Urology Services Inquiry

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

Fiona Reddick
Head of Cancer Services within Directorate of Acute Services
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

26 September 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/or 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

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

Chair's Notice

[No 99 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:

Fiona Reddick
Head of Cancer Services within Directorate of Acute Services
Operational Support Lead
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 24th October 2022.**

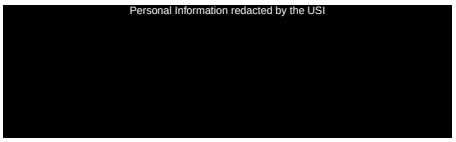
APPLICATION TO VARY OR REVOKE THE NOTICE

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 17th October 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 26th September 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE
[No 99 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

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

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"). 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. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

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 and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

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

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

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out 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.

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

13. What systems of governance do you use in fulfilling your role?

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

Urology Services Inquiry

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

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

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

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

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

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

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

Urology Services Inquiry

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

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

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

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

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

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

Staff

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

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

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

41. 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. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. 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?

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically 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?

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

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

UROLOGY SERVICES INQUIRY

USI Ref: Notice 99 of 2022
Date of Notice: 26 September 2022

Witness Statement of: Fiona Reddick

I, Fiona Reddick, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

General

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

1.1 I was not aware of the extent of the matters falling within the scope of the Terms of this Inquiry. I have highlighted the scope of my role in my response to questions 4 and 5. I have indicated in my responses that I was responsible for ensuring that cancer access ministerial targets were adhered to and that any issues or delays were escalated as appropriate. This would have been carried out using the Trust's escalation process and completing breach reports which would have been shared locally and at Health and Social Care Board level. I had no managerial responsibility for the Urology Cancer Nurse Specialists. I have addressed my managerial responsibilities

in question 4. I have provided a response regarding issues raised by myself in Question 17.

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"). 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. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

   2.1 I have attached documents at Questions 6 and 17. I have sought assistance from Emma Stinson, Public Inquiry Team, to help with the retrieval of documents to aid my response.

   2.2 All documents which have been referenced in this statement can be located in folder 'S21 99 of 2022 – Attachments'.

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 and, as far as possible, to address your answers in a chronological format.**

   If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

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

4.1 Prior to the establishment of the Southern Trust I was employed by the legacy trust Craigavon Area Hospital Group Trust between October 1999 and 2003 as a Staff Nurse in the Mandeville unit which is an outpatient setting for the management and treatment of Oncology and Haematology patients. In 2003 I was appointed as Clinical Sister for the same department. Neither of these posts related directly to Urology. We treated Urological patients who had a diagnosis of Prostate cancer and required chemotherapy for this. This particular group of patients would have been referred to Oncologists which is a central service based in Belfast Health and Social Care Trust. The method of referral was via the Urology Service. The Oncologist responsible for Urology cancer would have visited Craigavon Area Hospital site each Wednesday and held a clinic within the Mandeville unit. The Consultant Oncologist would prescribe treatment and this would have been delivered by nursing staff.

4.2 I was appointed as an Acute Oncology Nurse Specialist in January 2010 and held this position in Southern Health and Social Care Trust up until – July 2012. My role as an Acute Oncology Nurse was to see and manage patients who had been admitted to the general hospital wards with complications as a result of their chemotherapy treatment, or who were admitted as a result of their disease. My role was a liaison service between the Consultant looking after the patient and the Oncologists based in Belfast. I was appointed as Head of Cancer Services to the Southern Trust in July 2012 and continue in this role at present however I have been off on sick leave since February 2021 . My role was to manage the outpatient Oncology /Haematology service and ensure the safe delivery of cytotoxic treatments. I had managerial responsibility as Lead Nurse to Cancer Nurse

Specialists within Haematology, Acute Oncology, Lung, Colorectal, Upper GI, Gynae, Palliative and previously Breast up until 2017, as the Surgical Directorate strongly felt this should be managed within that speciality. In regard to Urology Service - Cancer Nurse Specialists were managed by the Lead Nurse (Gillian Henry/Dorothy Sharpe) and Head of Service for Urology.(Martina Corrigan) I am responsible in conjunction with the Assistant Director for Cancer and Clinical Services for monitoring cancer waiting time ministerial targets and access to first appointments for those with suspect cancer. I worked closely with other Heads of Service, service managers, Clinical Director for Cancer Services and Associate Medical Director for Cancer Services in order to ensure that MDTs were quorate and undertook and completed Cancer Peer Review in conjunction with Service manager for that area.

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

5.1 In my roles as Staff Nurse and Clinical Sister for the Mandeville unit (outpatient facility for Oncology/Haematology) 2003 – 2010, I reported to Ward sister Louise Gribben. In my role as Head of Cancer Services (July 2012 – present) – I report and have reported directly to the Assistant Director of Cancer and Clinical Services. Since commencing my post in 2012 I have had three different Assistant Directors firstly Ronan Carroll (up until April 2016), then Heather Trouton (up until September 2018 and following that Barry Conway and this is current. My role was to manage the outpatient Oncology/Haematology service and to ensure the safe delivery of cytotoxic treatments. I had managerial responsibility as Lead Nurse to Cancer Nurse Specialists within Haematology, Acute Oncology, Lung, Colorectal, Upper GI, Gynae, Palliative and previously Breast however the Surgical Directorate strongly felt this should be managed by the Surgical Directorate. Urology Cancer Nurse Specialists were managed by the Surgical Directorate Head

of Service Martina Corrigan and Lead Nurses Dorothy Sharpe and Gillian Henry. I do not have a clear rationale why this was. It was always the case during my tenure.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**

6.1 I have managerial responsibility for Clair Quin who is the band 7 ward manager for the Mandeville unit. I would have met with Clair on a weekly basis and indeed on a daily basis as required depending on the business of the day and if there were any issues that required immediate action. I met with various members of the team either as a group or individually. For example I would have met with the site specific Cancer Nurse Specialists as a group every few weeks to discuss professional and service items and then individually for appraisals and revalidation. This did not include Urology Specialist Nurses as indicated in Question 1. Some staff I would meet with on a weekly basis and others monthly or as often as is required. We would correspond regularly via email. I would carry out annual appraisals and Professional Development Plans (PDP) for staff within my area of responsibility. Appraisals and Personal Development Reviews are completed so that any issues in regard to a staff member's performance is highlighted and areas for improvement and support are identified. Mandatory training is recorded to ensure that staff are up to date. Objectives are set for the following year. I attach the Trust's Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework, which provides guidance around completing Personal Development Plans (attachment 1) and an example of a PDR completed by Mr Barry Conway, Assistant Director of Cancer and Clinical Services (attachment 2). Please see:

1. 20210722 Performance and Personal Development Review Policy

2. 20200225 KSF Personal Development Review

7. **What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?**

7.1 I have weekly one to one meetings with my Assistant Director who currently is Barry Conway. Prior to that it was Ronan Carroll from 2012 to 2016 and thereafter Heather Trouton until 2018. The purpose of the weekly 1:1 meetings is to go over areas within my area of responsibility such as performance, staffing and resources, finance and budget, review and discuss incidents, complaints, service developments and improvements and to provide updates from regional meetings, for example the roll out of RISOH (Regional Information System for Oncology and Haematology), OST (Oncology Services Transformation).

7.2 Within my Division I have weekly Head of Service meetings with my Assistant Director – Barry Conway and the other Heads of Service which are Denise Newell (Head of Radiology), Geoff Kennedy (Head of Laboratories), Wendy Clarke (Head of Maternity and Woman's Health and Charlotte Ann Wells (Head of Allied Health Professionals). Sharon Glenny (Operational Support Lead) would also attend these meetings. Urology would hold their performance meetings as a Speciality within the Surgical Directorate. Each week we go over the mains areas on Governance, Performance, Finance and Human Resources.-The focus rotates weekly on a four weekly cycle. Week 1 is Governance - we examine Datixs relevant to our areas, we look at any areas where there may be learning from or areas for improvement, we examine trends. We go over the risk register for our area and update accordingly. We look at complaints/incidents and also compliments. We listen to service user feedback and also learn from this. We would only know about Urology incidents if these were shared with us across from the Surgical Directorate. Week 2 examines Performance -

Sharon Glenny (Operational Support Lead) shares dashboards for each of our areas and highlights waiting times. We go through these dashboards in detail and identify ways in which we can improve. We also have regular Performance meetings on a monthly basis with the Health and Social Care Board (HSCB) to discuss our performance. Colleagues in the performance team would also liaise with HSCB. In relation to waiting times for patient access to Urology Services HSCB would be aware of this and indeed a regional Urology Professional Implementation Group (PIG) was established by HSCB to see what areas could be targeted in order to improve cancer access waiting times – Martina Corrigan and Mark Haynes were the Trust representatives on this group for Urology services. Week 3 would focus on Finance and Budget. We would collectively explore each of our budgets and go through expenditure spreadsheets. Week 4 would focus on Staffing and resources. We would look at sickness and absenteeism reports, vacancies, usage of locum and agency staff. The four weekly cycle would be a rolling programme to focus on each of the areas identified.

8. **Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out 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.**

8.1 My role was continually reviewed and monitored. As stated previously I had one to one meetings on a weekly basis with my Assistant Director Barry Conway. I also had annual Performance reviews (appraisals) completed by the Assistant Directors. As a professional nurse I also complete three yearly revalidation of my role and this is a statutory requirement in order to remain on my professional register. This is completed and signed off by a Senior nurse Ronan Carroll and Heather Trouton both Assistant Directors. Ronan Carroll completed this when he was my Assistant Director and Heather Trouton completed

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1 As highlighted previously my role is governed by ongoing monitoring of my performance via yearly appraisals within the Trust and revalidation through my professional body Nursing and Midwifery Council (NMC).

10. **What performance indicators, if any, are used to measure performance for your role?**

10.1 As previously highlighted, I carry out an annual performance review with my Assistant Director. The key areas are around Quality and Governance, Leading and People Management, Performance Management, Strategic Planning and Development, Operational Management of Cancer Clinical Nurse Specialists and Palliative Care Nurses, Financial and Resource Management, Information Management, Corporate and Divisional Responsibilities. I would refer you to Q8 regarding how my performance was measured.

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1 Ensuring that there were and are good governance structures within my areas of responsibility for example scrutinising performance reports and ongoing monitoring of these to see where there are areas for improvement. Open and transparent discussions with my team were also crucial. Ensuring that there is an annual Appraisal and Personal Development Plan carried out. Completing revalidation as required by Nursing and Midwifery Council (NMC) and the monitoring of complaints and incidents, trends and also feedback from staff/ service users.

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1 In my role within Cancer and Clinical Services I have no experience of these systems being by-passed. I did not work in the Urology Service and I would not be in a position to answer this.

13. **What systems of governance do you use in fulfilling your role?**

13.1 I escalate any concerns that I may have to the Assistant Director. I utilise the Trust's Datix system and also monitor this within my area of responsibility. I review complaints and comments on a weekly basis in order to determine if there are any trends or common themes. I listen to staff and service users experiences in order to see if there are any areas for improvement. I regularly undertake audit within my area of responsibility**.** This includes waiting times within the Mandeville unit department. The MQEM (Macmillan Quality Environment) Charter mark has been awarded to the Mandeville unit and this is achieved by carrying out audits in the department.

14. **Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.**

14.1 Yes, I work closely with the Trust's Quality Improvement Team in order to progress Quality and Service Improvement initiatives. I previously got support from this team to implement a pathway for the management of patients presenting to the emergency department with suspected neutropenic sepsis and the timely management of this in order to improve patient safety. In 2015 I secured co-funding from Macmillan and the Health and Social Care Board (HSCB) to appoint a Macmillan Cancer Service

Improvement Lead. This role was to work with Specialities in order to improve patient experience. Transforming Cancer Follow Up was a large piece of work in conjunction with HSCB which was rolled out across different tumour sites – Breast, Haematology, Colorectal. In 2018 I gained support working in conjunction with the Quality Improvement Team to improve patient pathways for patients attending Oncology/Haematology Outpatient setting.

15. **During your tenure, who did you understand was responsible for overseeing the quality of services in urology?**

15.1 Within Urology Services my understanding was that it was the responsibility of the Head of Service for that speciality in conjunction with their Assistant Director and ultimately reporting to the Director of Acute Services . From a Cancer Services perspective we held a Trust monthly Cancer performance meeting where all Specialities were invited and minutes, agenda and dashboard were shared. Martina Corrigan (Head Of Service for Urology) attended these meetings and would have always received the documents. The Urology MDT was also Peer Reviewed and the findings of this were shared with Martina Corrigan, Ronan Carroll, Heather Trouton and myself via the Trust Chief Executive and also to the HSCB.

16. **In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?**

16.1 It was my understanding that the clinical governance arrangements of the Urology service sat within the Speciality managed by the Head of Service (Martina Corrigan) working closely with her Clinical Director and Associate Medical Director. As my role is not within the Urology Service I would not have been privy as to how this was done.

This would have been done within the Surgical Speciality.

17. **Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfil your role within urology had on patient care, governance or risk?**

17.1 I highlighted on many occasions at Cancer performance meetings the risks to patients who had a suspect cancer and who were delayed on getting an appointment to be seen and commenced on a first definitive treatment within 62 days. I worked with the Urology MDT in order to prepare and be Peer Reviewed in October 2017 - please see attachment 3. The serious concerns raised during this assessment were escalated by myself for including on the Acute Directorate Risk Register, please see attachment 4 and 5. I secured funding via Macmillan and HSCB Cancer Nurse Specialist workforce Expansion Plan for an additional Urology Nurse Specialist and there were delays in getting this appointed. Please see:

3. 20201229 Urology MDT Peer review External Verification 2017 Action plan

4. 20191216 email re Risk Assessment Form urology Peer Review Dec19

5. 20191216 email re Risk Assessment Form urology Peer Review Dec19 A

18. **Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.**

18.1 Communication from the service was not always forthcoming. I felt there could have been better communication with me when recruiting and appointing Cancer Nurse Specialists. There were delays in the appointments of nurses even though I had secured funding. Feedback from the regional Urology Professional Implementation Group (PIG) was limited.

Urology services

19. **Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1 As highlighted previously from a Cancer Services perspective we held a Trust monthly Cancer performance meeting where all Specialities were invited and minutes, agenda and dashboard were shared Martina Corrigan attended as Head of Service for Urology.

20. **With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 I would refer to my response in Question 7.

21. **In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?**

20.2 My role was within Cancer and Clinical Services, however as I have indicated in questions 17 and 19 I liaised with the Surgical Directorate who had responsibility for Urology Services.

22. **What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?**

22.2 As I have referenced in Question 17, I escalated the serious concerns following the Peer Review Assessment for inclusion on the Acute Directorate Risk Register around quoracy of Oncology for the Urology MDT. However this was also raised via HSCB and Oncology pressures regional meetings were established to find solutions to a region-wide problem. I would have fed back regarding the Cancer Performance Dashboard to the Head of Service for Urology, ENT and Ophthalmology. At the time I would not have been privy to the detail of governance processes within the Urology Service, however, I am now aware during the completion of this response that the governance processes and procedures within Urology could have been more efficient and effective.

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

23.1 The only performance metrics within Urology Services that I would have had engagement in were the Cancer Performance Dashboards, where I highlighted on many occasions at Cancer performance meetings, where senior managers of the Surgical Directorate would have been in attendance, the risks to patients who had a suspect cancer and who were delayed on getting an appointment to be seen.

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

a. Waiting times

24.1 Yes, Cancer Waiting times for first appointments for those patients referred with a suspect cancer. As previously indicated there is ongoing monitoring, feedback at Trust and HSCB performance meetings. Please see response to Question 17.

b. Triage/GP referral letters

24.2 Yes, ongoing monitoring and escalations if there are any delays, by the Cancer Tracking Team.

c. Letter and note dictation

24.3 No

d. Patient care scheduling/Booking

24.4 No

e. Prescription of drugs

24.5 No

f. Administration of drugs

24.6 No

g. Private patient booking

24.7 No

h. Multi-disciplinary meetings (MDMs)/Attendance at MDMs

24.8 Yes Link in with the Specialities and their Heads of Service, Assistant Directors. Peer Review. As referred to in Q17 the issue of quoracy in Oncology and Radiology was escalated by myself on to the Acute Directorate Risk Register and raised regionally with HSCB.

i. Following up on results/sign off of results

24.9 No

j. Onward referral of patients for further care and treatment

24.10 No

k. Storage and management of health records

24.11 No

l. Operation of the Patient Administrative System (PAS)

24.12 No

m. Staffing

24.13 No

n. Clinical Nurse Specialists

24.14 No

o. Cancer Nurse Specialists

24.15 No

p. Palliative Care Nurses

24.16 Yes, please see response to Question 4.

q. Patient complaints/queries

24.17 No

Concerns

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

25.1 I would escalate my concern to the Assistant Director for Cancer Services as he is my line manager. Following this I would complete a Datix independently or in conjunction with the Assistant Director.

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

25.2 Having responsibility for cancer access targets I continuously flagged delays for first appointments at Cancer Performance meetings both at local and HSCB level. A breach report is completed each time that a patient breaches the cancer access ministerial target which is 62 days from date of referral to first definitive treatment. They are prepared by the cancer administration team. These reports are shared at the monthly Cancer Performance meeting. Breach reports were examined and shared in order to find improved ways of working. The issue of late triaging within Urology service has been escalated via Assistant Director to Director of Acute Services on various occasions. I would have been aware of this when examining breach reports and delays in first appointment to Urology service. The cancer team flagged and escalated delays regularly with the Urology Head of Service. MDM attendance (Urology) - there have been challenges with attendance at Urology MDM meetings in particular from Radiology and Oncology. This was escalated to HSCB and there were regular regional Oncology Pressures meetings to try to address this. There was also some regional work done to explore other ways of working

within MDTs - set up pathways. Urology MDTs were explored but this work was not taken forward by HSCB as clinicians were concerned that there would be too many protocols required for Urology patients as pathways were multi-faceted. There is an ongoing challenge with recruitment of Oncologists across the region and this has been well recognised at Department of Health level, and this continues.

27. **Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.**

27.1 I was not made aware or have been privy to any individual's practice within Urology services as this would have been managed within the Speciality and would not have been shared with me.

28. **If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?**

28.1 I highlighted the concern of delays in getting Urology patients triaged by Mr O'Brien, for further detail please see Question 29..

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

29.1 The issue of late triaging within Urology service has been escalated via Assistant Director to Director of Acute Services on various occasions. I would have been aware of this when examining breach reports and delays in first appointment to the Urology service. The cancer tracking team flagged

and escalated delays regularly with the Urology Head of Service. It was also flagged on risks at performance meetings both at Trust and HSCB level.

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

30.1 Yes, ultimately any delays in treatment and management of patients' clinical care can impact on their outcome. This risk was highlighted in order to see if anything further could be done to improve.

31. **Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.**

31.1 Cancer Performance is continually monitored and fed back to the individual Specialities but it is the Speciality's responsibility to monitor individual Consultants' performance via their appropriate professional mechanisms.

32. **In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?**

32.1 I am not always informed of the outcome if it sits within another Specialty other than Cancer and Clinical Services.

33. **Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?**

33.1 I was only privy to the Cancer performance information and this was flagged and escalated accordingly.

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

34.1 Delays for patients with a suspect cancer in getting access to a first appointment within Urology services were highlighted on many occasions both at local level and at HSCB level. This was reflected at monthly Cancer Performance meetings and also on the Trust's risk register. In relation to waiting times for patient access to Urology Services HSCB would be aware of this and indeed a regional Urology Professional Implementation Group was established to see what areas could be targeted in order to improve cancer access waiting times right across the region – Martina Corrigan and Mark Haynes were the Trust representatives on this group for Urology. Information from this was not shared with me in Cancer Services.

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

35.1 Improved communication and sharing concerns so that there can be learning.

Staff

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

36.1 Although my role was within Cancer and Clinical Services, any interactions I had with the Head of Service for Urology, ENT and Ophthalmology and the Cancer MDT Lead were amicable. I was unaware if there were any difficulties in working relationships between Urology staff and other Trust staff. Cancer related information and data would have been shared with Martina Corrigan on a regular basis by the cancer team. It was her responsibility to forward this to Consultants and team members within Urology service. Cancer Services sent escalations of delays for first appointments almost on a daily basis and it was the responsibility of Martina Corrigan to flag this. I had concerns about the delay in getting patients with a suspect cancer seen in a timely manner. This was flagged and escalated many times and was noted as a risk at each monthly Cancer Performance meeting both at local and HSCB level. At those Cancer Performance meetings, I had also highlighted to Martina Corrigan that Urology patients should have a keyworker Urology Cancer Nurse Specialist as part of a Key Performance Indicator (KPI). I would have highlighted this in other services whose patients required a CNS. I had been successful in securing additional funding via HSCB to appoint further Urology Nurse Specialists which was a regional requirement and stipulation, and was disappointed that this took so long to appoint indeed, I was surprised that I was not communicated with or involved in the recruitment of Cancer Nurse Specialists for Urology. This was kept within the Surgical Directorate. Communication with Cancer services was not always forthcoming.

37. **In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

37.1 I would not have been privy to this information within Urology services as referred to in Question 36.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any**

governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

38.1 I am now aware of governance concerns arising out of Urology services which I had not previously been made aware of. I was a member of the review team for Serious Adverse Incidents within Urology and it was only then that I became aware of some of the concerns.

39 Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

39.1 In my opinion and having access to information during the SAI Review process, I think earlier escalation of issues or concerns by Senior Managers in Urology may have led to timely and appropriate management of Urology patients. There is a clear need for open, honest and transparent lines of communication via all disciplines and professions.

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

40.1 Please see my response to Question 39

41 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. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

41.1 I would refer to my response to Question 39.

42 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?

42.1 I would refer to my response to Question No 39

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically 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?

43.1 I was not aware that there were such governance concerns in relation to Mr Aidan O'Brien as these would not have been shared with me. This would have been managed within the Surgical Directorate. I would also refer you to my response to Question 39.

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

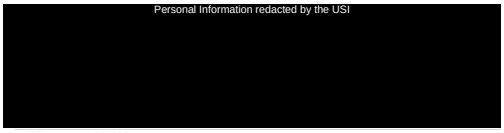
44.1 No there is nothing further that I wish to add.

NOTE:

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

Statement of Truth

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

Signed: _ 

__

Date: 8th December 2022

Section 21 Notice Number 99 of 2022

Witness Statement: Fiona Reddick

Index

Documents
1. 20210722_Performance and Personal Development Review Policy
2. 20200225 KSF Personal Development Review
3. 20201229 Urology MDT Peer review External Verification 2017 Action plan
4. 20191216 email re Risk Assessment Form urology Peer Review Dec19
5. 20191216 email re Risk Assessment Form urology Peer Review Dec19 A

Southern Health and Social Care Trust

Quality Care - for you, with you

Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework (KSF)

Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development
Directorate responsible for document:	HR & Organisational Development
Issue Date:	16 May 2019
Review Date:	09 October 2021
Reviewed On:	18 May 2021
Next Review Date:	17 May 2023

Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Performance and Personal Development Review Policy
Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development)
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Heather Clyde, Vocational Workforce and Assessment Centre
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	09 October 2018
Date approved by SMT:	N/A
Policy circulated to:	All Heads of Service/Department and Line Managers
Policy uploaded to:	Placed on Intranet and SharePoint

Version Control

Version:	Version 4.0
Supersedes:	Legacy Policies for Craigavon and Banbridge, Craigavon Area Hospital, Newry & Mourne, and Armagh & Dungannon Trusts

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Version 1.0	Contact Details, Introduction to Policy 1:7, Appendix 2 Revalidation incorporated.	01/12/2008	Assistant Director Human Resources / ELD – Mrs Heather Ellis
Version 2.0	Contact Details, Appendix 2 Revalidation Form Removed	22/03/2016	Director Human Resources Mrs Vivienne Toal
Version 3.0	Hyperlinks added at 3.8 and 3.12 and 8.0. Differentiation between Supervision and Appraisal added at 5.1. KSF PDP Form updated (Appendix 1). Contacted details updated (Appendix 3). 9.4 change in wording due to UK leaving EU – becomes - UK General Data Protection Regulations (UK GDPR) 2018.	15/02/2021	Anne Forsythe, Head of Workforce & Organisational Development

Contents

Appendices

1.0 Introduction

1.1 The Southern Health and Social Care Trust (hereafter referred to as "the Trust") is committed to ensuring that robust corporate governance arrangements are in place in the operation of its business.

1.2 The Trust is committed to performance review and personal development and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each of member of staff to develop their potential.

1.3 The Trust will ensure that each member of staff knows what is expected of them including standards of conduct and performance required of them, this will be done through personal feedback from their line manager and set in the context of objective setting and review.

1.4 In support of this, the performance review and personal development documentation has been based on the NHS Knowledge and Skills Framework (KSF). KSF defines and describes the knowledge and skills that Health and Social Care staff need to apply in order to deliver quality services. It provides a single consistent, comprehensive and explicit framework on which to base performance review and personal development for staff. KSF is used to develop outlines for individual jobs. These outlines provide links to gateways for pay progression.

1.5 As part of this process, Continued Professional Development (CPD) will be discussed. Each individual profession will have their own requirements for this and reference should be made to these guidelines as appropriate.

1.6 The Trust is committed to supporting staff in their CPD and expects all qualified staff to undertake the necessary amount/levels of CPD as required by their profession. CPD is a personal commitment to keeping your personal professional knowledge up to date and improving your capabilities throughout your working life. It is about knowing where you are today, where you want to be in the future and making sure you have formulated a direction in association with your line manager in order to help you get there.

1.7 Also with reference to management standards Health & Social Care in Northern Ireland have adopted The Healthcare Leadership Model which has been developed by the NHS Leadership Academy. It is an evidenced based research model that reflects the values of the NHS. It comprises of nine dimensions and the model provides NHS staff with a means of analysing their leadership roles and responsibilities.

1.8 Other agreed competency frameworks may also be used for reference.

2.0 Purpose and Aims

2.1 The Southern Trust, through this policy ensures that staff have a strong and effective performance review and personal development which has a very positive effect on the individual's performance, their development and that of the organisation and can therefore contribute greatly to the improvement and development of the services the Trust provides for its patients and clients.

2.2 Recognise achievements and provide help in overcoming obstacles to successful performance.

2.3 Through this policy the Trust will ensure the roll out of performance review and personal development using the KSF Framework across the organisation.

2.4 The Trust will ensure that all staff are clear about their responsibilities for staff development.

2.5 Provide the basis for future training and workforce development strategies and plans.

2.6 Encourage the development of a flexible learning culture across the organisation.

3.0 Objectives of this Policy

3.1 The process of performance review and personal development process begins with a focus on the review of an individual's work in relation to individual service and organisational objectives. This provides an opportunity to receive feedback from the line manager on work performance, ways in which performance can be sustained or improved, and have these laid out in the form of agreed objectives.

3.2 Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve.

3.3 The framework provided in the documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process - Appendix 1.

3.4 A set of agreed objectives will be formulated from this discussion between the member of staff and the line manager. The action points supporting these objectives should be written using the SMARTER criteria (Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Repeated).

3.5 The individual's objectives should reflect those of the Organisation, Directorate and Team. Where improvement is not required objectives may focus upon both maintenance and innovation.

3.6 The personal development review element of performance review focuses upon reviewing an individual's skills, knowledge and experience, and how they are applied in relation to the requirements of their post using the KSF outline. Training and development needs are identified; ways in which these needs can be

addressed are discussed and set out in the form of a Personal Development Plan (PDP).

3.7 Development review is a cyclical process that comprises of four stages:-

- A joint review between the individual and their line manager (or another person acting in that capacity) of the individual's work against the demands of their post, as set out in the KSF outline for that post.

- The formulation of an agreed PDP that identifies the individual's learning and development needs and interests.

- Learning and development by the individual, supported by their manager.

- Evaluation of the learning & development that has occurred and how the individual has applied it in their work.

3.8 Outlines developed for posts within the Trust are available from the Knowledge and Skills Framework link on share-point, (click here). It is only these outlines that should be used in the performance review. These outlines will be reviewed and further developed and are therefore liable to alteration. It is the responsibility of both parties to obtain the relevant and up to date outline as part of the preparation for a performance review. However, in the event of an outline not being available the KSF team within the Vocational Workforce Assessment Centre (VWAC) should be contacted for guidance (see Appendix 2).

3.9 The performance review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. Demonstrable knowledge and skills evident in a person's work will be considered in relation to all the dimensions included in the outline.

3.10 A Personal Development Plan (PDP) is formulated from this performance review. This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post.

3.11 The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

3.12 PDP's need to be completed annually. Line Managers should record completion of a PDP directly on HRPTS (click here for guidance). Alternatively, completed PDP's can be forwarded to the Vocational Workforce Assessment Centre to be recorded centrally. .

3.13 Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to

Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

4.0 Policy Statement

The Trust has an obligation to fully implement the Agenda for Change initiative. The Trust will ensure that there are effective systems in place to support the appraisal process and include ensuring that all supervisors have the appropriate knowledge and skills to completely undertake this role.

5.0 Scope of Policy

This policy applies to all permanent staff and those on a fixed term contract and long term agency staff (6 months) other than Medical, Dental staff, and Directors for which there are separate arrangements.

5.1 It is important to differentiate between supervision and appraisal. Whilst Supervision activities should inform, and are informed by, the KSF PDR process, neither activity should be substituted for the other, as each activity has a different purpose.

6.0 Responsibilities

In the Southern Trust there are key individuals with responsibility for ensuring KSF PDR process is implemented.

6.1 Chief Executive

The Chief Executive has overall responsibility and accountability for the quality of service provision. Appraisal plays an important role in ensuring the delivery of high quality, safe and effective care.

6.2 Directors

All Directors have responsibility for ensuring that arrangements are in place to implement and ensure compliance with this policy and that resources are available to support the process including that supervisors have the appropriate skills and knowledge to undertake appraisal. Directors also have responsibility to complete KSF reviews and PDP's for all those staff they manage.

6.3 Assistant Directors

Assistant Directors have responsibility for coordinating and facilitating implementation of the KSF process. They are responsible for agreeing the models to be employed within their area of responsibility and must ensure that appropriate resources are in place to meet the requirements of this policy. They are responsible for monitoring the level and quality of activity and supporting operational and professional Heads of Services and managers in the implementation of this policy. They also have responsibility to carryout KSF reviews and PDP's for all staff they manage.

6.4 Head of Service / Line Managers

The Head of Service/Line Manager has a responsibility to carryout KSF reviews for all those staff they manage. The Head of Service/Line Manager must also avail of KSF reviews and act as a supervisor for identified staff. S/he is also responsible for ensuring that arrangements are in place for the implementation and local monitoring of KSF activities.

6.5 Supervisors

Supervisors have a responsibility to maintain and develop their own skills and competencies relevant to KSF review in line with this policy. They have a responsibility to participate in and prepare for agreed KSF meetings. It is their responsibility to keep a record of the appraisal meeting and implement agreed action.

6.6 Supervisees

Supervisees have a responsibility to engage fully in the KSF process. They have a responsibility to participate in and where relevant, prepare for the agreed meeting. Where required supervisees should keep a record of appraisal and implement agreed actions.

7.0 Evaluation & Review

Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

8.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

Policy on Professional and Operational Management Interface within the Integrated Care Teams – click here

9.0 Equality & Human Rights Considerations

9.1 This policy 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.

9.2 Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to equality impact assessment.

9.3 Similarly, this policy 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.

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

9.4 Staff must comply with relevant legislation, professional standards and guidance and other DHSSPS publications as follows:-

UK General Data Protection Regulations (UK GDPR) 2018.

10.0 Sources of Advice & Further Information

Further information about the Performance and Personal Development Review Policy can be obtained from the: Vocational Workforce Assessment Centre, St Luke's Hospital, Hill Building, Armagh, BT61 7NQ.

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: _____ **Staff Number:** _____

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☐ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☐ **NO** ☐ **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** **Line Manager's Feedback on staff members performance over past year:**
Objectives for Next Year:	

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Equality, Good Relations and Human Rights – Making A Difference		
	Fire Safety		
	Infection Prevention Control		
	Information Governance Awareness		
	Cyber Security Awareness		
	Moving and Handling		
	Safeguarding People, Children & Vulnerable Adults		
Role Specific Essential Training	Basic ICT		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	MAPA (level 3 or 4)		
	Professional Registration		
	Right Patient, Right Blood (Theory/Competency)		
	Waste Management		
Best practice/ Development (Relevant to current job role)	(eg Coaching)		

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

PLEASE SEND COMPLETED PART B TO:
VWAC, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL: Personal Information redacted by the USI

Appendix 2

Flowchart for completing KSF

Personal Development Review and Plan

	Line Manager	Staff Member
BEFORE MEETING	Read post outline and job description for staff member	Read post outline and job description Reflect on how you have achieved the levels
DURING MEETING	Discuss general performance and progress Evaluate skills against post-outline and job description Agree areas for further development where necessary Discuss career development Complete PART A of form including staff member's comments and line manager's feedback from discussion	
AFTER MEETING	Keep a copy of completed form Set an annual review date (or sooner if actions identified in Part A require on-going meetings)	Keep a copy of completed form Undertake any actions identified in Part A Undertake agreed learning and development activities

FORWARD PART B TO VWAC TEAM

Contacts for KSF (Knowledge & Skills Framework)

Lynn Irwin **Senior HR Manager (Vocational Workforce Development)**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Margretta Chambers **Union Representative KSF Advisor**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Ann McCann **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Gemma Cunningham **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Tara Davison **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Carol McGreevy **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Heather Clyde **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI
Forward PDPs to	Tel: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI

Part A KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title / Pay Band *Head of Cancer Services - Band 8B*

Staff Number Personal Information redacted by the USI

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? Post Outlines can be accessed via Trust Intranet (KSF link) **YES** ☑ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☑ **NO** ☐ **If no, record below what action to be taken:**	**STAFF MEMBERS COMMENTS** **Overview of work progressed and ongoing across my portfolio in the past year is as follows:** **I have been working with Assistant Director –Barry Conway for the last 20 months** **Over the past year I have continued to work to the requirements of the job description for Head of Cancer Services.** **I continue to work with colleagues in specialities to ensure that we strive to meet Cancer Access Targets. This is monitored continuously in order to achieve a high percentage of performance.** **I have worked with my Assistant Director and Clinical Director of Cancer Services in order to establish a cancer Strategic Forum. The first meeting was held November 2019 and one of the actions from this is to progress direct access to CT scans for patients with suspected Lung cancer.** **I have represented the Southern Trust for a large piece of regional work led by Dr Gillian Rankin for Oncology Services Transformation in which we developed several prototypes to include extended working days for both pharmacy and nursing, the introduction of two step model for oncology treatments, and implementation of non- medical prescribers to clinics. There were actions out of this work which I have been able to take forward and progress such as Early workforce bid for Speciality Doctor in Oncology, Advanced Nurse Practitioner in oncology and also admin support. There are ongoing regional Oncology pressures and stabilisation meetings which I attend.** **I manage Acute Oncology Services (AOS) and led the work for Peer review visit in 2018. The nurse led service was commended for the way in which they supported patients who had been admitted with complications following SACT treatment, disease progression or cancer of unknown primary. I had worked up an AOS workforce expansion plan and presented to cancer commissioning for consideration.** **Cancer Peer Review is an ongoing process working with the Quality Surveillance team. I prepared for Cancer Peer of the Systemic Anti- Cancer Treatment (SACT) service which took place November 2019. I work closely with all cancer MDTs to ensure that we are compliant with the standards required for decision**

	making when patients have a confirmed cancer diagnosis. **I continue to manage a caseload of specialist staff and complete their annual appraisals ensuring that they keep up to date with mandatory training and are supported in their professional development.** **I manage the Haematology outpatient service and we have been able to successfully recruit three new Consultants to the team – we are now funded for 5.0WTE Consultants. I have also supported a band 7 Specialist Haematology Nurse to undertake her Advanced Nurse Practitioner Course. We have also appointed various Cancer Clinical Nurse Specialists to teams supported through the five year CNS workforce expansion plan. I have also supported some of the CNSs to undertake and complete their Non Medical Prescribing.** **I have led the implementation of RISOH Regional Information System for Oncology/Haematology. It has been implemented within Oncology and plans are now underway to explore how this can be progressed within Haematology.** **I work in collaboration with other key stakeholders and am a member of the Palliative Care Services Steering and working groups to ensure that pieces of work are progressed so that patients at end of life are managed appropriately to ensure maximum comfort.** **I continue to work with various teams to develop nurse led follow up within specialities in order to free up Consultant slots.** **<u>Challenges over the past 12 months:</u>** - **Emerging nursing workforce challenges in the Mandeville Unit** - **Gaps in key positions due to secondment / sick leave – department manager and service improvement post** - **Concerns about the impact of changes to service provision impacting on the local service. Need to ensure ongoing input and support from the Trust both at senior manager and senior clinician level at regional meetings** - **Funding due to expire for the Cancer Services Improvement post in July 2020. We should take the opportunity to review our service improvement structure at this stage.** - **The absence of a standalone lead nurse for Cancer Services is a pressure. To date I have performed this role alongside my HOS duties. We should continue to monitor this and review in the context of any future structure changes in Acute.**

	Line Manager update: - **Fiona continues to perform her duties to a high standard.** - **If and when structures are being changed in Acute Directorate, I plan to give move support to Fiona specifically in attending high level regional meetings to provide more support to her.**

Objectives for Next Year:

- **Continue to work hard to meet and fulfil the requirements of my job role.**
- **Ensure that Cancer Access targets are met and that performance continues to be high. This will include progressing specific service improvement work through the Strategic Cancer Group to help deliver improvement. This will include the commencement of the Lung direct access to low CT pilot.**
- **Continue to review all of my areas to ensure that areas for service improvement are identified and achieved.**
- **Keep up to date with knowledge and skills and attend mandatory training as necessary. Support nursing colleagues in completing NMC Revalidation.**
- **Continue to monitor and review all of my services for further service improvement and development in order to provide a high standard of quality care to service users**
- **Be involved locally and regionally in the stabilisation of Oncology / Haematology Services. This will include continuing to make the case for services to be delivered close to the patient especially for frail patients including Lung.**
- **Continue to work closely with the workstream leads in the development of a cancer strategy for NI – especially for the Treatment Sub Group and for the Care and Support Sub Group.**
- **Continue to sit on the Right By You Project Steering Group and be involved in the development and implementation of a pilot service seeking to provide additional support for patients and relatives that with a cancer diagnosis**

Reviewee (Staff Member) Name (please print): Fiona Reddick

Signature Fiona Reddick **Date** 25 February 2020

Reviewer (Manager / Supervisor) Name (please print): Barry Conway

Signature Barry Conway **Date** 25 February 2020

Part B ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Section

Staff No Personal Information redacted by the USI **NMC PIN** Personal Information redacted by the USI

Next Professional Revalidation date: September 2020

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	N/A	
	Departmental Induction/Orientation	N/A	
	Fire Safety	10/02/2020	
	Record Keeping/Data Protection	April 2020	
	Moving and Handling	April 2020	
Corporate Mandatory Training ROLE SPECIFIC	Infection Prevention Control	April 2020	
	Safeguarding People, Children & Vulnerable Adults	10/02/2020	
	Waste Management	April 2020	
	Right Patient, Right Blood (Theory/Competency)	Desist	
	Control of Substances Hazardous to Health (COSHH)	10/02/2020	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
Essential for Post	Professional Registration	September 2020	
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)	Basic Life Support	N/A	
	Annual mentorship	N/A	
	Personal Development	2021/21	To be nominated to complete the Scottish Fellowship Coaching and Leadership Improvement Programme
	Professional Development	2020/21	Opportunity to attend appropriate study days or conferences throughout the year to support professional development

Professional supervision dates **1** 18 December 2019 **2**
Undertaken in current year / since last Appraisal

Reviewee (Staff Member) Name (please print): Fiona Reddick

Signature Fiona Reddick **Date** 25 February 2020

Reviewer (Manager / Supervisor) Name (please print): Barry Conway

Signature Barry Conway **Date** 25 February 2020

ONLY COMPLETE THIS SECTION IN YOUR REVALIDATION YEAR

Name of Confirmer: _____ **Date of confirmation** _____

Is your Confirmer a NMC Registrant? YES / *(circle as appropriate)*

REGISTRANT'S LINE MANAGER TO EMAIL COMPLETED PART B FORM TO:

[redacted]
Personal Information redacted by the USI

Update on the concerns identified from the Urology MDT Peer review External Verification - October 2017

EV RAG rating – RED; % compliance 2017: 65%

Serious concerns	**Update May 2018**
1. No cover in place for the clinical oncologist and the consultant radiologist	Clinical Oncology representation (core & cover) – provided through the regional Oncology Centre when possible but is not the same person each time and is still not consistent Consultant radiology representation – no cover for the radiologist though an expression of interest is being developed to recruit an additional radiologist with urology interest/expertise
2. 11% quoracy due to low clinical oncology and radiology attendance	Quoracy has decreased from previous year (25% down to 11%). Only 5 meetings were quorate throughout 2016 and it is perceived that this has decreased even further. Therefore more patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about diagnosis and care. This could lead to delays in the decision making processes and treatment.
3. Long waits for routine referrals	Due to increasing number of referrals, the service is concentrating resource on meeting red flags and urgent demand. Routine referrals waiting times have increased from 52 weeks to 128 weeks (present day). Referrals are triaged by consultants so there is the opportunity for routine referrals to be upgraded.
4. Nephron sparing surgery undertaken locally	This issue was resolved at the time of the external validation as Mr Haynes was providing support to undertake nephron sparing surgery at Belfast City Hospital. The situation has

	now changed as the BT surgeon has left and there is no capacity to provide a centralised service. Currently this is being provided by both the Southern trust and the Western trust.

Other Concerns identified	Update
Out-sourced cancer diagnostics	There has been inaccurate reporting of MRI Prostates. This could place patients at risk as clinicians rely on these reports to inform decision making and counsel patients.
Job plan - MDT Clinical Lead	Dedicated time and support is required for the MDT Clinical Lead to fully undertake the role, including administration support.
Audits	There is a lack of resource to support the implementation of audits to inform quality improvement and service development.

Hughes, NicoleX

From: Reddick, Fiona
Sent: 16 December 2019 13:14
To: Kerr, Vivienne
Cc: Conway, Barry
Subject: Risk Assessment Form urology Peer Review Dec19
Attachments: Risk Assessment Form urology Peer Review Dec19.doc

Hi Vivienne

Please find attached updated risk assessment for urology MDT to replace risk 3728. The other elements for skin and Head and neck came now be closed off

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head Of Cancer Services
Macmillan Building
Southern Health and Social Care Trust (SHSCT)
Personal Information redacted by USI or Personal Information redacted by USI

SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM		**Risk ID No**
Directorate: Acute	**Facility/Department/Team:** Cancer Services	**Date:** **16/12/2019**

Where is this being carried out? *(e.g. Trust premises/home of client/staff/ private nursing home etc)*	**Objective(s):**
Trust	Provide safe, high quality and effective care

Risk Title: *(Threat to achievement of objective)*
Serious concerns highighted following Peer Review visit of Urology MDT

Description of Risk:
(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)
Cover for Oncology and radiology not always there at weekly MDT
Individual attendance at MDT was lower than should be
Quoracy at MDT

Outline the potential for harm: *(Consider injury to client, staff, litigation, etc)*
Inability for fully informed decision making which may result in risk to patients who are on a cancer pathway
I

	Likelihood e.g. Likely	**Consequence/ Impact** e.g. Moderate	**Risk Rating** L and C = RR e.g. Likely and Moderate = AMBER

Summary of current control measures: *(Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive).*
Ongoing discussions with Radiology and Oncology colleagues to ensure maximum attendance at Urology MDT

Assessment of Risk (after control measures in place)	**Likelihood** e.g. Likely	**Consequence/ Impact** e.g. Moderate	**Risk Rating** L and C = RR e.g. Likely and Moderate = AMBER

Are these controls: (a) Effective or
(b) Require Further Action *(if [b], complete Action Plan)*

Please list control measures considered but discounted and why:

ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):				
Action/Treatment	**Action Lead**	**Start Date**	**Target Date**	**Progress**
Date of first review (to be determined by risk rating)				

Predicted Risk Assessment once all control measures are implemented	**Likelihood** e.g. Likely	**Consequence/ Impact** e.g. Moderate	**Risk Rating** L and C =RR e.g. Likely and Moderate = AMBER

ANTICIPATED RESOURCE IMPLICATIONS (details and cost)	**£**

Funding identified?	**Yes**	**No**	**N/A**	**Source of funding**

Action	**Date**	**By Whom (PRINT & SIGN)**
To be managed by Facility/Department Team Manager/Leader		
Referred to Directorate Risk Register	**16.12.2019**	**Fiona Reddick**
Shared with another Team/Directorate Risk Committee for information/consideration		
Referred to Trust Risk Management Forum		
Referred to Corporate Risk Register		

Risk Assessor(s)		
Name (PRINT & SIGN)	Designation	Date
Manager		
Name (PRINT & SIGN)	Designation	Date

MONITORING			
Summary of current position			
Current Risk Rating	**Likelihood**	**Consequence/ Impact**	**Risk Rating**
Name (PRINT & SIGN)	**Designation**	**Date of Review**	
Summary of current position			
Current Risk Rating	**Likelihood**	**Consequence/ Impact**	**Risk Rating**
Name (PRINT & SIGN)	**Designation**	**Date of Review**	
Summary of current position			
Current Risk Rating	**Likelihood**	**Consequence/ Impact**	**Risk Rating**
Name (PRINT & SIGN)	**Designation**	**Date of Review**	