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

Siobhan Hynds
Deputy Director - HR Services
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

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

Chair's Notice

[No 47 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:

Siobhan Hynds
Deputy Director - HR Services
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

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

APPLICATION TO VARY OR REVOKE THE NOTICE

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

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

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

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 47 of 2022]

General

1. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. 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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

Your position(s) within the SHSCT

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

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

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

Policies and Procedures for Handling Concerns

7. Were you aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* published 23 September 2010? If so, when you were aware of concerns, did you implement those Guidelines? If so, please set out in full how you did so on every occasion and with whom you engaged. If not, please explain why not.

8. If you were not aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* what was your understanding of the reporting of concerns relating to other doctors practices? How, if at all, did this understanding inform your response to concerns you were aware of regarding urology services?

9. In your role as Head of Employee Relations / Deputy Director of HR & Organisational Development what, if any, training or guidance did you receive with regard to:

    I. The MHPS framework;
    II. The Trust Guidelines; and
    III. The handling of performance concerns generally.

10. Specifically, what if any training or guidance did you receive with regard to:

I. The conduct of "*preliminary enquiries*" under Section I paragraph 15 of MHPS or the undertaking of an *"initial verification of the issues raised"* under paragraph 2.4 of the Trust Guidelines.
II. Decision making by the Clinical Manager as to whether to adopt an informal approach or initiate a formal investigation.
III. Considerations of imposition of Immediate Exclusion or restrictions under Section I paragraphs 18-27 of MHPS.
IV. The conduct of Formal Investigations under Section 1 paragraphs 28-38 of MHPS

11. Outline how you understood the role of HR Manager was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Clinical Manager;
II. Case Manager;
III. Case Investigator;
IV. Medical Director;
V. Service Director;
VI. HR Director;
VII. Chief Executive;
VIII. Designated Board member;
IX. The clinician who is the subject of the investigation; and
X. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or bodies.

Handling of Concerns relating to Mr. O'Brien

12. In respect of concerns raised regarding Mr. Aidan O'Brien:

I. When did you first become aware that there were concerns in relation to the performance of Mr. O'Brien?
II. If different, also state when you became aware that there would be an

investigation into matters concerning the performance of Mr O'Brien?

III. Who communicated these matters to you and in what terms?

IV. Upon receiving this information what action did you take?

13. Outline the circumstances and the process by which you understand concerns in relation to Mr. O'Brien came to be discussed by the Oversight Group on 13th September 2016 and address the following:

    I. From what source did the concerns and information discussed at that meeting emanate?
    II. What do you understand to have been decided at that meeting?
    III. What if any action did you take on foot of same?
    IV. If no action was taken, please explain why and refer to all relevant correspondence.

14. Outline when and in what circumstances you became aware of the following Serious Adverse Incident investigations and that they raised concerns about Mr O'Brien, and outline what action you took upon becoming aware of those concerns:

    I. Patient "Patient 10" (Personal Information redacted by the USI),
    II. The care of five patients (Personal Information redacted by the USI); and
    III. Patient "Patient 16" (Personal Information redacted by the USI

15. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 22 December 2016 and address the following:

    I. What information was before the Oversight Group on that date, and from what source did the information discussed at that meeting emanate?
    II. What do you understand to have been decided at that meeting, and what action was to take place following that meeting?
    III. What steps did you take as Medical Director to ensure that those actions took place?

16. When, and in what circumstances, did you first became aware of concerns, or

receive any information which could have given rise to a concern that Mr. O'Brien may have been affording advantageous scheduling to private patients.

17. Outline all the steps you undertook from December 2016 to January 2017 as part of the *"further scoping"* of concerns as referred to in Dr Wright's letter dated 30 March 2017, see copy attached, in relation to the following four areas:

    I. Un-triaged referrals to Mr. Aidan O'Brien;
    II. Patient notes tracked out to Mr. Aidan O'Brien;
    III. Undictated patient outcomes from outpatient clinics by Mr. Aidan O'Brien; and
    IV. The scheduling of private patients by Mr. Aidan O'Brien.

18. What steps did you take, in conjunction with Mr. Weir, to prepare a preliminary report for consideration by the Case Manager and Case Conference on 26th January 2017? What action did you take to assess the substance or accuracy of the concerns, whether to verify or refute them?

19. With reference to specific provisions of Section I of the MHPS and the Trust Guidelines, outline all steps taken by you once a decision had been made to conduct an investigation into Mr. Aidan O'Brien's practice in line with that Framework and guidelines. Outline any engagement with Mr. O'Brien, the designated Board member, Case Manager and Case Investigator and any other relevant individuals.

20. What role or input, if any, did you have in relation to the formulation of the Terms of Reference for the formal investigation to be conducted under the MHPS Framework and Trust Guidelines in relation to Mr. O'Brien? Outline all steps you took, information you considered and advice you received when finalising those Terms. Describe the various iterations or drafts of the Terms of Reference and the reasons for any amendments, and indicate when and in what manner these were communicated to Mr O'Brien.

21. With regard to the Return to Work Plan / Monitoring Arrangements dated 9th February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr O'Brien's compliance with the Return to Work Plan and provide copies of all documentation showing the discharge of those roles with regard

to each of the four concerns identified, namely:

I. Un-triaged referrals to Mr. Aidan O'Brien;
II. Patient notes tracked out to Mr. Aidan O'Brien;
III. Undictated patient outcomes from outpatient clinics by Mr. Aidan O'Brien; and
IV. The scheduling of private patients by Mr. Aidan O'Brien.

22. What is your understanding of the period of time during which this Return to Work Plan/Monitoring Arrangements remained in operation, and which person(s) were responsible for overseeing its operation in ay respect?

23. With specific reference to each of the concerns listed at (20) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

24. Section I paragraph 37 of MHPS sets out a series of timescales for the completion of investigations by the Case Investigator and comments from the Practitioner. From your perspective as HR manager, what is your understanding of the factors which contributed to any delays with regard to the following:

I. The conduct of the investigation;
II. The preparation of the investigation report;
III. The provision of comments by Mr. O'Brien; and
IV. The making of the determination by the Case Manager.

Outline what actions, if any, you took to ensure that momentum was maintained during the process, as required by Section I paragraph 8 of MHPS and paragraph 2.10 of the Trust Guidelines. Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

A. Case Investigator;
B. Case Manager;
C. the designated Board member;

D. Mr. Aidan O'Brien; and
E. Any other relevant person under the MHPS framework and the Trust Guidelines.

25. Outline what steps, if any, you took during the MHPS investigation, and outline the extent to which you were kept appraised of developments during the MHPS investigation?

MHPS Determination

26. Outline the content of all discussions you had with Dr Ahmed Khan, regarding his Determination under Section I paragraph 38 of MHPS.

27. On 28 September 2018, Dr Ahmed Khan, as Case Manager, made his Determination with regard to the investigation into Mr. O'Brien. This Determination, inter alia, stated that the following actions take place:

I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr. O'Brien to provide assurance with monitoring provided by the Clinical Director;
II. That Mr. O'Brien's failing be put to a conduct panel hearing; and
III. That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.

With specific reference to each of the determinations listed at (I) – (III) above address:

A. Who was responsible for the implementation of each of these actions?
B. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and
C. If applicable, what factors prevented that implementation.

D. If the Action Plan as per 27(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

Implementation and Effectiveness of MHPS

28. Having regard to your experience as Head of Employee Relations / Deputy Director of HR & Organisational Development, in relation to the investigation into the performance of Mr. Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr. O'Brien?

29. Consider and outline the extent to which you feel you can effectively discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

30. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the problems which were found to have existed in connection with the practice of Mr. O'Brien.

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 47 of 2022
Date of Notice: 29 April 2022

Note: An addendum with amendments to this statement was received by the Inquiry on 16 March 2023 and can be found at WIT-91921 to WIT-91923. Annotated by the Urology Services Inquiry.

Witness Statement of: Siobhan Hynds

I, Siobhan Hynds, will say as follows:-

SCHEDULE [No 47 of 2022]

I. Having regard to the Terms of Reference of the Urology Services Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of sub-paragraph (e) of those Terms of Reference concerning, inter alia, 'Maintaining High Professional Standards in the Modern HPSS' ('MHPS Framework') and the Trust's investigation. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order using the form provided.

1.1 I was on a period of annual leave from 24 December 2016 to 9 January 2017. When I went on leave on 24 December 2016, I was unaware of any concerns in respect of Mr Aidan O'Brien, Consultant Urologist.

1.2 I was made aware of concerns regarding Mr O'Brien on 28 December 2016 via a phone call from the Director of Human Resources & Organisational Development (HROD), Mrs Vivienne Toal. Mrs Toal was also on a period of annual leave over the Christmas period. I don't recall the detail of the conversation. However, from e-mail correspondence from Mrs Toal to Ms Lynne Hainey on 28

December 2016 which was copied to me, my understanding is that Mrs Toal had contacted me to discuss urgent HR support for a meeting that was planned on 30 December 2016 with Mr O'Brien and the then Medical Director, Dr Richard Wright. Mrs Toal had e-mailed initial details of the concerns to Ms Hainey on 28 December, including a note of an Oversight meeting held on 22 December 2016 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/ 20161228 Email from Lynne Hainey to Vivienne Toal re request to meet with AOB to exclude and 20161228 Email from Simon Gibson to Lynne Hainey re meeting with AOB to exclude _attachment).*** The e-mails outlined information regarding previous discussions on the concerns and information regarding key roles as part of the MHPS process. Within this correspondence it was confirmed that a decision had been made by Dr Richard Wright, Medical Director to exclude Mr O'Brien pending investigation of the issues.

1.3 Ms Lynne Hainey, HR Manager was covering the Employee Relations team over the Christmas period and it was agreed by Mrs Toal and I, that Ms Hainey would attend the meeting to support Dr Wright.

1.4 During the course of 28 December 2016, I was included in a series of e-mails regarding the meeting on 30 December. It was as part of the e-mail from Mrs Toal to Ms Hainey on 28 December 2016 and the Action note of the 22 December 2016 meeting sent to me by Ms Hainey on the 28 December, that I first became aware of the nature of the concerns including, that the issue of the SAI related to a patient and a potential second patient, and that there had been previous discussions regarding the management of the concerns. At this point I was not aware of the identity of either patient. ***(located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/no 77 – Simon Gibson/ 20161228 - Email - FW Investigation – AOBrien).***

1.5 From e-mail correspondence, I am aware that Ms Hainey e-mailed me on 28 December, regarding a matter related to a concern about Mr O'Brien's scheduling of a private patient. I can see from e-mail correspondence that I responded to her on 3 January 2017 to ask if she had included private patients as an issue of concern at the meeting on 30 December. Ms Hainey advised that she

had not as it had not been agreed at the Oversight discussion on 22 December 2016 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170103 - Email - Re Management of PP's - non chronological listing)***

1.6 Ms Hainey was sent a number of pieces of correspondence on 28 December 2016 by Mr Simon Gibson, Assistant Director, Medical Director's Office which included a draft terms of reference for the investigation and a letter dated 23 March 2016 which outlined a previous attempt at addressing the concerns with Mr O'Brien. Ms Hainey shared this correspondence with me via email on 28 December 2016 at 4:09PM and noted the content of the letter dated 23 March – she commented *'I will have a look at the letter and the Terms of Reference but note the letter (4th attachment) dating back to March 2016'.*

1.7 I don't specifically recall what I thought about the significance of 23 March 2016 letter at that time other that it highlighted that concerns had been on-going from at least March 2016.

1.8 I can also see from e-mail correspondence Ms Hainey sent to me on 28 December 2016, that she had a concern about the agenda for the meeting that had been issued to Mr O'Brien, as the agenda made no specific reference to the matter of exclusion. I don't recall any discussion about it at the time and I am unable to see from correspondence if the agenda was altered prior to the meeting.

1.9 Between 28 December 2016 and my return on 10 January 2017, I had no specific role under the MHPS process. My involvement was support to Ms Hainey as her line manager as she attended the meeting on 30 December 2016. Generally, management of concerns about doctors and dentists would have been managed by the Medical HR Team led by Mrs Zoe Parks, Head of Medical HR however at this time Mrs Parks was on a period of maternity leave and therefore the Employee Relations team was involved to support these cases.

1.10 Ms Hainey confirmed via e-mail to Mrs Toal and me on 30 December 2016 at 12:06PM, that she had attended the meeting on 30 December and advised

that she would type a note of the meeting for Dr Wright to share with Mr O'Brien. I understand Ms Hainey shared this note with Dr Wright to be issued to Mr O'Brien (**located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170103 - Email - Re Management of PP's - non chronological listing)**

1.11 At the meeting on 30 December 2016, Mr O'Brien was requested to return all Trust patient files held at his home to Mrs Martina Corrigan by 3rd January 2017.

1.12 On 5 January 2017, Mr O'Brien attended an Occupational Health appointment regarding his fitness for work as he had been on a period of sick leave Personal Information redacted by USI .

1.13 On 6 January 2017, Mrs Toal e-mailed me at 1:52PM to advise that we needed to discuss on-going HR support for the MHPS process and asked if we could discuss on Monday 9 January 2017 on my return from leave ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170103 - Email - Re Management of PP's - non chronological listing).***

1.14 On 10 January 2017, Ms Hainey e-mailed me at 12:39PM to advise that the Head of Occupational Health advised that Mr O'Brien was unfit for work ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/ 20170110 - Email - Fw query).***

1.15 On my return to work, I attended a pre-arranged oversight meeting on 10 January 2017 at 1pm. The Oversight members present were, Dr Richard Wright, Medical Director (Chair), Mrs Vivienne Toal, Director of HROD, and Mrs Esther Gishkori, Director of Acute Services. Also in attendance was myself, Mr Simon Gibson, Assistant Director, Medical Director's Office, Mr Ronan Carroll, Assistant Director, Acute Services and Ms Tracey Boyce, Director of Pharmacy, Acute Governance Lead. This was the first meeting I had attended in respect of the concerns regarding Mr O'Brien and it was at this meeting that I became of the detail and the extent to which the concerns had already been assessed. At the

meeting it was agreed that I would undertake the role of providing HR support to the MHPS process and specifically to Mr Colin Weir who had been appointed as Case Investigator for the formal MHPS investigation. The concerns discussed at the meeting were in respect of Mr O'Brien's administrative practices and the impact of the practice on patients. There were 3 main concerns discussed which were in respect of untriaged referrals, notes being kept at home and undictated outcomes. Mr Ronan Carroll raised a fourth concern for discussion which was in related to the scheduling of Mr O'Brien's private patients.

1.16 A 'terms of reference' (TOR) for the investigation, had been drafted by Mr Simon Gibson prior to the meeting of 30 December. These draft TOR were discussed at the meeting on 10 January 2017. Following the 10 January meeting, I was asked to amend the TOR to reflect the issues discussed and to circulate them to the Oversight Committee for approval. Once approved they were to be shared with the case manager and case investigator. I have provided a detailed account of my involvement in the drafting of the TOR in response to question 20 below.

1.17 Mr Colin Weir e-mailed me, Dr Ahmed Khan and Mr Ronan Carroll on 17 January 2017 to advise that he had been telephoned by Mr O'Brien on the evening of 16 January 2017 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170117 - Email - A O'B)***. Mr Weir advised that Mr O'Brien had raised issues regarding the process and sought clarity on the initial 4-week exclusion and the name of the designated Board member assigned to the case. I was aware that Mr O'Brien should have been advised of some of the information he was seeking from the initial note of the meeting of 30 December 2016 so I sought to clarify from Ms Hainey if the note had been issued to Mr O'Brien. Separately I also advised Mr Weir that I would draft the necessary correspondence to Mr O'Brien that evening as I was in meetings during the workday.

1.18 In an e-mail dated 18 January 2017, Ms Hainey confirmed that the note of the meeting had not yet been issued but that a letter had been sent to Mr O'Brien on 6 January 2017 from Dr Wright setting out information in respect of the 4-week immediate exclusion and the name of the case manager and case investigator.

The name of the designated Board member was not included in this correspondence. I asked Ms Hainey to issue the note of the meeting when approved by Dr Wright. I received a copy of the final version of the notes issued to Mr O'Brien from Mr Gibson via e-mail on 19 January 2017 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170118 - Email - FW NOTES FOR MR O'BRIEN & 20170118 - Email - FW NOTES FOR MR O'BRIEN 1).***

1.19 I updated the draft terms of reference in light of the discussions at the meeting on 10 January 2017 and shared these with the Oversight Committee for their approval on 18 January 2017.

1.20 At the same time, plans were on-going for an initial meeting with Mr O'Brien and a follow up case conference meeting within the 4 week timescale in order to determine the next steps following the period of immediate exclusion.

1.21 On 19 January 2017 Mr Gibson provided comments and additions to the drafted Terms of Reference for approval by the Oversight Committee. Dr Wright confirmed his agreement to the revisions by Mr Gibson and asked for the terms of reference to be shared with the case manager and case investigator.

1.22 On 19 January 2017, I also attended a meeting with Dr A Khan, Case Manager and Mr C Weir, Case Investigator to discuss plans for meeting with Mr O'Brien and to ensure our timescales were compliant with the requirements under the MHPS Framework in respect of immediate exclusion. Telephone contact was made on the same day with Mr O'Brien to request his attendance at a meeting with the case investigator on 24 January 2017. This was followed up in writing to Mr O'Brien on 20 January 2017. Under MHPS, it was a requirement to have met with Mr O'Brien to enable him to state his case in respect of the concerns raised and to allow him the opportunity to propose alternatives to formal exclusion. Under MHPS timescales decisions in respect of immediate exclusion and formal exclusion were required no later than 27 January 2017. In order to meet these timescales a case conference meeting was also established for 26 January 2017.

1.23 Mr O'Brien confirmed his attendance at the meeting on 24 January via e-mail correspondence to Mr Weir and I on 22 January 2017. Within this correspondence, Mr O'Brien also confirmed that he would be accompanied to the meeting by his son, Mr Michael O'Brien ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/ 20170122 - Email - Fwd Strictly Private – Confidential).***

1.24 A further letter was issued to Mr O'Brien from Mr Weir dated 23 January 2017 seeking information from Mr O'Brien about the whereabouts of 13 missing sets of patients notes. The letter requested Mr O'Brien's assistance in locating the notes. The 13 sets of notes were tracked out to Mr O'Brien and could not be located.

1.25 On 24 January 2017 Mr Weir and I met with Mr O'Brien and his son Personal information redacted by USI in Trust Headquarters, Craigavon Area Hospital. Mr O'Brien was given an opportunity to hear the detail of the concerns and to provide a response to the concerns. Mr O'Brien was also given the opportunity to propose alternatives to formal exclusion and a full note of the meeting was documented.

1.26 On 24 January 2017 Mr O'Brien provided a detailed response on the matters of the 13 sets of patient notes that were missing. It was evident from his response that some of the 13 sets of notes were for patients that had never been under his care. Others were very many years missing. Mr O'Brien's response to the matter of the 13 sets of notes was shared with Mr Ronan Carroll from the Acute Services operational team for further exploration ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170124 - Attachment - scan0001).***

1.27 On 25 January 2017, Mrs Ester Giskhori, Director of Acute Services and member of the Oversight Committee advised that she was not available to attend the case conference meeting on 26 January due to annual leave. She requested Mrs Anne McVey, Assistant Director of Acute Services attend the meeting in her place. She also advised that she had received a copy of Mr O'Brien's response to the SAI for patient Patient 10 and asked Mrs McVey to bring this to the Oversight meeting.

Mrs Toal, member of the Oversight Committee, asked for the response to the SAI be held separately from the case conference as it was not part of the MHPS process or the concerns put to Mr O'Brien as part of the initial meeting under MHPS. The SAI was a separate process which was due to report but had not concluded at the time of the case conference.

1.28 On 26 January 2017 the report for the case conference was shared with the members of the Oversight Committee and Dr Ahmed Khan as Case Manager for discussion at the planned meeting later that day.

1.29 The case conference report was presented to Dr Khan and the oversight members on 26 January 2017. I have provided a detailed account of my involvement in matters related to the case conference report in my response to question 18 below.

1.30 Following discussion at the meeting it was determined that formal exclusion was not required and that Mr O'Brien should return to work with a plan in place for supervision and monitoring of his administrative practices while the investigation proceeded. It was agreed at the meeting that Dr Khan as case manager would telephone Mr O'Brien to advise him of this decision. Dr Khan made a telephone call to Mr O'Brien on the afternoon of 26 January 2017 to notify him of the decision.

1.31 Mr O'Brien at that time remained unfit for work and it was agreed that a meeting would take place between him and Dr Khan to discuss the supervision / monitoring plan when he was fit to return to work.

1.32 A meeting was initially planned for Monday 3 February 2017 with Dr Khan and Mr O'Brien to discuss the detail of his return to work plan. The details of the monitoring arrangements were required from the acute services operational team and it was not possible to finalise these details by 3 February. Mr O'Brien was notified of this via e-mail on 31 January 2017 and arrangements were put in place to meet at a later date.

1.33 On 6 February 2017 I sent a number of correspondences:

1.34 I sent a letter to Mr O'Brien on behalf of Dr Khan on 6 February 2017 to invite him to attend a meeting on 9 February 2017 in Daisy Hill Hospital to discuss the monitoring plan for his return to work ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 7720170206 - Email - Letter from Case Manager to Mr A O'B 06 February 2017).*** I also sent Mr O'Brien a second e-mail enclosing the note of the meeting of 24 January 2017 for his information and comment. I copied both correspondences to Mr John Wilkinson, designated Board member and provided an e-mail update in respect of the MHPS case ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 7720170206 - Email - STRICTLY PRIVATE AND CONFIDENTIAL).***

1.35 On 7 February 2017 I e-mailed Ronan Carroll and Ester Gishkori in respect of the detail of the monitoring return to work plan for Mr O'Brien to get agreement on the content ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 7720170207 - Email - RE Return to Work Action Plan February 2017)*** Mrs Martina Corrigan also contributed to the monitoring plan. I also e-mailed with Mr Weir, Dr Khan and the members of the Oversight Committee to get agreement on a draft of the Terms of Reference for the investigation. It was necessary to have both documents agreed and finalised for the planned meeting with Mr O'Brien on 9 February 2017.

1.36 The return to work plan was finalised and agreed on 9 February in advance of the meeting with Mr O'Brien. I also liaised with the Trust's Occupational Health service via telephone to understand Mr O'Brien's fitness for work following his attendance for review on the same day. I have provided a detailed account of my involvement in matters related to the return to work plan in my response to question 21 below.

1.37 As at 9 February 2017, Mr O'Brien was assessed as unfit for work. It was anticipated that he would be fit to return to work within 10 days on a phased return to work which was to be 50% of his contracted hours in the first week and 75% of

his contracted hours in the second week. It was also recommended that Mr O'Brien did not operate during his phased return to work. Occupational Health advised that Mr O'Brien would be fit for his full range of duties following the phased return period.

1.38 On 7 February 2017, Mr O'Brien attended a meeting with Mr John Wilkinson to discuss a number of concerns he had about the investigation process. In response to this meeting, I arranged for Mr Wilkinson to receive legal advice from the Trust's legal advisors on the issues raised and the role of the designated Board member. I also co-ordinated a call with the Trust's legal advisors and the Oversight members regarding the investigation process.

1.39 Mr O'Brien returned to work on a phased basis with effect from 20 February 2022.

1.40 On 21 February 2017 Dr Wright advised Dr Khan that following advice he had received a decision had been taken by the Oversight members to replace Mr Colin Weir as Case Investigator. Dr Wright had asked Dr Neta Chada to undertake the role of Case Investigator and alerted Dr Khan as Case Manager to that decision.

1.41 On 22 February 2017 Mr O'Brien contacted me via e-mail to request a copy of the Policies and Procedures referred to as part of the return to work action plan. I shared this request with Mr Carroll as the return to work action plan had been developed and agreed by him. Mr Carroll replied to me with the documents as referred and I shared this onwards with Mr O'Brien ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 7720170222 - Email - FW Trust Policies and Procedures)***

1.42 Dr Ahmed Khan issued a letter to Mr O'Brien dated 24 February 2017 to address the concerns raised with Mr Wilkinson about the process of the MHPS investigation. I drafted this letter for Dr Khan's review and agreement ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no***

7720170224 - Email - RE Letter from Case Manager to Mr A O'B 24 February 2017 1

1.43 I sent Dr Chada an e-mail on 3 March 2017 to provide her with the relevant correspondence and notes of discussion during January and February 2017 regarding the MHPS investigation process. I advised Dr Chada to make contact with Mr O'Brien to introduce herself as case investigator. I also requested an update from Mrs Corrigan and Mr Carroll in respect of the look back review that was being carried out by Mr O'Brien's Consultant colleagues. At that point, Mrs Corrigan gave me a brief e-mail update as to what had been gathered at that date however specific details in respect of individual patients and the impact on their care was not yet available ***(located at S21 47 of 2022 Attachments 1. RE Investigation)***

1.44 An e-mail on 3 March 2017 from Ronan Carroll to me was the first notification to me that a second patient Patient 13 had been identified for an SAI process ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170303 - Email - RE Investigation).***

1.45 On 6 March 2017 I contacted Martina Corrigan to arrange a meeting with her under the formal MHPS investigation process to take a witness statement from her. Mrs Corrigan had been the operational head of service managing Mr O'Brien during 2016 and 2017 and I felt it was important that we gathered information from her at the outset of the investigation as this would assist in helping determine who else was needed as a witness in the process.

1.46 On 6 March 2017 I also e-mailed Dr Chada to ask her to e-mail an update to Mr O'Brien regarding the investigation and specifically the initial witnesses we intended to meet with. Mr O'Brien was advised that we would be initially meeting with Mrs Corrigan, Mr Carroll, Mr Young and Mrs Graham. The e-mail also advised Mr O'Brien that a full witness list would be provided as witnesses were identified. Separately on the same day, I shared the same witness information with Dr Khan as Case Manager for on-ward sharing with Mr O'Brien ***(located at Relevant to***

HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170306 - Email - Witness List).

1.47 On 15 March 2017 I sent an e-mail to Dr Khan with a final draft terms of reference for his consideration, agreement and on-ward sharing with Mr O'Brien if he was content with the information as presented. I also attached an update witness list for sharing with Mr O'Brien which included Mr Weir and Mr Eamon Mackle as additional witnesses at that time. I advised Dr Khan that the meetings with witnesses were commencing and that the terms of reference and witness list needed to be shared with Mr O'Brien as a requirement under MHPS ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170315 - Email - Terms of Reference for Investigation FINAL)***

1.48 On 15 March 2017, Dr Chada and I met with Mrs Martina Corrigan as the first witness in the investigation process and then with Mr Michael Young on 23 March 2017.

1.49 On 16 March 2017, I emailed Mr O'Brien a copy of the terms of reference for the formal investigation, which had been agreed and I also shared a copy of an initial witness list, at the request of Dr Khan ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170316 - Email - Strictly Private and Confidential).***

1.50 During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

Name	Job Title	Date
Mrs Martina Corrigan	Head of Service	15 March 2017
Mr Michael Young	Consultant Urologist	23 March 2017
Mrs Claire Graham	Head of Information Governance	03 April 2017
Mr Ronan Carroll	Assistant Director	06 April 2017
Mr Eamon Mackle	Consultant Surgeon	24 April 2017
Mr Anthony Glackin	Consultant Urologist	3 May 2017
Ms Anita Carroll	Assistant Director	19 May 2017

Mr Colin Weir	Clinical Director	24 May 2017
Mr Mark Haynes	Consultant Urologist	24 May 2017
Ms Noeleen Elliott	Personal Secretary	24 May 2017
Mrs Helen Forde	Head of Health Records	05 June 2017
Mrs Heather Trouton	Assistant Director	05 June 2017
Mrs Katherine Robinson	Referral & Booking Centre Manager	05 June 2017

1.51 I have included in the following paragraphs for ease of reference, the detailed timeline as set out in the formal case investigation report for ease of reference.

1.52 On 14 June 2017 Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170614 - Email - STRICTLY PRIVATE AND CONFIDENTIAL - TO BE OPENED BY ADDRESSEE ONLY & 20170614 - Attachment - Letter to A O'Brien from Case Investigator 12 June 2017)***

1.53 On 19 June 2017 Mr O'Brien requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Mr O'Brien requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

1.54 On 05 July 2017, Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170705 - Email - RE Meeting on 31 July 2017 1).***

1.55 On 03 August 2017 a first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern. Mr O'Brien was in attendance, accompanied by his son Michael O'Brien. Dr Chada and I were also in attendance. At the meeting on 3 August 2017 it was agreed that a response

would not be taken in respect of the term of reference number 4 in respect of private patients until patient information requested by Mr O'Brien had been furnished to him. It was agreed that a further meeting date would be arranged for this purpose once all information had been provided. Mr O'Brien's responses to the remaining terms of reference were gathered.

1.56 On 16 October 2017, a meeting date for the second investigation meeting was agreed for 06 November 2017. A second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of the term of reference 4. Mr O'Brien was in attendance, accompanied by his son Michael O'Brien. Dr Chada and I were also in attendance. At the meeting of 6 November 2017, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

1.57 By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore I e-mailed Mr O'Brien to query this with Mr O'Brien and sought an update.

1.58 By the 22 February 2018, no response was received and a further email reminder was sent to Mr O'Brien on 22 February 2018. On the same day, Mr O'Brien responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the 6 November meeting and indicated he would provide commentary on all documents by 31 March 2018. In view of the timeframe to date, Mr O'Brien was asked to provide comments by 9 March 2018 rather than 31 March 2018 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180223 - Email - RE MHPS Process)***

1.59 By 16 March 2018 Mr O'Brien had not responded and a further reminder was sent to Mr O'Brien requesting his comments no later than 26 March 2018. It

was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

1.60 No comments were received from Mr O'Brien on 26 March 2018.

1.61 On 29 March 2018 a final opportunity was provided to Mr O'Brien to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180329 - Email - RE MHPS Process)***

1.62 By 30 March 2018, no comments had been received from Mr O'Brien.

1.63 On 2 April 2018, Mr O'Brien returned comments on the statements from the meetings of 3 August and 6 November. Mr O'Brien also queried requested amendments to notes of meetings on 30 December 2016 and 24 January 2017 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180402 - Email – Investigation)***

1.64 Points 1.50 to 1.63 above provide an overview of the key dates during the course of the investigation.

1.65 The formal investigated concluded on 21 June 2018 when the case manager, Dr Chada provided the investigation report to Dr Khan.

1.66 Dr Khan was on an extended period of annual leave and was therefore unable to review the report until the start of August 2018.

1.67 On 1 October, Dr Khan and I met with Mr O'Brien to share with him the details of the case manager's determination. I have provided a detailed account of my involvement in matters related to the case manager's determination in my response to question 26 below.

2. Provide any and all documents within your custody or under your control relating to paragraph (e) of the Terms of Reference except where those documents have been previously provided to the Inquiry by the SHSCT. 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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

2.1 To the best of my knowledge, all documents within my custody and control relating to paragraph (e) of the Terms of Reference have been provided to the Inquiry previously or are currently attached.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. When answering the questions set out below you will need to equip yourself with a copy of *Maintaining High Professional Standards in the Modern HPSS' framework ('MHPS')* and the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' ('Trust Guidelines').*

3.1 I believe I have answered all questions.

Your position(s) within the SHSCT

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

4.1 I commenced employment with Newry and Mourne Health and Social Services Trust on 20 June 1997. This Trust, under the Review of Public Administration in 2007, was one of 4 Trusts in Northern Ireland merged to form the Southern Health and Social Care Trust. I have remained in employment with the Trust and its successor from 20 June 1997 to date without break.

4.2 Prior to my employment with the Trust, I obtained:

a. 9 GCSEs Grade A-C in 1991/92
b. 3 A Levels Grade A-C in 1993
c. BA (Hons) Business Studies with Diploma in Industrial Studies (2:1) in June 1997

4.3 During my employment with Newry and Mourne HSS Trust, I obtained:

a. Post Graduate Diploma in Human Resource Management 1999 - 2001, pass with commendation.
b. Graduate Membership of the Chartered Institute of Personnel and Development (CIPD) 2001
c. Chartered Membership of the Chartered Institute of Personnel and Development (CIPD) 2007

4.4 Other qualifications:

a. RSA Stage 3 Part 1 Word-Processing June 1999
b. ECDL (European Computer Driving Licence)

4.5 My occupational history prior to commencing employment with the Southern HSC Trust is as follows:

Dates of Employment	Post Held
Approx. 1990 to 1995	Retail Assistant (part-time during school)
June 1995 to June 1996	Administrative Assistant, North Eastern University, Boston, USA (Industrial Placement)
Approx. 1996 to 1997	Retail Assistant (part-time during university)
20 June 1997 – 19 July 1998	Clerical Officer Grade 2 – Personnel

09 June 1997 – 19 September 1997	Clerical Officer Ivybrook Social Services/ Personnel
20 July 1998 – 02 July 2000	Personnel Assistant Grade 3
03 July 2000 – 16 January 2003	Personnel Officer Grade 5
17 January 2003 – 31 January 2008	Human Resource Officer (Senior Manager 2)

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

5.1 My employment history with the Southern HSC Trust:

Dates of Employment	**Post Held**
01 February 2008 – 22 May 2011	Human Resources Manager Band 7
23 May 2011 – 13 September 2015	Employee Relations Manager Band 8A
14 September 2015 – 29 November 2015	HR Assistant Director for OPPC Band 8B (Acting)
30 November 2015 – 31 January 2016	Employee Relations Manager Band 8A
01 February 2016 – 31 December 2018	Head of Employee Relations Band 8A
01 January 2019 – Present	Deputy Director HR Services Band 8C

5.2 The duties and responsibilities of each post include:

Human Resources Manager Band 7 ***(located at S21 47 of 2022 Attachments 2. Human Resources Manager Band 7)***

01 February 2008 – 22 May 2011

5.3 The main duties and responsibilities as set out in the job description for this role were to assist the Head of Employee Engagement and Relations in the provision and ongoing development of a positive employee relations climate and to provide specialist HR advice on a range of Employee Relations (ER) issues, including disciplinary and grievance matters, attendance management, capability issues, bullying and harassment allegations. I was also responsible for ensuring

that systems and processes were in place to ensure ER issues such as Tribunal proceedings, redeployments, probationary and preceptorship periods were effectively discharged. The role also required management of a team of ER case management staff and attendance management staff.

5.4 The job description is an accurate reflection of the role.

Employee Relations Manager Band 8A *(located at S21 47 of 2022 Attachments 3. Employee Relations Manager Band 8A)*
23 May 2011 – 13 September 2015

5.5 The main duties and responsibilities of this role were as per the HR Manager Band 7 job description described above and were extended to assume in addition to the above, responsibility for the central ER team. This included responsibility for ensuring systems and processes were in place for pay processing, operational implementation of organisational change initiatives including redeployments, management of contracts of employment, advice on terms and conditions of service and leading the job matching and job evaluation processes. Line management responsibility extended to managing the ER case and attendance teams along with the pay and conditions processing and advisory teams.

5.6 The job description is an accurate reflection of the role.

HR Assistant Director for OPPC Band 8B (Acting) (located at S21 47 of 2022 Attachments 4. HR Assistant Director for OPPC Band 8B (Acting))
14 September 2015 – 29 November 2015

5.7 The duties and responsibilities of this role were to take a lead with senior managers within OPPC on strategic development, organisational design and change management for the service and to deliver on the directorate's workforce plan and modernisation plan and to work closely with managers in the directorate to deliver high quality people management practices.

5.8 The job description is an accurate reflection of the role.

Employee Relations Manager Band 8A *(located at S21 47 of 2022 Attachments 3. Employee Relations Manager Band 8A)*
30 November 2015 – 31 January 2016

5.9 The main duties and responsibilities of this role were as per the HR Manager Band 7 job description described above and were extended to assume in addition to the above, responsibility for the central ER team. This included responsibility for ensuring systems and processes were in place for pay processing, operational implementation of organisational change initiatives including redeployments, management of contracts of employment, advice on terms and conditions of service and leading the job matching and job evaluation processes. Line management responsibility extended to managing the ER case and attendance teams along with the pay and conditions processing and advisory teams.

5.10 The job description is an accurate reflection of the role.

Head of Employee Relations Band 8A *(located at S21 47 of 2022 Attachments 5. Head of Employee Relations Band 8A)*
01 February 2016 – 31 December 2018

5.11 When I took over the role of Head of Employee Relations in February 2016, I did not receive an updated job description. As I was the same band working in the ER service, when the structure in HROD changed at that time, I assumed full duties of and responsibility for the ER service reporting directly to the Director of HROD. The role of Head of Employee Engagement and Relations was held by Mrs Vivienne Toal up until 31 January 2016. The role was a Band 8b and had responsibility for employee engagement. The employee engagement duties moved with Vivienne Toal when she took over the role of Head of Organisational Development. I assumed the role of Head of Employee Relations on 1 February

2016 at Band 8a. I reported directly to the Director of Human Resources & Organisational Development in this role.

5.12 My duties and responsibilities were that as described for the ER Manager role and I held in addition, responsibility for leading the delivery of the ER service, ensuring the development and implementation of policies and procedures that would maximise the contribution of staff towards the aims and objectives of the Trust. I was responsible for taking a lead role in developing and promoting a culture that would promote the health and well-being of staff and for developing structures and processes that would allow for direct employee participation in decision-making along with developing genuine partnership with staff side organisations. I worked as part of the corporate HR team, to contribute to the development of a full range of Human Resource initiatives and achievement of performance objectives.

5.13 I have attached the Head of Employee Engagement and Relations job description that was in place from the instigation of the Southern HSC Trust in 2007 and also the updated Head of Employee Relations job description in 2019 when I vacated the role. Both job descriptions describe the duties of the role for the postholders in place at the respective time.

Deputy Director HR Services Band 8C *(located at S21 47 of 2022 Attachments 6. Deputy Director HR Services Band 8C)*

01 January 2019 – Present

5.14 The main duties of my current role as set out in the job description are to support the Director of HROD and the Senior Management Team in enabling the Trust to deliver on its strategic goals and significant transformations agenda. I am responsible for the strategic development and management of a portfolio of core HR services delivered across the Trust. I am accountable for the achievement of key strategic and operational objectives in respect of attendance management, employment law, medical staffing including medical locums and recruitment, pay and conditions, resourcing including bank services, workforce information, HRPTS systems management and litigation.

5.15 The job description accurately reflects the range of services for which I am accountable. Progression of much of the work as set out in the job description has been impacted by the 2 years of the Covid-19 pandemic and the current recovery period.

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

6.1 The line management reporting arrangements for each role:

Human Resources Manager Band 7

01 February 2008 – 22 May 2011

6.2 My line manager in this role was Mrs Vivienne Toal, as Head of Employee Engagement and Relations.

6.3 Within this role I was responsible for managing the case and attendance team which included ER case management including grievance, disciplinary, conflict, bullying & harassment, whistleblowing, industrial tribunal and other employment legal claims, performance management, absence management (long term and short term absence).

6.4 The team reporting to me included 4 band 6 Senior HR Advisors, a band 5 attendance officer, 3 band 4 attendance officers, a band 3 administrative support role and a band 2 administrative support role. Some individuals within the team worked part-time hours, at times there were gaps due to vacancies, maternity leaves etc.

Employee Relations Manager Band 8A

23 May 2011 – 13 September 2015

6.5 My line manager in this role was Mrs Vivienne Toal, as Head of Employee Engagement and Relations. The job description as set out described the

reporting relationship as directly to the Director of Human Resources & Organisational Development. This was not the reporting relationship until February 2016 when I took over the role of Head of Employee Relations.

6.6 Within this role I managed the case and attendance management teams within the Employee Relations service including cover for ER case management including grievance, disciplinary, conflict, bullying & harassment, whistleblowing, industrial tribunal and other employment legal claims, performance management, absence management (long term and short term absence).

6.7 The team reporting to me included a band 7 team leader, 4 band 6 Senior HR Advisors, a band 5 attendance officer, 3 band 4 attendance officers, a band 3 administrative support role and a band 2 administrative support role.

6.8 I also managed the pay processing team and the pay and conditions advisory team. The pay processing staff consisted of a band 4 supervisor, approximately 6 band 3 pay processors and a band 2 administrative support role who ensured all new starts, contractual changes, leavers and pay enhancements were processed for each pay period. They were also responsible for the processing of maternity leave pays, flexi working changes, issuing of contractual documentation and HR filing.

6.9 The pay advisory team had a band 7 team leader, a band 6 senior HR advisor, 2 band 5 HR advisors, a band 4 HR assistant and varying numbers of band 3 and band 2 support roles.

6.10 Some individuals within the team worked part-time hours, at times there were gaps due to vacancies, maternity leaves etc.

HR Assistant Director for OPPC Band 8B (Acting)

14 September 2015 – 29 November 2015

6.11 My line manager in this role was Mr Kieran Donaghy, Director of Human Resources & Organisational Development.

6.12 I provided short term cover in the role of HR Assistant Director / Business Partner aligned to the Older People and Primary Care Service (OPPC) for my colleague who was released to undertake an urgent piece of work within the Trust's Resourcing service.

6.13 Within this role I provided HR advice and guidance to the senior management team within OPPC. I had no direct reports in this role.

Employee Relations Manager Band 8A

30 November 2015 – 31 January 2016

6.14 As set out above.

Head of Employee Relations Band 8A

01 February 2016 – 31 December 2018

6.15 My line manager in this role was Mr Kieran Donaghy, Director of HROD.

6.16 Within this role I managed ER service delivery. I managed the case and attendance management teams with responsibility for grievance, disciplinary, conflict, bullying & harassment, whistleblowing, industrial tribunal and other employment legal claims, performance management, absence management (long-term and short-term absence).

6.17 The team reporting to me included a band 7 team leader, 4 band 6 Senior HR Advisors, a band 5 attendance officer, 3 band 4 attendance officers, a band 3 administrative support role and a band 2 administrative support role.

6.18 I also managed the pay processing team and the pay and conditions advisory team. The pay processing staff consisted of a band 4 supervisor, approximately 6 band 3 pay processors and a band 2 administrative support role who ensured all new starts, contractual changes, leavers and pay enhancements were processed for each pay period. They were also responsible for the processing of maternity leave pays, flexi working changes, issuing of contractual documentation and HR filing.

6.19 The pay advisory team had a band 7 team leader, a band 6 senior HR advisor, 2 band 5 HR advisors, a band 4 HR assistant and varying numbers of band 3 and band 2 support roles.

6.20 Responsibility for the Medical HR service did not sit within Employee Relations. This was a separate service managed by Mrs Zoe Parks. Management of medical employee cases under MHPS was the responsibility of the Medical HR service.

6.21 Some individuals within the team worked part-time hours, at times there were gaps due to vacancies, maternity leaves etc.

Deputy Director HR Services Band 8C

01 January 2019 – Present

6.22 My line manager in this role is Mrs Vivienne Toal, Director of Human Resources and Organisational Development.

6.23 Within my remit in this role, I have responsibility for a range of HR Services each with a Head of Service aligned. In total, I have 5 Heads of Services reporting directly to me. I also have direct line management responsibility for seconded Trade Union representatives and my personal secretary.

6.24 The services I have responsibility for are:

a) <u>Employee Relations – Head of Service Mrs Sarah Moore</u>
Covers pay, term and conditions advisory service, pay processing, contract processing, AFC job evaluation and matching and is the key liaison on behalf of the Trust with the HSC Payroll Service Centre to ensure the agreed performance standards are met. Also includes, ER case management including grievance, disciplinary, conflict, bullying & harassment, whistleblowing, industrial tribunal and other employment legal claims, performance management, absence management (long-term and short-term absence).

b) Resourcing – Head of Service Mrs Edel Quinn

Covers all recruitment and selection activity and advisory service, management of the Trust's bank systems across all non-medical staff groups, management of agency placements, agency framework and agency invoicing. Also includes development of innovative resourcing solutions in response to significant workforce shortages, key liaison on behalf of the Trust with the HSC Recruitment Shared Service Centre to ensure the agreed performance standards are met, directly oversees Senior Executive recruitment.

c) Medical HR - Head of Service Mrs Zoe Parks

Covers the following services for the Trust's medical workforce - pay, term and conditions advisory service, pay processing, contract processing, rota monitoring, job planning, ER case management including MHPS, grievance, conflict, bullying & harassment, whistleblowing, industrial tribunal and other employment legal claims, performance management, absence management (long-term and short-term absence).

d) Workforce Information and Analytics – Head of Service Mrs Karen Anderson

Covers workforce reporting, workforce analytics, responses to subject access requests in HROD, HROD governance including risk registers, business continuity planning, audit, datix, complaints. Also includes management of HRPTS system access and organisational management structures for HRPTS.

e) Litigation – Head of Service Ms Lynne Hainey

Covers PL & EL claims management, medical negligence claims management, coroner inquests, medico-legal subject access requests, governance improvements including lessons learned sharing from litigation cases.

6.25 See attached a staff in post list for the staff who reported to me in my roles within Employee Relations roles from 1 February 2008 until 31 December

2018 ***(located at S21 47 of 2022 Attachments 7. Employee Relations Staff in Post 2008 to 2018)***

Policies and Procedures for Handling Concerns

7. Were you aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* published 23 September 2010? If so, when you were aware of concerns, did you implement those Guidelines? If so, please set out in full how you did so on every occasion and with whom you engaged. If not, please explain why not.

7.1 Yes, I was aware of the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance dated 23 September 2010. I was involved in the drafting of this document in conjunction with a range of senior Trust managers at that time including: Mr Kieran Donaghy Director of HROD, Mrs Vivienne Toal, the Head of Employee Relations, Ms Anne Brennan, Senior Manager in the Medical Directors office and Mrs Zoe Parks, Medical HR Manager. Input to the document was also sought from a range of key stakeholders including senior medical managers and NCAS at the time.

7.2 The Trust Guidelines and the Maintaining High Professional Standards (MHPS) Framework is always my guide when I am advised of concerns regarding doctors' or dentists' performance.

7.3 Generally, concerns about the performance of a doctor or a dentist are reported to me and other staff within the HROD directorate from clinical or operational managers. These may be reported directly to individual HR staff members for advice or via the Trust's doctor and dentist oversight group for discussion and advice.

7.4 The oversight group consists of the Medical Director, the Director of HROD and the relevant service Director. I attend in support of the Director of HROD and the Deputy Medical Director attends in support of the Medical Director. The meeting is co-ordinated by the Head of Medical HR and the Medical HR Staffing manager who record notes of the meeting and provide case updates at the

meeting. Each service area is provided with a separate timeslot and the relevant Associate Medical Director and operational Assistant Director attends to discuss existing cases within their area and any new concerns that have arisen.

7.5 I have been involved in MHPS cases with the Southern HSC Trust in various ways. I have been involved in discussion of cases at oversight meeting, I have supported clinical managers with formal investigation processes and I have provided HR advice and support to clinical managers to ensure they follow MHPS process in cases. I have always used the MHPS documents to assist medical colleagues manage concerns. My support roles to the process are set out below.

Case 1 – 2006

7.6 This was a case involving serious performance issues of a doctor and which was being managed for many years between 2006 and 2013. I was not initially involved in the matters relating to this case but became involved in approximately June 2009. The practitioner had been dismissed by the Trust but reinstated on appeal. One of the conditions of reinstatement of the practitioner was for a comprehensive NCAS assessment to be undertaken. I became involved in providing HR advice and support to this case, along with Mrs Zoe Parks, Medical Staffing Manager. In June 2009, my advice to the Director of Acute Services was that we needed to go back to the MHPS Framework to manage the practitioner and the NCAS assessment process. The Trust Guidelines were not in place at that time.

7.7 An oversight meeting was held led by the Trust's Chief Executive and agreement was confirmed regarding re-instigating MHPS. A case manager and case investigator were appointed.

7.8 There were many complexities to the case involving contractual terms and pay issues. The practitioner had been and remained excluded from practicing as a GP within the Out of Hours Service while the assessment by NCAS was undertaken. An Interim Order Panel of the General Medical Council had suspended the practitioners' registration at the time.

7.9 The Board, pursuant to its role of maintaining the Performers List, was also involved and had discussions with NCAS to arrange a placement for the practitioner so as to facilitate an assessment by NCAS. The NCAS assessment was undertaken in October and November 2009 and the final report was issued on the 15th March 2010.

7.10 The practitioner underwent an occupational health assessment, a behavioural assessment and a clinical assessment which included simulated cases and a communication assessment. In the conclusions to the NCAS report, it stated that the practitioner's performance was significantly below the level expected of a General Practitioner. At a meeting between NCAS, the HSCB and SHSCT GP Out Of Hours representatives it was agreed that NCAS would outline a possible remediation programme to address the issues raised in their report. When this was completed, in the light of the NCAS report and the scope of the remediation requirement the HSCB referred the practitioner to the General Medical Council and as a result the practitioner was suspended from the Medical List.

7.11 The Trust moved forward with an investigation under formal MHPS to explore the viability of the remediation programme in order to inform any decision the Trust may require to make with regards to continued employment. Dr Raymond Mullan, Non-Executive Director was the appointed designated Board member.

7.12 By February 2011, the practitioner had not engaged with the investigation process and was unwell. In March 2011, the GMC initiated their process and it was agreed that the Trust would hold in abeyance the formal investigation under MHPS while the GMC process was underway. At the end of December 2011, a meeting was held with the practitioner to consider continued employment in light of a decision by the GMC, which left the practitioner unable to work in the role for which they were employed. The practitioner was ultimately dismissed. Through this very lengthy case, I supported the clinical manager and oversight group with correspondence with the practitioner up to the point of dismissal. Legal challenges were managed during 2012 and 2013.

Case 2 - August 2012

7.13 I undertook the role of HR Manager under the Trust's Guidelines for Handling Concerns about Doctors and Dentists in this case. I assisted both the Case Investigator and Case Manager. I provided advice and admin support to screen the concern. It was determined that a formal investigation was required, I assisted the Case Investigator with the investigation process ensuring HR advice was provided in line with MHPS and I provided admin support for drafting correspondence to the practitioner. On conclusion of the investigation, I attended at a meeting with the practitioner and the Case Manager to share the report with the practitioner for comment. The Case Manager recommended the concerns regarding serious inappropriate behaviour by the practitioner should be considered by a conduct panel. The practitioner resigned from the employment of the Trust prior to a conduct hearing process being undertaken. I drafted correspondence on behalf of the Case Manager to the practitioner following the resignation to conclude the process.

Case 3 – October 2012

7.14 In this case, I assisted the Clinical Manager, the Case Investigator and the Case Manager as HR Manager under the Trust's Guidelines. I attended an initial meeting with the Clinical Manager and the practitioner to communicate a decision to place the practitioner on a period of immediate exclusion given the serious nature of the concerns. I provided HR advice and admin support to the Clinical Manager screening the concern and I provided HR advice and admin assistance for the subsequent formal investigation process with the Case Investigator. A meeting was held 4 weeks after the exclusion and a decision was taken to continue with formal exclusion. Immediately after this, the GMC took a decision to suspend the practitioners' registration for a period of 18 months. The concerns were in respect of serious addiction to drugs and alcohol including theft of medications from the Trust. There had been previous GMC involvement with the practitioner in respect of previous similar concerns. The practitioner was unable to work given the GMC decision and the practitioner did not return to work with the Trust.

Case 4 – May 2016

7.15 This case was in respect of concerns about a practitioner's clinical practice and behaviours, which had been raised by members of the multi-disciplinary team. The concern was screened by the Clinical Manager and HR support was provided by Ms Sarah Moore. I was not involved in the preliminary enquiries screening. The AMD in place at the time made the decision following the preliminary enquiry screening to seek the advice of NCAS and a mediation process was commenced.

7.16 I attended a meeting with the practitioner, Trade Union representative and a number of clinical and operational managers at the end of December 2016 to discuss issues of concerns the practitioner had raised, to discuss plans for return to work and the practicalities of the return to work for the practitioner. This was not part of a formal MHPS process.

Case 5 – July 2016

7.17 I provided HR support and advice in this case to the Case Manager. I attended an initial meeting with the practitioner and the Medical Director, Dr R Wright, to inform the practitioner of the nature of the concerns that had been raised and to update on the decision to move to a formal investigation process following preliminary enquiries. The concerns were in respect of private practice and other payments. After this meeting, the formal investigation process proceeded with HR support to the Case Investigator provided by Ms Sarah Moore. At the conclusion of the formal investigation, I attended a meeting with the practitioner and the Case Manager. I was not involved in the initial process of screening the concern or the formal investigation process. My role was to advise and assist the Case Manager at a meeting to ensure process was followed in sharing of the formal investigation report with the practitioner for comment. I also assisted the Case Manager at a second meeting with the practitioner to communicate the decision of the case manager at the conclusion of the investigation. No formal conduct or performance processes were recommended. My role was to advise on process and to draft correspondences to the practitioner on behalf of the Case Manager.

Case 6 – September 2016

7.18 The concern raised in this case was a concern about e-mail correspondence between two Consultant colleagues. The nature of the concern was a matter that fell under the Trust's Harassment at Work Procedure in place at that time. I provided advice and support to the Medical Director, Dr Richard Wright on process in this case at the outset. I took legal advice due to the complexity. It was agreed following legal advice that we would follow the procedure set down in MHPS to handle the concerns and in doing so also take cognisance of the Harassment at Work Procedure. This meant that the investigation was to follow the process set out in Section 1 of MHPS but also take into account the requirements of the Harassment at Work Procedure given that the nature of the concerns fell within the realm of that Procedure.

7.19 Dr Wright and I met with the practitioner who had raised the concern, to outline the process following preliminary enquiry screening of the concern. Subsequently we also met with the practitioner responding to the concern to outline the investigation process. As part of that meeting, it was communicated to the practitioner that the Trust would be standing them down from a senior management role, pending conclusion of the investigation. The practitioner took the decision to resign from the management role very soon after the meeting.

7.20 I was not involved in the formal investigation process. Ms Lynne Hainey provided the HR support to the investigation. Following conclusion of the formal investigation, I assisted the Case Manager with correspondence to the practitioners to share the report and seeking comment on the report in line with the timescales under MHPS. The determination from the Case Manager was to put the matter to a conduct panel. I drafted the correspondence to the practitioners communicating this decision for the Case Manager. I also attended a meeting with the practitioner who had raised the concern along with Dr Richard Wright to discuss the Case Manager's decision.

7.21 I co-ordinated dates for a conduct panel to meet and drafted the correspondences for the Case Manager in respect of the conduct hearing. I also assisted the conduct panel with drafting of final correspondence to the practitioner detailing the decision of the conduct panel.

7.22 Case 7 – Mr O'Brien – December 2016

Case 8 – August 2017

7.23 A concern had been raised about a practitioner in respect of them undertaking private work in NHS time. I was an apology at the initial oversight meeting. Mrs Helen Walker, Assistant Director HROD attended to provide HR advice. Following the initial oversight meeting, the concern was screened and the findings brought back to an oversight meeting in September 2017. I attended the oversight meeting in September 2017.

7.23 The findings of the preliminary enquiries were discussed and a decision recorded that no further action was required under MHPS.

8. If you were not aware of the '*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance'* what was your understanding of the reporting of concerns relating to other doctors practices? How, if at all, did this understanding inform your response to concerns you were aware of regarding urology services?

8.1 I was aware of the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance from 2010 and of the MHPS Framework from 2005. My understanding of the reporting of concerns is that the clinical manager who identifies a concern must quickly gather the facts to ascertain the nature, detail and seriousness of the concern. They must then decide if an informal or formal process is required. They can do this by seeking advice from the Medical Director and Director of HR.

8.2 This didn't inform my response to the concerns as I became involved in the process at a point when a decision had already been made to commence a formal process. I undertook the role of HR Manager under the Trust's Guidelines for Managing Concerns about doctors' and dentists' performance to support the Case Investigator and Case Manager with a formal investigation under MHPS in respect of the concerns relating to Mr O'Brien. I advised both the Case Manager

and Case Investigator in line with the requirements of MHPS during the course of the investigation including contacts and correspondence with Mr O'Brien as the practitioner.

9. In your role as Head of Employee Relations/ Deputy Director of HR & Organisational Development what, if any, training or guidance did you receive with regard to:

I. The MHPS framework;

II. The Trust Guidelines; and

III. The handling of performance concerns generally.

9.1 In my roles as Head of Employee Relations / Deputy Director – HR Services, I received the following training:

a) I attended the Trust's Development Programme for AMDs and CDs on 7 and 8th March 2017, which covered the MHPS Framework and specifically Case Investigator training by NCAS trainers.

b) I attended and presented at a training session on 24 September 2010 which was a Trust Medical Leadership Forum facilitated by NCAS. This session provided training to medical managers on the MHPS Framework, Case Scenarios and the Trust Guidelines, which I had been involved in drafting.

c) I have not attended any specific training on the handling of performance concerns in either of these roles.

9.2 In terms of training wider than the two roles as set out above:

a) Training in respect of handling performance concerns was part of my training from my Post Graduate Diploma course, my CIPD qualification and developed across more than 20 years' experience working in HR roles.

b) I attended Regional training by the Directorate of Legal Services for Non-Executive Directors (NEDs) on MHPS in November 2021

c) I attended training on the MHPS Framework in my role of HR Officer with the Newry and Mourne HSS Trust in 2005/2006 when the Framework was initially implemented. I do not have any records pertaining to that training.

10. Specifically, what if any training or guidance did you receive with regard to:

I. The conduct of "*preliminary enquiries*" under Section I paragraph 15 of MHPS or the undertaking of an *"initial verification of the issues raised"* under paragraph 2.4 of the Trust Guidelines.

II. Decision making by the Clinical Manager as to whether to adopt an informal approach or initiate a formal investigation.

III. Considerations of imposition of Immediate Exclusion or restrictions under Section I paragraphs 18-27 of MHPS.

IV. The conduct of Formal Investigations under Section 1 paragraphs 28-38 of MHPS

10.1 In respect of the specific aspects of MHPS, I have received the following training:

I. Conducting preliminary enquiries under Section 1 paragraph 15 of MHPS - NCAS trainers covered this at the session I attended on 24 September 2010 and the Case Investigator training I attended on 7 and 8 March 2017. I have not attended specific training on paragraph 2.4 of the Trust Guidelines however; this paragraph mirrors Section 1 paragraph 15 of MHPS.

II. Decision making by the Clinical Manager as to whether to adopt an informal approach or initiate a formal investigation – this was covered as part of the Case Investigator training I attended on 7 and 8 March 2017, in so far as it was outlined that this was a decision that was required to be made by the Clinical Manager, once screening of the

concern was completed. I do not recall if guidance was provided or specific examples discussed as to how a Clinical Manager would make such a decision other than it would be based on facts as screened.

III. Considerations of imposition of Immediate Exclusion or Restrictions under Section 1 paragraphs 18-27 of MHPS – this was covered as part of the Case Investigator training I attended on 7 and 8 March 2017.

IV. The conduct of formal investigations under Section 1 paragraphs 28-38 of MHPS – this was covered by NCAS trainers at the session I attended on 24 September 2010 and the Case Investigator training I attended on 7 and 8 March 2017.

10.2 The two-day training session on MHPS case investigation held on 7, 8 March 2017 was in-depth detailed training on screening, and conducting an MHPS investigation and the processes required at the conclusion of the investigation. This session also covered exclusion and restriction of duties as considerations as part of the MHPS process.

11.Outline how you understood the role of HR Manager was to relate to and engage with the following individuals under the MHPS Framework and the Trust Guidelines:

I. Clinical Manager;

II. Case Manager;

III. Case Investigator;

IV. Medical Director;

V. Service Director;

VI. HR Director;

VII. Chief Executive;

VIII. Designated Board member;

IX. The clinician who is the subject of the investigation; and

X. Any other relevant person under the MHPS framework and the Trust Guidelines, including any external person(s) or

bodies.

11.1 The MHPS Framework documents no specific role for HR Manager. There is specific reference to the role of the Director of HR only.

11.2 The Trust's Guidance specifically refers to the role of the HR Manager as part of the process. The HR Manager role is included in this guidance and outlines in practice how cases are managed and supported within the Trust. In general, terms, the role of the HR Manager is to provide advice and administrative support to the various specified roles under the Trust's Guidelines. It is not a decision-making role.

11.3 My understanding of how the role of the HR Manager was to relate to and engage with each of the specific roles under the Trust Guidelines is:

a) Clinical Manager – to provide advice and administrative support to any clinical manager with concerns about a doctor's or dentist's performance or conduct. To guide them in line with the MHPS Framework and Trust Guidelines. To assist the Clinical Manager to gather enough information to enable them to assess / screen the seriousness of the concern/complaint.
b) Case Manager - to provide advice and administrative support to any case manager with responsibility for managing concerns about a doctor's or dentist's performance or conduct. To guide them in line with the MHPS Framework and Trust Guidelines. To assist the Case Manager with matters of restriction of duty / exclusion, process of sharing the formal investigation report with the practitioner for comment and documenting their decision in respect of the actions / next steps following conclusion of the investigation process.
c) Case Investigator - to provide advice and administrative support to any case investigator investigating concerns about a doctor's or dentist's performance or conduct. To guide them in line with the MHPS Framework and Trust Guidelines. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within

the Trust. The role of the HR manager is to co-ordinate meetings, document statements, gather documentary and other evidence relevant to the investigation, provide HR advice and guidance on process matters, draft correspondence and reports as required to support the Case investigator.

d) Medical Director - to assist the clinical manager / case manager to provide updates on case progress to the Medical Director. The HR Director provides HR advice and guidance on MHPS process to the Medical Director. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within the Trust.

e) Service Director – to assist the clinical manager / case manager to provide updates on case progress to the Service Director. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within the Trust.

f) HR Director – to provide updates on case progress. To act as a professional resource with experience and knowledge of MHPS and Trust Guidelines to support the HR Director. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within the Trust.

g) Chief Executive – to assist the clinical manager / case manager provide updates on case progress to the Chief Executive. The HR Director provides HR advice and guidance on MHPS process to the Chief Executive. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within the Trust.

h) Designated Board member - to assist the clinical manager / case manager provide updates on case progress to the designated Board member. In my role as HR Manager, I have also supported the designated Board member with administrative support when corresponding with a practitioner. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within the Trust.

i) The Clinician (subject of the investigation) – to assist the clinical manager / case manager / case investigator to support the Clinician and provide updates on case progress. To assist in gathering relevant

information from the Clinician. This is not specifically outlined in the Trust guidelines but is in practice the process followed with cases within the Trust.

j) Any other relevant person – there is no specific documented role within the Trust Guidelines. The HR Manager will support the HR Director in liaison with external bodies such as CFPS, PSNI, GMC, NCAS.

Handling of Concerns relating to Mr O'Brien

12. In respect of concerns raised regarding Mr. Aidan O'Brien:

I. When did you first become aware that there were concerns in relation to the performance of Mr. O'Brien?

II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?

III. Who communicated these matters to you and in what terms?

IV. Upon receiving this information what action did you take?

12.1 I first became aware that there were concerns in relation to the performance of Mr O'Brien on 28 December 2016. I do not recall the specific discussion. I have relied on e-mail correspondence from 28 December 2016 between myself and Mrs Vivienne Toal and myself and Ms Lynne Hainey for my account in respect of this question. I was on a period of leave over the Christmas period 2016 when I received a telephone call and e-mail correspondence about concerns and the requirement for a meeting on 30 December 2016 ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20161228 Email from Lynne Hainey to Vivienne Toal re request to meet with AOB to exclude).***

12.2 As stated above, I became aware of concerns relating to the performance of Mr O'Brien on 28 December 2016 and that an imminent meeting was to take place with Mr O'Brien to discuss immediate exclusion. This was the first time I was aware of any concerns. I was not party to any discussions about the handling of the concerns prior to this date or the decision to immediately exclude

Mr O'Brien. As part of discussions between 28 December and 10 January 2017, I understood there were previous discussions about concerns in respect of Mr O'Brien. I was not party to those discussions at the time. These discussions had resulted in the decision to meet with Mr O'Brien on 30 December 2016 to discuss his immediate exclusion and that the concerns needed to be formally investigated. I have limited recall of the detail of the initial conversation/s in December 2016 with Mrs Toal or Ms Hainey which were during a period of my leave.

12.3 I was on annual leave and the Director of HROD (Mrs Vivienne Toal) was on a period of leave in or around the same time. I believe I received a telephone call from the Director of HROD regarding who was covering within the Employee Relations team over the Christmas period. I do not specifically recall the detail of this phone call. I understood there was an urgent meeting to be held on 30 December 2016 with a doctor, Mr O'Brien, regarding concerns about his practice. I believe the Director of HROD was seeking to identify appropriate HR support to accompany the Medical Director (Dr Richard Wright) to attend the meeting. I do not recall the conversation, however from e-mail correspondence on 28 December 2016 between Mrs Toal and Ms Hainey, it is clear that Lynne Hainey was covering and was asked to attend the meeting with Dr R Wright and Mr A O'Brien.

12.4 I believe I liaised with Ms Lynne Hainey who was providing the senior, experienced cover within Employee Relations over the holiday period to arrange for her to assist the Medical Director at the 30 December 2016 meeting.

12.5 From e-mail correspondence dated 28 December 2016, I note Lynne Hainey and I had a discussion on 28 December 2016 regarding the 30 December 2016 meeting. I don't recall the discussion. Between 28 December and 30 December 2016, Lynne Hainey sent me a number of e-mails. I do not specifically recall the discussions ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20161228 - Email - Action note - 22nd December – AOB)***

12.6 At the time of the 30 December 2016 meeting, Mrs Zoe Parks was Personal Information redacted by USI not at work. Mrs Parks would have been the normal initial point of contact for MHPS cases and provided HR support as part of the MHPS process. Given Mrs Parks' absence, cover for medical employee cases, was being provided by the employee relations team. The medical HR team did not have any other staff experienced in supporting employee investigations but the employee relations team provide HR support and advice to all non-medical employee investigations. I had assumed Head of Service responsibility for Employee Relations (ER) in February 2016 and it was not usual for me to carry an investigation caseload as I had multiple non-medical cases to oversee with the ER team. Ms Hainey was covering the team leader role in ER and I can recall discussions about capacity and workloads within the team including who was to take on the support role for Mr O'Brien's case. I believe that during conversations between myself, Mrs Toal and Ms Hainey, we determined that Ms Hainey would assist with the 30 December meeting but that I would then take responsibility for it on my return to work. Therefore, Ms Hainey copied me into all relevant correspondence shared with her at that time.

12.7 I returned from leave on 10 January 2017 and I was involved in discussions at an oversight meeting about the concerns, the decision to place Mr O'Brien on immediate exclusion, the need for facts to be gathered in respect of the concerns, and who would support the process from within HROD. There is a recorded note of the 10 January discussions ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20170119 - Attachment - Action note - 10th January - AOB FINAL)***

13. Outline the circumstances and the process by which you understand concerns in relation to Mr. O'Brien came to be discussed by the Oversight Group on 13th September 2016 and address the following:

I. From what source did the concerns and information discussed at that meeting emanate?

II. What do you understand to have been decided at that meeting?

III. What if any action did you take on foot of same?

IV. If no action was taken, please explain why and refer to all relevant correspondence.

13.1 I was not aware of the oversight meetings or discussions relating to concerns about the performance of Mr O'Brien in 2016 including the oversight meeting held on 13 September 2016. I became aware of the oversight discussions in 2016, later during the course of the formal investigation process. I do not know for sure the specific date I became aware of the 13 September oversight discussions but I believe it was at the 10 January 2017 oversight discussion.

I. I was not aware of the 13 September 2016 oversight discussions until January 2017 therefore I do not know from what source the concerns and information discussed at that meeting emanated.
II. I was not in attendance at the 13 September 2016 oversight meeting and therefore have no understanding of what was decided at that meeting.
III. I took no action.
IV. I took no action as I was not aware of the concerns, the discussions or the meeting held on 13 September 2016 until January 2017.

14. Outline when and in what circumstances you became aware of the following Serious Adverse Incident investigations and that they raised concerns about Mr O'Brien, and outline what action you took upon becoming aware of those concerns:

I. Patient "Patient 10" (Personal Information redacted by the USI),
II. The care of five patients (Personal Information redacted by the USI); and
III. Patient "Patient 16" (Personal Information redacted by the USI

14.1 I first became aware of concerns in respect of Mr O'Brien's performance on 28 December 2016. The decision to exclude Mr O'Brien on 30 December 2016 was taken following an Oversight meeting on 22 December 2016. I was not in attendance at either of these meetings.

i. I was made aware at an oversight meeting on 10 January 2017 of the detail of the concerns in respect of Mr O'Brien. Dr Wright, Mrs Toal and Mrs Giskhori

were present, also in attendance was myself, Mr Gibson, Mr Carroll and Ms Boyce. Prior to this, through e-mail correspondence on 28 December 2016 I had been given some information about the concerns. I do not specifically recall the detail of those conversations or what was discussed. I cannot recall if I knew about patient Patient 10 - Personal Information redacted by the USI on 28 December 2016. At the oversight meeting on 10 January 2017, I became aware of more detail regarding the concerns. This included that the decision taken by the oversight committee to exclude Mr O'Brien on 30 December 2018 was based on concerns about Mr O'Brien's administrative practices and the initial findings of an SAI investigation in respect of patient Patient 10 that highlighted concerns about treatment delay of this patient. At the time I first became aware of the concerns regarding patient Patient 10, a process to manage the concerns under MHPS was already underway. My role as part of that process was to support the case investigator and case manager with the MHPS investigation.

ii. The care of five patients:

a. It was as part of the early discussions about the MHPS investigation process in January 2017 that I became aware that there were also concerns about other patients having potentially been harmed because of delays in triage by Mr O'Brien. In January 2017 I was not aware of the specific patients involved but I was updated as each additional patient concern was identified, over the course of the next months, as each were identified by Mr O'Brien's clinical colleagues who were doing a look back exercise. I have outlined below each date I became aware regarding each patient.

b. I was aware from the Oversight meeting on 10 January 2017 that Mr O'Brien's colleagues, Mr Haynes, Mr Glackin, Mr Young and Mr O'Donoghue were involved in a process of re-triage of the referrals located in Mr O'Brien office. This was considered the priority piece of work during January 2017 and I was aware that urology consultants were tasked with looking at the triage and determining if any referrals needed to be re-categorised in terms of urgency. The referrals that had originally

come in to Mr O'Brien and that had not been triaged by him had been added to the Trust's waiting lists as per the GP assessment of priority. The urology consultants were undertaking a review of each referral to determine if the GP category was right or if any needed to be upgraded as more urgent.

c. During this process, 28 patients were identified as requiring urgent or red flag categorisation. All patients were booked to be assessed and reviewed by the urology team during February and March 2017.

d. This process was on going and as each case was identified, the operational team, usually Mr Carroll or Mrs Corrigan updated me if a patient was to be part of an SAI process.

e. The SAI processes looking at individual patients were running alongside the MHPS process, which was focusing on Mr O'Brien's performance concerns. On 3 March 2017, I requested an update from Mr Ronan Carroll and Mrs Martina Corrigan, via e-mail, regarding the work that was being undertaken by Mr O'Brien's Consultant colleagues. In an e-mail response on the same day, it was confirmed by reply:

"Update
1 - Untriaged referrals updated yesterday – this pt in red text will require an SAI. At time of typing I don't know if pt has been informed re this confirmed diagnosis and the prognosis. I do not know if AOB has also been informed as he did not attend the MDT yesterday, where this pt was discussed

62 Day Pathway
19 patients in total
1 patient Personal Information redacted by the USI ***) with confirmed High Grade Urothelial cancer, G3 pT4a. cancer (path confirmed today)*** *This patient has had TURBT so pathway has been closed at D209, he is listed for MDM discussion today re further management*

12 are now closed,
3 awaiting diagnostics/results
3 awaiting TRUSB appointment.

Also

2 - outcome of undictated outpt clinics – essentially has not started – consultants aware this needs to start and be completed
3 - trawl of PP's within 2016 operating – there are approx. 900 pts to go through on NIECR. About 450 pts have been checked and 6 out of the 450 have been seen by AOB at some point which is 1.3%

Monitoring of AOB work e.g. OPD, theatres etc has not yet commenced as prior to his return all the required activity had been reallocated to locum"

f. This was patient Patient 13 (2nd patient).

g. On the same date I asked for an update from Mrs Corrigan on when Dr Chada and I might be able to get the specific detail of each case that was being identified for SAI investigation.

h. On 15 March 2017, I received an e-mail from Mr Carroll notifying me that another patient had been identified – it read: *'Another pt upgraded and now has had cancer diagnosis'*

i. On 16 March 2017, I received an update from Mr Carroll advising that this was not another patient but was patient Patient 13 that had previously been notified to me.

j. On 6 April 2017, I received a further e-mail from Mr Carroll notifying me of another patient with a referral upgrade and a cancer diagnosis. This was patient Patient 14 (3rd patient). Mr Carrol advised in that same e-mail that the remaining patients would be known the following week.

k. 0n 7 April 2017, I received a further update e-mail from Mr Carroll notifying me of another patient with a confirmed cancer diagnosis and referral upgrade. This was patient Patient 11 (4th patient).

l. Mrs Vivienne Toal e-mailed me on 11 April 2017 seeking to know the status of the three SAI processes and to understand what, if anything, Mr O'Brien was aware of. I advised that the first SAI process (relating to patient Patient 10 was underway but the second and third had not yet commenced. I suggested that Dr Khan, as the Case Manager, should advise Mr O'Brien of the cases. I can ascertain from e-mail correspondence on 12 April 2017 that Dr Wright requested Dr Khan to meet with Mr O'Brien to notify him of the SAI cases and on the same day, Dr Khan requested a telephone conversation with me. I do not recall the telephone call.

m. I became aware of a fifth patient Patient 12 as part of an e-mail update from Mr Ronan Carroll on 8 May 2017. At this stage, I was aware that all upgrade referrals had been assessed and there were four patients in addition to patient Patient 10 (1st patient) who had required upgrade and had subsequently had a cancer diagnosis.

I was not aware of the concern related to Personal Information redacted by the USI at the time of the MHPS investigation. I have been able to find an e-mail ***(located at S21 47 of 2022 Attachments 8. sai papers as agreed)*** sent to me from Mrs Melanie McClements, Director of Acute Services dated 13 February 2020 sharing with me, Mrs Toal, Dr O'Kane and Mr Gibson a copy of the approved SAI report. The e-mail message states:

Patient 16 *approved last month, the other 5 are on this Friday's agenda, aggregated one attached for ease, thanks mel'*

iii. I took no specific action as a result of being notified of this concern and the approval of the SAI report. I was aware of discussions at the time of the

conclusion of the SAI reports and communications required to families. SAI processes are not something any of my HROD colleagues or I would be involved in and therefore I took this for information only.

15. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 22 December 2016 and address the following:

I. What information was before the Oversight Group on that date, and from what source did the information discussed at that meeting emanate?

II. What do you understand to have been decided at that meeting, and what action was to take place following that meeting?

III. What steps did you take as Medical Director to ensure that those actions took place?

15.1 I was not aware of the oversight meetings or discussions relating to concerns about the performance of Mr O'Brien in 2016 including the oversight meeting held on 22 December 2016. I first became aware of concerns in respect of Mr O'Brien on 28 December 2016.

i. I have no knowledge of what information was before the Oversight Group on 22 December 2016 or where the information emanated from.

ii. I was not in attendance at the meeting on 22 December 2016 and therefore was not aware of any actions to take place following the meeting.

iii. I was not in attendance at the meeting on 22 December 2016 and therefore was not aware of any actions to implement.

16. When, and in what circumstances, did you first became aware of concerns, or receive any information which could have given rise to a concern that Mr. O'Brien may have been affording advantageous scheduling

to private patients.

16.1 On 28 December 2016, I received an e-mail from Mrs Vivienne Toal, Director of HROD advising me of the concerns in respect of Mr O'Brien's administrative practices. In e-mail correspondence on this same date, Ms Lynne Hainey advised me that a concern in respect of private patients had also emerged and asked for my view on whether or not she should include this in the detail of the discussions at the meeting on 30 December. I was on leave on 28 December and had picked up a number of e-mails in respect of the 30 December meeting but I did not respond to this issue on that date. I do not recall why other than I was on leave and likely responding to the most urgent issues ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20161228 - Email - FW Management of PP's - non chronological listing & located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/ 20161228 Email from Vivienne Toal to Lynne Hainey re request to meet with AOB to exclude)***

16.2 From e-mail correspondence in early January, I can see that I queried with Ms Hainey if she had included the issue at the meeting on 30 December. Ms Hainey advised that she had not as it had not been discussed at the Oversight meeting on 22 December.

16.3 In December 2016, no specific details of the concern had been shared with me.

16.4 I attended an oversight meeting held on 10 January 2017 when the issue of concern was discussed. I have set out previously in this response the individuals in attendance at the meeting and I have referenced the note from the meeting. The Assistant Director in Acute Services (Mr Ronan Carroll) provided an update on three initial concerns that had led to the decision to exclude Mr O'Brien, these were:

a) Untriaged referrals
b) Notes being kept at home
c) Undictated clinics

16.5 At the meeting, a fourth concern was identified. This was in relation to the scheduling of private patients. This was the first time I became aware of some of the detail of the concern. The update at the 10 January 2017 meeting was that a review of TURP (transurethral resection of the prostate) patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients appeared to be significantly less than for other patients. The concern was that Mr O'Brien was scheduling his own patients in non-chronological order.

16.6 Scoping of the extent of this as a concern was still underway and the operational team were to advise the oversight group as more information was gathered.

17. Outline all the steps you undertook from December 2016 to January 2017 as part of the *"further scoping"* of concerns as referred to in Dr Wright's letter dated 30 March 2017, see copy attached, in relation to the following four areas:

I. Un-triaged referrals to Mr. Aidan O'Brien;
II. Patient notes tracked out to Mr. Aidan O'Brien;
III. Undictated patient outcomes from outpatient clinics by Mr. Aidan O'Brien; and
IV. The scheduling of private patients by Mr. Aidan O'Brien.

17.1 Between 10 January and 24 January 2017, 'scoping' of the concerns was led by the operational team. I was aware this included Mr Carroll, Mrs Corrigan and Mrs Sharon Glenny. It also involved Mr O'Brien's four Consultant Urology colleagues, Mr Young, Mr Glackin, Mr Haynes and Mr O'Donoghue. The Director of Pharmacy, Dr Tracey Boyce was also involved. I was not involved in this process.

17.2 The scoping of the concerns was to determine the detail in respect of the numbers of un-triaged referrals, the number of referrals that should have been upgraded and the impact of the un-triaged referrals on patient care. Work was also on going in respect of the counting of the patient notes returned from Mr O'Brien's home and the number of clinics not dictated. As part of the work on going by the operational team led by Mr Carroll, Mrs Corrigan and Urology Consultants, they also reviewed a cohort of Mr O'Brien's private patients who had been seen for a TURP procedure. This was because an initial concern had been identified about one private patient who had undergone this procedure.

17.3 The operational team provided updates to Mr Colin Weir, myself and members of the Oversight Group, as information was gathered. Given the scale of the numbers involved, the exact detail in terms of numbers of un-triaged referrals, undictated clinics and private patient concerns was an on-going scoping picture across January 2017. The scoping required individuals with experience and knowledge of the patient systems, patient lists, waiting lists, and clinical expertise in urology.

17.4 Mr Weir and I met with Mr O'Brien on 24 January 2017 to provide an opportunity to hear from Mr O'Brien in respect of the concerns and to discuss options other than exclusion after the initial 4-week immediate exclusion period.

I. I was not involved in the scoping of un-triaged referrals to Mr O'Brien
II. I was not involved in the scoping of the patient notes tracked out to Mr O'Brien
III. I was not involved in the scoping of undictated patient outcomes from outpatient clinics by Mr O'Brien.
IV. I was not involved in the scoping of concerns in respect of the scheduling of private patients by Mr O'Brien.

18. What steps did you take, in conjunction with Mr. Weir, to prepare a preliminary report for consideration by the Case Manager and Case Conference on 26th January 2017? What action did you take to assess the

substance or accuracy of the concerns, whether to verify or refute them?

18.1 I was assigned to the HR Manager role under the Trust's Guidelines to support Mr Weir as the Case Investigator in this case. This was a decision taken at the oversight meeting on 10 January 2017. Mr O'Brien had been placed on immediate exclusion on 30 December 2016 and it is a requirement under MHPS that a case conference meeting is held to determine if formal exclusion is to be put in place, after the initial 4-week period of immediate exclusion. The case conference took place on 26 January 2017.

18.2 I provided HR advice and administrative support to Mr Weir during the period between 10 January 2017 and 26 January 2017. At the oversight meeting on 10 January, which was the first time I became aware of the detail of the concerns, an update on the nature of the concerns was provided and at that point, the concerns were outlined as:

a) From June 2015, there were 783 un-triaged referrals, all of which need to be tracked and reviewed to ascertain the status of the patients in relation to the condition for which they were referred.
b) There were 4 letters, consultant to consultant referrals, which hadn't been recorded on PAS.
c) There were 307 sets of patient notes returned by Mr O'Brien from his home.
d) 88 sets of notes located within Mr O'Brien's office.
e) 27 sets of notes, tracked to Mr O'Brien, going back to 2003.
f) There were 668 patients with no outcomes formally dictated from Mr O'Brien's outpatient clinics, 272 from the SWAH clinic and 289 from other clinics.
g) There were 107 patients still being investigated.
h) Following a review of TURP patients there were nine identified patients who had been seen privately as outpatients who then had their procedure within the NHS. The waiting times for these patients appeared to be significantly less than for other patients.

18.3 This data had been gathered and updated from the position of concern that was initially discussed at the oversight meeting on 22 December 2016. I was aware of this data from the 10 January 2017 meeting. At that time in December 16, the concern/s were:

a) That, from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals.
b) That there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan is for these patients.
c) That some of the patients seen by Mr O'Brien may have had their notes taken back to his home, and are not available within the hospital. The clinical management plan for these patients is unclear, and may be delayed.

18.4 Operational and clinical managers from Acute Services were underway with a process of establishing the detail in respect of the concerns. Neither Mr Colin Weir, Case Investigator nor I were involved in that process but were provided with updates as data emerged. As part of assessing the accuracy of the concerns, a meeting was planned with Mr O'Brien.

18.5 I co-ordinated a meeting with Mr O'Brien, his son Personal information redacted by USI, Mr Weir and myself to meet on 24 January 2017. The purpose of this meeting was to allow Mr Weir to put the concerns to Mr O'Brien as they were known at that time, seek a response to the issues of concern and to enable Mr O'Brien to put forward suggested alternatives to formal exclusion.

18.6 At the meeting on 24 January 2017, the concerns identified at the 10 January 2017 oversight meeting were put to Mr O'Brien for response.

18.7 In respect to the concern regarding triage of referrals, Mr O'Brien spoke about the difficulties he had due to volume of work and advised this made it impossible for him to do all triage. Mr O'Brien did not dispute the matter put to him

that he had hundreds of non-red flag referrals in his desk that had not been triaged. While we understood the exact numbers of un-triaged referrals was still be finally established, we were clear from our discussion with Mr O'Brien that this was an issue for concern.

18.8 In respect of the patient notes at home, we knew as fact that Mr O'Brien had a large number of patient files at home. We knew this because he had returned a significant volume of files to Mrs Martina Corrigan on 3 January 2017, as had been requested by Dr Richard Wright. At the meeting on 24 January 2017 when this concern was put to Mr O'Brien, he advised that he had not returned 307 sets of notes as some had already been in his office. Mr O'Brien did not quantify the number of files he believed were in his office. It was however clear from the discussion and the notes returned to Mrs Corrigan that Mr O'Brien had been holding a significant number of patient files at home. It was evident that this was an issue of concern.

18.9 There were 13 sets of notes missing which were tracked on the electronic system to Mr O'Brien. Mr O'Brien had provided an account for each of the 13 sets of notes, which was accepted by Mr Weir, and set aside as an on-going concern in respect of Mr O'Brien. Further searches for the notes were made.

18.10 In respect of the undictated clinics, Mr O'Brien expressed surprised at the number of suggested undictated clinics indicating that instead of it being 272 in SWAH he believed it to be about 110. Mr O'Brien advised that he did not know what the other 289 clinics related to. While we understood the exact numbers were still being finally established, we were clear from our discussion with Mr O'Brien that this was an issue for concern.

18.11 In respect of the concern relating to private practice, at the meeting on 24 January 2017, Mr O'Brien advised of his concerns in respect of the inference and the potential reputational damage. He advised that he would make a written submission at a later date. As at the 24 January 2017, it was clear that this was an issue of concern that had not been answered and therefore remained open as a concern.

18.12 Based on Mr O'Brien's response to the issues of concern at the meeting on 24 January 2017, it was evident that further and fuller investigation of the matters was required. The meeting did not provide sufficient assurance in respect of the concerns.

18.13 On this basis and following discussion with Mr Weir, I drafted a Case Conference report for consideration and amendment by Mr Weir. I shared this draft in an e-mail to Mr Weir dated 26 January 2017 at 12.39AM. Mr Weir responded to me by e-mail at 10:23 AM on 26 January 2017 with some minor changes for me to adopt ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170126 - Email - RE Preliminary report from Case Investigator 26 January 2017 - STRICTLY CONFIDENTIAL).*** Once the changes were made, I forwarded the report to Dr Ahmed Khan as the Case Manager and advised him to seek NCAS advice to inform the decision of the case conference, which was due to take place at 2.30PM on 26 January. I also shared the report with all parties attending the case conference via e-mail at 1.20PM ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170126 - Email - Preliminary report from Case Investigator 26 January 2017 FINAL)***

19. With reference to specific provisions of Section I of the MHPS and the Trust Guidelines, outline all steps taken by you once a decision had been made to conduct an investigation into Mr. Aidan O'Brien's practice in line with that Framework and guidelines. Outline any engagement with Mr. O'Brien, the designated Board member, Case Manager and Case Investigator and any other relevant individuals.

19.1 In line with Section I of the MHPS and Trust Guidelines, I became involved in the MHPS process at the point that a formal investigation was required.

a) *MHPS Section I Pt 5 and 6*

I had no involvement in the preliminary screening of the concerns or the decision to exclude.

b) *MHPS Section I Pt 7 and 8*

The role of case manager, case investigator and designated Board member had been assigned prior to my involvement.

c) *MHPS Section I Pt 9 and 14*

Engagement with NCAS had commenced prior to my involvement.

d) *MHPS Section I Pt 15 and 17*

I was not involved in the process or any discussions regarding an informal approach. I became involved in the process when a decision had been made that a formal investigation was required.

e) *MHPS Section I Pt 18 - 22 and 24-27*

A decision to place Mr O'Brien on immediate exclusion had been made and a meeting to discuss the immediate exclusion arranged prior to my knowledge or involvement in the matter.

f) *MHPS Section I Pt 23*

The period of immediate exclusion commenced on 30 December 2016 and ended on 26 January 2017. During the immediate 4-week exclusion period, I provided HR support to the investigation process. I attended a meeting with Mr Weir and Mr O'Brien on 24 January 2017 to provide an opportunity for Mr O'Brien to respond to the concerns and to propose alternatives to formal exclusion.

Mr O'Brien was advised of the service available to him through Occupational Health and had been assessed at the outset of the investigation process as he had been absent from work. Advice from NCAS was sought during the process and Mr O'Brien was informed of his representation / accompaniment rights at each stage of the investigation process.

g) *MHPS Section I Pt 28*

The roles as required to be appointed under this section was completed. Mr Colin Weir was appointed as Case Investigator and Dr Ahmed Khan had been appointed as Case Manager. I had no involvement in the discussion or decision in respect these appointments. Mr Weir was replaced by Dr Neta Chada as Case Investigator prior to the commencement of the formal investigation. I supported and advised Dr Chada in my role as HR Manager under the Trust's Guidelines.

h) *MHPS Section I Pt 29*

The concerns were investigated fully but not within the timescale as set out within MHPS. Relevant documentation was sourced and secured for the purposes of the investigation process. A substantive timeline of the investigation process was recorded within the investigation report.

i) *MHPS Section I Pt 30*

Mr O'Brien was afforded his rights of accompaniment / representation at all stages of the formal investigation process.

j) *MHPS Section I Pt 31 - 33*

The case investigator, Dr Neta Chada was a senior clinician and medical manager with the Trust appointed to undertake the investigation. Dr Chada provided comment and direction to me as HR support to her in the gathering and collation of documents and witness statements. A written record of the investigation process was kept and she made no decision on the action to be taken following conclusion of the investigation. This was passed to the Case Manager.

k) *MHPS Section I Pt 34 - 36*

The case manager, Dr Ahmed Khan was a senior clinician and medical manager within the Trust. The role of Case Manager was delegated to him by the Medical Director, Dr Richard Wright. Dr Khan corresponded with Mr O'Brien advising him of the terms of reference for the investigation and the witnesses involved. He provided a copy of the investigation report to Mr O'Brien for Mr O'Brien to comment on the

factual accuracy of the report, following which, Dr Khan considered the investigation report along with Mr O'Brien's comments to make a determination on next appropriate steps.

l) MHPS Section I Pt 37

The formal investigation process was not completed within 4 weeks. The formal investigation process commenced in March 2017 and was completed with a report to the Case Manager on 12 June 2018. A letter to Mr O'Brien dated 21 June 2018 from Dr Khan was sent advising that the report was available for him to collect from the Trust's Headquarters. Dr Khan notified me via e-mailed on 21 June 2018 that he was not in a position to review the report until his return from leave during the first week of August 2018 and would require release from his role to so. The report however was shared with Mr O'Brien for his comments on the factual accuracy of the report and any mitigation in line with MHPS.

In my experience of supporting clinical managers with MHPS cases, completion of a formal investigation within 4 weeks has never been achieved. The concerns relating to Mr O'Brien were multiple, involving many hundreds of patient records / notes and many witnesses. It was complex and very resource intensive. It was entirely impractical that such an investigation could be completed within a 4-week period. Added to this, the 4-week requirement for completion of a formal investigation is at odds with the 4-week immediate exclusion timescale providing the opportunity to establish facts during that initial 4-week period.

m) MHPS Section I Pt 38

The report provided to the Case manager on 12 June 2018 provided extensive information and evidence to support his decision-making role in line with MHPS.

20. What role or input, if any, did you have in relation to the formulation of the Terms of Reference for the formal investigation to be conducted under the MHPS Framework and Trust Guidelines in relation to Mr. O'Brien?

Outline all steps you took, information you considered and advice you received when finalising those Terms. Describe the various iterations or drafts of the Terms of Reference and the reasons for any amendments, and indicate when and in what manner these were communicated to Mr O'Brien.

20.1 Ms Lynne Hainey copied me into an e-mail she had received from Mr Simon Gibson on 28 December 2016 in which he had shared with her a number of documents including a draft terms of reference (TOR). I understand Mr Gibson had drafted these and had invited Ms Hainey to amend or comment. The initial TOR stated:

I. To determine whether there has been unreasonable delays in the triaging of outpatient letters by Dr O'Brien, and whether patients may have come to harm as a result of these delays

II. To determine whether patients notes have been stored at home by Dr O'Brien, whether these have been at home for significant periods of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties

III. To determine whether there has been an unreasonable delay by Dr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients

IV. To determine whether Dr O'Brien offered an advantage to NHS patients awaiting a procedure who had previously attended him in a private outpatient capacity, to the disadvantage of other patients awaiting a procedure, by not listing patients in chronological order

20.2 Ms Hainey e-mailed me on 29 December 2016 to advise that she had reviewed the TOR however; she had also received a copy of an NCAS letter from Mr Gibson, which was likely to impact again on the draft TOR ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20161229 - Email - Terms of Reference for Investigation December 2016).*** When Ms

Hainey shared the revised TOR, she had updated the document into a template for TOR that was used for MHPS cases within the Trust. I cannot recall if I advised her to do that or if she herself used the previous HR template. The TOR was changed to:

"Matters to be investigated:

I. To determine whether there have been unreasonable delays in the triaging of outpatient/GP letters by Dr O'Brien, and whether patients may have come to harm, or had un-necessary delays in treatment, as a result

II. To determine whether patients notes have been stored at home by Dr O'Brien, whether these have been at home for significant periods of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

III. To determine whether there has been an unreasonable delay by Dr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients as a result."

20.3 The fourth TOR drafted by Mr Gibson had been removed.

20.4 I can only presume this was removed because at the time Ms Hainey was reviewing the TOR, it was suggested that these would be shared with Mr O'Brien at the 30 December meeting. As the concern regarding private patients had not been discussed at the 22 December 2016 meeting with the oversight group and was therefore not being raised at 30 December meeting, this is why Ms Hainey removed it from the draft TOR on 29 December.

20.5 The draft TOR were not shared at the 30 December meeting. At the oversight meeting on 10 January 2017, the draft terms of reference were reviewed and discussed. An action note ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170111 - Attachment - Action note - 10th January – AOB*)** from the meeting was:

"Draft Terms of Reference were reviewed. It was agreed that these should now be amended to reflect the issues identified as outlined above, and circulated to the Oversight Committee for approval. Action: Siobhan Hynds"

20.6 I updated the draft terms of reference in light of the discussions at the meeting on 10 January and shared these with the Oversight Committee for their approval on 18 January 2017. The revised TOR stated:

"Matters to be investigated:

I. *To determine whether there have been unacceptable and/or unreasonable delays in the triaging of outpatient/GP letters by Dr O'Brien, and whether patients have come to harm, or had un-necessary delays in treatment, as a result.*

II. *To determine if all patient notes for Dr O'Brien's patients are tracked and stored within the Trust. To determine whether patient notes have been stored at home by Dr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.*

III. *To determine whether there has been an unreasonable delay by Dr O'Brien in dictating outpatient clinics, and whether there may have been delays in clinical management plans for these patients as a result.*

IV. *To determine if Dr O'Brien has seen private patients as outpatients and then scheduled the private patients for their procedure on the NHS in non-chronological order."*

20.7 TOR number one had a change to include '*or had un-necessary delays*' and TOR number 4 was added again with slightly revised wording.

20.8 I shared these revised TOR for amendment and / or comment with Dr Richard Wright, Mrs Esher Gishkori and Mrs Vivienne Toal and copied to Mr Gibson.

20.9 On 19 January 2017, Mr Gibson provided comments and additions to the drafted Terms of Reference. Mr Gibson advised that he had considered the draft in the context of NCAS and had amended to make the TOR specific, focused and quantitative.

20.10 The amendments stated:

I. *"To determine whether there have been unacceptable and/or unreasonable delays in the care relating to 783 referral letters untriaged by Mr O'Brien during the period June 2015 to October 2016 and whether patients have come to harm, or had unnecessary delays in treatment, as a result.*

II. *To determine whether the length of time the 307 sets of patient notes were stored at home by Dr O'Brien has affected the clinical management plans for these patients either within Urology or within other clinical specialties.*

III. *To determine whether there has been an unreasonable delay by Dr O'Brien in dictating clinic outcomes from 668 outpatient consultations, and whether there may have been delays in clinical management plans for these patients as a result.*

IV. *With an initial focus on patients undergoing an endoscopic resection of their prostate in 2016, to determine whether Dr O'Brien has seen private patients as outpatients and then scheduled the private patients for their procedure on the NHS in non-chronological order, contrary to Trust policies and procedures"*

20.11 Dr Wright confirmed his agreement to the revisions by Mr Gibson on 19 January and asked for the terms of reference to be shared with the case manager and case investigator.

20.12 I have no record of an e-mail reply from Mrs Giskhori or Mrs Toal on the draft TOR at that time. I have no doubt that Mrs Toal and I would have had discussion however in the days after 19 January 2017 about the TOR.

20.13 The case conference meeting was held on 26 January 2017 and it is recorded in the note of the meeting:

'This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference now required.'

20.14 On 7 February, I sent Mr Weir the previously drafted TOR in follow up to the actions from 26 January meeting. Mr Weir made some amendments to the TOR and returned them to me on the same day. The revised TOR stated:

"Matters to be investigated:

i. *To determine whether there have been unacceptable and/or unreasonable delays in the triaging of outpatient/GP letters by Mr O'Brien, and whether patients have come to harm, or had un-necessary delays in treatment, as a result.*
ii. *To determine if triaging delays would be considered well outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment*
iii. *To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust. To determine whether patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties. To determine if any patient notes are missing.*
iv. *To determine whether there has been an unreasonable delay or a delay well outside acceptable practice by Mr O'Brien in dictating*

outpatient clinics, and whether there may have been delays in clinical management plans for these patients as a result.

v. *To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority"*

20.15 Mr Weir added TOR (ii) above in order to establish variation from acceptable practice and not only if there was harm caused. He also changed the wording on TOR (v) to ensure the fact was not missed that some patients may have seen Mr O'Brien because they had a more pressing clinical need.

20.16 On 7 February 2017, I shared the redrafted TOR with Dr Khan for his agreement and the members of the Oversight Committee. I hoped to have both documents agreed and finalised for the planned meeting with Mr O'Brien on 9 February 2017.

20.17 I have no correspondence on file from Dr Khan or the oversight members with reply comments on the draft TOR. During February 2017 and up to 6 March 2017, Mr O'Brien made representations to Mr John Wilkinson and submitted a range of questions about the process. The TOR were not issued during this time and I believe this was because the focus was on responding to Mr O'Brien's correspondences. I recall conversations were happening with the Trust's legal advisors at that time.

20.18 I believe that as a result of the discussions and advice sought the TOR were revised, re-worded an additional TOR was added to ascertain the history of the management knowledge of the concerns relating to Mr O'Brien's practice.

20.19 I sent a further e-mail to Dr Khan on 6 March re-sending the TOR for agreement ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170306 - Email - FW Terms of Reference for Investigation FINAL*)** On 15 March 2017, I sent an e-mail to Dr Khan with a final draft terms of reference for his consideration, agreement and on-ward sharing with Mr O'Brien if he was content with the information as presented. I also attached

an update witness list for sharing with Mr O'Brien, which included Mr Weir and Mr Eamon Mackle as additional witnesses at that time. I advised Dr Khan that the meetings with witnesses were commencing and that the terms of reference and witness list needed to be shared with Mr O'Brien as a requirement under MHPS.

20.20 On 16 March 2017, I emailed Mr O'Brien a copy of the terms of reference for the formal investigation, which had been agreed and I also shared a copy of an initial witness list, at the request of Dr Khan ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170316 - Email - Strictly Private and Confidential)***

20.21 The final TOR shared with Mr O'Brien on 16 March 2017 stated:

"Matters to be investigated:

I. *(a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.*
   a. *(b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.*
   b. *(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.*
   c. *(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.*

II. *(a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.*
   a. *(b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.*

b. *(c) To determine if any patient notes tracked to Mr O'Brien are missing.*

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

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

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

IV. *To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.*

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

21. With regard to the Return to Work Plan / Monitoring Arrangements dated 9 February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr. O'Brien's compliance with the Return to Work Plan and provide copies of all documentation showing the discharge of those roles with regard to each of the four concerns identified, namely:

I. Un-triaged referrals to Mr. Aidan O'Brien;

II. Patient notes tracked out to Mr. Aidan O'Brien;

III. Undictated patient outcomes from outpatient clinics by Mr. Aidan O'Brien; and

IV. The scheduling of private patients by Mr. Aidan O'Brien.

21.1 I had no role in the monitoring arrangements of the return to work plan shared with Mr O'Brien at a meeting with him on 9th February 2017. As an action

from the meeting on 26 January 2017, Mrs Giskhori e-mailed me on 2 February 2017 to discuss a number of matters including the monitoring arrangements. Within this e-mail to me ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20170202 - Email - RE Action note - 26th January - AOB draft SH comments)***, she wrote:

> *"Thank you for this and Anne McVey briefed me fully the day following the meeting.*
> *I just have a few questions.*
> 1. *Is there a time scale for the developing of the monitoring process which Ronan and I will assume responsibility for?*
> 2. *Is it OK therefore for us to involve the other clinicians in developing the above? I am aware that Colin Weir is part of the investigative team but is also the CD for Mr O'Brien. Mark Haines is the other CD for surgery but also works as a urologist in the team.*
>
> *Sorry for the basic questions but I would rather be crystal clear about my roles and responsibilities at the beginning."*

21.2 In follow up to Mrs Gishkori's e-mail, I suggested a meeting to discuss the plan with her and Mr Carroll. It was agreed we would meet and we met on Monday 6th February 2017. Following our discussions at the meeting, I did an initial draft of the plan and shared it with Mr Ronan Carroll via e-mail on 7 February 2017, and copied to Mrs Gishkori seeking their comment and input to the plan. On the same date, Mr Carroll requested input from Mrs Corrigan to the plan via e-mail. Mr Carroll shared Mrs Corrigan's amendments via e-mail to me on 8 February 2017. I revised the plan and sent it to Mr Carroll, Mrs Corrigan, Mr Weir and Dr Khan for their final comment and input. In e-mails on 9 February 2017, Mr Weir and Dr Khan confirmed their contentment with the plan. The requirement set out within the monitoring plan was that *'any deviation from compliance with this action plan must be referred to the MHPS Case Manager immediately'* ***(located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/ 20170209 - Email - RE Return to Work Action Plan February 2017 FINAL 1 & 20170209 - Email - RE Return to Work Action Plan February 2017 FINAL 2)***

21.3 I was aware that Mrs Corrigan was undertaking the monitoring of the plan and overseen by Mr Carroll. Mrs Corrigan initially provided updates to Dr Khan about compliance with the plan. At a point, Dr Khan advised that he only needed to be informed of any deviation and therefore the regular updates ceased.

21.4 Mrs Corrigan and I did have discussions on the monitoring plan and the monitoring process but I did not have sight of or access to the mechanisms by which Mrs Corrigan was monitoring compliance. I am not familiar with the systems, mechanisms or processes involved however, I understood Mrs Corrigan was:

I. Un-triaged referrals to Mr O'Brien
Tracking all referrals that came in during the week Mr O'Brien was Consultant of the Week and ensuring each referral had been returned at the end of his week, triaged by Mr O'Brien and each was added to the Trust's waiting list as per Mr O'Brien's assessment of priority.

II. Patient notes tracked out to Mr O'Brien
Monitoring of patient notes required Mrs Corrigan to monitor the notes tracked out to Mr O'Brien and his secretary and to do a check on the volume of notes periodically sitting in Mr O'Brien's office. Mr O'Brien was not permitted to have notes at home.

III. Undictated patient outcomes from outpatient clinics by Mr O'Brien
Mr O'Brien was moved to a digital dictation system used by his colleagues and Mrs Corrigan monitored dictation electronically against each patient contact.

IV. Scheduling of private patients by Mr O'Brien
I understood that Mr O'Brien was unable to schedule patients as had been his practice and scheduling was taken over by the scheduling team as was the process for his consultant colleagues.

22. What is your understanding of the period of time during which this Return to Work Plan/Monitoring Arrangements remained in operation, and

which person(s) were responsible for overseeing its operation in ay respect?

22.1 The Return to Work Plan / Monitoring plan was put in place as an alternative means to formal exclusion. It became operational from Mr O'Brien's return to work in March 2017. I understand the responsibility for monitoring Mr O'Brien's performance against the return to work plan was with the operational team in the acute services directorate under the leadership at the time of Mrs Esther Gishkori and under the management of Mrs Martina Corrigan, Head of Service and Mr Ronan Carroll, Assistant Director. In line with normal professional supervision, I understood that general performance management of Mr O'Brien was also the responsibility of the Clinical Director, who was Mr Weir at that time. Mrs Corrigan and Mr Carroll were responsible for notifying the Case Manager (Dr Ahmed Khan) of any deviations from the monitoring arrangements as set out within the plan. Given the monitoring arrangements were in place to provide assurance about Mr O'Brien's administrative practices until the matters were investigated under MHPS, it was my understanding this was to remain in place until the conclusion of the process including any action or decision stemming from the MHPS investigation. The MHPS process had not entirely concluded at the time of Mr O'Brien's retirement from the Trust.

23. With specific reference to each of the concerns listed at (20) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

23.1 I was aware during the course of the investigation that Mrs Corrigan continued to be responsible for monitoring Mr O'Brien's compliance with the return to work plan. I had not been notified of any concerns regarding compliance. For completeness when finalising the investigation report, I e-mailed Mr Carroll and Mrs Corrigan on 18 May 2018 to ask if there had been any deviation from the monitoring plan as I was finalising the draft report for Dr Chada's consideration.

23.2 Mrs Corrigan replied to me in an e-mail dated 22 May 2018, copied also to Mr Carroll ***(located at S21 47 of 2022 Attachments, 9. RE Return to Work Action Plan February 2017 FINAL.)*** and advised:

"Apart from one deviation on 1 February 2018 when Mr O'Brien had to be spoken to regarding a delay in Red Flag Triage and he immediately addressed it, I can confirm that he has adhered to his return to work action plan, which I monitor on a weekly basis.
Concern 1 – one deviation when the red flag was not triaged for 6 days – he was spoken to and it was resolved that evening and his reason was due to the busyness of his oncall week when he had spent quite a bit of it in emergency theatre.
Concern 2 – adhered to – no notes are stored off premises nor in his office
Concern 3 – adhered to – Mr O'Brien uses digital dictation and dictates on all charts after clinics and he has an outcome on all patients including DNA patients
Concern 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,"

23.3 During June 2018, Mrs Corrigan also provided weekly updates on Mr O'Brien's adherence to the monitoring plan with no issues of concern reported prior to conclusion of the investigation and sharing of the report.

24. Section I paragraph 37 of MHPS sets out a series of timescales for the completion of investigations by the Case Investigator and comments from the Practitioner. From your perspective as HR manager, what is your understanding of the factors which contributed to any delays with regard to the following:

I. The conduct of the investigation;

II. The preparation of the investigation report;

III. The provision of comments by Mr. O'Brien; and

IV. The making of the determination by the Case Manager.

Outline what actions, if any, you took to ensure that momentum was

maintained during the process, as required by Section I paragraph 8 of MHPS and paragraph 2.10 of the Trust Guidelines. Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

A. Case Investigator;

B. Case Manager;

C. The designated Board member;

D. Mr. Aidan O'Brien; and

E. Any other relevant person under the MHPS framework and the Trust Guidelines.

24.1 Under Section 1 paragraph 37 of MHPS the key timescales for the formal investigation process are:

a. The Case Investigator should other than in exceptional circumstances, complete the investigation within 4 weeks of appointment
b. Submit their case report to the Case Manager within a further 5 working days
c. The Case Manager must give the practitioner, the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. (This can be extended in complex cases or due to annual leave).

24.2 In respect to delays with:

i. The conduct of the investigation
ii. The preparation of the investigation report
iii. The provision of comments by Mr O'Brien
iv. The making of the determination by the Case Manager

I have answered this question by setting out, in question 1 and in the paragraph's below and, a comprehensive chronology of events to

highlight the factors, which contributed to delays, and the action I took to ensure momentum was maintained during the process. All documentation referred to has been previously provided.

24.3 The decision to move to a formal investigation process was communicated to Mr O'Brien on 30 December 2016. Mr O'Brien was also placed on immediate exclusion, which under MHPS provides a 4-week period '*to allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion'*.

24.4 I have previously commented on how this sits at odds with the requirement to '*complete the investigation within 4 weeks of appointment'* of the case investigator.

24.5 During the period of 30 December 2016 to 26 January 2017 when the case conference meeting was held, time was spent with the operational team gathering initial information, oversight discussions, initial discussions between myself and Mr Weir, co-ordination of the meeting with Mr O'Brien and from my perspective generally gathering an understanding of the issues of concern.

24.6 It is necessary to put this into the context whereby all parties involved in the oversight discussions, the operational and clinical staff in Acute Services, HR, the case manager, the case investigator were all undertaking exceptionally busy roles at the same time. From my perspective, I was in my first year of taking over responsibility for the ER service, I had staffing gaps and pressures and a significant workload requiring staff within the team and myself to work many additional hours over normal contracted hours on a very regular basis. I returned from a period of leave from 24 December to 9 January 2017 with a large backlog of e-mails and other deadlines for existing cases however, because of staffing pressures and gaps, including [redacted] of Mrs Parks, it resulted in me assuming responsibility for this case when it was always going to be hugely challenging. Mrs Toal and I discussed these challenges at the time but options were limited. This was from the outset, a complex case with a history going back some years and involving vast volumes of data.

24.7 I am setting this out from my perspective to demonstrate that a 4-week timescale was not achievable for me. All others involved were also maintaining full roles, many patient facing, which had to be prioritised and so I presume they faced the same capacity challenges as I did. Maintaining services by all parties while managing a complex case like this one without additional resource or protected time will inevitably result in delays. I know that this presents as a challenge across HSCNI.

24.8 Simply co-ordinating diaries for many of those involved proved hugely challenging. I spent a significant amount of time, in hours and out of hours, drafting correspondences and co-ordinating agreement of the correspondences. Time was also spent responding to written correspondences from Mr O'Brien.

24.9 The case conference of 26 January 2017 confirmed the decision to formally investigate the concerns. Mr Weir had been appointed as case investigator however was subsequently replaced on 21 February 2017 due to a conflict and replaced by Dr Neta Chada. Dr Chada required time to update and familiarise herself with what had preceded her appointment.

24.10 If we take 4 weeks from the time of Dr Chada's appointment until the date she shared the report with the case manager, the time period is 21 February 2017 to 12 June 2018, which is clearly much longer than the MHPS timescale of 4 weeks. I am of the view that this case falls into the 'exceptional circumstances' caveat of Section I paragraph 37 of MHPS given the scale and complexity of the issues. That said, I accept that there are periods during the course of the investigation process that could and should have been completed more swiftly.

24.11 The case investigator's report sets out a timeline in respect of the investigation process, which I am in agreement with and will rely on for the purpose of answering this question.

24.12 The terms of reference for the investigation were finalised and shared with Mr O'Brien on 16 March 2017. I had also begun to co-ordinate dates to meet

with witnesses. We met with 13 witnesses to take their statements between 15 March 2017 and 5 June 2017. The timescale was primarily impacted by the availability of Dr Chada because of her clinical and managerial commitments. Co-ordinating with the witnesses' diaries and my own diary also impacted on the timescale. Gathering witness information was a key part of the evidence gathering process. Each meeting required between 1 hour and 2 ½ hours to meet with witnesses. I then needed to type the handwritten notes into statements for sharing and agreeing with the witnesses. Easter was in the middle of this period on 16th April 2017 and this also impacted timescales.

24.13 I then began co-ordination of a meeting with Mr O'Brien. A letter was sent to Mr O'Brien on 14 June 2017 requesting to meet with him on 28 June 2017. This was not suitable for Mr O'Brien. In correspondence dated 19 June 2017, Mr O'Brien requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. Further dates were discussed, including 1 July 2017 as suggested by Mr O'Brien. This was a Saturday and not a working day for Dr Chada or myself however in the interests of making progress, Dr Chada and I were happy to accommodate this. Mr O'Brien requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

24.14 On reflection, this was too long a period to wait without making progress and further attempts by me to secure an earlier date should have been made. Given holiday commitments of Dr Chada and myself in July 2017 and other work pressures, we accepted 31 July 2017.

24.15 Mr O'Brien subsequently advised that the date of 31 July was not suitable and a date of 3 August 2017 was agreed. At this point, the period of time from initially beginning to request dates until a meeting was actually confirmed was 14 June to 3 August 2017. This was a period of greater than 6 weeks and looking at this now, it was the responsibility of Dr Chada and I to maintain momentum with the investigation process in the event it was being delayed and we should not have allowed this to drift as it did. At the time however, this period of time which crossed the July holiday period, would have been especially busy due to leave across

teams and on reflection it is likely this delay provided some 'breathing space' to focus on other priorities.

24.16 At the meeting on 3 August 2017, the concerns were put to Mr O'Brien for his response with the exception of the issue related to private practice. Mr O'Brien asked for the specific patient information to be furnished to him in order to make a response. This was reasonable in my view and we agreed to arrange another date for the purposes of dealing with this concern when he had all of the required information.

24.17 During the first half of August 2017, I was working on finalising and getting agreed statements signed and returned from the witnesses. I reviewed my e-mails during September 2017 and cannot determine what progress was being made during this time from that review. In October 2017, co-ordination of the second meeting with Mr O'Brien was on going and correspondence was sent to him on 16 October 2017 advising of a meeting date for the second investigation meeting on 06 November 2017.

24.18 From my perspective, there is an unexplained delay during September and some of October 2017. During the investigation there was time spent reading and commenting on documents, setting up meetings with witnesses, writing up notes and drafting documents. I cannot attribute any of this work to the delay in September and October following a review of my e-mails at the time.

24.19 On 6 November 2017, the second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. At this meeting, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

24.20 Again, on reflection I along with Dr Chada should have insisted on a commitment from Mr O'Brien to prioritise the comments on his witness statements

and return them sooner. Mr O'Brien was not expressing any urgency to get matters completed.

24.21 By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore I e-mailed Mr O'Brien seeking an update. I did not receive a response and so followed up with a further email reminder on 22 February 2018. On this date, Mr O'Brien requested a copy of the statement from the 6 November meeting and indicated he would provide commentary on all documents by 31 March 2018.

24.22 It was evident to me by this stage that the timescale was drifting and that there was a lack of urgency on the part of Mr O'Brien to engage to assist in bringing the process to a conclusion.

24.23 I liaised with Dr Chada and we agreed that this was too long given the extended period already afforded to Mr O'Brien and therefore I e-mailed him to ask him to provide comments by 9 March 2018 rather than 31 March 2018.

24.24 Mr O'Brien did not provide his comments by 9 March 2018 and therefore I sent a further e-mail on 16 March 2018 requesting comments no later than 26 March 2018. I advised Mr O'Brien at that point that Dr Chada would progress with the investigation report and conclude without his comments if they were not provided by 26 March 2018. Mr O'Brien did not comply with my request and did not provide his comments by 26 March 2018.

24.25 It was increasingly concerning to me by this point that Mr O'Brien was either working to his own initially requested deadline of 31 March 2018 and ignoring the timescales set by Dr Chada or was purposely delaying the conclusion of the process. At this point Mr O'Brien had his original statement for comment for almost 6 months.

24.26 I wrote again to Mr O'Brien on 29 March 2018 advising that he was required to provide comments by 12 noon on 30 March 2018 after which the

investigation report would be drafted without consideration of his comments. Mr O'Brien did not provide his comments on 30 March 2018.

24.27 On 2 April 2018, almost a month after the request for comments on 9 March 2018, Mr O'Brien sent comments on the statements from the meetings of 3 August and 6 November. He also queried requested amendments to notes of meetings on 30 December 2016 and 24 January 2017. Mr O'Brien's comments were appended to the final report for completeness for the case manager in making his decision.

24.28 During April and May 2018 Dr Chada and I worked on the investigation report. I e-mailed Dr Chada on 21 May 2018 to advise that I was finalising an initial draft and would send it through for her comment.

24.29 I e-mailed Dr Chada on 23 May 2018 to advise that I was not yet finished with drafting the full report and provided her with a copy of my draft to date for her comment. Dr Chada replied to me on 23 May 2018 suggesting we meet later that day regarding the report and we made arrangements to do so in Armagh.

24.30 On 24 May 2018, I e-mailed Dr Khan's secretary regarding a meeting with him the following Friday. Dr Chada and I wished to meet with him regarding the investigation report. Due to diary issues, the meeting was confirmed for 12 June 2018.

24.31 Dr Chada sent me her comments on the report I had shared with her via e-mail on 29 May 2018. I sent an e-mail to Dr Chada on 10 June 2018 with my further comments on the draft report. There was a final comment missing from the document, which we had discussed about Mr O'Brien's reflection / insight, and I asked Dr Chada to conclude her comment on this. Dr Chada replied to me with her comment on this matter within the report on 11 June 2018. I made all necessary changes to the report and shared the final version with Dr Chada on 11 June 2018 in advance of handing the report over to Dr Khan at the meeting with him the following day, 12 June 2018.

24.32 The report was shared with Dr Khan and Dr Khan made arrangements with Mr O'Brien in a letter of 21 June 2018 for him to collect a copy from the Trust rather than post sensitive information.

24.33 On the same date, Dr Khan notified me by e-mail that he had agreed to stay on as Case Manager for this case. This was conditional on the review of the report and his determination being completed on his return from leave in the first week of August 2018 and that he be freed up to do so, with my support. Dr Khan had changed roles and was undertaking the role of Acting Medical Director at this time. I was happy to provide support to Dr Khan for this purpose given my knowledge of the case supporting the investigation process.

24.34 I contacted Dr Khan's secretary, Ms Laura White, via e-mail on 5th July 2018 to find out if she had received any comments back from Mr O'Brien on the case investigation report. She replied to me on 6th July 2018 to advise that she had heard nothing back.

24.35 Dr Khan was on leave so I contacted Mrs Toal via e-mail on 6th July 2018 to query whether I should follow up with Mr O'Brien for receipt of his comments. Before I received a reply from Mrs Toal, Ms White contacted me via e-mail on 9th July 2018 to advise that Mr O'Brien e-mailed the previous Friday (6th July) after she had left the office for the day. His e-mail stated:

> *"Laura, I had sent an email to Dr. Khan on Wednesday asking whether I could defer returning my comments regarding the investigation report until Tuesday rather than Monday as I will be in SWAH all day Monday, but he was out of office. I would be grateful if you could advise, Thank you,"*

24.36 Mrs White had spoken with Mrs Toal in Dr Khan's absence and had replied:

"Dear Mr O'Brien, I have checked out your request and have been advised that no later than close of play on Tuesday 10th July for your response will be fine. Regards,"

24.37 Dr Khan and I met on his return from leave on 2 August 2018 to discuss the next steps in respect of the MHPS investigation report. Dr Khan asked me to draft for him a correspondence to Mr O'Brien advising him that it was now his intention to complete the review of the report and to advise that he would be in contact in due course.

24.38 I was on leave at the beginning of the following week. Dr Khan contacted me via e-mail on 13th August to query if the letter had been drafted for sending. I replied to Dr Khan later that day and sent him the draft of the correspondence. Dr Khan sent the final correspondence to Mr O'Brien on 14 August 2018.

24.39 On the same day I began to co-ordinate a meeting for Dr Khan to meet with Mr Shane Devlin, Chief Executive and Mrs Vivienne Toal, Director of HROD. The purpose of this meeting was for Dr Khan to seek advices from the Chief Executive and HROD Director prior to concluding his case determination. I was advised at this time that Mrs Toal was returning from leave at the end of August and her diary was fully booked for the start of September and 20th September was the first date that was free. Mr Devlin was also free.

24.40 I was the on a period of annual leave 16 to 31 August 2018.

24.41 On my return to work, I discussed the case determination options paper with Dr Khan and on 11 September 2018 set diary time aside to draft initial comments. I shared this draft with Dr Khan in an e-mail to him on 12 September 2018. We had also arranged to meet in Daisy Hill on 13 September 2018 at 4pm to discuss the paper. Dr Khan sent me comments on the initial draft via e-mail on the morning of 13 September. He also stated:

"I would also like to add a paragraph in recommendations to suggest that a separate investigations should carried out to identify factors of system

wide failure and culture as why if this was known to directorate senior managers then no actions taken. This point cannot be addressed within this MHPS investigations due to limitations of its ToR, also MHPS framework doesn't allow this investigations to address that issue. Can you draft something so that when we meet this pm we can then review it."

24.42 I updated the draft paper and re-sent it to Dr Khan on 13 September 2018 prior to our meeting at 4pm to discuss finalising of the paper.

24.43 On 18 September 2018, Mr Devlin's secretary advised that the 20th September could not go ahead. I do not recall the specific reason and it is not documented in my e-mails.

24.44 On 20 September Dr Khan contacted me via e-mail to advise:

"Siobhan, I discuss this with Grainne today. She agrees that conduct panel hearing with restriction on practice i.e. action plan would be appropriate. Can you further update the attached report for this and add reference to GMC Good Med; practice standards. (See comment in red). Talk to you on Monday."

24.45 This e-mail referred to a discussion Dr Khan held with Ms Grainne Lynn, NCAS on 20 September 2018.

24.46 The meeting with Mr Devlin and Mrs Toal which Dr Khan and I both attended took place fairly soon after the initial planned date of 20 September 2018. I have no documentary evidence to rely upon to be factual exact on this. I believe the discussion took place in Trust Headquarters and everyone was available but I have no record of the date or time.

24.47 The case determination was finalised following this discussion. I sent Dr Khan a final draft of the case determination paper on 25 September 2018. On 25 September 2018, I also sent Dr Khan a draft e-mail for sending to Mr O'Brien

advising that he had completed his considerations of the investigation report and was now in a position to meet with him. Dr Khan sent the correspondence to Mr O'Brien on 26 September 2018 offering five dates on which he was available to meet.

24.48 Mr O'Brien was unable to meet on any of the proposed dates due to already scheduled clinical commitments and therefore proposed further alternative dates. Dr Khan e-mailed me on 27 September 2018:

> *Siobhan, see email. Can you keep Monday 1st Oct 11-1pm free for this please. I will confirm tomorrow morning. We are due to meet tomorrow to finalise this report anyway.*

24.49 The meeting with Mr O'Brien was confirmed for 1 October 2018 in Craigavon Area Hospital. On 28 September 2018, Dr Khan e-mailed me to advise:

> *"Siobhan, we will need to finalise this report today with few amendments as per NCAS letter. I met eith CX last evening, Final report have to be sent to CX this pm. As we are going to meet Mr AOB on Monday. An email confirming time and venue will also need to be sent to him this am. Can you come at 11ish to DHH instead to complete these together as I have another meeting at 1pm?"*

24.50 Dr Khan and I met on 28 September 2018 to discuss final changes to the case manager determination paper and later that day I sent him the final paper.

24.51 The meeting took place on 1 October 2018. Dr Khan and I attended. Mr O'Brien attended with both his son, who had accompanied him to meetings during the course of the investigation and also his wife. Both were present at the meeting.

24.52 Dr Khan presented the case manager determination to Mr O'Brien and advised him of the next steps as set out within the paper. I typed and shared key points of note from the meeting and shared this with Dr Khan in an e-mail dated 3 October 2018.

24.53 Throughout the course of the formal investigation, I, on behalf of Dr Chada, provided case updates to Dr Khan, Case Manager and on occasion directly to John Wilkinson, designated Board member. On other occasions, Dr Khan shared my updates on-wards with Mr Wilkinson. The updates provided details on the stage of the investigation, progress being made and information on delays. On review of the relevant e-mail updates, all of which have been previously provided, the dates are:

Case updates to Ahmed Khan from me

a) 12 April 2017 - I provided an update to Dr Khan.
b) 4 May 2017 – Dr Khan requested an e-mail update from me
c) 15 May 2017 – I provided the update to Dr Khan as requested.
d) 15 May 2017 – Dr Khan shared the update with Mr Wilkinson
e) 25 June 2017 – I sent an update to Dr Khan
f) 26 June 2017 – I requested Dr Khan to update Mr Wilkinson on case timescales.
g) 27 June 2017 – Dr Khan updated Mr Wilkinson
h) 4 October 2017 – I sent an update to Dr Khan
i) 4 October 2017 – Dr Khan shared the update with John Wilkinson
j) 20 November 2017 – I provided an update to Dr Khan
k) 7 February 2018 - Dr Khan requested an update from me
l) 15 February 2018 – I provided the update Dr Khan and Mr Wilkinson as requested.
m) 4 March 2018 – I provided an update to Dr Khan and Mr Wilkinson
n) 29 March 2018 – I provided an update sent to Dr Khan and Mr Wilkinson
o) 10 June – Mr Wilkinson requested an update on timescales involved with the case and asked me to endeavour to expedite ASAP.

24.54 I was not party to or have knowledge of, any discussions the case manager or the designated Board member had with Mr O'Brien or any other individual regarding delay within the investigation process.

25. Outline what steps, if any, you took during the MHPS investigation, and

outline the extent to which you were kept appraised of developments during the MHPS investigation?

25.1 My response to questions 17 through to 24 sets out a comprehensive chronology of the steps I took during the MHPS investigation. I was at all times fully appraised of developments with the MHPS investigation, as I was centrally involved in providing HR support.

MHPS Determination

26. Outline the content of all discussions you had with Dr Ahmed Khan, regarding his Determination under Section I paragraph 38 of MHPS.

26.1 My response to question 24 sets out the full chronology of e-mail correspondence between Dr Khan and I in respect of the discussions we had about the case manager determination.

26.2 Dr Khan and I also met a number of times to discuss the format of the paper, the content and Dr Khan's decision. I did not take a formal note of the discussions however, the change to each draft of the case manager's determination paper highlights the changes we discussed. All drafts have been previously provided.

26.3 During the course of the discussions on the review of the investigation report, we discussed the facts that were known and any fact that was in dispute. We discussed Mr O'Brien's response to the case investigator by way of his statements as part of the process. There was some difference in view, between the case investigator's report and Mr O'Brien, in terms of numbers of notes and undictated clinics, however this was largely immaterial given the scale of the concerns. The operational team were systematically working through the look back and we were assured all patients impacted would be picked up through this exercise. Mr O'Brien's response to the case investigator, in the main, focused on providing context and mitigation. There was no material dispute to the matters of concern.

26.4 On this basis it was evident there was a case of concern that required further action. Mr O'Brien's health was not a significant factor and we concluded early in the discussions that it was not a health related case.

26.5 There were then two key areas of focus in respect of the discussions we had, which were:

a) Performance versus conduct - how the case should be categorised.
b) The history of and knowledge by managers of the issues of concern going back a number of years and the system failings that contributed to the issues of concern reaching the level they had in December 2016.

26.6 We discussed at length the categorisation of the concerns in terms of whether this was a case of concern regarding conduct or a case of concern regarding clinical performance.

26.7 During the course of the investigation process and contained within the witness statements of clinical colleagues and operational managers, Mr O'Brien was highlighted as being a competent clinician. We heard from some witnesses that Mr O'Brien was an excellent surgeon and provided an excellent service to patients. There was no concern raised about Mr O'Brien's clinical management of a patient. The issues of concern, or rather frustrations, being raised was that Mr O'Brien was slow and very detailed in his patient reviews and follow up letters to the detriment of volume of patients i.e. he saw many fewer patients than his colleagues.

26.8 The focus of the investigation from the outset was on the administrative practices of Mr O'Brien. We heard during the course of the investigation that 'how' Mr O'Brien worked was different from his colleagues e.g. he did not use digital dictation and he was involved in the scheduling of his patients.

26.9 It was highlighted that discussions had happened over many years with Mr O'Brien about his requirement to comply with timely triage, dictation and about

the storage of notes and it seemed Mr O'Brien would alter his practice for a short period but then revert to his own way of working. Dr Khan and I discussed the fact that Mr O'Brien, during the course of the formal investigation, had been compliant with the monitoring arrangements in place highlighting that Mr O'Brien was capable of working in the 'expected or complaint' way.

26.10 We discussed the issue regarding storage of notes at home and his scheduling of private patients and the fact that these were matters entirely unrelated to clinical practice but something Mr O'Brien was making an active choice to do. We discussed that these matters were behavioural concerns.

26.11 The matters related to Mr O'Brien's triage and dictation were discussed at length. We considered his urology consultant colleagues as comparators in terms of workload. There was no doubt workloads were huge and this was the case for all urologists. Problems were known in the system about Mr O'Brien's triage and dictation and that it was 'behind or slow'. One of the key factors we discussed was Mr O'Brien's failing to explicitly advise anyone within the Trust of the scale of the problem or the fact that he was simply not triaging routine or urgent referrals at all. We discussed that Mr O'Brien was clinically competent and able to triage, he simply didn't do it. It was the same issue in respect of dictation. We discussed the responsibility on Mr O'Brien as a very senior medical staff member to be clearly highlighting the extent of the delay or backlog, which we didn't do.

26.12 We discussed that the onus was not solely on Mr O'Brien to have been highlighting the extent of the problem explicitly and clearly but that there required to be robust systems in place to ensure the extent of the concerns were known much earlier or in fact prevented from occurring at all. We discussed that there appeared to be an avoidance by managers over a number of years to robustly manage the concerns with Mr O'Brien and to ensure his practice was in line with his colleagues and the expected practice of the Trust. Dr Khan was clear that he wanted to highlight in his paper that the systemic issues required review.

26.13 It was based on these discussions that Dr Khan concluded a conduct process was appropriate rather than a clinical performance process. The full detail

of his considerations are set out in the case manager's determination paper, which was shared with Mr O'Brien at a meeting with him on 1 October 2018.

27. On 28 September 2018, Dr Ahmed Khan, as Case Manager, made his Determination with regard to the investigation into Mr. O'Brien. This Determination, inter alia, stated that the following actions take place:

I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr. O'Brien to provide assurance with monitoring provided by the Clinical Director;

II. That Mr. O'Brien's failing be put to a conduct panel hearing; and

III. That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.

With specific reference to each of the determinations listed at (I) – (III) above address:

A. Who was responsible for the implementation of each of these actions?

B. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and

C. If applicable, what factors prevented that implementation.

D. If the Action Plan as per 27(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

27.1 The case manager determination from Dr Khan did not go into detail about how the actions would or should progress. The detail of that was something that was always going to need some working through.

27.2 The case manager's determination was shared with Mr O'Brien on 1 October 2018 and it was my understanding that following the meeting with Mr O'Brien, discussion about how the actions were to be implemented would be

progressed, by Dr Khan as case manager who was also holding the role of Medical Director for the Trust. To progress each action, engagement was required with a number of people regarding each specific action:

I. The implementation of the Action Plan

27.3 I was not involved in or party to any discussions regarding the action plan.

II. The conduct panel hearing

27.4 In follow up to the 1 October 2018 meeting, I sent a draft correspondence to Dr Khan on 30 October for sending to Mr O'Brien, to begin to secure suitable dates for a conduct panel hearing. I do not recall if Dr Khan asked me for this draft or if I sent it to him in order to move this action along. This action was the one out of the three that required to be progressed with input from HR.

27.5 Following legal advice in respect of the process, it was advised that a panel member with urology specialism would be required for the panel as the issues of concern were professional misconduct.

27.6 I sent a further updated draft e-mail to Dr Khan on 26 November 2018 ***(located at S21 47 of 2022 Attachments 10. Draft e-mail to Mr O'Brien)*** to advise:

> *"Dr Khan, The previous draft e-mail referred to the 14th December as a possible date for the hearing. As the external panel member cannot do this date, I think we have no alternative but to notify Mr O'Brien that a date before Christmas is not possible due to diary commitments of those involved. I think we should ask him for his availability for January to see what we can work to. Are you happy to send an e-mail on this basis?"*

27.7 Dr Khan sent this e-mail on 28 November 2018 to Mr O'Brien. On 2 December, Mr O'Brien lodged a formal grievance with the Trust (***located at Relevant to HR/Evidence after 4 November HR/Reference 77/20181203 - Email***

- FW Re MHPS Investigation). He sent the e-mail to Dr Khan, copied to Mr Wilkinson. As part of this grievance e-mail, he set out:

> *"I have submitted an extensive Formal Written Grievance, dated 27 November 2018, to the Chief Executive of the Southern Health & Social Care Trust, Mr. Shane Devlin, in person, on Friday 30 November 2018. In doing so, I have requested that the Trust should immediately confirm that no steps will be taken to bring matters to a Conduct Panel hearing until the Grievance has been fully resolved."*

27.8 Once notified of this, I took no further steps to progress the conduct panel.

III. The independent review of administrative practices

27.9 In November 2018, I was not involved in or party to any discussions regarding the review. I recall Dr Khan speaking to me about it in terms of it needing to be progressed but I was not involved in any discussions about how this was to happen. I became aware because of my attendance at urology assurance group meetings in 2020 that this had not progressed in 2018.

Implementation and Effectiveness of MHPS

28. Having regard to your experience as Head of Employee Relations / Deputy Director of HR & Organisational Development, in relation to the investigation into the performance of Mr. Aidan O'Brien, what impression have you formed of the implementation and effectiveness of MHPS and the Trust Guidelines both generally, and specifically as regard the case of Mr. O'Brien?

28.1 I have been aware of and involved in using the MHPS Framework (2005) for many years. In regards to my experience in my roles of Head of Employee Relations / Deputy Director – HR Services, I would comment:

28.2 Within the Southern HSC Trust, the number of concerns being managed under the MHPS Framework has incrementally increased in usage since 2007. I

am aware that discussions started between DoH and Trusts about a review of the MHPS Framework but this did not complete. I feel it is important and necessary to progress this review as a matter of priority.

28.3 The MHPS Framework is the document setting out the requirements for managing concerns about performance and is the document relied on when a concern arises. The Trust Guidelines were put in place, as a requirement under MHPS, setting out how cases are practically managed.

28.4 The MHPS Framework:

a) Is a lengthy framework, difficult to read and follow as it is not always in a logical sequence.

b) It is a mix of statement and process, which is unhelpful and I feel the document could be much better structured to give a step by step process for employers and employees.

c) Because of the length and structure, it is complicated and as someone with experience in my role using the document, I find I need to read the document carefully every time, many times over to understand each step and what needs to be actioned.

d) For clinical managers who don't often use the Framework, I have found they require significant support to navigate the process.

e) The Framework refers to 'all concerns' when it points to when it should be used to manage performance concerns and registered with the Chief Executive. There is always on-going management of performance and it is impractical to suggest that the Framework will be used for every single concern.

f) The intention of the Framework, as it is set out, is to tackle blame culture and to ensure for swift and timely resolution of concerns. I agree with

this, however in practice, it doesn't always work. The case of Mr O'Brien had a historical 'tail' to it so when it came to being managed under MHPS that, along with the scale and volume of patient records involvement, meant that a quick process was unrealistic.

g) The timescale for completion of formal investigations is entirely unrealistic. For this to be achievable in any way, individuals with roles under the process would require to be released from their normal day to day roles. The co-ordination of diaries alone to commence a process when individuals already have full diary commitments is hugely problematic. The seniority of those individuals with specific roles under the Framework makes this impractical.

h) The timescale for completion of the investigation is the same as the timescale for completion of the fact finding during a period of immediate exclusion – this is a clear contradiction in timescales.

i) The term 'clinical performance' is broad and can be interpreted differently by different users of the Framework. In my experience, separating conduct issues from clinical impacts or decisions can be difficult. I feel that the clinical performance process is overly cumbersome and doesn't necessarily assist employers to easily deal with conduct matters.

j) It is challenging to navigate cases when local Procedures for managing absence, conduct and conflict should be used and how they link with MHPS.

k) The role of the designated Board member is unclear under the Framework, specifically when representations are made to the Board member. What is their role in dealing with such representations? In the case of Mr O'Brien this was a challenge.

l) Case managers and case investigators need to build expertise in managing cases to become proficient – this is difficult as the number of formal cases is generally small and these are individuals who may only undertake the role once or a small number of times in their careers.

m) The representation / accompaniment rights under the Framework are wider than those for other employees. The rights of an employee to have 'a friend who is legally qualified' accompany them as part of the internal process, 'but not act in that capacity' is a distinction without a difference, in practice. Legally qualified participants to the process inevitably legalise and slow the process.

n) In my experience, MHPS processes, right from the screening of a concern, becomes adversarial. The Framework, specifically the timescales, takes no account of the initial input or correspondences from a clinician. Having supported a range of different types of cases / concerns, I have experienced responses from clinicians to include distraction, deflection and non-engagement. Some clinicians become very unwell as a result of the process.

o) Resources and training – MHPS processes are resource intensive and as a Trust, capacity is always challenging. There are many individuals who are required to input time to an MHPS process.

p) In respect of the Trust Guidelines, specifically the HR role, I feel this requires greater clarity provided within the document. My role as part of the MHPS process in the case of Mr O'Brien commenced as support to the case investigator but expanded to providing support to the case manager and extended past the end of the investigation process mainly because of my knowledge of the case. Roles and responsibilities need to be defined under the Trust Guidelines.

29. Consider and outline the extent to which you feel you can effectively

discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

29.1 Each case is different and fact-specific. Supporting each case has been different in my experience. The main challenges I find are:

a) Capacity to undertake investigations quickly- this is always a challenge with an existing substantial workload. HROD has not been resourced adequately to support MHPS cases and so HR advisors are generally supporting these cases on top of their own roles. Mrs Parks is the main HR advisor for cases and is also carrying responsibility as Head of Service for the medical HR service.

b) It is a challenge for HR staff supporting case managers and case investigators as they, in my experience generally require significant support, as the MHPS process is something they are involved in infrequently. There is a need for robust training available for new clinical managers and HR managers, which I believe should be regionally provided and available through DoH.

c) Openness and candour needs reinforced as part of the Framework for all involved.

d) When issues of clinical performance arise in specialist areas, there is a reliance on colleagues with personal relationships over many years to raise or manage the concerns which proves difficult.

e) Medical management – Clinical Directors and Associate Medical Directors need training and job plan time to properly and effectively manage staff.

30. Having had the opportunity to reflect, outline whether in your view the MHPS process could have been better used in order to address the

problems which were found to have existed in connection with the practice of Mr. O'Brien.

30.1 Having had the opportunity to reflect I feel:

a) There were early missed opportunities to manage the concerns before the scale of the concerns escalated. More effective and robust management of Mr O'Brien's performance informally over many years may have reduced the risks to patient safety.

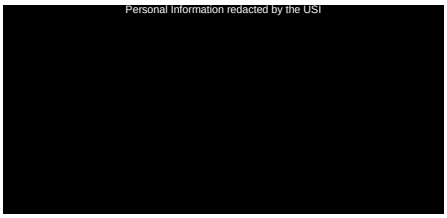
b) Holding to account – opportunities to address and ensure Mr O'Brien was working within the systems that others were e.g. scheduling of patients.

c) On reflection the formal investigation took too long and Mr O'Brien was at times enabled / permitted to dictate the timescale.

d) Given the scale of the concerns and what was known early on – release for key individuals to attend to the process should have been given.

Statement of Truth

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

Signed: 

Date: 03 August 2022

Section 21 Notice Number 47 of 2022

Witness Statement: Siobhan Hynds

Table of Attachments

Attachment	Document
1	RE Investigation
2	Human Resources Manager Band 7
3	Employee Relations Manager Band 8A
4	HR Assistant Director for OPPC Band 8B (Acting)
5	Head of Employee Relations Band 8A
6	Deputy Director HR Services Band 8C
7	staff in post list Employee Relations Staff in Post 2008 to 2018
8	sai papers as agreed
9	RE Return to Work Action Plan February 2017 FINAL.
10	Draft e-mail to Mr O'Brien

From: Carroll, Ronan <[redacted]>
Sent: 03 March 2017 10:23
To: Hynds, Siobhan; Corrigan, Martina
Cc: Chada, Neta
Subject: RE: Investigation

Importance: High

Siobhan
Update

1- Untriaged referrals updated yesterday – this pt in red text will require an SAI. At time of typing I don't know if pt has been informed re this confirmed diagnosis and the prognosis. I do not know if AOB has also been informed as he did not attend the MDT yesterday, where this pt was discussed

62 Day Pathway

- 19 patients in total
- **1 patient ([redacted]) with confirmed High Grade Urothelial cancer, G3 pT4a. cancer (path confirmed today)** This patient has had TURBT so pathway has been closed at D209, he is listed for MDM discussion today re further management
- 12 are now closed,
- 3 awaiting diagnostics/results
- 3 awaiting TRUSB appointment.

31 Day Pathway (not tracked)

- 5 patients in total
- 4 closed – no cancer
- 1 patient declined offers as was feeling well and has been discharged.

2 - outcome of undictated outpt clinics – essentially has not started – consultants aware this needs to start and be completed
3 - trawl of PP's within 2016 operating – there are approx. 900 pts to go through on NIECR. About 450 pts have been checked and 6 out of the 450 have been seen by AOB at some point which is 1.3%

Monitoring of AOB work e.g. OPD, theatres etc has not yet commenced as prior to his return all the required activity had been reallocated to locum

Hope this help
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Hynds, Siobhan
Sent: 03 March 2017 00:50
To: Carroll, Ronan; Corrigan, Martina
Cc: Chada, Neta
Subject: Investigation

Ronan / Martina

Can we get an update on the reviews being done by the Urologists? Is there any information which can be shared as part of the investigation yet?

Many thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by the USI Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI

Click on the above image for SharePoint: Employee Engagement & Relations information

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SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE	HR Manager – Employment Law & Case Management
BAND	
DEPARTMENT	Employee Engagement & Relations, HROD Directorate
LOCATION	
REPORTS TO	Head of Employee Engagement & Relations
ACCOUNTABLE TO	Director of Human Resources and Organisational Development

JOB SUMMARY:

The HR Manager in Employment Law and Case Management will assist the Head of Employee Engagement & Relations in the provision and ongoing development of a positive employee relations climate.

The postholder will provide specialist human resource advice on a range of employee relations issues including disciplinary and grievance matters, attendance management, capability issues, bullying and harassment allegations.

The postholder will also be responsible for ensuring that systems and processes are in place to ensure employee relations issues such as tribunal proceedings, redeployments, probationary and preceptorship periods etc. are effectively discharged.

MAIN RESPONSIBILITIES

Service Delivery & Policy Development

1. Play a key role in the development and maintenance of a positive employee relations climate within the Southern Trust.

2. Ensure that Case Management staff are appropriately allocated to support managers in the investigation / resolution of disciplinary and grievance and other employee relations issues, such as bullying / harassment allegations, performance / capability, attendance management.

3. Maintain a caseload of employee relations cases, particularly more complex cases, coaching and advising managers on dealing with difficult and contentious employment issues, liaising with legal advisers and statutory agencies as required. Participate, where appropriate, on panels and assist with decision making.

4. Play a key role, in close working collaboration with senior HR staff and other key stakeholders, in the development of a range of innovative and best practice initiatives to support reductions in levels of absence across the Trust.

5. Lead on the development and provision of 'drop in' sessions for managers at all levels within each locality area, covering a range of HR related topics such as grievance, attendance management, capability.

6. Manage and act as a resource in supporting and developing staff within the HR Case Management Team.

7. Assist the Head of Employee Engagement & Relations in the development, implementation and monitoring of a suite of easily understood employee relations policies, ensuring that support and training is provided to enable appropriate and consistent application.

8. Support the Head of Employee Engagement & Relations in determining the impact of new employment legislation / case law, implementing any subsequent changes in policy / practice through effective communication, including the issuing of guidelines and provision of training to secure appropriate and consistent application.

9. Support the Assistant Directors of HR in fulfilling their role as business partners within the various directorates. Participate in the delivery of projects or pieces of work as commissioned by the Head of Employee Engagement & Relations, Assistant Directors of HR or Director of HR & Organisational Development.

10. Ensure that robust systems are developed to monitor processes such as probationary & preceptorship periods, use and extension of temporary contracts, social work trainee periods etc.

11. Work with managers to ensure they fulfil their responsibilities with regards to improving the quality of working lives for staff and supporting healthy workplace initiatives.

Communication & Information Management

1. Establish and maintain an effective working relationship with Trade Union representatives on matters relating to employment law and case management.

2. Establish and maintain an effective working relationship with the Occupational Health Department in the delivery of initiatives to support good staff attendance.

3. Provide regular information to the Head of Employee Engagement & Relations on progress in relation to ongoing cases and employee relations activity.

4. Work with the Head of Employee Engagement and Relations in the provision of HR reports for the Trust Board to ensure full reporting against all HR aspects of the Trust's Delivery Plan, Priorities for Action, Directorate Performance Plan.

5. Develop an effective HR library of employment legislation / case law related information etc, which is easily accessible by all HR staff.

Building People Management Capacity

1. Develop, use and maintain a call logging system that will inform the assessment of support for managers development / training needs and demonstrate HR activity and interface with managers.

2. In collaboration with the Education, Learning & Development Department, assist in the development of a HR Manager's toolkit of easily understood procedures, guidelines, frequently asked questions etc in support of the range of HR policies, to underpin the skills competencies of managers in managing their staff.

3. In collaboration with other senior HR staff, support the development of capacity and capability of managers by designing and delivering specialist HR training courses on a range of HR policies and procedures.

4. Undertake ongoing critical analysis of employee relations information, eg disciplinary, grievance, bullying/harassment cases to identify trends or to highlight either practice deficiencies or potential development needs so that lessons learned can be effectively absorbed within the Trust.

5. Recognise and use opportunities where appropriate to adopt the role of 'coach' rather than 'advice giver' to encourage managers to develop their own solutions to people management problems.

Quality

1. Ensure that the needs of patients and their carers are at the core of the way the Trust delivers its services.

2. Support the achievement of relevant controls assurance standards for HR.

3. Ensure that robust performance management standards are developed and implemented within remit of the role.

People Management & Development

1. Deputise for the Head of Employee Engagement & Relations in his / her absence on a rotational basis with other HR Managers within the Employee Engagement & Relations function.

2. Lead and empower a team of HR staff providing expert advice to Trust Senior / Middle / Junior Managers within service areas.

3. Delegate appropriate responsibilities and authority to staff consistent with effective decision making whilst retaining accountability for results.

4. Review the performance of direct reports on a regular basis and to provide direction of personal development requirements and action in accordance with the Knowledge & Skills Framework.

5. Take responsibility for own performance and take action to identify personal development areas.

6. Maintain good staff relationships and morale amongst staff reports through effective feedback, recognition, appraisal and development.

General Requirements:

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
  - Smoke Free policy
  - IT Security Policy and Code of Conduct
  - standards of attendance, appearance and behaviour

- Comply fully with the Trust's policy and procedures regarding records management, as well as the Data Protection Act, accepting legal responsibility for all manual or electronic records held, created or used as part of his/her duties, and ensuring that confidentiality is maintained at all times.

- Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

HR MANAGER – EMPLOYMENT LAW & CASE MANAGEMENT, BAND 7

PERSONNEL SPECIFICATION

JOB TITLE HR Manager, Band 7

DIRECTORATE Human Resources and Organisational Development

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

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

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

1. You must be an employee of the HROD Directorate of the Southern Health & Social Care Trust, to be eligible to apply for this post. You must therefore clearly demonstrate this on your application form. **Please note that failure to do this will result in you not being shortlisted.**

2. Degree or recognised professional qualification or equivalent / higher qualification in a Business / Human Resources related subject AND a minimum of 2 years' HR experience at Band 6 or above, involving a key role in the provision of advice and guidance to managers on a range of HR matters.

   OR

HNC / HND or equivalent / higher qualification in a Business /Human Resources related subject AND a minimum of 3 years' experience in an administrative role, 2 years of which must be HR experience at Band 6 or above involving a key role in the provision of advice and guidance to managers on a range of HR matters.

OR

a minimum of 5 years' experience in an administrative role, 2 years of which must be HR experience at Band 6 or above involving a key role in in the provision of advice and guidance to managers on a range of HR matters.

3. Demonstrate effective communication skills, which will meet the needs of the post in full.
4. Experience of using Microsoft Office applications.
5. Have a knowledge of employment legislation and Terms and Conditions of employment.
6. Experience of working in partnership with trade union side.
7. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[2].

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

8. Have the ability to develop and maintain credibility with a range of staff / managers at all levels of the organization.
9. Have excellent organisational skills, and the ability to work within tight timescales.
10. Effective planning and organisational skills with an ability to prioritise own workload.
11. Ability to work on own initiative.
12. Ability to drive change successfully throughout the organisation.
13. Ability to develop and implement policies and/or strategies
14. An insight into the issues facing the Trust at a Corporate Level.

The following are desirable criteria.

15. Experience of undertaking complex investigations and production of associated reports.

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[2] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

88207052

SOUTHERN HEALTH AND SOCIAL SERVICES TRUST

Head of Employee Engagement & Relations

JOB DESCRIPTION

Reports to:
Director of Human Resources & Organisational Development

Role Purpose:
The post holder will be responsible for ensuring the development and implementation of policies and procedures that will maximise the contribution of staff towards the aims and objectives of the Trust. He/She will take a lead role in developing and promoting a culture that will promote the health and well being of staff. This will involve working with the Assistant HR Directors in the development of policies and procedures where the contribution of each member of staff is recognised and acknowledged. He/She will also develop structures and processes that allow for direct employee participation in decision making along with developing genuine partnership with staff side organisations. The post holder will also be responsible for ensuring that systems and processes are in place to ensure employee relations issues such as industrial tribunal proceedings, application of terms and conditions, disciplinary/grievances, redeployments etc are effectively discharged

KEY AREAS OF RESPONSIBILITY

1.0 Service Delivery and Policy Development

1.1 To assist the Director of Human Resources and Organisational Development and Assistant Directors in the development of policies and practices that promote and establish effective staff engagement.

1.2 To ensure that the Trusts structures, policies and procedures for consulting and informing staff not only meet the statutory standards but are reflective of best practice.

1.3 To develop an action plan with Assistant Directors HR to tackle identified need within each of the Directorates.

1.4 To support the Assistant Directors in undertaking a range of investigations such as discipline, grievance, harassment etc to ensure the necessary resources are deployed and that any lessons learnt are effectively absorbed within the Trust.

1.5 To establish systems within the Trust that ensures that the Trust is in a position to respond to Industrial Tribunals cases and to ensure that any lessons learnt are effectively absorbed within the Trust.

1.6 To support the Assistant Directors to ensure that the Trust is in a position to meet statutory obligations in the area of employee engagement both current and in the future.

1.7 To fully support senior staff in understanding the modernisation Agenda including Agenda for Change Terms and Conditions and in the implementation of these to meet the modernisation targets set by the Trust and the Department of Health, Social Services & Public Safety (NI).

2.0 Organisational and Workforce Development

2.1 To work closely with the Head of Education, Learning and Development in order to ensure that changes within the organisation are being communicated effectively and that they are promoting a culture that maximises the contribution of each individual towards the goals of the Trust.

2.2 To advise senior management on the development and implementation of policies and procedures in support of the changing employee engagement culture within the organisation.

2.3 To support Line Management in the provision of advice on the development, management, implementation and monitoring of the health and well being policy, including the policy on absence management.

3.0 Communication and Information Management

3.1 To work with the Director of Human Resources and Organisational Development and the Assistant Directors, to ensure that staff have opportunities to receive information about issues which affect their employment, including objectives and policies, Trust performance and standards to be met.

3.2 To work with the Assistant Directors to establish mechanisms within the Trust that promote the engagement of staff such as team briefings, staff appraisals focus groups etc and to monitor their effectiveness.

3.3 To take a lead role with the Head of Information and Resourcing, in the development of key indicators that continually monitor the health of the workforce.

3.4 To work with the Assistant Directors to develop mechanisms to capture the health of the workforce ranging from attitude surveys, focus groups, exist interviews, questionnaires' etc.

3.5 In conjunction with the Head of Communications to develop and implement effective HR communication policies to enable the promotion of an effective employee relations environment.

4.0 Quality

4.1 To promote good practice in monitoring of relevant Performance Management Targets, e.g. Priorities for Action.

4.2 To contribute information to the monitoring of HR Controls Assurance Standards, preparing responses and updating relevant Action Plans.

5.0 Financial and Resource Management

5.1 To work within Human Resources budgetary constraints, and assist senior staff in costing specific interventions.

5.2 Authorise expenditure in accordance with the financial limits and procedures delegated by the DHR.

6.0 People Management and Development

6.1 To lead and empower a highly specialist team of Human Resource staff, providing expert advice to Trust senior managers, and general advice through the business partnering model.

6.2 To delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.

6.3 To participate in the Trust's performance appraisal system reviewing the performance of direct reports on a regular basis.

6.4 To ensure to all staff develop an annual personal development plan and that development needs are met using a variety of methods.

6.5 To contribute as an effective member of the senior Human Resources team.

6.6 To take responsibility for his/her own performance and take action to address identified personal development areas.

6.7 Maintain good staff relationships and morale amongst the staff reporting to him/her.

6.8 To promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.

6.9 Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6.10 Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

6.11 Promote the Trust's policies on 'equality of opportunity', and the promotion of 'good relations' through his/her own actions, and ensure that these policies are adhered to by staff for whom he/she has responsibility.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the level of the post may be assigned from time to time.

GENERAL RESPONSIBILITIES

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

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

June 2007

SOUTHERN HEALTH AND SOCIAL SERVICES TRUST

Head of Employee Engagement & Relations

PERSONNEL SPECIFICATION

Knowledge, skills and experience required:

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

- have a university degree or relevant professional qualification, in Human Resource Management or Learning and Development at graduate or diploma level, **and** worked for at least 2 years in a senior human resources role*

OR

- have worked for at least 4 years in a senior human resources role*

AND

- have delivered against challenging performance objectives for a minimum of 2 years in the last 6 years meeting a range of key targets and making significant improvements**.
- possess excellent communication and interpersonal skills with a proven track record of having worked with a diverse range of stakeholders, internal and external to the organisation, for a minimum of 2 years in the last 6 years.
- have a proven track record of people management and organisational skills for a minimum of 2 years in the last 6 years.
- hold a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

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

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at the web-site: nhsleadershipqualities.nhs.uk Particular attention will be given to the following:

- Self Belief

- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

* "senior human resources role" is defined as experience gained working at a minimum level of Admin and Clerical Grade 6 or equivalent.

**"significant" is defined as contributing directly to key corporate objectives of the organisation.

June 2007

Southern Health and Social Care Trust
Assistant Director of Human Resources
Band 8B

Job Description

JOB SUMMARY

The Assistant Director of Human Resources will report professionally to Director of Human Resources and Organisational Development,(DHR&OD). He/she will be the primary HR interface within the directorate to which they are aligned and will form part of that directorate's senior management team and report directly to that Director on a day to day basis. As a member of that team he/she will provide leadership and high quality advice on HR issues and will commission appropriate HR interventions to meet the objectives of the various functions/departments within the directorate.

With the other HR Assistant Directors and the DHR&OD he/she will act as member of the Trust's Senior Management Team and actively support its role of ensuring that the Trust's corporate objectives are being supported and delivered within the HR Strategy. This will include corporate direction, organisational change, strategy development and implementation, HR quality assurance and corporate information. He/She will be allocated a lead role to ensure that specific objective(s) in the Trust's Human Resources Strategy are achieved.

KEY RESULTS AREAS

Service Delivery

- provide clear and strategic leadership in the development and implementation of human resource policies, procedures and practices, to ensure that the aligned directorate has a highly skilled, flexible and motivated workforce to provide high quality care.

- take a lead role, with senior managers in the aligned directorate, on strategic development, organisational design and change management and be responsible to the appropriate director for delivering in these areas.

- take a lead role in the development and delivery of the aligned directorate's workforce plan and modernisation, learning and development strategy and the implementation of workforce objectives.

- work closely with senior staff in the directorate to ensure that line managers and team leaders are empowered to deliver high quality people management practices and effectively implement Trust HR polices and procedures.

- achieve high levels of performance and excellence against human resource controls assurance standards.

- provide high quality advice on the HR implications of the Trust's Delivery Plan and support the delivery of same.

- identify issues and trends impinging on the directorate's ability to recruit and retain a highly skilled and flexible workforce and implement the appropriate HR interventions to support optimum staff productivity and performance.

- work closely with senior colleagues to ensure high quality employee relations in the directorate.

- lead on workforce quality initiatives for the directorate such as enabling line managers to secure maximum benefits realisation from the NHS Knowledge and Skills Framework and Investors in People.

Corporate Human Resources Management

- support the Director of Human Resources and Organisational Development with the development, implementation and review of all Trust HR policies and strategies.

- as delegated by the Director of Human Resources and Organisational Development assume the lead role for the effective implementation of Trust wide HR initiatives.

- deputise for the Director of Human Resources and Organisational Development as may be required and represent him/her at regional human resource fora.

Financial and Resource Management

- responsible for commissioning, both internally and externally, to ensure the education, training and development needs of staff within the aligned directorate are met.

- co-operate with and contribute to the establishment of an effective shared service framework for the delivery of human resources.

- work closely with other members of the aligned directorate's senior management team to ensure that efficiency targets that impact on the workforce are being achieved.

People Management

- provide leadership within the aligned directorate for the promotion of equality and diversity initiatives

- advise members of the senior management team within the aligned directorate on their management structures and practices, to support a culture of effective team working, continuous improvement and innovation.

- advise the directorate's senior management team on the effective management of staff support.

Corporate Responsibilities

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.

- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.

- maintain good staff relationships and morale amongst the staff reporting to him/her.

- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.

- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

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

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

GENERAL RESPONSIBILITIES

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

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.

- comply with the Trust's No Smoking Policy.

- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.

- adhere to equal opportunities policy throughout the course of their employment.

- ensure the ongoing confidence of the public in service provision.

- comply with the HPSS code of conduct.

RECORDS MANAGEMENT

The jobholder will be responsible to the Director for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

February 2007

Southern Health and Social Care Trust
Assistant Director of Human Resources
Band 8B

Personnel Specification:

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are working in a substantive post in either Armagh and Dungannon HSS Trust, Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community HSS Trust or Newry and Mourne HSS Trust and have:

- a university degree or relevant professional qualification in a human resource management related subject and worked for at least 2 years in a senior management role within Human Resources in a major complex organisation.

OR

- worked for at least 4 years in a senior management role within Human Resources in a major complex organisation.

AND

- delivered against challenging performance improvement programmes for a minimum of 2 years in the last 6 years meeting a range of key targets and making significant improvements.

- excellent communication and interpersonal skills with a proven track record of having worked with a diverse range of stakeholders, both internal and external to the organisation for a minimum of 2 years in the last 6 years.

- a proven track record of people management and organisational skills for a minimum of 2 years in the last 6 years.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified. Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework. Particular attention will be given to the following:

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

"senior management role" is defined as experience gained at Director, Assistant Director or equivalent to mean reporting directly to a Director.

"major complex organisation" is defined as one with at least 200 staff or an annual budget of at least £50m and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders.

February 2007

SOUTHERN HEALTH & SOCIAL CARE TRUST

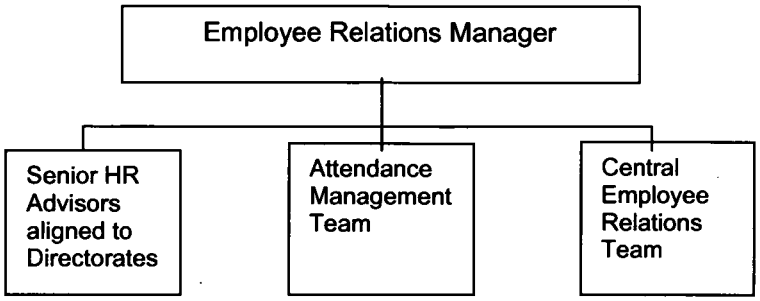
JOB DESCRIPTION

JOB TITLE: Employee Relations Manager

BAND: Band 8a

REPORTS TO: Director of Human Resources & Organisational Development (in the first instance).

ORGANISATIONAL STRUCTURE:



JOB SUMMARY: The postholder will be responsible for the efficient and effective management and leadership of the Employee Relations team who provide a comprehensive operational Employee Relations service to managers at all levels in order to support the Trust in achieving its objectives.

MAIN RESPONSIBILITIES

Service Delivery & Policy Development

1. The postholder will be responsible for ensuring systems and processes are in place to ensure employee relations issues such as caseload management, tribunal proceedings, attendance management, HRMS processing, operational implementation of organisational change initiatives including redeployments, probationary periods, management of temporary contracts, terms and conditions advice etc. are effectively managed.

2. Be responsible for the allocation of work and activity planning within the Employee Relations Team, ensuring the most appropriate and flexible use of resources, taking account of competing priorities.

3. Provide guidance to Senior HR Advisors on particular cases, coaching and advising them on dealing with difficult and contentious employment issues, liaising with legal advisors and statutory agencies as required. Participate, where appropriate, on panels and assist with decision making.

4. Provide guidance and direction to the Attendance Management Team in the management of sickness absence to bring about demonstrable reductions in sickness absence levels.

5. Assist in the development, implementation and monitoring of a suite of easily understood employee relations policies, ensuring that support and training is provided to enable appropriate and consistent application.

6. Assist in determining the impact of new employment legislation / case law, implementing any subsequent changes in policy / practice through effective communication, including the issuing of guidelines and provision of training to secure appropriate and consistent application.

Communication & Information Management

1. Ensure that regular team meetings take place with particular emphasis on ensuring that Senior HR Advisors aligned to Directorates meet regularly with senior staff within Employee Relations to update on employee initiatives ongoing within Directorates.

2. Establish and maintain an effective working relationship with Trade Union representatives on employee relations matters.

3. Provide regular information on progress in relation to ongoing cases and wider employee relations activity.

4. Work with the Head of Employee Engagement and Relations in the provision of HR reports for the Trust Board to ensure full reporting against all HR aspects of the Trust's Delivery Plan, Priorities for Action, Directorate Performance Plan.

5. Ensure an effective HR library of circulars, employment legislation / case law related information etc exists, which is easily accessible by all HR staff.

Building People Management Capacity

1. Develop, use and maintain a call logging system that will inform the assessment of support for managers development / training needs and demonstrate HR activity and interface with managers.

2. Implement a HR Manager's toolkit of easily understood procedures, guidelines, frequently asked questions etc in support of the range of HR policies, to underpin the skills competencies of managers in managing their staff.

3. In collaboration with other senior HR staff, support the development of capacity and capability of managers by designing and delivering specialist HR training courses on a range of HR policies and procedures.

4. Undertake ongoing critical analysis of employee relations information, eg disciplinary, grievance, bullying/harassment cases to identify trends or to highlight either practice deficiencies or potential development needs so that lessons learned can be effectively absorbed within the Trust.

5. Recognise and use opportunities where appropriate to adopt the role of 'coach' to encourage managers to develop their own solutions to people management problems.

Quality

1. Ensure that the needs of patients and their carers are at the core of the way the Trust delivers its services.

2. Support the achievement of relevant controls assurance standards for HR.

3. Ensure that robust performance management standards are developed and implemented within remit of the role.

People Management & Development

1. Deputise for the Head of Employee Engagement & Relations in his / her absence.

2. Lead and empower a team of Employee Relations staff providing expert advice to Trust Senior / Middle / Junior Managers within service areas.

3. Delegate appropriate responsibilities and authority to staff consistent with effective decision making whilst retaining accountability for results.

4. Review the performance of direct reports on a regular basis and to provide direction of personal development requirements and action in accordance with the Knowledge & Skills Framework.

5. Take responsibility for own performance and take action to identify personal development areas.

6. Maintain good staff relationships and morale amongst staff reports through effective feedback, recognition, appraisal and development.

General Requirements:

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
  - Smoke Free policy
  - IT Security Policy and Code of Conduct
  - standards of attendance, appearance and behaviour

- Comply fully with the Trust's policy and procedures regarding records management, as well as the Data Protection Act, accepting legal responsibility for all manual or electronic records held, created or used as part of his/her duties, and ensuring that confidentiality is maintained at all times.

- Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION FOR BAND 8a EMPLOYEE RELATIONS MANAGER

ELIGIBILITY

1. Substantive Band 7 postholder within Directorate of HROD.

QUALIFICATIONS / EXPERIENCE / SKILLS

1. Have a minimum of 2 years' experience at Band 7 or above in Human Resources, providing professional HR advice to service managers.
2. Hold a CIPD / CIPD accredited qualification to a minimum of degree level.
3. Have a minimum of 2 years' experience in staff management.
4. Experience of undertaking a range of case investigations such as disciplinary, harassment, bullying and the production of comprehensive reports.
5. Experience of policy development.
6. Hold a full current driving licence valid for use in the UK and have, on appointment, access to a car[1].

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

SKILLS / ABILITIES

1. Have an ability to provide effective leadership.
2. Excellent communication and influencing skills with a range of stakeholders internal and external to the organisation.
3. Excellent planning skills and ability to effectively manage multiple priorities.
4. Demonstrate a commitment to the provision of high quality services with an ability to further develop a culture of continuous improvement.

KNOWLEDGE

1. Comprehensive knowledge and understanding of all relevant employment legislation and codes of practice.
2. Knowledge of Agenda for Change Terms and Conditions of Service.

INTERVIEW ARRANGEMENTS – FOR NOTING BY ALL CANDIDATES

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at www.nhsleadershipqualities.nhs.uk. Particular attention will be given to the following competencies:

o *Drive for improvement*	
o *Self Management*	o *Seizing the future*

[1] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

o *Drive for results*	o *Leading change through people*
o *Holding to account*	o *Effective and strategic influencing*

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Title:	Deputy Director of Human Resources (HR Services)
Band:	8c
Directorate:	Human Resources & Organisational Development
Reports to:	Director Human Resources & Organisational Development (HROD)
Base Location:	Armagh – St Luke's Hospital site

JOB SUMMARY

The postholder will support the Director of HROD and Senior Management Team in enabling the Trust to deliver on its strategic goals and significant transformation agenda. S/he will be responsible for the strategic development and management of a portfolio of core HR services delivered across the Trust.

The postholder will be responsible for ensuring that HR services are delivered in a way that creates a place where our people want to work and that enables both managers and staff to do what they do best in focusing on meeting the needs of our service users. In doing so, the postholder will ensure a positive employment relations climate exists across Directorates, underpinned by effective consultation, negotiation and partnership arrangements with Trade Unions and professional organisations.

As a member of the HR Directorate senior leadership team, the postholder will be accountable for the achievement of key strategic and operational objectives in respect of the following functions:

- Attendance Management
- Employment Law
- Medical Staffing inc Medical Locums & Recruitment
- Pay & Conditions
- Resourcing inc Bank services
- Workforce Information
- HRPTS Systems Management
- Litigation

The postholder will provide leadership in the context of the need for continuous improvement, transformational change and service reform. S/he will be required to design and implement a new structure and model for HR service delivery, which is efficient, cost effective and has the agility to support the employee and manager needs in the context of wider regional collaboration and change, and strategic direction.

KEY RESULT AREAS

STRATEGIC PLANNING & DEVELOPMENT

1. As a key member of the senior HR Directorate leadership team, play a significant role in establishing, maintaining and communicating a clear and compelling strategic direction for HROD.

2. Contribute to the development of a strategic plan for the Directorate and lead on the development of the division-specific strategic plan.

3. Work collaboratively and strategically with the wider Corporate HR Team to champion an ethos of excellence in HR, promoting a consistent, enhanced staff experience and the alignment of HR services with the Trust's objectives.

4. Play a lead role in the development and implementation of human resource strategy, policies, procedures and practices in respect of all areas of responsibility, setting standards and adopting best practice.

5. Provide strategic leadership which ensures the Trust operates an excellent system of governance in respect of its workforce.

DIVISIONAL LEADERSHIP

1. Ensure that divisional management structures and practices support a culture of effective team working, collective leadership, continuous improvement and innovation.

2. Promote a culture of performance management within the division through individual and team accountability, commitment to regular and effective appraisals and fostering a culture of constructive feedback, learning and personal and team development.

3. Encourage staff involvement and engagement in the strategic development and operational delivery of the division's services.

4. Develop and implement a robust annual operational plan for the division.

5. Regularly monitor and review plans and adjust as required, taking ownership and accountability for positive outcomes within agreed timescales for all project and day to day activity within the remit of the post.

6. Drive improvements in performance, utilising technology where it will enhance results.

7. Implement arrangements to ensure strong financial management of all budgets within the remit of the post ensuring financial viability is maintained, best value achieved and all financial targets are met.

8. Develop and monitor appropriate controls within their remit of management.

9. Collaborate across the Directorate to focus on addressing key workforce issues.

10. Ensure expert advice is provided for areas within the remit of the post, keeping abreast of best practice, sharing knowledge and expertise with colleagues.

11. Coordinate the production of updates and reports on relevant aspects of corporate documents including Trust Delivery Plans, Corporate Plans, Directorate Plans, mid/end year accountability and other targets both local and regional, as and when requested.

12. Contribute to good industrial relations within the Trust by ensuring effective communication and working relationships with staff as well as relevant trade unions/staff organisations.

13. Deputise for the Director of HROD as required.

14. Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

15. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

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

SERVICE DELIVERY

1. Develop HR services that are customer focused and make it easier for line managers to fulfil their role when handling employee, resourcing and contractual issues.

2. Develop and implement a revised model for operational HR service delivery, ensuring focus on effective and efficient ways of working, reduced administration through a planned, systematic and lean approach to enable organisation performance by ensuring that employee and line manager needs are supported by simple, efficient yet effective processes.

3. Ensure that HR service reform and change initiatives are implemented and that maximum benefits realisation is achieved.

4. Ensure robust information governance arrangements for the HROD Directorate are in place ensuring compliance with relevant legislation and the Retention and Disposal Schedule.

5. Ensure the provision of high quality advice and guidance to managers on all contractual, employment, people management and resourcing issues. Promote close working with the HR Business Partners to capture the strategic issues and translate into organisational programs and initiatives.

6. Ensure there are robust recruitment plans in place for all staff groups and Directorates, and lead on effective advertising, careers events, open days, social media, international recruitment and any other appropriate attraction strategies.

7. Ensure the development of the capabilities of recruiting managers who recognise the significant role that any employee of the Trust can have on the outcomes and lives of our service users, and therefore the importance of high quality selection decisions.

8. Ensure the provision of high quality workforce analytics, and the production of workforce information in a format that is user friendly, appropriate to audience and highlights key messages both for corporate and external use, and for accountability purposes.

9. Realise the benefits of the Human Resources, Payroll and Travel (HRPTS) system.

10. In support of the Trust's approach to organisational development, create a positive, proactive approach to employee relations, delivering on a plan which drives improvement in capability and in workplace relationships through an early intervention approach and which supports staff and managers through effective and efficient formal procedures where necessary.

11. Provide leadership on complex employment cases, where appropriate. Manage and monitor employee relations caseloads to ensure successful and effective resolution.

12. To oversee the fair and effective operation of systems for pay and terms and conditions.

13. Ensure the Business Partner Assistant Directors are supported by appropriate divisional staff in relation to all management of change programmes and workforce implications arising from the transformation agenda.

14. Be responsible for the medical staffing service, ensuring consistent, effective procedures across all specialities to manage the medical workforce, whilst maintaining and managing the flexible workforce and developing strategies to reduce locum spend. Ensure clinical workforce planning is undertaken in collaboration with service Directorate colleagues in order to predict and prepare for future workforce needs.

15. Oversee the provision of medical and nursing 'locum' cover within services, including regular monitoring and analysis of usage, and ensure close collaborative working with Directorate teams to ensure the Trust's flexible resourcing models provide for consistency, transparency, and flexibility in the way staff are deployed and managed.

16. Further enhance HR relationships with BSO Shared Services Centres, and seek to facilitate effective 'customer' relationships between Shared Services and managers.

17. Ensure the Trust complies with all aspects of employment legislation, including the management of all Industrial/Fair Employment Tribunal/High Court applications acting as a witness for the Trust, where appropriate, and liaising/consulting with legal advisers and statutory agencies.

18. Determine the impact of relevant employment legislation ensuring implementation through effective communication, including the issue of guidelines and/or the initiation of training.

19. Ensure the provision of an investigation and management service on behalf of the Trust in relation to claims of litigation in respect of employer liability, occupier liability, clinical negligence and associated matters.

20. Develop strong and constructive relationships with trade union representatives and ensure that the Trust's Joint Negotiation and Consultation Forum and Local Negotiating Committee are supported effectively.

INFORMATION MANAGEMENT

1. Ensure the effective implementation of all Trust information management policies and procedures in the division.

2. Ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

COLLECTIVE LEADERSHIP

1. Develop and maintain working relationships with other Directorate colleagues to ensure achievement of Trust objectives.

2. Attend meetings of the Senior Management Team & Trust Board and its committees, as required.

3. To form effective, collaborative relationships with Department of Health, regional Trade Unions officials and other relevant external organisations to influence the development of region wide approaches in relation to the workforce.

4. Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

5. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HSC staff.

EMERGENCY PLANNING AND BUSINESS CONTINUITY RESPONSIBILITIES

1. Lead on the division's development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the General Data Protection Regulations (GDPR). mEmployees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, including full participation in Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

August 2018

PERSONNEL SPECIFICATION

JOB TITLE Deputy Director of HR (HR Services)

ESSENTIAL CRITERIA	
The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the selection / interview stage. You must therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted.	
Factor	**Criteria**
Eligibility	1. Be an employee of an organisation within Health & Social Care in Northern Ireland[1]
Qualifications/ Experience/ Skills & Knowledge	2. Hold a university degree or recognised professional qualification (e.g. CIPD) **and** a minimum of two years' experience in HR in a senior management[2] role in a major complex organisation[3] **OR** a minimum of five years' experience in HR in a senior management role in a major complex organisation. 3. Clear significant[4] personal evidence of:- • delivering against challenging HR performance management programmes, making significant improvements; • high level leadership and people management skills; • ensuring effective governance and risk management; • building strategic relationships with external agencies / partners 4. Be able to demonstrate the development and application of highly developed specialist knowledge and skills relevant to the post.
Other	5. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

[1] *'**Organisation within Health & Social Care NI'** is defined as any one of the following: HSC Trusts; Health & Social Care Board; Business Services Organisation;; Public Health Agency; Patient Client Council; Regulation & Quality Improvement Authority; NI Practice & Education Council; NI Medical & Dental Training Agency; NI Guardian Ad Litem Agency; NI Blood Transfusion Service, and; NI Social Care Council*

[2] *'**senior management'** is defined as experience gained at Head of Service Band 8a or equivalent or higher in a major complex organisation*

[3] *'**major complex organisation'** is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*

[4] *'**significant'** is defined as contributing directly to Key Corporate Objectives of the organisation concerned.*

[5] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

Selection / Interview stage
Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the ***NHS Leadership Academy Healthcare Leadership Model.*** Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.

Notes to applicants:

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;*
2. *Shortlisting will be carried out on the basis of the essential criteria set out above, using the information provided by you on your application form.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trust's Smoke Free Policy

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

August 2018

Southern Health & Social Care Trust **CONFIDENTIAL**

Staff in Post in Employee Relations during 1 April 2008 - 31 December 2018

Prepared by/HR Contact: [redacted], **Senior HR Data Analyst**

Prepared for: Siobhan Hynds, Deputy Director of HROD - HR Services

Ref: ad/2022/297 (Version 2)

Date: 13 July 2022

Staff in Employee Relations (excluding Staff Side/Litigation) from April 2008 - 31 December 2018 as per HRMS Staff in Post Reports/HRPTS

Notes

Prior to HRPTS (Dec 2013) Staff have been identified based on Cost Centre/Division on Staff in Post Reports from April 2008. Please note the Employee Engagement & Relations Cost Centre (905H) was only used from Oct 2018 onwards.

Highlighted Records have been added from HRMS Staff in Post Reports (from Apr 08 - Nov 13)

Staff aligned to Agenda for Change Cost Centres who migrated to AFC Staff Side Org Units are on HRPTS have been excluded. However there may be other Staff Side Staff, who left prior to HRPTS, listed below.

Last name	First name	Pers.No.	Date Commenced Post	Date Left Post	Contract Type	Work Contract	Position	Job Description	Band	Organizational Unit	Cost Center	Date Appointed to Trust	Date Left Trust	Notes
Personal Information redacted by the USI			16/11/2009		Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	13/09/1982		
			02/10/2012	27/04/2014	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	02/10/2012	22/07/2014	
			28/04/2014	22/07/2014	Temporary	Temp Higher Bd	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	02/10/2012	22/07/2014	
			03/05/2011	11/12/2011	Temporary	Temporary	ADMIN ASSISTANT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/05/2011		
					Block Booking	Temporary	ADMIN ASSISTANT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/05/2011		
			12/12/2011	31/12/2011	Block Booking	Temporary Move to Higher Band	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	03/05/2011		
			01/01/2012	20/10/2013	Permanent	Temporary Move to Higher Band	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	03/05/2011		
			21/10/2013	27/04/2014	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/05/2011		
			28/04/2014	31/03/2015	Permanent	Temp Higher Bd	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/05/2011		
			01/04/2015	30/06/2015	Permanent	Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/05/2011		
			01/07/2015	31/07/2016	Permanent	Temp Higher Bd	Contract Payroll & Travel Specialist	Admin & Clerical (5)	5	Pay & Employment Manager	HR EMPLOYEE RELATIONS	03/05/2011		
			01/08/2016	31/01/2017	Permanent	Permanent	Human Resources Advisor	Admin & Clerical (5)	5	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	03/05/2011		
			01/02/2017	07/05/2017	Permanent	Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/05/2011		
			08/05/2017	31/08/2017	Permanent	Temp Higher Bd	Human Resource Advisor	Admin & Clerical (5)	6	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/05/2011		
			01/09/2017	21/07/2019	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	03/05/2011		
			20/05/2009	02/10/2009	Temporary	Temporary	SUMMER SCHEME CO-ORDINATOR	ADMIN & CLERICAL (5)	5		EMPLOYEE ENGAGEMENT & RELATION	20/05/2009	02/10/2009	
			08/01/2018	31/03/2018	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	08/01/2018		
			01/04/2018		Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt MH	HR EMPLOYEE RELATIONS	08/01/2018		
			03/11/2005	14/05/2009	Secondment	Secondment (internal)		PORTER (2)	2		NMT AGENDA FOR CHANGE	18/07/1978	14/05/2009	
			01/03/2008		Permanent	Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	15/09/2003		Was on WLB Term Time from Apr 17 - Mar 19
						WLB Term Time	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	15/09/2003		
			31/03/2008	See notes	Permanent	Permanent	SENIOR HUMAN RESOURCE ADVISOR	ADMIN & CLERICAL (6)	6		EMPLOYEE ENGAGEMENT & RELATION	23/11/1995		On BOXI - Was aligned to Health & Safety Cost Centre from 31 Mar 08 - 31 Aug 09 then ER from 1 Mar 10 - 14 Jan 2013
			15/01/2013	23/06/2013	Permanent	Permanent	SENIOR HUMAN RESOURCE ADVISOR	ADMIN & CLERICAL (6)	6		EMPLOYEE ENGAGEMENT & RELATION	23/11/1995		
			15/05/2008	30/06/2010	Permanent	Permanent		ADMIN & CLERICAL (4)	4		NMT AGENDA FOR CHANGE	13/01/2003		
							PERSONAL SECRETARY	ADMIN & CLERICAL (4)	4		NMT AGENDA FOR CHANGE	13/01/2003		
			28/02/2007	30/06/2009	Temporary	Temporary		ADMIN & CLERICAL (7)	7		NMT AGENDA FOR CHANGE	28/02/2007	30/06/2009	
					Bank/As & When Required	Bank/As & When Required		ADMIN & CLERICAL (7)	7		NMT AGENDA FOR CHANGE	28/02/2007	30/06/2009	
			01/03/2008		Permanent	Permanent	Attendance Officer	Admin & Clerical (4)	4	Attendance Management Team	HR EMPLOYEE RELATIONS	21/01/2003		
										Case Mgt / Attendance Mgt CYPS	HR EMPLOYEE RELATIONS	21/01/2003		Was on WLB Term Time from Apr 14 - Mar 17
						WLB Term Time	Attendance Officer	Admin & Clerical (4)	4	Attendance Management Team	HR EMPLOYEE RELATIONS	21/01/2003		
										Case Mgt / Attendance Mgt CYPS	HR EMPLOYEE RELATIONS	21/01/2003		
			23/11/2009	01/11/2015	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	24/03/2004	07/05/2017	
			02/11/2015	06/02/2017	Permanent	Temp Higher Bd	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	HR EMPLOYEE RELATIONS	24/03/2004	07/05/2017	
			07/02/2017	07/05/2017	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt CYPS	HR EMPLOYEE RELATIONS	24/03/2004	07/05/2017	
			20/10/2008	31/10/2011	Permanent	Permanent	HUMAN RESOURCE ADVISOR	ADMIN & CLERICAL (5)	5		EMPLOYEE ENGAGEMENT & RELATION	03/10/1988	31/01/2017	
			01/11/2011	30/09/2015	Permanent	Temp Higher Bd	Human Resource Advisor	Admin & Clerical (6)	6	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/10/1988	31/01/2017	Temp Higher Bd Work Contract ended 29/9/15 on HRPTS
						Permanent	Human Resource Advisor	Admin & Clerical (6)	6	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/10/1988	31/01/2017	
			01/10/2015	31/01/2017	Permanent	Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	03/10/1988	31/01/2017	
			03/06/2009	21/02/2010	Temporary	Temporary	HUMAN RESOURCES ADMINISTRATOR	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
			22/02/2010	23/02/2010	Bank/As & When Required	Bank/As & When Required	HUMAN RESOURCES ADMINISTRATOR	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
			23/02/2010	12/06/2011	Bank/As & When Required	Bank/As & When Required	HUMAN RESOURCES ADMINISTRATOR	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
			13/06/2011	06/11/2011	Temporary	Temporary	HUMAN RESOURCES ADMINISTRATOR	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
					Block Booking	Temporary	HUMAN RESOURCES ADMINISTRATOR	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
			01/01/2012	22/07/2012	Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
			23/07/2012	05/11/2012	Permanent	Temporary Move to Higher Band	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	03/06/2009	15/11/2017	
			06/11/2012	03/01/2016	Permanent	Temp Higher Bd	Human Resources Officer	Admin & Clerical (4)	4	Agenda For Change	SHSCT AGENDA FOR CHANGE	03/06/2009	15/11/2017	
										Pay & Employment Manager	SHSCT AGENDA FOR CHANGE	03/06/2009	15/11/2017	
										Pay & Employment Team 1	SHSCT AGENDA FOR CHANGE	03/06/2009	15/11/2017	
			04/01/2016	30/04/2016	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	SHSCT AGENDA FOR CHANGE	03/06/2009	15/11/2017	
											HR EMPLOYEE RELATIONS	03/06/2009	15/11/2017	
			26/01/2009	31/12/2009	Temporary	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	26/01/2009	31/03/2021	
							HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	26/01/2009	31/03/2021	
			01/01/2010	30/11/2010	Permanent	Secondment (internal)	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	26/01/2009	31/03/2021	
			01/12/2010	31/05/2011	Permanent	Permanent	HUMAN RESOURCES ADMINISTRATOR	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	26/01/2009	31/03/2021	
			01/06/2011	22/01/2012	Permanent	Temporary Move to Higher Band	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	26/01/2009	31/03/2021	
			10/03/2010	04/08/2010	Bank/As & When Required	Bank/As & When Required	NURSE MANAGER	NURSE MANAGER (7)	7		EMPLOYEE ENGAGEMENT & RELATION	10/03/2010	04/08/2010	
			14/01/2011	20/01/2011	Bank/As & When Required	Bank/As & When Required	NURSE MANAGER	NURSE MANAGER (7)	7		EMPLOYEE ENGAGEMENT & RELATION	14/01/2011	20/01/2011	
			01/03/2008	05/04/2011	Permanent	Permanent	HUMAN RESOURCE ADVISOR	ADMIN & CLERICAL (5)	5		EMPLOYEE ENGAGEMENT & RELATION	01/03/1990	05/04/2011	
			26/09/2016	31/12/2016	Non Trust	Non Trust	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	26/09/2016	31/12/2016	
			03/01/2017	31/08/2017	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	03/01/2017	01/10/2017	
			01/05/2009	18/11/2009	Permanent	Permanent	PROJECT SUPPORT MANAGER	ADMIN & CLERICAL (5)	5		EMPLOYEE ENGAGEMENT & RELATION	16/02/2004		
						Secondment (internal)	PROJECT SUPPORT MANAGER	ADMIN & CLERICAL (5)	5		EMPLOYEE ENGAGEMENT & RELATION	16/02/2004		
			19/11/2009	23/11/2014	Permanent	Permanent	Project Support Manager	Admin & Clerical (5)	5	Employee Engagement & Relations	HR EMPLOYEE RELATIONS	16/02/2004		
			01/07/2015	09/05/2021	Permanent	Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	16/02/2004		
			14/03/2016	13/02/2019	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	14/03/2016		
			01/03/2008	08/01/2012	Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	02/02/2004		
			13/03/2017	05/06/2017	Permanent	Permanent	HR Assistant	Admin & Clerical (2)	2	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	13/03/2017	30/01/2018	
			04/09/2018	09/09/2018	Permanent	Permanent	Attendance Officer	Admin & Clerical (4)	4	Case Mgt /Attendance Mgt Acute	HR EMPLOYEE RELATIONS	01/03/2017		
			10/09/2018		Permanent	Second Internal	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	01/03/2017		Secondment Work Contract ended 14/10/18 on HRPTS
						Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	01/03/2017		
			28/02/2007	30/06/2009	Bank/As & When Required	Bank/As & When Required		ACUTE NURSE (6)	6		NMT AGENDA FOR CHANGE	28/02/2007	30/06/2009	
			01/04/2005	31/08/2011	Secondment	Secondment (internal)		MULTI SERVICES MANAGER	5		CBC AGENDA FOR CHANGE	12/02/1990	31/08/2011	
							STAFF SIDE SECRETARY	MULTI SERVICES MANAGER (5)	5		CBC AGENDA FOR CHANGE	12/02/1990	31/08/2011	

Received from Siobhan Hynds on 03/08/2022. Annotated by the Urology Services Inquiry.

Last name	First name	Pers.No.	Date Commenced Post	Date Left Post	Contract Type	Work Contract	Position	Job Description	Band	Organizational Unit	Cost Center	Date Appointed to Trust	Date Left Trust	Notes
Personal Information redacted by the USI			01/05/2005	27/10/2010	Permanent	Secondment (internal)		ADMIN & CLERICAL (4)	4		CBC AGENDA FOR CHANGE	17/07/1995		
							A4C PROJECT ASSISTANT	ADMIN & CLERICAL (4)	4		CBC AGENDA FOR CHANGE	17/07/1995		
					Secondment	Secondment (internal)	A4C PROJECT ASSISTANT	ADMIN & CLERICAL (4)	4		CBC AGENDA FOR CHANGE	17/07/1995		
			28/10/2010	27/06/2019	Permanent	Permanent	Attendance Officer	Admin & Clerical (4)	4	Attendance Management Team	HR EMPLOYEE RELATIONS	17/07/1995		
										Case Mgt / Attendance Mgt MH	HR EMPLOYEE RELATIONS	17/07/1995		
			27/03/2008	13/07/2014	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	23/07/2001		
			14/07/2014	08/02/2016	Permanent	Temp Higher Bd	Senior Human Resource Advisor	Admin & Clerical (6)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	23/07/2001		
			09/02/2016	31/08/2017	Permanent	Temp Higher Bd	Human Resources Manager	Admin & Clerical (7)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	23/07/2001		
								Admin & Clerical (8A)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	23/07/2001		Was on WLB Term Time from Apr 16 - Mar 17
						WLB Term Time	Human Resources Manager	Admin & Clerical (7)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	23/07/2001		
								Admin & Clerical (8A)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	23/07/2001		
			01/09/2017	03/04/2018	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt MH	HR EMPLOYEE RELATIONS	23/07/2001		
			08/07/2008	31/03/2009	Temporary	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	21/03/2005	03/02/2019	
			01/04/2009	07/11/2020	Permanent	Permanent	ATTENDANCE OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	21/03/2005	03/02/2019	
			01/02/2008	31/03/2014	Permanent	Permanent	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	HR EMPLOYEE RELATIONS	13/09/1965	31/03/2014	
			22/10/2009	01/03/2010	Temporary	Temporary	CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	22/10/2009	10/08/2015	
			02/03/2010	31/03/2010	Bank/As & When Required	Bank/As & When Required	CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	22/10/2009	10/08/2015	
			27/10/2008	01/11/2009	Permanent	Permanent		ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	30/10/2006		
							HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	30/10/2006		
			02/11/2009	07/11/2010	Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	30/10/2006		
			25/05/2009	20/09/2009	Temporary	Temporary	FILING & RECORDS CLERK	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	25/05/2009		
			01/03/2008	03/05/2010	Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	26/01/1998		
			01/03/2008	31/05/2010	Permanent	Permanent	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	02/01/1991	17/09/2020	
											EMPLOYEE ENGAGEMENT & RELATION			
			23/05/2011	13/09/2015	Permanent	Permanent	Human Resources Manager	Admin & Clerical (8A)	8A	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	20/06/1997		
			14/09/2015	29/11/2015	Permanent	Temp Higher Bd	Human Resources Manager	Admin & Clerical (8A)	8B	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	20/06/1997		
			30/11/2015	31/01/2016	Permanent	Permanent	Human Resources Manager	Admin & Clerical (8A)	8A	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	20/06/1997		
			01/02/2016	31/12/2018	Permanent	Permanent	HOS-Employee Engag & Relations	Admin & Clerical (8B)	8A	Employee Engagement & Relations	HR HEAD EMPLOYEE RELATIONS	20/06/1997		
			15/12/2014		Bank	Bank	Agenda For Change Job Evaluator -Bank	Admin & Clerical (5)	5	Employee Engagement & Relations	SHSCT AGENDA FOR CHANGE	15/12/2014		
			01/01/2009	31/03/2011	Temporary	Temporary	CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		CBC AGENDA FOR CHANGE	15/01/2007		
			01/04/2011	12/06/2011	Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	15/01/2007		
			13/06/2011	31/12/2011	Permanent	Temporary Move to Higher Band	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	15/01/2007		
			01/01/2012	03/05/2022	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	15/01/2007		
			27/10/2008	03/02/2009	Temporary	Temporary		ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	27/10/2008		
							HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	27/10/2008		
			15/07/2016	16/10/2016	Permanent	Permanent	HR Assistant	Admin & Clerical (2)	2	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	15/07/2016		
			14/08/2008	06/10/2009	Temporary	Temporary	STUDENT PLACEMENT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
			07/10/2009	18/05/2010	Bank/As & When Required	Bank/As & When Required	STUDENT PLACEMENT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
							CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
											CBC AGENDA FOR CHANGE	14/08/2008	31/03/2019	
			19/05/2010	16/10/2011	Temporary	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
											CBC AGENDA FOR CHANGE	14/08/2008	31/03/2019	
					Block Booking	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
											CBC AGENDA FOR CHANGE	14/08/2008	31/03/2019	
			01/06/2010		Temporary	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
											CBC AGENDA FOR CHANGE	14/08/2008	31/03/2019	
			17/10/2011	31/12/2011	Permanent	Temporary Move to Higher Band	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	14/08/2008	31/03/2019	
			01/01/2012	04/05/2014	Permanent	Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
			05/05/2014	13/07/2015	Permanent	Temp Higher Bd	Senior Human Resources Officer	Admin & Clerical (5)	5	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
			14/07/2015	08/05/2016	Permanent	Temp Higher Bd	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
			09/05/2016	07/09/2016	Permanent	Temp Higher Bd	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
										Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
			08/09/2016	09/09/2018	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
			10/09/2018	31/03/2019	Permanent	Second OUT Trst	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	14/08/2008	31/03/2019	
			16/02/2015	30/06/2015	Permanent	Permanent	Contract Payroll & Travel Specialist	Admin & Clerical (5)	5	Pay & Employment Manager	HR EMPLOYEE RELATIONS	20/09/2004		
			04/07/2017	31/03/2018	Temporary	Temporary	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt CYPS	HR EMPLOYEE RELATIONS	04/07/2017	31/03/2018	
			24/04/2018	22/06/2018	Temporary	Temporary	Human Resources Manager	Admin & Clerical (7)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	24/04/2018	22/06/2018	
			21/07/2017	02/09/2018	Temporary	Temporary	Admin & Clerical (3)	Admin & Clerical (3)	2	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	21/07/2017	29/11/2019	
			03/09/2018	11/11/2018	Permanent	Permanent	Admin & Clerical (3)	Admin & Clerical (3)	2	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	21/07/2017	29/11/2019	
							Admin & Clerical (2)	Admin & Clerical (2)	2	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	21/07/2017	29/11/2019	
			26/09/2016	12/01/2017	Permanent	Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	26/09/2016		
			13/01/2017	06/06/2017	Permanent	Temp Higher Bd	Admin & Clerical (3)	Admin & Clerical (3)	3	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	26/09/2016		
			07/06/2017	09/09/2018	Permanent	Temp Higher Bd	Attendance Officer	Admin & Clerical (4)	4	Case Mgt /Attendance Mgt Acute	HR EMPLOYEE RELATIONS	26/09/2016		
			10/09/2018	18/05/2022	Permanent	Permanent	Attendance Officer	Admin & Clerical (4)	4	Case Mgt /Attendance Mgt Acute	HR EMPLOYEE RELATIONS	26/09/2016		
			12/06/2017	12/06/2020	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	09/08/2004	12/06/2020	
			13/09/2004	31/03/2010	Secondment	Secondment (internal)		ADMIN & CLERICAL (6)	6		NMT AGENDA FOR CHANGE	28/03/1994	31/03/2010	
			01/04/1993	31/07/2008	Permanent	Permanent	(blank)	ADMIN & CLERICAL (6)	6		NMT AGENDA FOR CHANGE	01/10/1977	31/07/2008	
			03/06/2013	07/06/2014	Temporary	Temporary	Human Resources Placement Student	Admin & Clerical (2)	2	Attendance Management Team	AD BEST CARE BEST VALUE	03/06/2013	01/12/2016	
			08/06/2014	30/09/2014	Temporary	Temporary	Admin & Clerical (2)	Admin & Clerical (2)	2	Attendance Management Team	HR EMPLOYEE RELATIONS	03/06/2013	01/12/2016	
			27/11/2012	31/03/2015	Bank	Bank	Case Investigator -Bank	Admin & Clerical (8D)	8D	Employee Engagement & Relations	HR EMPLOYEE RELATIONS	27/11/2012	31/03/2015	
			24/07/2014	30/04/2015	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	24/07/2014		
			01/05/2015	30/04/2016	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	24/07/2014		
			01/05/2016	27/08/2017	Permanent	Second Internal	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	24/07/2014		
			28/08/2017	06/06/2018	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	24/07/2014		
			07/06/2018	04/09/2018	Permanent	Temp Higher Bd	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	24/07/2014		
			05/09/2018		Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	24/07/2014		
			28/04/2014	22/07/2014	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	28/04/2014		
			23/07/2014	30/04/2015	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	28/04/2014		
			01/05/2015	30/06/2015	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	28/04/2014		
			01/07/2015	13/10/2016	Permanent	Temp Higher Bd	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	28/04/2014		
			14/10/2016	03/04/2018	Permanent	Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	28/04/2014		
			04/04/2018	12/09/2018	Permanent	Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	28/04/2014		
			13/09/2018	22/03/2020	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	28/04/2014		
			05/05/2009	21/02/2010	Temporary	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	05/05/2009		
			22/02/2010	11/04/2010	Bank/As & When Required	Bank/As & When Required	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	05/05/2009		
			09/02/2016	31/07/2017	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	09/02/2016	31/07/2017	
										Case Mgt / Attendance Mgt MH	HR EMPLOYEE RELATIONS	09/02/2016	31/07/2017	
			07/05/2014		Bank	Bank	Admin & Clerical (7) -Bank	Admin & Clerical (7)	7	Employee Engagement & Relations	SHSCT AGENDA FOR CHANGE	07/05/2014		
			22/04/2013	10/04/2019	Permanent	Permanent	Attendance Officer	Admin & Clerical (4)	4	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	03/05/2011	10/04/2019	
										Case Mgt /Attendance Mgt Acute	HR EMPLOYEE RELATIONS	03/05/2011	10/04/2019	
						WLB Term Time	Attendance Officer	Admin & Clerical (4)	4	Attendance Management Team	HR EMPLOYEE RELATIONS	03/05/2011	10/04/2019	Was on WLB Term Time from Apr 16 - Mar 17
										Case Mgt /Attendance Mgt Acute	HR EMPLOYEE RELATIONS	03/05/2011	10/04/2019	

Last name	First name	Pers.No.	Date Commenced Post	Date Left Post	Contract Type	Work Contract	Position	Job Description	Band	Organizational Unit	Cost Center	Date Appointed to Trust	Date Left Trust	Notes
Personal Information redacted by the USI			17/07/2017	30/09/2018	Temporary	Temporary	Human Resources Placement Student	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	17/07/2017		
											HR WORKFORCE INFORMATION	17/07/2017		
			01/10/2018	11/12/2019	Permanent	Temp Higher Bd	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	17/07/2017		Temp Higher Bd Work Contract ended 1/7/19 on HRPTS
						Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	17/07/2017		
			09/01/2012	29/07/2012	Block Booking	Temporary	CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	09/01/2012	26/12/2014	
								ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	09/01/2012	26/12/2014	
			30/07/2012	26/12/2014	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	09/01/2012	26/12/2014	
			10/07/2014	30/09/2014	Temporary	Temporary	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	10/07/2014	30/09/2014	
			16/02/2015	11/06/2017	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	19/03/1991		
			12/06/2017		Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	19/03/1991		
			09/10/2009	10/11/2009	Temporary	Temporary	FILING ROOM CLERK	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	09/10/2009	10/11/2009	
			26/10/2009	28/12/2009	Temporary	Temporary	CLERICAL OFFICER II	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	26/10/2009	24/05/2013	
			01/03/2008	31/01/2017	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	05/02/2001		
										Case Mgt / Attendance Mgt CYPS	HR EMPLOYEE RELATIONS	05/02/2001		
			01/02/2017	02/04/2017	Permanent	Second Internal	Senior Human Resource Advisor	Admin & Clerical (6)	6	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	05/02/2001		
			03/04/2017	13/08/2017	Permanent	Temp Higher Bd	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	HR EMPLOYEE RELATIONS	05/02/2001		
									8A	Pay & Employment Manager	HR EMPLOYEE RELATIONS	05/02/2001		
			14/08/2017	31/03/2019	Permanent	Permanent	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	HR EMPLOYEE RELATIONS	05/02/2001		
			01/02/2015		Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	21/08/1995		
										Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	21/08/1995		
										Case Mgt / Attendance Mgt MH	HR EMPLOYEE RELATIONS	21/08/1995		
			21/08/2018	16/04/2020	Temporary	Temporary	Human Resources Placement Student	Admin & Clerical (2)	2	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	21/08/2018		
			04/11/2015	31/05/2016	Temporary	Block Booking	HR Assistant	Admin & Clerical (2)	2	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	04/11/2015	15/04/2022	
			01/06/2016	04/06/2017	Temporary	Block Booking	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	04/11/2015	15/04/2022	
			01/06/2015	21/08/2015	Non Trust	Non Trust	YES Trainee	Admin & Clerical (1)		Attendance Management Team	HR EMPLOYEE RELATIONS	01/06/2015	21/08/2015	
			24/08/2015	30/11/2015	Temporary	Block Booking	Admin & Clerical (2)	Admin & Clerical (2)	2	Attendance Management Team	HR EMPLOYEE RELATIONS	24/08/2015	06/04/2016	
			26/05/2008	29/02/2016	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	09/10/1989	30/09/2018	
			04/01/2017	22/11/2018	Permanent	Permanent	HR Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	04/01/2017	15/01/2021	
			01/09/2008	16/06/2009	Temporary	Temporary	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (3)	3		EMPLOYEE ENGAGEMENT & RELATION	20/07/2006	17/07/2011	
			01/08/2016	31/07/2017	Temporary	Second INTO Tst	Contract Payroll & Travel Specialist	Admin & Clerical (5)	5	Pay & Employment Manager	HR EMPLOYEE RELATIONS	01/08/2016	31/07/2017	
							Human Resources Officer	Admin & Clerical (4)	5	Pay & Employment Manager	HR EMPLOYEE RELATIONS	01/08/2016	31/07/2017	
			01/03/2008	16/11/2008	Permanent	Permanent	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	23/01/1995	20/09/2013	
			17/11/2008	20/09/2013	Permanent	Secondment (internal)	HUMAN RESOURCES OFFICER	ADMIN & CLERICAL (4)	4		CBC AGENDA FOR CHANGE	23/01/1995	20/09/2013	
			01/03/2008	25/05/2016	Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	07/06/1994	30/06/2021	Was Admin & Clerical (4) up until Feb 13
			01/03/2008	25/05/2016	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	07/06/1994	30/06/2021	
			26/05/2016	30/06/2021	Permanent	Employ Break	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	07/06/1994	30/06/2021	
			01/03/2008		Permanent	Permanent	HUMAN RESOURCES ASSISTANT	ADMIN & CLERICAL (4)	4		EMPLOYEE ENGAGEMENT & RELATION	04/06/1984		Was Admin & Clerical (4) up until Feb 13
			01/03/2008		Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	04/06/1984		
			19/08/2016	11/03/2018	Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	19/08/2016		
			12/03/2018	12/06/2022	Permanent	Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Manager	HR EMPLOYEE RELATIONS	19/08/2016		
			01/06/2007	30/06/2008	Secondment	Secondment (internal)		ADMIN & CLERICAL (7)	7		CBC AGENDA FOR CHANGE	12/08/1991		
			01/09/2017		Permanent	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	12/08/2014		
			26/10/2009	28/02/2010	Temporary	Temporary	CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	26/10/2009	06/09/2011	
			01/03/2010	31/03/2010	Bank/As & When Required	Bank/As & When Required	CLERICAL OFFICER	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	26/10/2009	06/09/2011	
			01/09/2008	31/03/2014	Permanent	Second Internal	Admin & Clerical (6)	Admin & Clerical (6)	6	Agenda For Change	SHSCT AGENDA FOR CHANGE	07/11/2005	31/03/2014	
			02/07/2013	31/03/2014	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	02/07/2012	09/04/2017	
			01/04/2014	31/07/2015	Permanent	Second Internal	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	HR EMPLOYEE RELATIONS	02/07/2012	09/04/2017	
			01/08/2015	09/04/2017	Permanent	Permanent	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	HR EMPLOYEE RELATIONS	02/07/2012	09/04/2017	
			21/08/2017	11/03/2018	Permanent	Permanent	HR Assistant	Admin & Clerical (2)	2	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	08/09/2008		
			12/03/2018	27/05/2018	Permanent	Temp Higher Bd	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	08/09/2008		
			08/06/2009		Bank	Bank	Admin & Clerical (7) -Bank	Admin & Clerical (7)	7	Employee Engagement & Relations	SHSCT AGENDA FOR CHANGE	08/06/2009		
			02/07/2007	31/05/2011	Permanent	Permanent		ADMIN & CLERICAL (8A)	8A		HR HEAD EMPLOYEE REL & ENGAGE	08/06/1998		
							HEAD OF EMPLOYEE ENGAG & RELAT	ADMIN & CLERICAL (8A)	8A		HR HEAD EMPLOYEE REL & ENGAGE	08/06/1998		
			01/06/2011	31/01/2016	Permanent	Permanent	HOS-Employee Engag & Relations	Admin & Clerical (8B)	8B	Employee Engagement & Relations	HR HEAD EMPLOYEE RELATIONS	08/06/1998		
			01/03/2008	31/05/2021	Permanent	Permanent	HR Officer / Training Officer	Admin & Clerical (5)	5	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	27/03/1995	31/05/2021	
							Human Resources Manager	Admin & Clerical (6)	6	Attendance Management Team	HR EMPLOYEE RELATIONS	27/03/1995	31/05/2021	
						WLB Term Time	HR Officer / Training Officer	Admin & Clerical (5)	5	Case Mgt / Attendance Mgt OPPC	HR EMPLOYEE RELATIONS	27/03/1995	31/05/2021	Was on WLB Term Time from Apr 16 - Mar 17
								Admin & Clerical (6)	6	Attendance Management Team	HR EMPLOYEE RELATIONS	27/03/1995	31/05/2021	
			28/05/2013	31/08/2013	Temporary	Temporary	HUMAN RESOURCES PLACEMENT STUD	ADMIN & CLERICAL (2)	2		EMPLOYEE ENGAGEMENT & RELATION	28/05/2013	31/10/2017	
			18/01/2010	31/10/2011	Permanent	Permanent	HUMAN RESOURCE ADVISOR	ADMIN & CLERICAL (5)	5		EMPLOYEE ENGAGEMENT & RELATION	01/07/1993	31/01/2016	
			01/11/2011	30/09/2015	Permanent	Temp Higher Bd	Human Resources Advisor	Admin & Clerical (6)	6	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	04/01/1983	31/01/2016	
			01/10/2015	31/01/2016	Permanent	Permanent	Human Resources Advisor	Admin & Clerical (5)	5	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	04/01/1983	31/01/2016	
			18/09/2017	31/03/2018	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt /Attendance Mgt Acute	HR EMPLOYEE RELATIONS	18/09/2017	31/07/2020	
			01/04/2018	30/09/2018	Permanent	Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Case Mgt / Attendance Mgt CYPS	HR EMPLOYEE RELATIONS	18/09/2017	31/07/2020	
			01/10/2018	31/07/2020	Permanent	Permanent	Human Resources Manager	Admin & Clerical (7)	7	Employee Engagement & Relations Team	HR EMPLOYEE RELATIONS	18/09/2017	31/07/2020	
			05/08/2015	30/04/2016	Permanent	Second Internal	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	HR EMPLOYEE RELATIONS	22/07/2013		
			01/05/2016	07/08/2016	Permanent	Second Internal	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	HR EMPLOYEE RELATIONS	22/07/2013		

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

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

HR Analytics and Governance Team, Workforce Information Department, HROD Directorate

Received from Siobhan Hynds on 03/08/2022. Annotated by the Urology Services Inquiry.

From: McClements, Melanie
To: OKane, Maria; Gibson, Simon; Hynds, Siobhan; Vivienne Toal (SHSCT)
Subject: sai papers as agreed
Date: 13 February 2020 15:02:29
Attachments: image001.emz
image002.png
oledata.mso
image003.emz
image004.png
image005.emz
image007.png
image008.emz
image009.png
image010.emz
image011.png
image012.emz
image013.png
Personal Information redacted by the USI Urology Report Patient 16 _FINAL amended 06_01_2020 after MDH (2).docx

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Patient 16 approved last month, the other 5 are on this Friday's agenda, aggregated one attached for ease, thanks mel

Southern Health and Social Care Trust

APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off:

Southern Health and Social Care Trust

1.0 EXECUTIVE SUMMARY

Patient 16 was a Personal Information redacted by the USI man who had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient 16 was considered for palliative pelvic radiotherapy in January 2016, but urology stents already in-situ required renewal prior to radiotherapy. There was a protracted delay in the management of the stents. In December 2016, due to disease progression, palliative radiotherapy was no longer considered an option for Patient 16. Patient 16 died on the 27th December 2016.

Causative Factor(s)

There was a treatment and care delay - specifically, to the changing of ureteric stents, due to,

1. Lack of effective communication systems and processes; and
2. Long Waiting Lists leading to delay.

The Review Team consider that the delay was probably significant in terms of,

- an easier progression through the process of having the stents removed and replaced;
- reduction in the level of pain and discomfort reported towards the end of life.

However, in relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental.

Recommendations

TRUST

Recommendation 1

The Trust will explore and evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR.

Recommendation 2

The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter.

Recommendation 3

The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff.

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This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4
The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB
Recommendation 5
In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6
The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of Patient 16 in the period after referral to the SHSCT urology service using National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 16 that resulted in an unnecessary delay in treatment and care.

3. The investigation / Review Team will provide a draft report for the Director of Acute

Southern Health and Social Care Trust

3.0 SAI REVIEW TERMS OF REFERENCE

Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.

4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

Patient 16. DOB = Personal Information redacted by the USI

Previous history of traumatic C5/6 (? C6/7) spinal injury due to fall, spinal surgery circa 1976, Personal Information redacted by the USI

July 2012 - diagnosed with colon cancer. Following admission to Daisy Hill Hospital (DHH), with a large bowel obstruction underwent an emergency sigmoid colectomy on 2 July 2012.

September 2012 – first referral to Oncology outpatient services.

25 October 2012 - attended the Oncology clinic where, following discussion, Patient 16 opted not to proceed with chemotherapy, with concerns regarding potential urinary sepsis considered as

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a significant factor in the decision.

03 August 2014 - attended DHH ED with severe abdominal pain. Admitted to DHH and had resection of a recurrence of a small bowel tumour; discharged 2 September 2014.

September 2014 - referred back to the Oncology service. After further discussion, it was agreed that, rather than proceeding with palliative chemotherapy, he would be kept under surgical review, and treatment considered in the event of progressive disease.

15 December 2014 - attended Colorectal Consultant Surgeon 9 (ConsSurg9) who planned to review Patient 16 in 4 months.

02 March 2015 - Patient 16's review appointment brought forward at the request of his daughter. Patient 16 was reviewed at surgical outpatient clinic. He reported abdominal pain and his carcinoembryonic antigen (CEA) test (blood test used to help diagnose and manage certain types of cancer) was increasing.

11 March 2015 - CT scan detected a left sided pelvic mass, causing hydronephrosis (a swelling of a kidney due to a build-up of urine). It happens when urine cannot drain out from the kidney to the bladder from a blockage or obstruction), and a new lung nodule.

12 March 2015 – Discussed at Cancer Multidisciplinary Team (MDT) meeting. ConsSurg9 wrote to Consultant Urologist 11 (ConsUrol11) referring for consideration of a ureteric stent to relieve the blockage. ***Red Flag*** label. Patient 16 was also referred back to Oncology (ConsOnc10).

12 March 2015 – letter from ConsSurg9 to patient and copied to GP, " ..... *I have referred you to kidney specialist to see about placing a little tube to relieve that blockage.*"

26 March 2015 - reviewed at Consultant Urology 15's (ConsUrol15) clinic. The clinic letter notes, '*He was seen by the Oncologists today and is planned for chemotherapy. As such we have arranged for him to be admitted electively on 31st March for insertion of a left ureteric stent. Pre-op assessment has been completed at the clinic today*'

26 March 2015 - at the Oncology clinic, decided to proceed with palliative Oxaliplatin and Capecitabine chemotherapy, (treatment began on 23 April 2015).

31 March 2015 - admitted to CAH presumed to be under care of ConsUrol13 and had cystoscopy + optical urethrotomy + ureteroscopy + insertion of ureteric stent. Performed by ST4Urol12 with assistance by ConsUrol13. Operation note, "*Oncologists to contact when chemotherapy complete for stent removal / replacement".*
01 April 2015 – Theatre / Recovery Care Pathway. "*Pt transferred from Recovery Day 1..... A/W ConsUrol13 to R/V .... ".*

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02 April 2015 – Discharge Notification. " ..... admitted under the care of ConsUrol13.... into 3 South Elective Ward ..... on 31/03.2015 ....." .

02 April 2015 – handwritten in clinical notes. Ward Round ConsUrol19 / ConsUrol13 noted, "*Care taken over by ConUrol11 ..... (referral by ConsSurg9) ..... ConsUrol13 will keep patient."* This is thought to mean that it was decided that care of patient remained with ConsUrol13. The previous 4 entries are taken to indicate that ConsUrol13 assumed the overall care of Patient 16 at or around the 31 March 2015.

02 April 2015 – discharged; discharge letter sent to GP and was to be copied to Mandeville Unit (CAH) stating, "*Urology to be contacted when chemotherapy is completed so that stent removal/change can be planned."*

02 April 2015 - Patient 16 added to ConsUrol13 Urgent waiting list. Date for this (noted below) was October 2015. However, was finally admitted 29 June 2016.

10 August 2015 - reviewed by ConsSurg9; the clinic letter notes '*He is feeling very well. He is coming to the end of his palliative chemotherapy'.*

27 August 2015 - at Oncology clinic; noted an improvement in the CEA tumour marker, but chemotherapy was complicated by extravasation. It was decided to proceed with Capecitabine only for the final two cycles.

08 October 2015 - Chemotherapy completed. Letter from Consultant Oncologist 2 (ConsOnc2) to GP and copied to ConsSurg9, but not to a Consultant Urologist.

26 November 2015 - letter dictated (typed on 27th) by ConsOnc10 to ConsUrol13 and copied to ConsSurg9, regarding ureteric stent change, " *... has undergone a 6 month course of palliative chemotherapy ..... I would be grateful if you could consider if this would be an appropriate time to arrange change of his stent*".
This was date stamped in the CAH chart 11 December 2015 but there is no Consultant note/signature/handwriting evident on letter.
Copy of same letter in the DHH chart is initialled by ConsSurg9 with a hand-written note, '*file' and '? review date'.* There is an additional note in red ink, '*Due 02/16 already on OPD sorted'.*

30 November 2015 email to ConsUrol13 from his secretary '*Patient 16 was ringing this morning regarding his change of left nephrostomy drain..."*

30 December 2015 – email to ConsUrol13 from his secretary, "*The above patient is on your planned w/l for removal of left ureteric stent, ureteroscopy and ? restenting – October 2015. Patient 16 's daughter was ringing this am regarding a date for her father's surgery. She advised that her father is experiencing pain and would appreciate a date for his surgery as soon as*

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possible".

21 January 2016 – attended Oncology clinic. Letter dictated by SpROnc14 to GP; copied to ConsSurg9, but not to a Consultant Urologist. Date stamped in the SHSCT on 4 February 2016, the letter noted, "*He is still awaiting a stent change and I will re-contact the Urology team regarding this*".
Further treatment options discussed including palliative radiotherapy – once the stent is out.

04 March 2016 – email from audiotypist to ConsUrol13 secretary, "*Patient phoned re TCI date for removal of stent."*

24 March 2016 - further letter,
dictated by ConsOnc2 to Patient 16's GP;
copied to ConsSurg9, initialled by ConsSurg9;
not copied to a Consultant Urologist;
dictated 24 March 2016 and typed on 22 April 2016; and
date stamped as received in DHH chart on 5 May 2016.
This letter highlighted that CT on 8 February 2016 showed, '*stable pelvic disease. However, progression of the left hydro-ureter and hydronephrosis with the development of a small right upper lobe pulmonary nodule and progression of a small left upper lobe pulmonary nodule. CEA had also risen ..... Has heard nothing further from urology and unclear whether stent is to be removed or replaced (placed approximately 1 year ago). After discussion, the plan is not to proceed with further chemotherapy presently ....'.*

09 May 2016 - review by the ConsSurg9; wrote to GP and ConUrol11, to review Patient 16's '*Please see and review Urological care'*. ….. "*His main symptoms currently appear to be related to longstanding left ureteric stent which has been in now for about a year and a half. Could you perhaps review whether or not this could be removed/replaced?"*

10 May 2016 - email to ConsUrol13 from his secretary, "*This patient was ringing to advise that he had an appointment with ConsSurg9 yesterday and was told that all of his current symptoms are related to his stent which should have been removed last year .....* Patient 16 *would appreciate if you could give him a date very soon to have his stent removed."*

02 June 2016 - letter dictated/typed following Oncology clinic from SpROnc14 to GP and copied to ConsSurg9, but not to a Consultant Urologist. Date stamped as being received in the DHH chart on 8 June 2016, signed by ConsSurg9. The letter documents, "*I have recommended that we will re-contact the urology team for review and whenever his stent is changed and if his urinary symptoms are stable and creatinine is satisfactory that we could consider palliative IMDG chemotherapy. We will aim to review him back in 10 weeks' time and will write a letter to ConUrol11 in the meantime".*

02 June 2016 - letter dictated/typed from SpROnc14 to ConUrol11, requesting '*your intervention to facilitate his ongoing oncological management'*.

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date stamped in SHSCT on 8 June 2016.
Hand-written note (black ink) stating, "*known to ConsUrol15, stented 3/2015, review imaging, ? 'NT required".*
Another hand-written note (blue ink), "*very probably. email ConsUrol15 to discuss mane, 22.6.16".*

24 June 2016 – email from ConsUro13 to his secretary, "*Please send letters of admission .... admission on 29 June 2016 as follows ....* Patient 16 *for Left Ureterography, Ureteroscopy and Removal / Replacement of Left Ureteric stent".*

The Oncologists continued to review Patient 16 regularly as an outpatient and highlighted at each appointment. '*Options for progressive symptomatic disease were discussed at each of those appointments, which included second line palliative chemotherapy, or palliative pelvic radiotherapy. The timing and choice of modality would depend on a number of factors, including radiological and biochemical indications of progression, performance status, symptomatology, relative risk of urosepsis and patient preference'*. [evidence = Oncology complaint response]

.....however, he was pre-admitted on the 24 June 2016 for 29 June 2016.

29 June 2016 - Admitted for surgery. Note that Patient 16 was added to the waiting list 02 April 2015 with first request by ConsOnc10 to ConsUrol13 made on the 26 November 2015 that chemotherapy had finished i.e. provides evidence for delay.

29 June 2016 – admission. Operated in theatre for elective optical urethrotomy, left sided stent removal and laser to encrustation to distal end and left ureteroscopy under the care of ConsUrol13. Postoperatively, Patient 16 developed Urosepsis and was commenced on antibiotics (Tazocin and Gentamicin post procedure and then Metronidazole).

30 June 2016 – Further procedure, left nephrostomy tube inserted.

06 July 2016 – FY1 note in Clinical record, "*Discuss with ConsUrol13 re long term plan*."

08 July 2016 – email from ConsUrol13 to secretary to place Patient 16 on W/L for stenting.

09 July 2016 - discharged. Discharge letter, Follow-up arrangements were,
ConsUrol13, Nephrogram as o/p scan requested.
Please CC discharge letter to ConsUro13 secretary to arranged follow up appointment once nephrogram performed'.

10 July 2016 - added to ConsUrol13's urgent waiting list. Pre-admitted on the 27 July 2016 for 10 August 2016.

22 July 2016 - Oncology review appointment ConsOnc10. Therapeutic options were again

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discussed, with palliative pelvic radiotherapy being the preferred treatment choice, dependent on any further planned urology intervention.
ConsOnc10 notes, the following day he spoke to ConsUrol13, who requested that radiotherapy be postponed until after a further attempt at ureteric stent insertion, which was scheduled to take place in August.

23 July 2016 - letter was dictated to GP; typed on 27 July 2016 (date stamped in SHSCT 04 August 2016 signed by ConsSurg9); copied to the ConsSurg9 and ConsUrol13.

10 August 2016 - admitted to CAH and had uteroscopy (sic) and ureteric stenting.

10 August 2016 - email from ConsUrol13 to secretary to place Patient 16 on W/L for replacement of stent – February 2017.

12 August 2016 - discharged.
Discharge letter arrangements for Follow-up were, "*Neph tube removal in 2/52, Stents changed in 6/12 - ConsUrol13".*

12 August 2016 - request to radiology by ConUrol11; performed on 1 September 2016.
Radiology report documented "*Nephrostomy tube was exchanged in the usual fashion. No immediate complications".*

13 October 2016 - CT scan showed progression of both pelvic and pulmonary disease, as well as new hepatic metastatic disease.

30 November 2016 – email from ConsUrol13 secretary to ConsUrol13. "*Patient ringing this am regarding change of left nephrostomy drain. He had it changed in September and was due to have it changed again in 12 weeks however he is not on a waiting list for this. Can you please advise."*

01 December 2016 – attended ConsOnc2 clinic; noted Patient 16 was suffering from a urinary tract infection and had problems related to his nephrostomy. CT scan reveals bigger pelvic mass, 2 lung nodules which are bigger and 2 liver metastases.
Note on the 2 December 2016, "*regarding wife and daughter very unhappy with management primarily related to Urology. But also feeling that a lack of liaison between Urology and Oncology has left an opportunity for pelvic radiotherapy being missed..... Whilst I apologised for any delay within our service, the main areas of concern appear to be elsewhere*."
ConsOnc2 spoke with ConsUrol13's secretary and noted, "*arrangements are already in place for nephrostomy tube replacement and ureteric stent removal in Craigavon on 6 December 2016".*

01 December 2016 – email from ConsUrol13 to secretary requesting formal notification for admission for removal of stent.

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06 December 2016 - admitted to CAH; had an exchange of left nephrostomy tube, flexible cystoscopy, dilation of urethral stricture and removal of left ureteric stent by ConsUrol11 and was discharged on 8 December 2016.
Discharge letter to GP dictated by ConUrol11; copied to ConsUrol13.

09 December 2016 - admitted to DHH with a small bowel obstruction. His care was managed conservatively; he refused surgical intervention and following comfort care, Patient 16 died on Personal information redacted by USI

21 December 2016 – letter of complaint received in Governance Office, CAH from daughter; letter dated 05 December 2016. Complaint, "*centres on the poor response to communication between Oncology and Urology departments in Craigavon Hospital and the consequences of this which include; unnecessary suffering and denied access to a treatment option for cancer".*

6.0 FINDINGS

Summary of sequence of events

11 March 2015	CT scan detected a left sided pelvic mass, causing hydronephrosis.
12 March 2015	MDT meeting. ConsUrol11 requested to insert stent.
26 March 2015	reviewed at ConsUrol15 clinic.
26 March 2015	reviewed at Oncology clinic, proceed with Chemotherapy.
31 March 2015	admitted to CAH under care of ConsUrol13 and stent inserted. Operation note, "*Oncologists to contact when chemotherapy complete for stent removal / replacement".*
02 April 2015	discharged. "*Urology to be contacted when chemotherapy is completed so that stent removal/change can be planned."*
02 April 2015	added to ConsUrol13 Urgent waiting list.
23 April 2015	Chemotherapy started.
08 October 2015	Chemotherapy completed.
26 November 2015	**Letter, ConsOnc10 asks ConsUrol13 to consider changing stent.**
11 December 2015	date stamp letter received in Craigavon.
30 December 2015	email to ConsUrol13 from his secretary, on W/L for October 2015. Daughter rang regarding date for surgery.
21 January 2106	SpROnc14 to re-contact Urology. Copied to ConsSurg9, not Urology.
04 March 2016	email from audiotypist to ConsUrol13 secretary, query date for surgery.
24 March 2016	further letter from ConsOnc2 to ConsSurg9, not Urology. " ... has heard nothing further from Urology". Date stamp 5 May 2016.
09 May 2016	review by ConsSurg9; wrote to ConUrol11. "*Please see and review Urological care. ..stent has been in now for about a 1½* year. *Could you*

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6.0 FINDINGS	
	perhaps review whether or not this could be removed/replaced?"
10 May 2016	email to ConsUrol13 from his secretary, "*Patient ringing....current symptoms related to stent .....give him a date for removal."*
02 June 2016	letter from SpROnc14 to ConUrol11 requesting, "*your intervention to facilitate his ongoing oncological management".*
24 June 2016	email from ConsUro13 to his secretary, "*Please send letters of admission .... admission on 29 June 2016 as follows ....* Patient 16 *".*
29 June 2016	**admission. Operated on for stent removal by ConsUrol13.**

Therefore, after the original stent was inserted on the 31 March 2015 and the patient discharged on the 2nd April 2015, Chemotherapy could start, and the stent would then be removed or replaced 6-9 months later. The last dose of chemotherapy was given on the 8th October 2015 and the letter to ConsUrol13 was sent on the 26th November 2015, (typed on 27th November 2015).

The crucial period regarding any unnecessary delay in treatment and care in this case (as indicated between the entries above in bold) appears to be from the time the patient was deemed ready to have his stent removed or replaced i.e. 26th November 2015, and when he was finally admitted for his surgery i.e. 29th June 2016, a period of 217 days or 31 weeks. Also, did this delay remove a window of opportunity for a course of pelvic radiotherapy?

The 26th November 2015 letter to ConsUrol13 perhaps was not received in CAH until 11th December 2015. There is no evidence that he received and/or acknowledged the receipt of letter. The question is, "Did he ever receive i.e. see, this letter?"

A copy of the 26th November 2015 letter appears to have been received and acknowledged by ConsSurg9 who queried a review date. An entry in red ink (probably secretary) appears to indicate there was an OPD date of 02/16, presumably February 2016. No action seems to have happened following receipt of the 26th November 2015 letter.

An email was sent to ConsUrol13 on the 30th December 2015 indicating the patient was on a waiting list for October 2015 and patient's daughter rang regarding a date for surgery. There appears to be no record of a response to this email.

The next possible reminder to the Urology service was the 21/01/2016 letter. It is uncertain whether SpROnc14 contacted Urology. Letter was copied to ConsSurg9. The letter indicates that palliative radiotherapy was being considered. There is no apparent action taken at this time.

On the 4th March an email to ConsUrol13's secretary indicated the patient had requested a date to come in for removal of stent. There is no apparent action taken at this time.

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At Oncology clinic review on the 24th March 2016, ConsOnc2 sent another letter to ConsSurg9 indicating disease progression and that nothing further had been heard from Urology. This letter appears to have been typed almost a month later (22/04/2106) and not received in CAH until 5th May 2016. ConsSurg9 seems to have seen this letter.

ConsSurg9 reviewed Patient 16 at Surgical OPD on 9th May 2016 and has then written to ConsUrol11 on the 9th May 2016 asking him to review Patient 16's Urological care.

Then, on the 10 May 2016 a further email sent to ConsUrol13 from his secretary informing ConsUrol13 that the patient rang the office and asked for an appointment to have his stent removed. There is no apparent action taken at this time.

Further letter on the 2nd June 2016 from SpROnc14 to ConsUrol11 asking for his intervention to facilitate oncological management. Letter not copied to ConsUrol13. The Oncology team would consider IMDG chemotherapy once the stent is changed and if his urinary symptoms are stable. This letter, received on the 8 June 2016, has been acknowledged and annotated by ConsUrol11 on the 22 June 2016, which led to an expedited appointment for surgical intervention on 29 June 2016, 454 days after being listed and 217 days after chemotherapy had ceased.

Then, on 24th June 2016 email from ConsUrol13 to secretary requesting admission for Patient 16 on the 29th June 2016 for surgery.

Surgery on the 29th June 2016 proceeds with removal of the stent without replacement. The postoperative course is difficult with a period of urosepsis. Further surgery on 10th August 2016 when stent was inserted with much resistance. Followed by period of disease progression, further Urology surgery in December 2016 with terminal admission shortly afterwards. Patient died on Personal information redacted by USI

In relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental. [Source = Complaint response]

<u>Communication between Oncology service, Surgery and Urology</u>

The Oncology medical staff copied ConsSurg9 into GP correspondence. However, the Review Team noted that Urology was not always copied into all Oncology correspondence. On occasion, there was evidence of Oncology letters sent or copied to,

- ConsUrol13 on 26 November 2015, 23 July 2016 and 2 December 2016.
- SpROnc14 sent to ConsUrol11, dictated on 2 June 2016.

but on others it was not. It appears especially odd that on the 8th October 2015, when chemotherapy was stopped, Oncology wrote to ConsSurg9 but not ConsUrol13 who should have been waiting to hear that information, prior to removal/replacement of the stent, as

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agreed back in March/April 2105.

Acknowledging receipt and sight of correspondence

In the medical chart, there is evidence that some Consultants signed letters from other specialties and on occasions annotated the letter with instructions including ConsSurg9 and COnsUrol11.

There is no evidence of the letters sent to ConsUrol13 being initialled to acknowledge receipt. The important 26th November 2015 letter from ConsOnc10 to ConsUrol13 initially requesting change of the stent was date stamped in the CAH chart, 11th December 2015, but there is no Consultant note/signature/handwriting evident on letter to acknowledge receipt. This calls into question whether ConsUrol13 was made aware, at that time, that the stent change was required.

However, there were several email communications received shortly afterwards that should have brought this to his attention. This series of communication issues could be characterised as indicating a lack of acknowledging, reviewing and/or actioning correspondence.

Assurance for tracking correspondence

The Review Team noted that letters to Consultants are not tracked and there is no process in place to ensure they have been reviewed and actioned by Consultants.

Correspondence on NIECR

The Oncology service is based in Belfast City Hospital Cancer Centre and the Oncology medical team visit CAH to do clinics. The Oncologists do not have access to Southern HSC Trust intranet services. The Oncologists highlighted, '*Dictated, typed, verified and recorded letters remain the preferred method of communication between disciplines, though admittedly delays can occur due to shortages of administrative staff. On occasions where was a clinical imperative for urgent communication, phone calls and emails were made from Oncologists to the Urology service*'. [Source = Complaint response]

Oncology letters were not available on the NIECR which made reviewing the full patient journey difficult for clinicians.

The Booking Centre Manager has highlighted that on occasions letters may have been filed or held in a backlog with no evidence of Consultant review. On the 4th April 2017 correspondence was sent by the Booking Centre Manager to Operation Support Leads for action by secretaries, this stated '…… *if not on NIECR, filing is a priority. Also, please ensure all your staff know that no letters or results should ever be filed in charts without a Consultant's signature. For example, Oncology letters are not on NIECR and when they are sent to Consultants here, it is up to the Consultant to read the letter, and sign before the secretary files. It is important that these letters in particular are filed because they are not on*

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NIECR.'

Waiting List

Patients with urological conditions which affect the normal functioning of the upper urinary tract are at risk of losing kidney function and consequently renal failure. The duration of Urology waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting is associated with progressively increasing risk of urosepsis, and its associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months.

Waiting times in Urology are long due to a demand & capacity mismatch. In June 2016, ConsUrol13 had 273 patients on his inpatient day case waiting list, with 158 on his urgent waiting list, 75 of these patients had been waiting over 52 weeks.

When Patient 16 was added to the urgent Urology waiting list in April 2015, the Urgent Urology Waiting list patients position on 30 June 2016 was,

0-13 Wks	13-17 Wks	17-21 Wks	21-26 Wks	26-31 Wks	31-36 Wks	36-41 Wks	41-46 Wks	46-52 Wks	Over 52 Wks
202	32	36	46	28	25	21	13	11	106

The longest patient waiting was for over 127 weeks with 6 patients waiting over 114 weeks and 18 patients over 100 weeks.

7.0 CONCLUSIONS

There was a treatment and care delay – specifically, to the changing of ureteric stents, due to,

1. Lack of effective communication systems and processes; and
2. Long Waiting Lists leading to delay.

The Review Team consider that the delay probably was significant in terms of,

- an easier progression through the process of having the stents removed and replaced;
- reduction in the level of pain and discomfort reported towards the end of life.

However, in relation to the possibility of missing treatment opportunities, Oncology have commented that with the benefit of hindsight, it is clear that palliative radiotherapy would not have affected the clinical outcome and could have been detrimental.

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1. Lack of effective communication systems and processes

Contributory factors

Task Factors (policy and guidelines) / Communication

Communication between Oncology and other services can be by telephone in urgent situations but is mostly by letter which can lead to delay or omission in communication in relation to patient care. There were gaps of weeks to over a month between dictation, typing, sending, receipt and acknowledging of letters with action, such as addition to a waiting list, taking further time; followed by time actually waiting while on the waiting list.

Oncology letters were not on NIECR (Note: possibly this has now been rectified) and thus not accessible outside of patients' clinical notes for other clinical teams to access and use when planning treatment.

The Trust has no formal process for tracking letters or emails and ensuring they have been received, acknowledged, reviewed and actioned.

There were also many occasions when letters from Oncology which contained urological issues were not copied to Urology. On some occasions, when they did copy to Urology it was to ConsUrol11 and not the Urologist in charge i.e. ConsUrol13.

Contributory factor

Staff factor

The Review Team noted, throughout this case, the number of times that communication opportunities involving ConsUrol13 appeared to have been missed, resulting in Patient 16's stent not being removed and/or replaced in a timely manner. Throughout this case, there were letters not received or acknowledged, emails not actioned and phone messages from the patient and family that also did not result in action.

2. Long Waiting Lists leading to delay

Contributory factor

Workload/scheduling

The Review Team noted that the long waiting times for Routine and Urgent Urology inpatient and day case treatment contributed in the delay in Patient 16 having his stent changed, and therefore a delay in decisions regarding palliative treatment.

8.0 LESSONS LEARNED

1. Communication between the Oncologists from the Belfast Trust and the Clinicians in the SHSCT was mostly by letter. This appears to be too inefficient with respect to timeliness, especially for potential cancer patients being investigated and cancer patients already on a treatment pathway. Correspondence can also become misplaced or lost especially if it comes in from another Trust.

2. There is no formal Trust guidance/process on what is expected of clinicians when dealing

with clinical matters using paper correspondence; particularly for recording receipt, acknowledgement, reviewed and actioned. This should include what is expected of clinicians when triaging referral letters including Consultant to Consultant written documentation. This includes letters where the action required could be the addition to either inpatient or outpatient waiting lists by clinical priority.

3. The SHSCT does not have formal guidance on managing letters e.g. by tracking, to ensure they are managed in a consistent, timely and appropriate way by all clinicians. Good practice was noted by some clinicians.

4. The above lessons learnt also applies to the use of correspondence by email.

5. Correspondence and communication between clinical teams, especially when they involve 'visiting' clinical teams, should include all the SHSCT teams/clinicians directly involved in the patient's care, particularly when they are referred to in the correspondence.

6. Long Urology waiting lists mean that some patients are often unable to be treated in a clinically appropriate time, leading to delay in treatment and care and possible adverse outcomes.

9.0 RECOMMENDATIONS AND ACTION PLANNING

TRUST

Recommendation 1

The Trust will explore and evaluate methods of communication between clinicians; other than paper. This will be especially for 'visiting' clinical teams not based in the SHSCT and also especially when their clinic letters are not available on NIECR.

Recommendation 2

The Trust should develop written policy/guidance for clinicians and administrative staff concerning writing clinic or discharge letters, to ensure all clinical teams/clinicians, directly involved in the patient's care, are copied into the correspondence, especially if they are referred to in the letter.

Recommendation 3

The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff.

This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an

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9.0 RECOMMENDATIONS AND ACTION PLANNING

appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4
The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB
Recommendation 5
In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6
The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Melanie McClements, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

"Patient 16" family

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Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

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SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

Service User or their nominated representative

From: Corrigan, Martina < Personal Information redacted by the USI >
Sent: 22 May 2018 17:29
To: Hynds, Siobhan; Ronan Carroll (SHSCT)
Subject: RE: Return to Work Action Plan February 2017 FINAL.

Hi Siobhan

Apart from one deviation on 1 February 2018 when Mr O'Brien had to be spoken to regarding a delay in Red Flag Triage and he immediately addressed it, I can confirm that he has adhered to his return to work action plan, which I monitor on a weekly basis.

CONCERN 1 – one deviation when the red flag was not triaged for 6 days – he was spoken to and it was resolved that evening and his reason was due to the busyness of his oncall week when he had spent quite a bit of it in emergency theatre.
CONCERN 2 – adhered to – no notes are stored off premises nor in his office
CONCERN 3 – adhered to – Mr O'Brien uses digital dictation and dictates on all charts after clinics and he has an outcome on all patients including DNA patients
CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,
Should you require anything further, please do not hesitate to contact me.

Regards

Martina

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

INTERNAL: EXT Personal Information
EXTERNAL Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Hynds, Siobhan
Sent: 18 May 2018 15:04
To: Corrigan, Martina; Carroll, Ronan
Subject: Return to Work Action Plan February 2017 FINAL.
Importance: High

Hi Martina / Ronan

I am finalising the investigation report and just wanted to check that in line with the attached action plan – has this been adhered to fully by AOB from February 2017? Has there been any deviation from it.

I just wanted to confirm either way for the purposes of the report.

Thanks

Siobhan

From: Hynds, Siobhan <Personal Information redacted by the USI>
Sent: 26 November 2018 18:28
To: Khan, Ahmed
Subject: Draft e-mail to Mr O'Brien

Importance: High

Dr Khan

The previous draft e-mail referred to the 14th December as a possible date for the hearing. As the external panel member cannot do this date, I think we have no alternative but to notify Mr O'Brien that a date before Christmas is not possible due to diary commitments of those involved. I think we should ask him for his availability for January to see what we can work to. Are you happy to send an e-mail on this basis?

Dear Mr O'Brien

I have been working to identify a suitable date for the MHPS conduct hearing we discussed at our meeting on 1 October. There are a significant number of diaries to be co-ordinated and a number of dates I was holding in November and December are no longer viable due to the diary commitments of others.

I am therefore contacting you to let you know that it is likely it will early January before a date is able to be confirmed. To this end, I would be grateful if you could let me know your availability for a full day hearing in the first 3 weeks of January. You will need to ensure your representative is also available. I will try to co-ordinate other diaries around your availability.

All paperwork for the hearing will be shared with you in advance of any date set for the hearing.

Regards,

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by the USI Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI