	28/02/2006		GRADE 5	32324A	CAH MED RECORDS - CANCER SERVIC	CRAIGAVON AREA HOSPITAL
				01/03/2006	29/07/2007	Permanent	GRADE 5	32324A	CAH MED RECORDS - CANCER SERVIC	CRAIGAVON AREA HOSPITAL

Confidentiality & Data Protection - This report has been compiled and is intended for use only by the official recipient. Please remember your responsibilities under data protection legislation, for example, by ensuring personal information is kept secure and not left in view of unauthorised staff or visitors, is only used for the purpose intended, and is not shared with anyone who should not have access to it. Also, once personal information has been used for its intended purpose it should be appropriately destroyed, or kept in a secure location if it is required for future use.

Timeliness Issues & HRPTS Recording - In order to ensure that information is reported correctly from HRPTS, it is essential that on line processes or off line forms are actioned or forwarded for action on HRPTS as soon as possible. Delays will result in reported information not being up to date.

Data Quality - If you believe the information in this report does not accurately reflect the current position, please contact the HR Analytics & Governance Team.

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

JOB TITLE: Cancer Services and MDT Co-ordinator (Grade 5)

LOCATION: Cancer Services Directorate

REPORTS TO: Lead Nurse Cancer Services

JOB PURPOSE: To ensure:

- The daily administrative co-ordination of the Directorate through the provision of high quality, cost effective support to clinical staff.
- To co-ordinate multidisciplinary functioning across Cancer Services
- The post holder will play an active role in the continuing development of the Directorate

MAIN DUTIES:

Clinical Information

- Ensure the collection/provision of accurate and timely data relating to cancer services activity thereby enabling the Lead Cancer Clinician and Nurse to monitor and develop the service within a changing/developing area of practice involving numerous cancer sites

- To ensure the accurate, timely and complete recording of information within the Cancer Services on the Patient Administrative System (PAS).

- To monitor Directorate activity on a monthly basis, assessing compliance with contractual obligation and produce relevant reports.

- Work with the Trust Lead Clinician and Lead Nurse to co-ordinate the preparation of peer review visits, including self-assessment against the national measures.

- Work with the Trust Lead Clinician and Lead Nurse to ensure the implementation of the resulting action plans for continuous quality improvement.

- To assist with the implementation of new systems, both computerised and manual within the Cancer Services, including regional initiatives in collaboration with the Cancer Centre

- To provide IT support to all new Cancer Services IT systems within the Trust, liaising regionally with the Cancer Centre, providing training and workshops for all relevant staff Trust wide

Staff Management

- To manage secretarial and clerical staff within the Directorate including Multidisciplinary Team administrative staff ensuring cost effectiveness and efficiency in liaison with the Lead Nurse for Cancer Services.

- To participate in disciplinary matters in liaison with the Lead Nurse for Cancer Services.
- To develop and implement staff appraisal.
- To monitor sickness and absenteeism.
- To participate in the recruitment and selection of staff in accordance with the Trust's policies.
- Assist in the monitoring of the secretarial and clerical budget.

Multidisciplinary Team Co-ordination

- Ongoing Research of National and Regional MDT guidelines providing support to Lead Cancer Nurse and Lead Clinicans in each cancer site to develop effective MDT's facilitating service development.
- Assess resource requirements and establish MDT Admin & Clerical services in each cancer site specific team
- Co-ordinate implementation/functioning of MDT meetings in each cancer site i.e. breast, palliative care, colorectal, urology, upper GI, lung in line with National Guidelines
- Work in collaboration with each MDT Lead Clinician to develop/design effective data collection proforma for patients to be discussed at MDTs ensuring all patients are discussed and outcomes are recorded and reviewed
- Attend MDT meetings, record and collate data providing up-dates/reports of outcomes of investigation and actions to be undertaken in each implementation/MDT group meeting to Lead Cancer Team
- Facilitate effective communication networks between Lead Cancer Team and each MDT Lead Clinician and Clinical Team
- Provide Lead Cancer Clinician and Lead Cancer Nurse with regular updates on requirements in the ongoing establishment of MDT in each cancer site
- Prepare and write reports on behalf of Lead Cancer Clinician on MDT Proposals
- Record attendance at meetings taking notes for dictation by member of medical team
- Manage the Admin & Clerical team supporting multidisciplinary teams in line with staff management requirements
- Liaise with Southern Board representatives in relation to managing systems, including electronic, that inform GPs of patients diagnosis, decisions made regarding proposed treatments
- Work in collaboration with NICAN to ensure MDT guidelines, awareness/information are provided across Cancer Services
- Report regularly to the Lead Clinician/Lead Nurse on compliance/non compliance of standards
- Work with key MDT members to identify areas where targets are not achieved to facilitate process mapping to identify bottlenecks in service provision

General Duties

- In collaboration with the Lead Clinician and Lead Nurse facilitate and co-ordinate directorate meetings between site specific directorates and AHPs
- To provide personal secretarial support to the Lead Cancer Nurse as required
- Ensure effective working relationships and links with managerial colleagues in other relevant directorates, organizations
- Ensure a Trust approach to planning, organizing and staffing the admin & clerical service, with continuing input from human resources and finance colleagues
- Assist in the preparation of business cases and other bids, and the smooth functioning of the administrative systems with cancer services
- To assist in the preparation and monitoring of Directorate budgets.
- To assist the Directorate in the identification of capital and revenue requirements and to prepare submissions for new and replacement equipment.
- To ensure that all medical records used within the Directorate are managed and stored in an appropriate manner and with due regard to confidentiality.
- To assist in responses to queries from SHSSB, Cancer Centre, Nican and NI Assembly as appropriate re Cancer Services.
- To assist in the implementation of new government Cancer Services initiatives within the SHSSB, including working in collaboration with the Lead Clinician and Lead Nurse to implement modernization as advised by NICAN (N.Ireland Cancer Network)
- To provide support to the Lead Cancer Specialist in setting up new Cancer Services implementation groups, liaising with relevant Lead Consultants within Units in SHSSB.
- Liaise with NICAN in relation to regional audits and projects for the Cancer Unit and Cancer Services

GENERAL REQUIREMENTS:

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and report any accidents/incidents, defects with work equipment or inadequate safety arrangements to the Clinical Director.
- Comply with the Trust's policy on smoking.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

Operational Support Lead - Acute Services (4 posts)

Ref: 88207120
Closing Date: 20 June 2007 12:00
Location: Craigavon Area Hospital / Daisy Hill Hospital
Contract: Permanent
Salary: Band 7 (£26,269 - £36,416)
Hours: Full-time / Job Share
Interview Dates: Expected late June / early July

Southern Health and Social Care Trust

Job Description:

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Operational Support Lead

BAND: Band 7

REPORTS TO: Assistant Director of a division within Acute Services

JOB PURPOSE: To work as a key member within a division of the Trust's Acute Services Directorate, responsible for managing the day-to-day operational functions associated with patient access and flow in line with the reform and modernisation agenda, quality of patient care and resources available.

To assist the Assistant Director within the division in the delivery of the operational functions associated with the development of a booked elective pathway and maintenance of patient access via management of the Primary Target Lists (PTL) and waiting list management processes. Where applicable, to assist the Assistant Director within the division in the delivery of the operational functions associated with the maintenance of patient access to Medicine and Unscheduled Care services in line with DHSSPS standards of care.

To assume day to day line management responsibility for the administrative and clerical staff within the division (Personal Secretaries, Audio Typists, Ward Clerks), ensuring efficient and flexible administrative support to clinical teams.

MAIN DUTIES:

OPERATIONAL MANAGEMENT – PATIENT ACCESS AND FLOW:

1. Engage with senior medical, nursing, administrative and allied health professional teams to ensure that the main focus continues to be on the management of specialty specific PTLs to meet maximum patient access targets for inpatient and daycase patients and where applicable to meet access targets for unscheduled care.

2. Work with clinical directorate teams to develop realistic capacity plans to facilitate planning for the achievement of PTL schedules and to ensure identified capacity is fully utilised across the division. Similarly for the planning of unscheduled care capacity requirements.

3. Support and facilitate elective and non-elective clinical teams in sustaining patient

flow, for example assisting in capacity assessment, job planning and service development issues particularly in relation to issues affecting capacity and service provision.

4. Assess the waiting list and unscheduled access target positions for risk, identify and communicate issues affecting access and work with clinical and functional directorate teams to ensure plans are in place to deal with bottle-necks and pressures, escalating as appropriate.
5. Support staff from all key disciplines to ensure a whole system approach to improve and sustain waiting list and unscheduled care management and the development of elective and non elective access pathways.

6. Ensure the Trust is compliant with regional access policy issues for elective and non elective patients and that all supporting processes are in place, documented and implemented.

7. Manage development projects as directed by the Assistant Director for the division to further improve patient access and operational performance across the hospital system.

8. Be the main point of contact for day-to-day operational performance issues for the division.

9. Develop excellent working relations with key stakeholders to encourage collaborative working.

10. Provide updates on performance at Trust and regional meetings as required.

INFORMATION AND ANALYSIS:

1. Work with the Trust's Information Department to co-ordinate the collection and analysis of data to facilitate the monitoring of elective and non elective access and flows across the hospital system.

2. To analyse complex performance information to identify areas for improvement and to work collaboratively to develop plans to deliver improvement.

3. To monitor ongoing projects to assess outcomes, benchmarked against expected outcomes.

GENERAL MANAGEMENT:

1. Assume day to day line management responsibility for the administrative and clerical staff within the division.

2. Participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of staff. Provide guidance on personal development requirements, advise on and initiate, where appropriate, further training.

3. Maintain good staff relationships and morale amongst staff reporting to him/her.

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

5. Participate as required in selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

7. 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

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 in 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.

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 postholder works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Assistant Director of the division.

Personnel Specification:

Personnel Specification

Knowledge, skills and experience required:

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 have:

- university degree or relevant professional qualification and worked for at least 1 year in a middle management role* within an acute hospital clinical support service

OR

- have worked for at least 3 years in a middle management role* within an acute hospital clinical support service.

AND

- experience of playing a lead role / managing projects within a multi-disciplinary environment within tight timescales.
- experience of playing a lead role in the successful implementation of change initiatives.
- a proven track record of people management and organisational skills.
- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

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 this post and the extent to which they satisfy each criterion specified

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at nhsleadershipqualities.nhs.uk Particular attention will be given to the following:

- Self Belief
- Self Management
- Drive for results
- Leading change through people
- Effective and strategic influencing

The following additional clarification is provided:

*"middle management role" is defined as experience gained *for example* at Admin & Clerical Grade 5 and above or Nursing & Midwifery Grade F and above or equivalent. The role must have included staff management responsibility.

June 2007

Other Information:

Downloads: SHSCT rpa

Instructions: Instructions for Completing Application Form

Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE Head of General & Oral Surgery
Temporary for 9 months in the first instance

BAND 8B

DIRECTORATE Acute

INITIAL LOCATION Craigavon Area Hospital

REPORTS TO Assistant Director

JOB SUMMARY

- To be responsible for the operational management and strategic development of General Surgery services across the Southern Trust.
- To be responsible for leadership, service provision and service development of General Surgery services and ensuring high quality patient centred services.
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets.
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Division's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources.
- As a head of service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY DUTIES / RESPONSIBILITIES

1. Quality & Governance

1.1 Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.

1.2 Be committed to supporting honest, open communication and effective multi-disciplinary working.

1.3 Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

1.4 Support the Assistant Director with the implementation of quality initiatives such as Investors in People and Charter Standards.

2. Leading & People Management

2.1 Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.

2.2 Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.

2.3 Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.

2.4 Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.

2.5 Ensure the division implements and adheres to Trust HR policies and procedures.

2.6 Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

3. Service Delivery

3.1 Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.

3.2 Support the Assistant Director in achieving key access and performance targets for each service through robust planning and service improvement.

3.3 Make sure that services are delivered to the standard and quality expected by the DHSSPS, Regional Authority and by the Trust Board.

3.4 Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.

3.5 Identify and contribute to local and national development initiatives e.g. clinical networks and national programmes.

3.6 Make sure that all recommendations arising from RQIA inspections are

implemented in a timely manner.

3.7 Act as a member of the division's senior management team and contribute to its policy development processes.

3.8 Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.

3.9 Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

4.1 Assist with the development of the strategic plan for the delivery of operational services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSSA priorities.

4.2 Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic planning initiatives and targets.

4.3 Work with members of relevant teams on the innovative development of new and existing services.

5. Financial & Resource Management

5.1 Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.

5.2 Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.

5.3 Participate in contract and service level negotiations with commissioners.

5.4 Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.

5.5 Update and monitor the operational policies of the Division and take account of risk management needs.

5.6 Ensure procedures are in place to report, investigate and monitor clinical

incidents putting action in place to address areas of concern.

5.7 Ensure that environmental standards are appropriate for safe & clean care delivery.

6. Information Management

6.1 Ensure the effective implementation of all Trust information management policies and procedures within the Division.

6.2 Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

7. Corporate & Divisional Responsibilities

7.1 Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Services.

7.2 Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.

7.3 Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.

7.4 Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.

7.5 Participate in and comply with requirements in the production of performance reports.

7.6 Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements

and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

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

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

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

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE	Head of General & Oral Surgery Band 8B – Temporary for 6 months in the first instance
DIRECTORATE	Acute Services
SALARY	£45,254 - £55,945 per annum
HOURS	Full Time

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

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so 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. You must be an employee of the Southern Health & Social Care Trust, **Acute Directorate only** to be eligible to apply for this post. You must therefore clearly demonstrate this on your expression of interest proforma.

QUALIFICATIONS / EXPERIENCE / SKILLS

1. Hold a relevant[1], University Degree or recognised Professional Qualification or equivalent qualification **AND** Two years experience in a Senior

[1] *'relevant' will be defined as a business or health related field*

Role[2] **OR** Have at least 5 years experience in a Senior Role[2].

2. Have a minimum of 1 years experience in a lead role delivering objectives which have led to a significant[3] improvement in service.

3. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant[3] change initiative.

4. Have a minimum of 2 years experience in staff management.

5. Hold a full current driving license valid for use in the UK and have access to a car on appointment[4].

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

6. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.

7. Have an ability to provide effective leadership.

8. Demonstrate evidence of highly effective planning and organisational skills.

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

INTERVIEW ARRANGEMENTS – FOR NOTING BY ALL CANDIDATES

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 this post and the extent to which they satisfy each criterion specified

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[2] 'Senior Role' is defined as Band 7 or equivalent or above.

[3] 'Significant' is defined as contributing directly to key Directorate objectives

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

The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at www.nhsleadershipacademy.nhs.uk. Particular attention will be given to the following:

- *Inspiring shared purpose*
- *Leading with care*
- *Evaluating information*
- *Connecting our service*
- *Sharing the vision*
- *Engaging the Team*
- *Holding to account*
- *Developing capability*
- *Influencing for results*

Informal enquiries to: Email: Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Head of Trauma & Orthopaedics

REPORTS TO: Assistant Director of ATICs & Surgery & Elective Care

BAND: 8B

JOB SUMMARY

1. To be responsible for the operational management and strategic development of Trauma & Orthopaedic Services across the Southern Trust.

2. To be responsible for leadership, service provision and service development of Trauma & Orthopaedic Services and ensuring high quality patient centred services.

3. To be responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets.

4. To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Division's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources.

5. As a head of service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives

KEY RESULT AREAS

1. Quality & Governance

- Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.

- Be committed to supporting honest, open communication and effective multi-disciplinary working.

- Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

- Support the Assistant Director with the implementation of quality initiatives such as Investors in People and Charter Standards.

2. Leading & People Management

- Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the division characterised by high standards and openness.

- Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.

- Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF Framework.

- Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.

- Ensure the division implements and adheres to Trust HR policies and procedures.

- Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

3. Service Delivery

- Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.

- Support the Assistant Director in achieving key access and performance targets for each service through robust planning and service improvement.

- Make sure that services are delivered to the standard and quality expected by the DHSSPS, Regional Authority and by the Trust Board.

- Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.

- Identify and contribute to local and national development initiatives e.g. clinical networks and national programmes.

- Make sure that all recommendations arising from RQIA inspections are implemented in a timely manner.

- Act as a member of the division's senior management team and contribute to its policy development processes.

- Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.

- Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

- Assist with the development of the strategic plan for the delivery of operational services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSSA priorities.

- Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic planning initiatives and targets.

- Work with members of relevant teams on the innovative development of new and existing services.

5. Financial & Resource Management

- Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.

- Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.

- Participate in contract and service level negotiations with commissioners.

- Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.

- Update and monitor the operational policies of the Division and take account of risk management needs.

- Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

- Ensure that environmental standards are appropriate for safe & clean care delivery.

6. Information Management

- Ensure the effective implementation of all Trust information management policies and procedures within the Division.

- Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

7. Corporate & Divisional Responsibilities

- Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Elective Services.

- Attend meetings of the Trust Board, its committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.

- Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the Directorate's management team.

- Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.

- Participate in and comply with requirements in the production of performance reports.

- Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.

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

8. General Management Responsibilities

- Participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

- Ensure that the review of performance identified above is performed for all levels of staff within your remit of responsibility in accordance with the Trust policy.

- Maintain good staff relationships and morale amongst the staff reporting to you.

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

- Delegate appropriate responsibility and authority to the level of staff within your 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 you in accordance with procedures laid down by the Trust.

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

- Promote the Trust's policy on equality of opportunity through your own actions and ensure that this policy is adhered to by staff for whom you are responsible.

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 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.

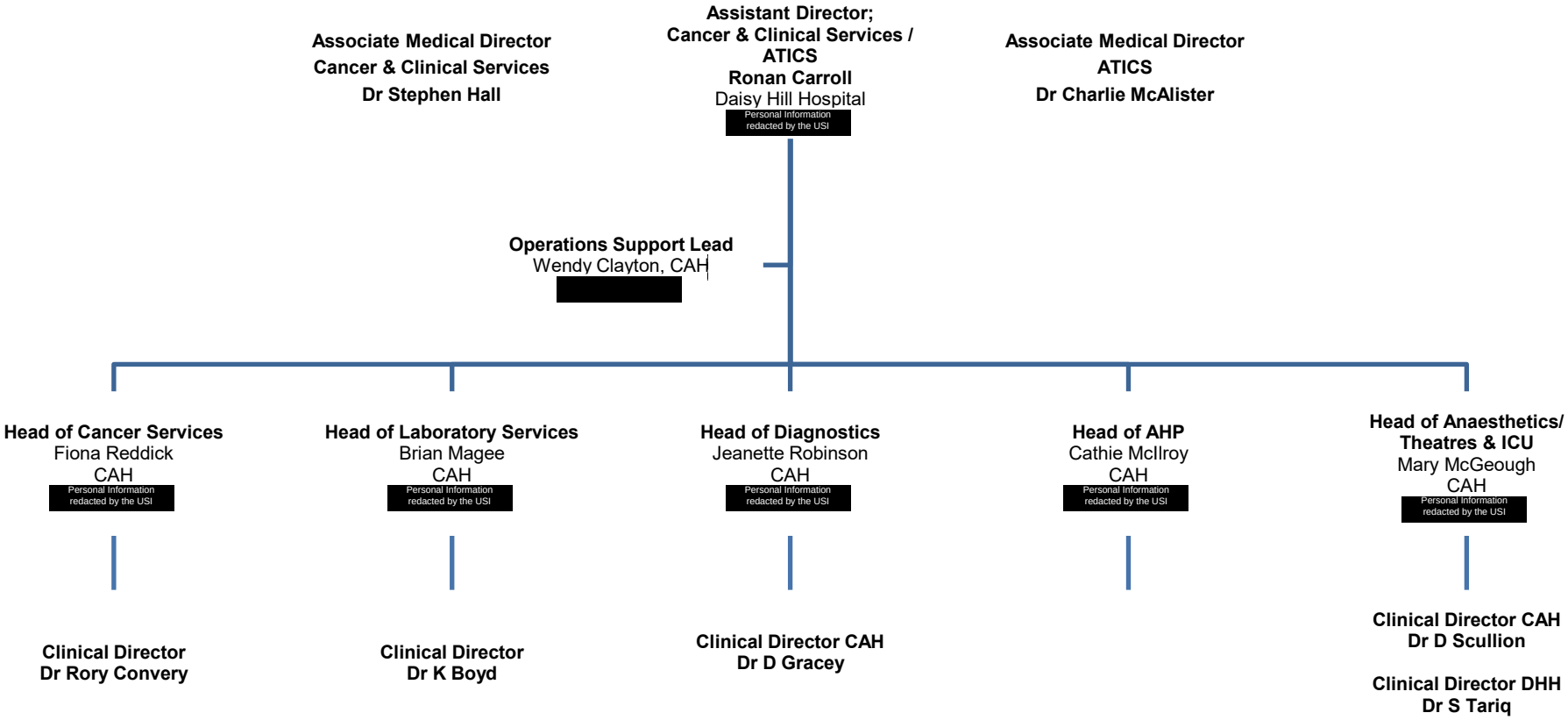
- Adhere to equal opportunities policy throughout the course of their employment.

- Ensure the ongoing confidence of the public in service provision.

- Comply with the HPSS code of conduct.

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. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Assistant Director of Surgery & Elective Care.

Cancer & Clinical Services / ATICS



Southern Health and Social Care Trust

Quality Care - for you, with you

SEC/ATICs Organisational Structure

Assistant Director Surgery & Elective Care / Anaesthetics, Theatres and Intensive Care Services

Ronan Carroll

Operational Support Lead

Wendy Clayton

Personal Secretary

Maria Lisiak Witczak

Head of Service ENT, Urology & Opthamology

Martina Corrigan

Lead Nurse
Dorothy Sharpe
Linda Hamilton
Josie Matthews

Head of Service Trauma & Orthopaedics

Brigeen Kellyh

Lead Nurse
Linda Hamilton

Head of Service General & Oral Surgery

Amie Nelson

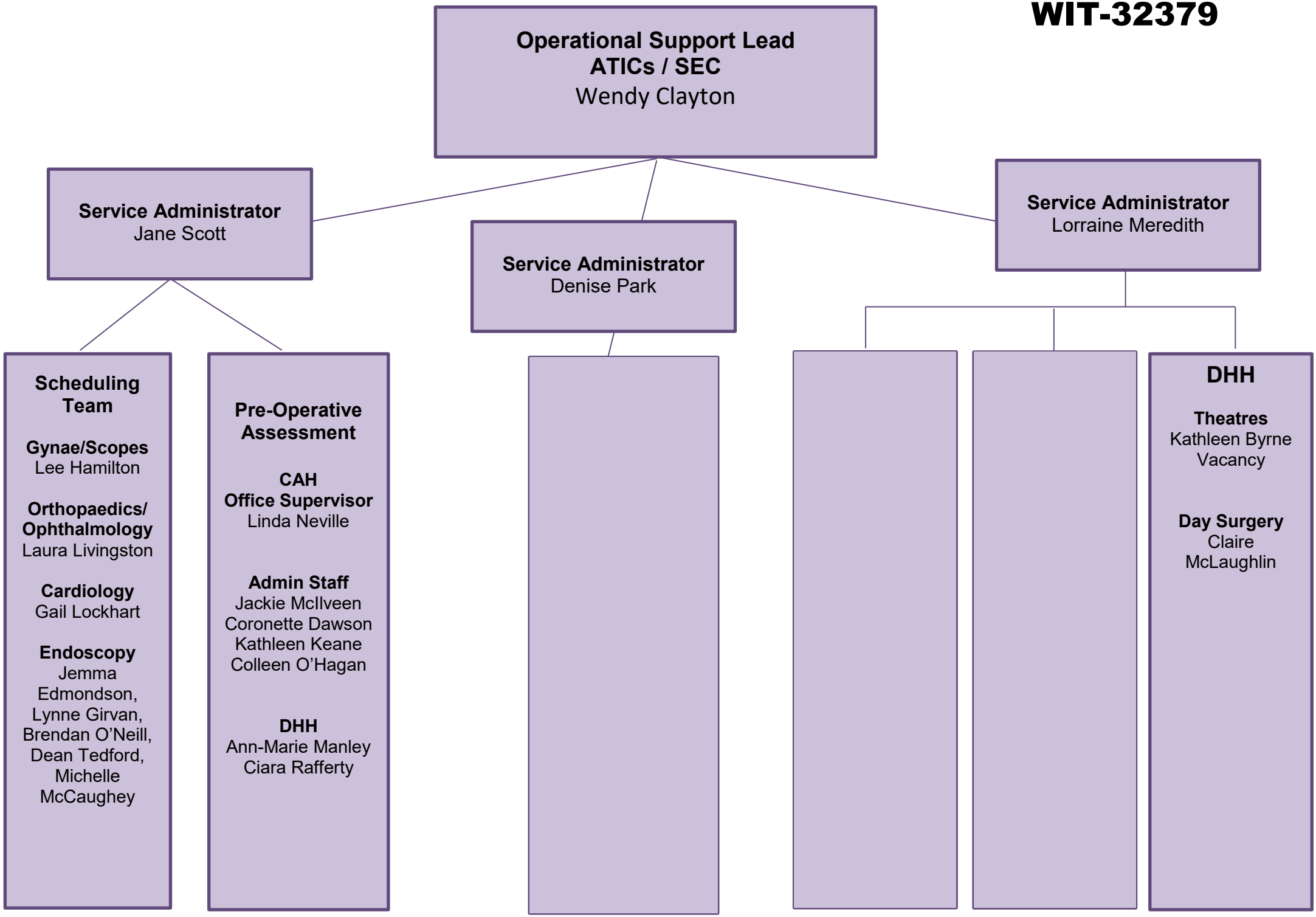
Lead Nurse
Dorothy Sharpe
Josie Matthews

Head of Service Anaesthetics, Theatres and Intensive Care Services

Helena Murray

Lead Nurse
Emmajane Kearney
Marti McKenna

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.



Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Interim Head of Service General & Oral Surgery and Breast Services

Wendy Clayton

Lead Nurse

Josie Matthews

4 North

Personal Information redacted by the USI

Ward Manager
Emma McCann

Clinical Sisters
Kathryn Sheridan
Therese McKeown

Ward Manager Support

House Keeper

4 South

Personal Information redacted by the USI

Ward Manager
Tracey McGuigan

Clinical Sisters
Ashlene Kelly

Ward Manager Support

House Keeper

Female Surgical DHH

Ward Manager
Helen Fee

Clinical Sisters
Alison Campbell
Eimear Grant
Clare Digney

Ward Manager Support

House Keeper

Male Surgical DHH

Ward Manager
Margaret Donnelly

Clinical Sisters
Jenny Lavery
Margarita Carragher

Ward Manager Support

House Keeper

HDU DHH

Ward Manager

Clinical Sisters

Ward Manager Support

House Keeper

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Head of Service Trauma & Orthopaedics

Brigeen Kelly
Interim Wendy Clayton from Sept 2019

Operational Support Lead
Wendy Clayton

Interim Jane Scott

Lead Nurse
Sarah Ward

Trauma

Ward Manager
Louise Currie

Clinical Sisters
Rachel McKeown
Rachel Jameson
Jemma Jones
Melanie Menary

Ward Manager Support

House Keeper

Orthopaedics

Ward Manager
Maureen Farley

Clinical Sisters
Joanne Ussher
Stephanie Doherty
Alanna Holliday

Ward Manager Support

House Keeper

Fracture Clinic CAH

Ward Manager
Joanne Cochrane

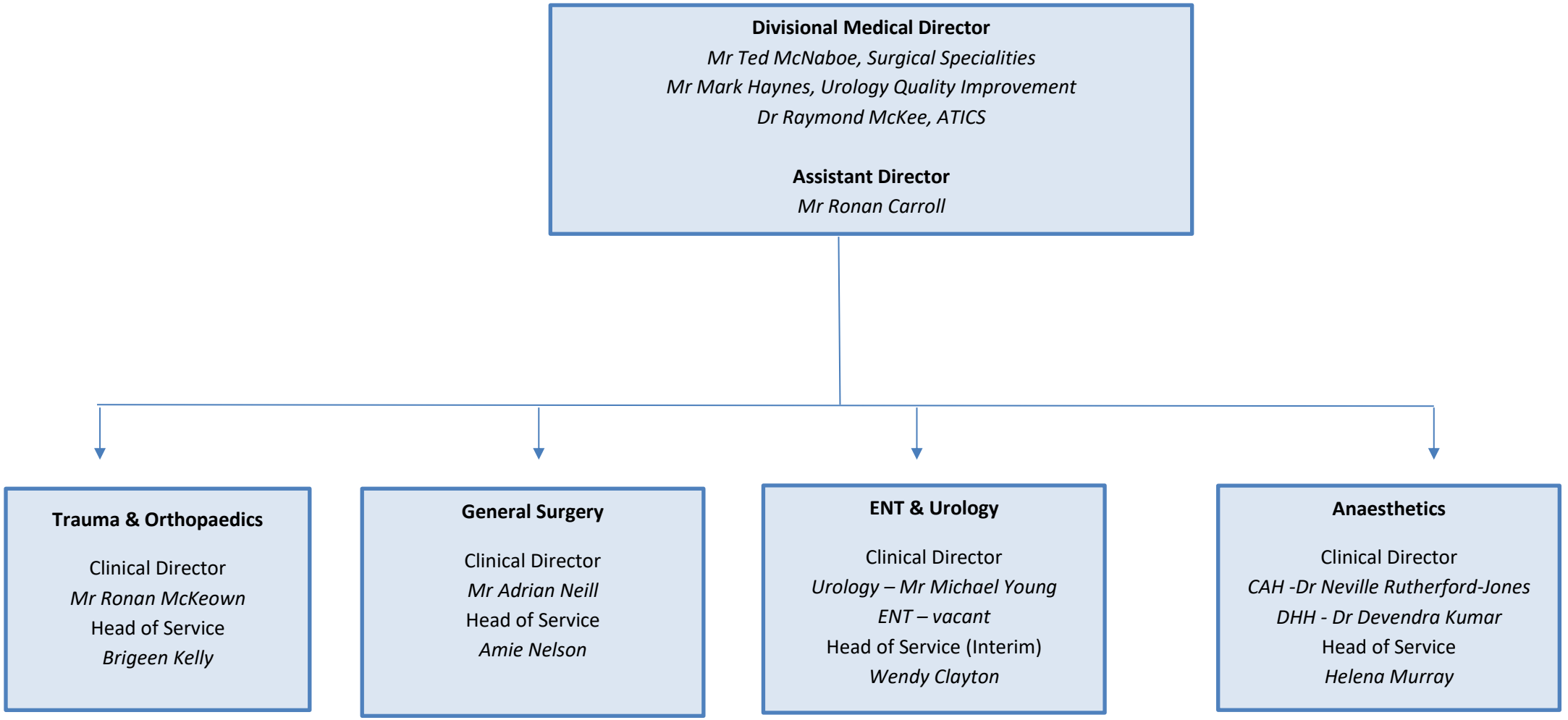
Clinical Sisters
Yvonne Hagan (Acting)

Ward Manager Support

House Keeper

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Management Structure Surgery & Elective Care(SEC) & Anaesthetics, Theatres and Intensive Care (ATICs)



Assistant Director
Ronan Carroll

Head of Service
ENT, Urology, Outpatients & Ophthalmology
Martina Corrigan (on secondment)
Wendy Clayton

Lead Nurse
Paula McKay

Lead Nurse
Josie Matthews

Lead Nurse
Tracey McGuigan

3 South
CAH

Ward Sister
Laura White

Clinical Sisters
A Lyttle
C Crothers
C O Neill
F Murray
H.Stewart

Thorndale Unit
Joanna Percival

Clinical Sister
D Campbell

CNS
Jenny McMahon
K O Neil
L McCourt
P Thompson
J Young

Outpatients CAH
Ward Sister
Joanna Percival

Clinical Sisters
L McCarraher
FMGrath
C McKenna

Outpatients DHH & Banbridge Clinic
Ward Sister
Marilyn Mulligan

Clinical Sisters
Julie McNeilly
S Carville

Outpatients STH & Armagh
Ward Manager
Jacinta McAlinden

Clinical Sisters

Elective Admissions
Ward

Ward Sister
Nichola McClenaghan

Clinical Sisters
L Knox
B O Neill

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Thorndale Consultant Departmental Meeting
4th February 2021 at 12:45

Notes of meeting

Present:

Michael Young	Tony Glackin	John O'Donoghue
Wendy Clayton	Martina Corrigan	Laura McAuley
Shawgi Omer	Nasir Khan	

Agenda	Discussion	Action
Apologies	Mark Haynes	
Covid update	4North has reopened again for surgical admissions following outbreak. I**CU** – 7 xcovid level 3 ventilated patients and 2 x covid level 2 **Wards** – CAH 156 covid positive (includes 9 ICU) and DHH 26 covid patients Outpatient staff are still required to be redeployed to the wards. This will be reviewed again next Monday 8th Feb. Re-start plan drafted 1. STH daysurgery diagnostics 2. DHH urgent bookable 3. Outpatients	
Elective Activity	**Theatres** Continue with 1 all day urgent bookable list on CAH only Confirmation of w/c 15th Feb in CAH: • Tue 16th Feb – Regional AM / Urology PM – Mr Haynes Independent Sector Sessions for w/c 15th Feb 2021 circulated: • Mon 15th Feb – UIC AM – Mr Young • Mon 15th Feb – LVH all day – Mr Glackin • Tue 16th Feb – KPH all day – Mr O'Donoghue • Sat 20th Feb – UIC all day – Mr Glackin **Outpatients** **Telephone triage** – discussion undertaken regarding the under utilisation of the telephone triage system. JO'D advised that this week he would have had from 0-3 calls	

	per day. At present there is no need for 2 consultants in Thorndale, the consultant on-call will take the triage mobile Mr Omer / Mr Khan both agreed to work in other hospital sites i.e LVH, KPH and UIC. Wendy to forward practice privilege forms	
Capital	Agreed urology equipment on the Acute capital list: 2 cook lasers (1 x CAH and 1 x DHH) and 1 trilogy system camera stacks Still waiting to hear if successful with the bid, will not hear until 15th Feb 2021 Single use flexible cystoscopes – will permit to bring the equipment to wards. Wendy to link into Tony re ordering	
TURP waiting list	Mark had suggested a project for Saba re screening TURP waiting list 1. Does the patient want their surgery 2. Are they suitable to travel Require evidence gathering of the outcomes Longest waiting catheter TURP is currently approx 280 weeks The patient needs a discussion in relation to all possible pathway options, also any engagement with the patient may raise the expectation that surgery is imminent. Need to factor in to whatever process is undertaken and needs consultant supervision To discuss further with Mark Jenny was keen to get a LUTS clinic up and running with Saba and prostate outlet.	
Medical students	Laura advised that Queens 3rd year students are starting again this week, consultants are happy for the students to attend theatres Laura teaches weekly and has linked in with the Registrars re teaching	
Any other business	Chair of the SAI group is looking to meet with all of the urology team Martina to confirm date	

	Departmental meeting – Tony acknowledged usefulness of the weekly departmental meeting. Meetings to be opened to all of the urology team. Wendy to circulate zoom invite each week.	
Next meeting	Thursday 11th Feb at 12:45	

Thorndale Consultant Departmental Meeting
20th May 2021 at 12:45

NOTES OF MEETING
Present:

Michael Young	Wendy Clayton	Mark Haynes
Martina Corrigan	Leanne McCourt	John O'Donoghue
Jenny McMahon	Kate O'Neill	Jason Young
Patricia Thompson		

Agenda	Discussion/Action
Apologies	Sarah Ward
Actions from previous meeting	**CNS medical mentorship** – CNS's emailed Lisa Houlihan last week. Lisa's advice was that the mentorship needs to be meaningful so the structure is dependent on the need. CNS to bring back to a plan to the next **DHH paed patients review** – JOD is currently reviewing the urology paed waiting list, patients to be validated before commencing paed surgery. Mr O'Donoghue to be the Paed Urology Surgeon lead Mr Glackin happy to participate with sessions **Scheduling** – Wendy advised that centralising the scheduling has been discussed with the AD and also the secretary's line managers. Further discussion required and updates to be brought back to the next week. **Clinical Fellow recruitment** – 2 x posts are going out for advertisement this week with closing date will be Thursday 10th June.
Elective/Outpatient activity update a. Scheduling b. Haematuria clinics	**Catheter Changes** Jenny raised the management of complex catheter changes/flexi and removal of stents. Currently Jenny is receiving a lot of referrals from variety of sources. Queried if there was funded session in Thorndale for the catheter change It was agreed that there needs to be a time allocated in Thorndale which does not coincide with a new patient clinic so procedure room is available. It was suggested the need for an electronic referral

	form Mr Glackin highlighted this service is not to take away from community service **Action:** Jenny to develop proforma and bring back to the departmental meeting in 2 weeks time for discussion/approval **Haematuria clinics –** Mr Young queried how many haematuria clinics were required in a week. It was agreed that Wendy would assess the red flag demand and then scheduled either a new or haematuria red flag clinic in the allocated session. In addition to the Thorndale haematuria there are also approximately 2 x LVH haematuria clinics each week and are working well at 8-9 per/session Currently the team has nearly caught up with TPs in STH. There is potential for some for doing some flexis in STH, however, the TP sessions are only once week so they need to be scheduled and kept up to date first. The number of TP GA patients are minimal - a session may be required once every 8 weeks.
Any other business	Visconn – virtual consultation system. Tony has agreed to pilot for his Uro oncology clinics.
Date of next meeting	Thursday 3rd June 2021

Thorndale Consultant Departmental Meeting
4th March 2021 at 13:00

Present:

Michael Young	John O'Donoghue	Wendy Clayton
Jason Young	Laura McAuley	Nasir Khan
Jenny McMahon	Tony Glackin	Patricia Thompson
Kate O'Neill	Jay Atkinson	Leanne McCourt

Martina Corrigan
Maria O'Kane

Agenda	Discussion
Apologies	
Triage & Job plan	Triage of GP letters, keen to pursue advanced triaging with wider team. Currently consultants already undertake advance triage e.g organise CT, USS ahead of face to face appointment **<u>Options for discussion</u>**: 1. Separate out triaging or keep triage as part of oncall week 2. some of the referrals could be triaged and processed by some of the CNS team TG – there is not enough time on call to do anything substantial for all referrals in particular routine referrals. Patients that would benefit would be bladder diaries, USS scans and could be undertaken by any member of the team e.g junior medical team or CNS's. Skills across the team to deliver in a different way Need protocols, agreement from the trust and included in job plans TG has reservations about advance triage and phoning every patients Time needs to be allocated properly to whoever is triaging ? go back to ICATs triage. CNS – no issue with principle as long as protocols are in place and standard letters agreed Jason advised Belfast has a scrotal clinic run by speciality doctor. Whatever is designed needs to be mindful of the training needs of the juniors Triage outcomes – HOT clinics, LUTS assessment needs Electronic triage has about 6-8 choices, the dialogue box is not intended for us, it is for RBC. To link in with Kate Cunningham when ready re electronic triage Martina is going led the Service Improvement with Mr T McNaboe
Covid Update	Wendy gave an update on current covid-19 position within the Trust

	Wards are down to 36 covid patients (last Thursday was 55 patients). Down to only 1 covid + ward in CAH and 3 patients in ICU
SIA	**Martina gave an update on SAI's** The 9 SAI's that have been worked on for the past number of months have come to a conclusion. They have been shared with HSCB and DOH. They are being discussed this afternoon and tomorrow The families and AOB will receive a copy of the SAIs on Monday along with the urology team. Monthly Chief Executive meeting on this Tuesday morning, this will be a supportive meeting and not to go through SAI's in great details. Dr O'Kane queried if the team needed time out to read all SAIs. Martina asked if the team wanted the meeting to go ahead next Tuesday. Some of the team decided to not attend the meeting to give them time to read the SAI's
Next meeting	Thursday, 11th March 2021

Urology Team Departmental Meeting
11th November 2021 at 12:45
NOTES OF MEETING

Present

Wendy Clayton	Kate O'Neill	Leanne McCourt
Jenny McMahon	Patricia Thompson	Jason Young
Matthew Tyson	Emma	Tony Glackin
Mark Haynes	Michael Young	Matthew Tyson
John O'Donoghue	Laura McAuley	Leanne McCourt

Agenda	Summary of Discussion
Apologies	
Covid update	**Covid numbers:** • CAH – 100 admissions • Clinical covid - 0 • Covid patients ICU – 8 • ICU still holding beds, in a difficult position at present, when ICU beds increased Wendy will inform everyone
Elective/Outpatient activity update	**352/Kingsbridge** • New outpatients for 352/Kingsbridge • Personal Information redacted, 352 is preparing a list and cost of procedures which can be carried out on their premises • Contract will be for 400 new outpatients **November Urology Performance numbers attached**  NOVEMBER 21 Urology PERFORMAN **Totally Healthcare** • TURP – Contract will be signed this week • Mark suggested sharing with GPs and any contract variation can follow later • First 20 patients to be complete by end of Dec 2021 **Urodynamics** • Jenny is trying to set up clinics running Tuesday with Mr. Donoghue and Mr. Young, however, at present no nursing support available • Wendy to speak with Dolores if any of the South Tyrone nursing staff can help out **Increase in P2 patients** • Outpatients 1-2 weeks red flag flexible cystoscopy due to outsourcing • Red flag Prostrate – 1-2 weeks good position • Work on new urgent to bring figures down, unable to proceed with routines at present • Further work to be carried out in relation to triage forms by adding a further box re. condition and add to ECR, Belfast using something similar and work well • Trying to bring numbers down in relation to backlog, new referrals decreased from 422 averaging at 200 • Wendy – additionality monies available anyone in need is interested in doing review backlog clinics. MY and AJG already undertaking some additional sessions
Staffing	• Junior staff under pressure at present

	• SHO starting Monday 15/11/2021 • Clinical Fellow starting at end of month, Matthew suggested Senior Clinical Fellow, possibly a higher degree post, discussion needed re. funding Wendy will speak with Matthew
TROC referral pathway	• TROC – some patients suitable for independent sector, some patients not needing treatment, TROC very challenging • Caution on consultations with patients regarding procedures which may not happen etc. Anthony referred to one of his patients who caused problems because of previous consultations and information given • Protocol for CAH and DHH ie. where patients are sent, new dates for December – follow up in January • Discussed TROC referral forms attached  TROC referral pathway and forms N • TROC – Jason sent email re. covid – agreement needed on this procedure on moving forward feedback welcome – add to Agenda in 2 weeks
Poster submission from CAH urology unit	• Laura – will speak with Registrars regarding poster presentation
Urology CNS update	• Jason and Laura updated everyone regarding ESWL email attached • Laura – ESWL work to be carried out from January • • Release of Flexible endoscopy lists for November, due to being unable to get patients to go to LVH. It too admin staff 2 days to book one half session • Wendy to email CNSs with list of which Consultants who manager 'other' consultant queries, Laura happy to help with any query
AOB	• Ambulatory Unit – refurb to commence in the next few weeks. Unfortunately, due to IPC restrictions under to have an ambulatory service on the ward. Therefore, it is anticipated that the ambulatory unit will go to General Surgery Urology and ENT will have to look for accommodation for their ambulatory patients • Mark discussed an option of an Elective care unit – conversations have started with Senior Managers and planners • Screens for disposal statoscopes has disappears - there is only one left for Thorndale. CNS to forward photo of the screen to Wendy who email out to the lead nurses for circulation to wards
Next meeting	Thursday 18th November 2021 – The PI Solicitors will be attending next weeks Departmental meeting

Urology PERFORMANCE – NOVEMBER 2021

Urology Priority 2 update as at 3/11/2021:

- P2B = 35 pts
- P2C = 108 pts
- P2D = 261 pts

Total = 407 pts

The priority 2 case load includes a mixture of proven cancers, clinically suspected cancers, and benign disease. Within the proven cancer patients a small number are undergoing multimodality treatment and have narrow treatment windows.

In order for our decision making to be objective and transparent as we assign our limited capacity to patients requiring surgery, it is agreed that we approach this activity along the following priorities, using waiting time (days on surgical waiting list) as the additional metric.

Priority A = proven cancer with short treatment window post chemotherapy / radiotherapy
Priority B = proven cancer
Priority C = suspected cancer
Priority D = benign disease

New Outpatient waiting lists (with no dates)

Total new outpatients on waiting list = **5223 patients**

- There are 228 Red Flags with longest wait = **44 weeks**
- There are 1498 Urgent patients with longest wait = **291 weeks**
- There are 3474 Routine patients with longest wait = **297 weeks**

4/11/2021

Tumour site	Number W/L	Longest wait (weeks)	Comments
Haematuria	22	44 (pregnant does not want until after baby) 1-2 weeks	**Only 22 patients left to book, 7 stragglers of patients cancelling. Once cleansed waiting time only 1-2 weeks**
Prostate	54	4 weeks	
Others			
Testes	1	1 week	
Urology	9	2 weeks	**1 pt at 10 weeks and 1 at 4 weeks, being cleansed.**

New URGENT Outpatients waiting with no dates

	Urgent	Routine
	November 2021	November 2021
Weeks waiting	Total with no dates	Total with no dates
0-10	343	166
11-20	112	120
21-30	122	143
31-40	125	123
41-50	86	80
51-60	98	85
61-70	104	74
71-80	84	70
81-90	87	112
91-100	204	134
101-110	105	170
111-120	113	160
121-130	6	162
131-140	3	145
141-150	4	131
151-160	1	161
161-170	1	172
171-180	2	129
181-190	0	106
191-200	1	109
201-210	2	92
211-220	0	115
221-230	2	113
231-240	3	111
241-250	0	119
251-260	0	105
261-270	2	87
271-280	3	73
281-290	0	84
291-300	1	31
Total	1614	3482

Urology Referrals per year (year is April-March)

Year	**Total	Average per month
2017-2018	13750	1145
2018-2019	12663	1055
2019- 2020	12556	1046
2020-2021	6905	575
2021-2022 (to October 21)	2960	422

Review outpatient backlog update (as at for 1st November 21)

	Oct 21		Nov 21	
	Total	**Longest date**	**Total**	**Longest Date**
Glackin	48	May 2020	56	May 2020
O' Donoghue	401	Mach 2017	441	March 2017
Young	479	December 2016	558	December 2016
Haynes	101	February 2019	114	February 2019
Omer	42	March 2018	46	March 2018
Khan	132	April 2021	37	April 2021
O' Brien	367	July 2013	345	July 2013
Tyson	41	May 2019	58	May 2019
Jacob	37	July 2017	42	July 2017
Total	**2133**		**1697**	

Adult Inpatient and Day case waiting lists – position of 05/11/2021

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	68	149	62	241	54	159	44	167
O'Donoghue	197	297	34	336	61	243	47	344
Young	217	373	60	378	209	366	158	377
Haynes	105	319	52	356	60	235	40	279
Khan	29	45	2	33	49	114	11	42
O'Brien	145	378	50	369	18	376	20	340
Tyson	32	139	6	133	6	128	7	134
Jacob	13	274	16	293	12	205	71	260
Total	**806**		**282**		**469**		**398**	

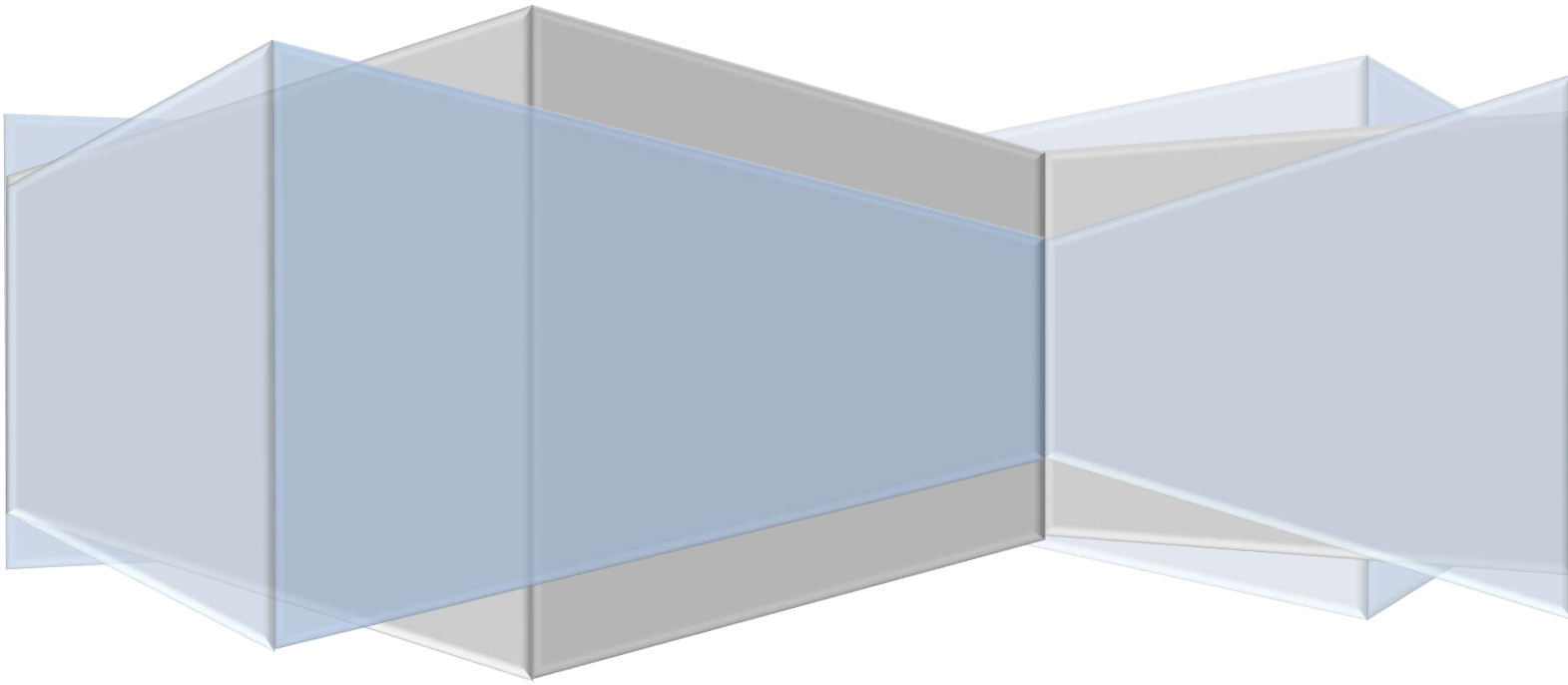
Summary Adults – total = 1955 pts
Urgent Inpatients = 806 patients; longest wait 378 Weeks
Routine Inpatients = 282 patients; longest wait 378 weeks
Urgent days = 449 patients; longest wait 376 weeks
Routine days = 398 patients, longest wait 377 weeks

Southern Trust

Review of Trial Removal of Catheter referral pathway

New patient referrals, Nov 2021

McAuley, Laura: McMahon, Jenny: Young, Jason



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Trial Removal Of Catheter (TROC) Service

Originally the TROC service commenced November 2015 with the primary aim of ensuring urology patients had their catheter removed in a timely fashion and had a plan of care in place. This was a Joint service between the Urology nursing team and the Continence Service with TDU to serve as referral point. All urology patients were to be offered an appointment with an Urologist prior to or following their TROC in Outpatient (OP) setting.

An audit of 200 patients (Nov 15 – Jan 17) identified that:

- 158 referral forms / requests received
- 42 other sources
    - Phonecalls from patients expecting a date (approx. 20)
    - Wards / Continence team enquiring when TROC would be offered (approx. 15)
    - walk ins and non urology sources (2)

TROC Clinics:

- 99 patients referred to community nursing team (SHSCT & SWAH)
- 101 patients attended TDU
    - Unsuitable for community (clinical reason)
    - Attending TDU for another appointment and TROC arranged parallel
    - Needed catheter x 2-3 days only and / or due to waiting time in community ~ 4 weeks
    - Outside SHSCT community boundary and NHSCT unable to provide TROC service

Outcomes:

- 122 patients had a successful TROC, 6 patients deceased
- 16 patients failed their initial TROC and were reviewed again
- 22 patients waitlisted for TURP
- 30 patients managed with either LT catheter or ISC
- 2 patients non urology source/ seen elsewhere privately

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Based on this audit, problems encountered and items identified for discussion included:

- Patients were being informed that TDU will arrange a TROC on a specific date (and often no referral has been received).
- Waiting times in community for TROC approx. 4 weeks, this increases burden on TDU
- Incomplete TROC forms particularly following inpatient procedure & no letter available on ECR for several days / weeks – this is difficult to advise community team on follow up etc.
- Patients attending TDU for TROC – where possible an appointment was arranged with the Urologist on the day, patients referred to the community team are instructed to write back to the referring consultant with the outcome of TROC that a suitable review can be arranged
- How should patients who attend ED in acute retention of urine be appropriately managed through the TROC service?

Further TROC Audit Nov 2019:

20 patients were selected consecutively between 22.5.19 & 27.06.19

Referrals:

- 19/20 referrals received into TDU and 1 referral sent to community service directly
- 13/20 (TROC referral form) 5/20 (email) 2 /20 patients phoned the booking centre following ED attendance
- 10/20 TROC in in TDU, 7/20 referred to community & 3/20 had TROC as inpatient (after form had been received)
- All TROC's were performed on requested date in TDU or within a couple of days in community

Outcomes: Successful TROC (15) Failed & LT catheter / ISC (4) Deceased (1)

Referral Forms:

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We identified 4 basic criteria that we felt should be included: **Who**: H&C / Hospital Number **Why**: Catheter was inserted **Where**: TDU / Community **When**: Preferred TROC date

- 12 forms were available – All 4 criteria met (6), 3 criteria met (5), 2 criteria met (1)

It is felt that the Thorndale clinic should be used for patients who would be unsuitable for community – i.e. difficult catheterisations / urgent TROC (needed within a couple of days) or if the consultant wants to co-ordinate other clinical activity to coincide.

From this information, and following a discussion with 2 ED consultants and 2 nurses, the ongoing issues are:

- TDU is being used as a triaging service for TROC from OPD, wards and ED, regardless of whether they have had a urological assessment or not

- Referral forms are not correctly completed

- ED referrals have insufficient clinical information on which to base a management decision and patient's being given unrealistic time frames for rv without catheter support in the community

- there is uncertainty and inconsistency in how and to whom referrals should be made resulting in various email and communication pathways being used to ensure a patient is appropriately followed up. This is an inefficient use of TDU specialty nursing staff.

Covid 19 since these audits has created added challenges in managing the TROC service but also new nurse led pathways have been created.

The aim of this project is to construct a referral pathway to ensure referring clinicians for TROC access appropriate services with appropriate clinical information in a consistent manner. This in turn should improve the patient experience by better managing their expectations and improve utility of services.

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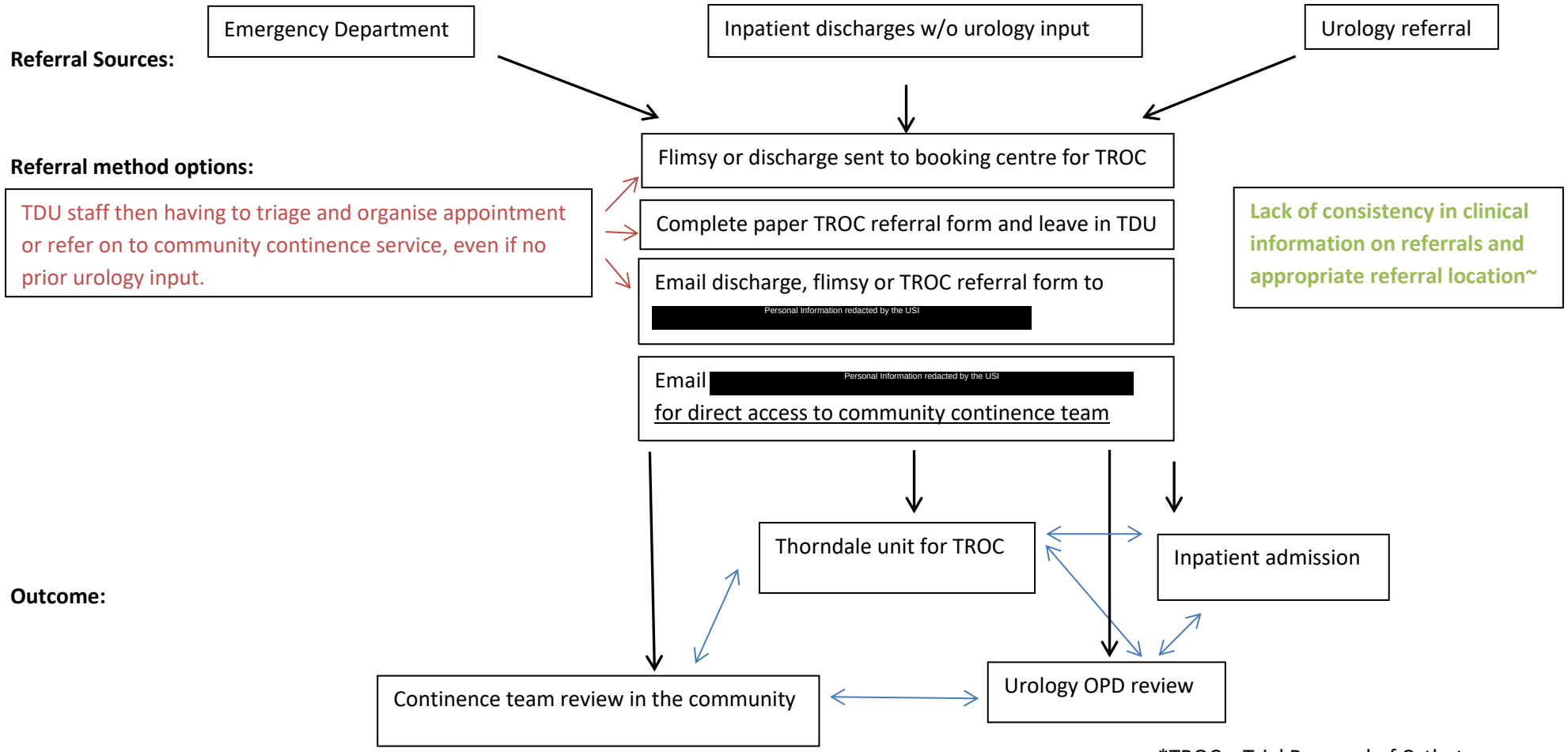
Current pathway and paperwork

Craigavon site (Nov 2021)

Southern Health and Social Care Trust

'New catheterisation' TROC* referral pathway – Current as of Nov 2019



*TROC – Trial Removal of Catheter
~ see audit data

Craigavon site (Nov 2021)

TROC & Catheter Change Referrals

Southern Health and Social Care Trust

SERVICE	LOCATION
Trial removal of urethral catheter (TROC) **Patients who have been seen and assessed by a urology doctor:** • Complete TROC form and forward to [redacted] • Patients will be offered a date at next available clinic in the Thorndale unit :– waiting times can be 2-3 weeks • Ensure patients have been referred to community nurses for support with catheter care and provided with sufficient catheter supplies whilst awaiting an appointment **All other patients:** • Refer to the community continence service via email to: [redacted] • Patients will be offered a date at next available community clinic :– waiting times can be 2-3 weeks • Ensure patients have been referred to community nurses for support with catheter care and provided with sufficient catheter supplies whilst awaiting an appointment	**Thorndale Unit** **SHSCT Community clinics**
1ST Change of supra-pubic catheter / Change of urethral catheter which may require cystoscopy or guidewire. • Send copy of discharge letter to [redacted] with request clearly visible as to when catheter is due changed otherwise a default date of 10 weeks will be given. • Inform patients they will receive an appointment date in the post • Ensure patients have been referred to community nurses for support with catheter care and provided with sufficient catheter supplies whilst awaiting an appointment • Patients who require routine change of urethral or supra-pubic catheter should be referred to the community continence service via email to: [redacted]	**Thorndale Unit**

Southern Health and Social Care Trust

Trial Removal of Catheter

(TROC) Referral Form

To be completed by urology doctor after patient assessment

Date of referral: **Urology Consultant:**

Name and contact number for doctor requesting TROC:

Ideal TROC date - Week commencing:

Indication for catheter insertion:

Acute (Painful) retention □ Chronic (Painless) retention □

Post-Operative retention □ **Catheter residual volume: mls.**

(***must be recorded)***

Other □ Details: _____

Post op to facilitate healing: □ Remove catheter in _____ days

Acceptable post void residual: _____ (default is < 200mls)

Suitable for intermittent self-catheterisation if fails TROC? Yes ( ) No ( )

Suitable for TROC with community continence nurse? Yes ( ) No ( )

Does patient need to learn intermittent self-dilatation? Yes ( ) No ( )

Location of stricture if applicable: *Meatal / Distal urethra ( ) Other ( )*

Any other instructions / information?

Has other Review been planned for this patient? Yes ( ) No ( )

If yes please provide details:

Please return completed form to TROC Service Thorndale Unit Main OPD

Please inform patient that waiting times may be 2-4 weeks

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TROC Clinic – Record of Administration / Appointment

Referred to community continence team to arrange TROC: Yes ( ) No ( )

Date:

Details:

Appointment arranged at Thorndale TROC clinic (CNLTROC) Yes ( ) N/A ( )

Allergies: **Relevant Medical history:**

Relevant Medications:

TROC DATE: Catheter removed by:
Time:

Advised to eat and drink as normal and void on demand □

Aware to return to dept. for post void bladder scan at □

TROC Outcome: Pass ( ) Fail ( )

Urology Review planned:

- Patient has been informed to seek medical advice if any problems encountered following TROC: Yes ( ) No ( )
- Patient is aware of plans for urology follow up: Yes ( ) No ( )

Nurse Signature: Date:

Time:

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Newly catheterised patients for TROC

Suggested pathway and paperwork

Nov 2021

Craigavon site (Nov 2021)

Southern Health and Social Care Trust

TROC Referral Pathway

Newly catheterised patients

Complete TROC clinical assessment and referral form

↓

All patients should receive:

- Catheter care instructions and supplies
- Advice that follow-up may be up to 6weeks time
- Take home pack containing catheter information leaflet with contact numbers for ongoing support

↙ ↘

Urology Review required?

Forward completed form with ED flimsy or inpatient discharge letter to booking centre for Consultant Urology Triage

All other patients

Forward completed form with ED flimsy or inpatient discharge letter to the community continence / district nursing team via

[redacted]
Personal Information redacted by the USI

↓

Consultant Urology Triage

Outcome to booking centre to arrange follow up

↙ ↘

Urology OPD Review prior to TROC

TROC – Complete 'Urology Staff Only' section on form

Craigavon site (Nov 2021)

Southern Health and Social Care Trust

Trial Removal of Catheter (TROC) Clinical Assessment and Referral Form

To be completed by referring doctor after patient assessment

Date of referral: _____

Name of referrer: _____

Location: _____

Affix addressograph or provide patient details including patient contact number

Indication for catheterisation:

Acute (Painful) retention □

Chronic (Painless) retention □

Post-Operative retention □

Other □ Details: _____

Post op to facilitate healing: □ Remove catheter in _____ days

NECESSARY information checklist for every patient:

Information:	Done(√)	Findings:
Prostate examination (DRE)		**(e.g. benign/ malignant, tender/non tender)**
Residual volume (mls)		
Renal function (eGFR)		**Baseline:** **Current:**
Difficult insertion		**Yes** **No** Details:
Current medications		Tamsulosin/ alpha blocker **Y / N** Finasteride/ dutasteride **Y / N**
Refer all patients to community nursing support for catheter care until review		**Refer via:** ***Intranet Sharepoint - Community Pathways - Continence*** for referral form and email
Patient provided with catheter care bag and information		
CSU sent on catheterisation		

Discussed with urology oncall? Y / N **Urologist name**:_____

Urology review/ follow-up required? Y / N

*** <u>Please do not guarantee patient a time window for review and catheter removal.</u>***

Craigavon site (Nov 2021)

Southern Health and Social Care Trust

For completion by Urology Staff Only

If patient requires TROC in Thorndale Unit please specify reason below so an appropriate appointment will be arranged e.g. after cystogram, ongoing urology rv required

Acceptable post void residual: (default < 200mls) _____

Suitable for intermittent self-catheterisation if fails TROC? Yes ( ) No ( )

Does patient need to learn intermittent self-dilatation? Yes ( ) No ( )

Location of stricture if applicable: _____

Any other instructions / information?

If TROC successful, does this patient require ongoing urology review?

Yes ( ) No ( ) *(please provide details)*

Leave referral in TDU office or email: [redacted] Personal Information redacted by the USI

Craigavon site (Nov 2021)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Risk Likelihood Scoring Table

Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

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SECTION TWO - APPENDICES

SECTION THREE - ADDENDUM

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

SECTION ONE - PROCEDURE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a ‘statutory duty of quality’ on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any

case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2012 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide'. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  It is acknowledged these incidents should already have been reported to RQIA as a ***'notifiable event'*** *by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be

undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for

consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting [redacted]

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  '.hscni.net',
  'n-i.nhs.uk'
  'ni.gov.uk' or
  '.ni.gov.net'

  No sensitive or patient/service user data must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  Note: Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  Step 1 Contact the recipient and ask for their email address.
  Step 2 Send a test email to the address provided to ensure that you have inserted the correct email address.
  Step 3 Ask the recipient on receiving the test email to reply confirming receipt.
  Step 4 Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel Personal Information redacted by the USI

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level

- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to [redacted]

HSC Trusts to copy RQIA at [redacted] in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated

correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to [redacted]
Personal Information redacted by the USI

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising

of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

12.6 Review/Learning Summary Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

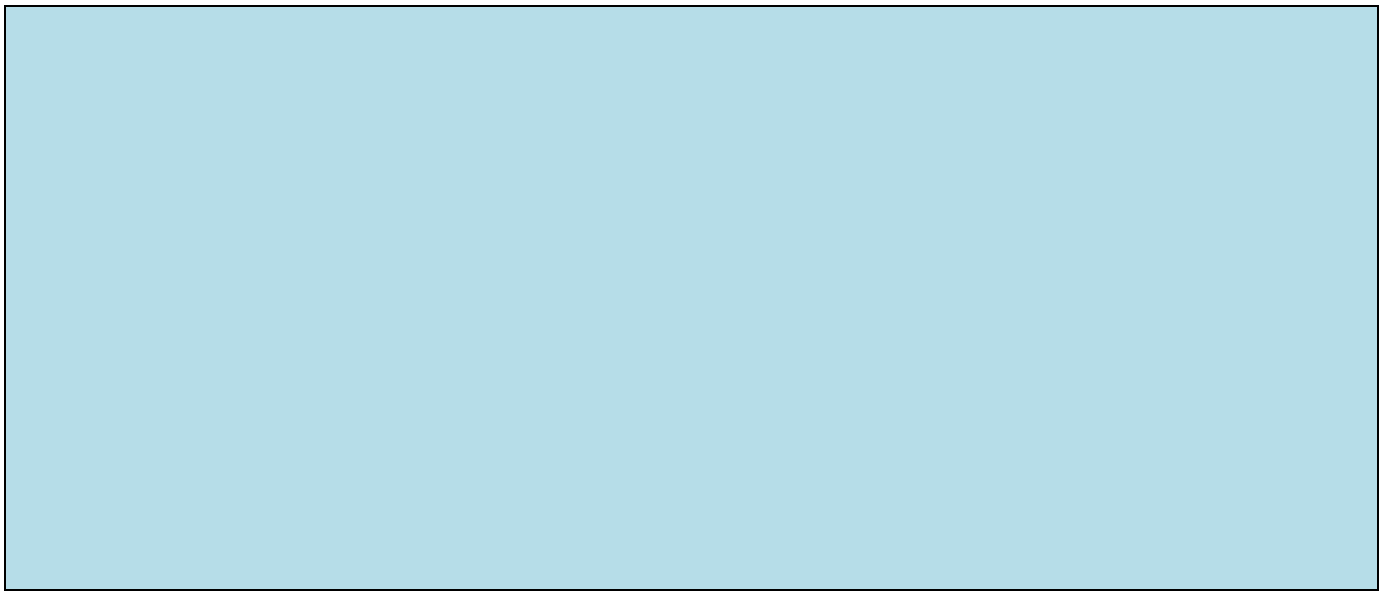
13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION TWO APPENDICES



APPENDIX 1

Revised November 2016 (Version 1.1)

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: [redacted]
and (*where relevant*) [redacted]
Personal Information redacted by the USI

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes
SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT? Yes/No *(please select)*	If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
Where relevant *please provide details on the current condition of the service user the incident relates to.*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)*	YES	NO	N/A

14. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.

The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: Personal Information redacted by the USI
and (*where relevant*) Personal Information redacted by the USI

APPENDIX 3
Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ DESIGNATION: _____

Email: **Telephone:** **Date: DD / MM / YYYY**

Completed proforma should be sent to: Personal Information redacted by the USI

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY
14. WHAT HAS BEEN LEARNED:
15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?
16. RECOMMENDATIONS (please state by whom and timescale)
17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:
18. FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	24. DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**	**NO**	**N/A**	**Not Known**
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory*	
8. SUMMARY OF EVENT: ***As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)***	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER: *Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10*	10. TEAM MEMBERS PRESENT: *NAMES AND DESIGNATIONS*
11. SERVICE USER DETAILS: ***Complete where applicable*** *DOB / GENDER / AGE*	
12. WHAT HAPPENED? *(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).*	
13. WHY DID IT HAPPEN? *(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)*	

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

20. PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*

24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1] / Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
			NO	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 7
Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

The following is a sample list of statements of purpose that may be included in the terms of reference:

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] *http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787*

[5] *http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355*

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report				
	b) Plan to share final review report at a later date and further engagement planned				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate** (✓)				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the review
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

- ## Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

- ## Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

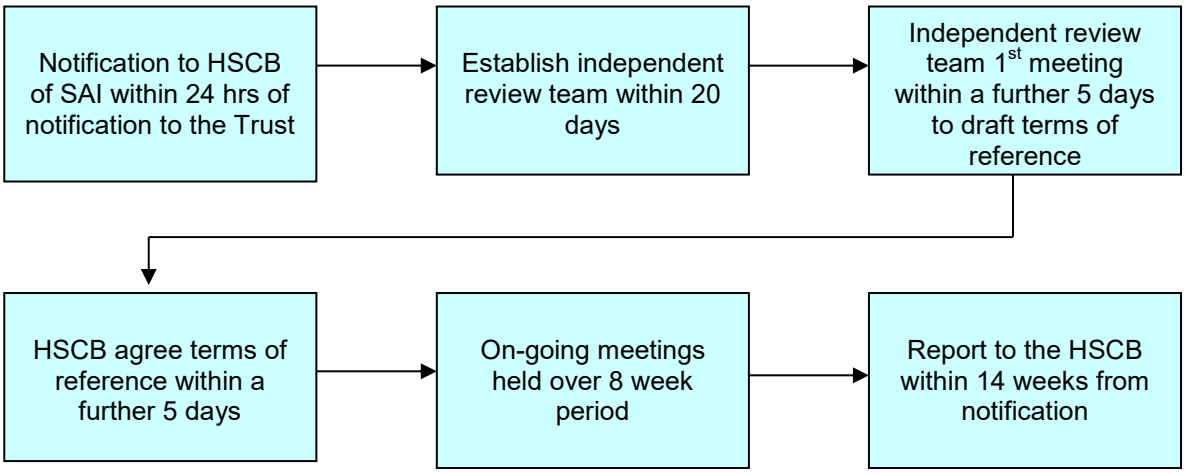
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 15

ADMINISTRATIVE PROTOCOL

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: Personal Information redacted by the USI

and RQIA: Personal Information redacted by the USI

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

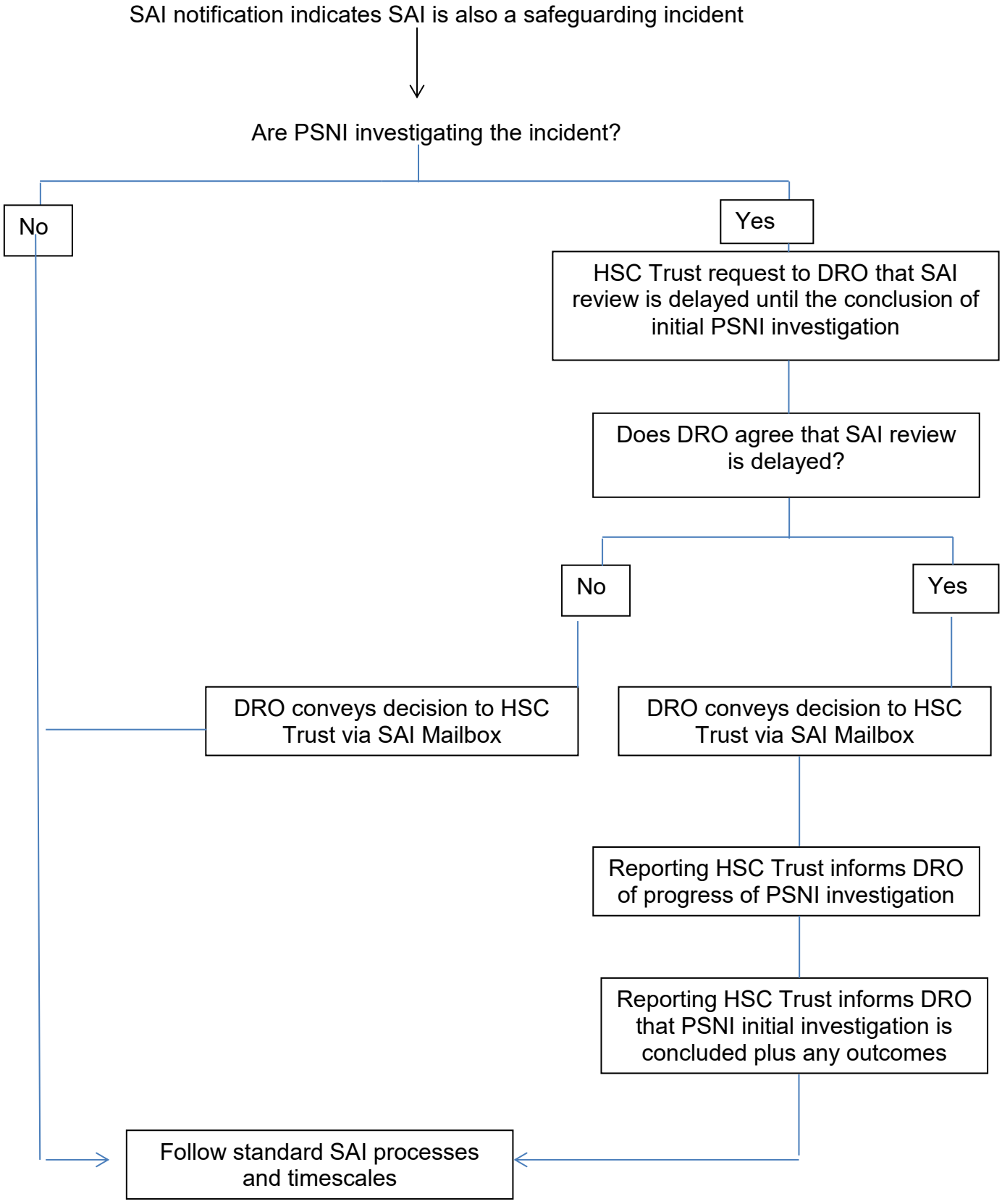
In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

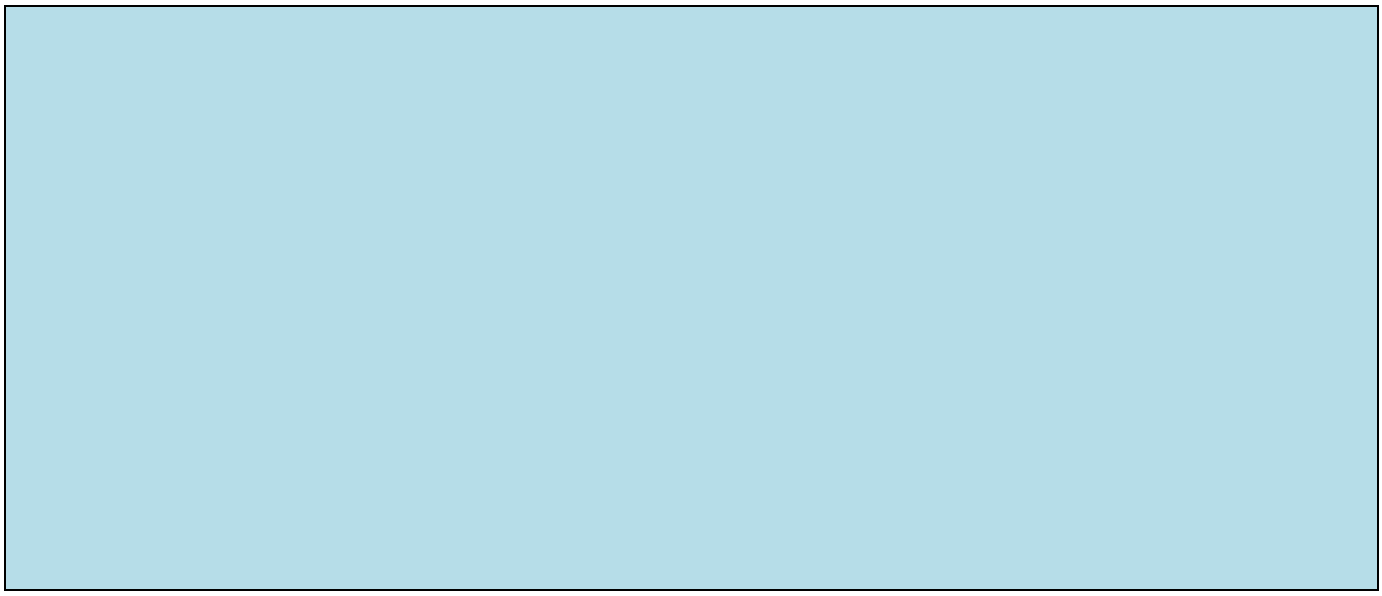
In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM



ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff

should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social

care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with

the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit