Dr Maria O'Kane
Interim Chief Executive & Accounting officer
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Dr O'Kane,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 29 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:

Dr. Maria O'Kane
Interim Chief Executive & Accounting officer
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 [redacted]
Personal information redacted by USI

Christine Smith QC
Chair of Urology Services Inquiry

SCHEDULE

[No 29 of 2022]

General

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

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

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

Your position(s) within the SHSCT

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

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

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

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

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

Urology services/Urology unit - staffing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Engagement with unit staff

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

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

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

Governance – generally

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concerns regarding the urology unit

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. O'Brien

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Learning

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

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

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

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

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

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

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

NOTE:

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

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

UROLOGY SERVICES INQUIRY

USI Ref: Notice 29 of 2022

Date of Notice: 29th April 2022

Witness Statement of: Maria O'Kane

I, Maria O'Kane, will say as follows:-

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

1.1 At the outset I remind myself that the Terms of Reference for the Inquiry are as outlined below

a. To review the Southern Health and Social Care Trust's (the Trust) handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice. The Inquiry shall determine whether there were any related concerns or circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and making complaints.

b. To evaluate the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a "lookback review" of patients seen by the urology consultant Mr Aidan O'Brien (for the period from January 2019 until May 2020). This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the Health and Social Care Board, Public Health Agency and the Department. It also includes any other areas which directly bear on patient care and safety and an assessment of the role of the Board of the Trust.

c. To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty.

d. To afford those patients affected, and/or their immediate families, an opportunity to report their experiences to the Inquiry.

e. To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy.

f. To identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose.

g. To examine and report on any other matters which the Chairman considers arise in connection with the Inquiry's investigations in fulfilment of these Terms of Reference.

An explanation of your role, responsibilities and duties

1.2 As outlined in the extensive documentation and narrative contained in the ensuing answers to questions, I have been employed as Chief Executive of the Southern Health and Social Care Trust since the 1st May 2022, as Temporary Accounting Officer since the 14th February 2022, and as Medical Director since the 1st December 2018. Prior to this, I have been employed in the NHS in various medical and senior managerial posts throughout Northern Ireland since graduating as a Medical Doctor in August 1990. The details of these are contained in the body and attachments of this submission and I will not repeat them here.

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.

1.3 Further details of these matters are provided below in my answers from question 52 onwards. However, an overview is set out in the following paragraphs.

1.4 As outlined in the narrative described throughout Answer 54, Mr O'Brien was unknown to me prior to my arrival in the Southern HSC Trust in December 2018. Following a meeting, as part of the arrival handover to me of information, at which I was present between the then Interim Medical Director, Dr Ahmed Khan, and the GMC ELA, Joanne Donnelly, I learned that a Maintaining High Professional Standards Investigation had been carried out in relation to a Urology Consultant, the result of which was an action plan in relation to administrative activity, and that there were not thought to be any concerns about his clinical practice and that he did not require formal referral to the GMC. Corrected minutes attached;

The relevant documents can be located in S21 29 OF 2022, 1. MEDICAL DIRECTOR HANDOVER FROM DR KHAN, 2. 20220616 E GMC Meeting Minutes and Corrections, 3. 20220616 E GMC Meeting Minutes and Corrections 2, 4. 20220616 E GMC Meeting Minutes and Corrections 2 A1

1.5 Over the course of the next few weeks, I familiarised myself with Mr O'Brien's hard copy Maintaining High Professional Standards (MHPS) files. These outlined that, as a result of concerns raised in a letter to him by Mrs Heather Trouton, Assistant Director for Surgery, and Mr Eamon Mackle, Associate Medical Director in Surgery, on the 23rd March 2016, that further investigation had revealed that Mr O'Brien had not been compliant with the usual administrative processes that support timely and appropriate care, as a result of which patients had not been triaged in keeping with regional guidance and there were concerns that patients had come to harm as a result of delay.

1.6 Further investigation following this had revealed 4 concerns regarding Mr O'Brien: that there were significant numbers of unprocessed triage referral forms, patients' charts stored in Mr O'Brien's home and office, that a number of private patients had been prioritised on surgical lists, and that clinics had not been dictated leading to delays in referrals and procedures. After a period of exclusion from his role from December 2016 until January 2017, an administration action plan was implemented.
ATTACHMENT – MHPS ACTION PLAN 2017 document located at *Relevant to HR/reference no 33/GRIEVANCE PANEL 1/20170200 - Return to Work Action Plan DR AOB*

1.7 When I arrived in the Trust the action plan was being monitored and reported to Dr Khan as MHPS Case Manager until December 2018, when Dr Khan requested that reporting should be by exception.

Document can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20181123 - Email - RE AOB Action plan 2

1.8 Before my arrival, Serious Adverse Incident Reviews had been instigated regarding the concerns raised and were chaired by Dr Julian Johnston. These were subsequently published in May 2020.

SAIs Dr JULIAN JOHNSTON 2020 documents located at Relevant to Acute, Document No 54, 20200522 Final Report and Patient 16 *20200127 Final Report*

1.9 On my review of the MHPS papers available, I was concerned that Mr O'Brien's behaviour had impacted on patient safety and that he had limited insight into the impact of this and his responsibilities. As a consequence of this, I referred him to the GMC on 28th March 2019.

GMC REFERRAL FORM 2019 documents located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20190402 - Email - FW GMC Referral, 20190402 - Attachment - Case Manager Determination AO'B FINAL 280918, 20190402 - Attachment -Return to Work Action Plan February 2017 FINAL, 20190402 - Attachment -December 2016, 20190402 - Attachment -September 2018, 20190402 - Attachment - March 2019 and AO'B fitness-to-practise-referral-form. Document located at S21 No 29 of 2022, 5. 20190402 AO'B fitness-to-practise-referral-form

1.10 In March 2019, Mr Haynes raised queries about the robustness of the Patient Administration System (PAS) and this was challenged with Mr O'Brien's secretary and administration managers and assurances were given that processes were being followed by Mr O'Brien.

ATTACHMENT – EMAIL 20190331_RE Urology backlogs Confidential document can be located at *Relevant to MDO/Evidence after 4 November MDO/reference 51 a/20190331_RE Urology backlogs Confidential*

1.11 Mrs Corrigan then raised concerns in September 2019 that there were delays in dictating clinics and triaging patients.

EMAIL 20190918_RE AOB concerns – escalation document can be located at Relevant to MDO/Evidence after 4 November MDO/reference 51 a/20190918_RE AOB concerns - escalation.pdf

1.12 These concerns were escalated to the Case Manager, Dr Khan, and attributed to Mr O'Brien being distracted [redacted] Review suggested that the difficulties extended to the end of June 2019. Mr O'Brien was given extra time beyond his week on-call as Surgeon of the Week to complete these. There were no further escalations between this and the 7th June 2020, when Mr Haynes noted a discrepancy in that a number of patients who were placed on a list for surgery were not listed on the Patient Administration System, which suggested that a separate list of these patients was being kept by Mr O'Brien.

ATTACHMENT – EMAIL 20200619 RE Patients to be added to Urgent Bookable List documents can be located at *Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, no 77 – emails Mr Mark Haynes – AMD and Consultant Urologist, 20200611-email patients to be added to urgent bookable list – att9*

1.13 I have since learned that, when Mrs Corrigan was absent [Personal information redacted by USI] from June to November 2018, Mr O'Brien had not been monitored and, on Mrs Corrigan's return to work in November 2018, it was identified that there had been slippage in triage and that this was quickly rectified when brought to Mr O'Brien's attention. More information is supplied in my answers from Question 52 onwards, specifically in response to Question 54.

1.14 On the basis of this discrepancy noted in paragraph ix above, advice was sought from the General Medical Council, the Deputy Chief Medical Officer and NHS Resolutions. An initial investigation and rapid review of the previous 18 months' cases was undertaken which revealed concerns in relation to 9 patients as a result of delayed dictation by Mr O'Brien, all of whom met the threshold for SAI reviews. Dr Hughes reported on these in April 2021 and, in the course of these, raised concerns in relation to Bicalutamide prescribing, referral to and onward management of patients from Cancer Multidisciplinary

Meetings and involvement of Clinical Nurse Specialists in patient care. Mr O'Brien retired from the Southern Trust on the 17th July 2020, upon which Responsible Officer status reverted to the GMC.

ATTACHMENT – DR DERMOT HUGHES SAI FINAL REPORTS document can be located at *Relevant to Acute, Evidence After 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching*

ATTACHMENT – NHS RESOLUTIONS CORRESPONDENCE documents can be located at *Relevant to MDO, Evidence after 4 November MDO, reference no 68, NCAS NHS Resolutions SW, Relevant to MDO, Evidence Added or Renamed 19 01 2022, No 68 (iii), NHS Resolutions MOK and NHS Resolutions SW*

DEPUTY CMO EMAIL documents can be located at *S21 No 29 of 2022, 6. 20200811 E Discussion with Naresh Chada, 20200708 Note of Zoom Mtg with Joanne Donnelly*

1.15 The review of patients from the last 18 months of Mr O'Brien's tenure in the Trust before his retirement at this point has revealed 82 patients (up until 11th July 2022) whose care meets the threshold for Serious Adverse Incident Review and who, for expediency, are being reviewed using an adjusted evidence-based Structured Clinical Record Review ('SCRR') process developed with input from the Royal College of Physicians.

ATTACHMENT – UAG MINUTES DECEMBER 2020 documents can be located at *S21 29 of 2022, 7. UROLOGY ASSURANCE GROUP - UAG - Minutes of Meeting 18 December 2020*
ATTACHMENT – SCRR FORM document can be located at *S21 No 29 of 2022, 8. SCRR FORM*

1.16 In the meantime, Mr O'Brien is no longer employed by the Southern Health and Social Care Trust and has restrictions on his practice, most recently altered on the 14th June 2022 by the GMC which remains his Responsible Officer.

ATTACHMENT - GMC 1394911 Screenshot of GMC Medical Register document can be located at *S21 No 29 of 2022, 9. GMC 1394911 Screenshot of GMC Medical Register*

1.17 All of this occurred against a background of extensive waiting lists in urology in the context of an historically under-commissioned service and a shortage of urology staff.

1.18 I have a number of reflections on what I believe led to all of this and what we might learn for improvement in the future. I have set these out below in my response to Question 68.

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

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

to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

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

4.1 My full name is Dr Ellen Maria O'Kane, GMC registration 3485673. I qualified as a Medical Doctor through Queen's University in 1990 with BCh, BAO, MB, was awarded the MRCPsych Member of the Royal College of Psychiatrists in 1994 and Fellowship of the Royal College of Psychiatrists in 2005 (FRCPsych). I completed an MA in Psychoanalytic Studies in 2001 and an MSc in Health and Social Services Policy and Management in 1998. I completed the Scottish Patient Safety Fellowship through NHS Scotland in 2014-2015 and have trained as a Dartmouth Improvement Coach.

4.2 Since 1st May 2022 I have been Chief Executive of the Southern Health and Social Care Trust having previously been Medical Director within the organisation between 1st December 2018 and 30th April 2022. By way of context the Southern Health and Social Care Trust has a budget of approximately £0.8 Billion and circa 14,000 staff. My personal focus is relentlessly on improving patient care and safety through supporting and developing the work of those who provide direct patient care. This focus is underpinned by my value base, my professional training as a doctor and my experience as a senior leader in the Southern Health and Social Care Trust and previously in the Belfast Health and Social Care Trust. As an Executive Director within the Southern Health and Social Care Trust since 1st December 2018 I have responsibility as an Executive Member of Trust Board and the Senior Management Team for delivering the operational and strategic objectives of the Trust.

4.3 I am a Scottish Patient Safety Fellow and have completed training as a Dartmouth Patient Safety Coach which is designed to equip attendees with additional skills and knowledge to further enhance the quality of care and services for patients. As a

registered Medical Professional, I have undertaken annual appraisal and have met the goals set for personal and professional development. I met at least monthly on a formal basis with the Chief Executive to review and update workplans for my areas of responsibility.

4.4 I have undertaken ongoing management and leadership development opportunities throughout the past 3 years both with the HSC Leadership Centre and Oxford University. I undertake regular reflective review of my leadership and management experiences with a Senior Organisational Consultant from the Tavistock Clinic in London which specialises in supporting talent development for large organisations. I have been accredited by the British Psychoanalytic Council as an Organisational Consultant in 2020.

4.5 I have worked in the NHS for 30 years and prior to employment in Southern Trust I held a number of senior managerial and leadership roles in the Belfast Trust and nationally through the Royal College of Psychiatrists.

4.6 The tables below outline my occupational history prior to commencing employment with the Southern Health and Social Care Trust.

4.7 Substantive Posts Held (1999 – 2018)

Role	Employer	Date Commenced	Date Ended
Consultant Psychiatrist (Acting)	Homefirst Community Trust (Ballymena Sector)	1999	2000
Consultant Psychiatrist	Homefirst Community Trust (Newtonabbey Sector)	2000	2004
Consultant Psychiatrist	Mater Hospital Trust (North Belfast Sector)	2004	2007
Consultant Psychiatrist	Belfast Health and Social Care Trust	2007	30th November 2018

4.8 Management Posts Held (1999 – 2018)

Role	Employer	Date Commenced	Date Ended
Training Programme Director Psychotherapy (NIMDTA)	Belfast Health and Social Care Trust	2000	2009
Clinical Director Mental Health	Belfast Health and Social Care Trust	2007	2010
Self-Harm and Personality Disorder Services (Trust and regional lead)	Belfast Health and Social Care Trust	2010	30th November 2018
Associate Medical Director Older People and Primary Care becoming	Belfast Health and Social Care Trust	2010	2017

Chair of Division Mental Health	Belfast Health and Social Care Trust	2017	30th November 2018
Deputy Medical Director	Belfast Health and Social Care Trust	2015	September 2018

4.9 Additional Posts Held (1999 – 2018)

Role	Employer	Date Commenced	Date Ended
British Medical Association Chair of the NI Junior Doctors' Committee	British Medical Association	1994	1998
NI Regional trainee representative at national Royal College of Psychiatrists	Royal College of Psychiatrists	1997	2000
Regional Chair of the Psychotherapy Faculty	Royal College of Psychiatrists	2009	2012
Regional Lead for Mental Health Policy	Royal College of Psychiatrists	2012	2015
Deputy Chair of the Royal College of Psychiatrists	Royal College of Psychiatrists	2015	2018
Royal College of Psychiatrists Invited Review Service Lead	Royal College of Psychiatrists	2019	2022
Royal College of Psychiatrists Board Member Accreditation Board for Serious Adverse Incidents (SIRAN)	Royal College of Psychiatrists	2020	Current

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 The following table sets out my employment history within the Southern Health and Social Care Trust.

Role	Start Date	End Date	Comments on Role	Comments on Job Description
Medical Director	1st December 2018	30th April 2022	Initial appointment to Southern Health and Social Care Trust	• As Medical Director I was Director for Infection Prevention and Control – this is not referenced in the job description. • As Medical Director I was Trust Clinical Lead for the introduction of the Mental Capacity Act – this

				is not referenced in the job description. • Under the terms of the Medical job description I was also Directorial Lead for Emergency Planning. With the onset of the ongoing pandemic throughout my tenure as Medical Director from February 2020 until 30 April 2022 these roles Of Director of Infection Prevention Control and Emergency Planning in particular consumed significant amounts of time as I was heavily involved with the Chief Executive in leading the organisation through the Covid-19 pandemic.
Director Mental Health and Disability Services	1st April 2021	14th February 2022	Concurrent role with Medical Director portfolio pending appointment of replacement post.	• I was I was supported in this role by the retired former Director of Mental Health and Disability Services (12 hours per week).
Temporary Accounting Officer	14th February 2022	Current	Assumed role following Shane Devlin, CX standing down. I was appointed a temporary Accounting Officer for the Southern Health and Social Care Trust following competitive interview when I was interviewed for the role of Chief Executive on 28th January 2022. The role of Accounting Officer is a legal requirement within legislation and was agreed through the Department of Health as a holding position while contractual arrangements were finalised in relation to my undertaking the post of Chief Executive.	Concurrent with Medical Director post between (14th February and 30th April 2022).
Chief Executive	1st May 2022	Current	Current post	This role has proved extremely challenging in the intervening period. In addition to the demands of the Urology Inquiry, the Trust is facing significant pressures in relation to capacity and demand exacerbated by the ongoing Covid 19 pandemic, regional staff shortages as much as 30% in some areas, increasingly long waiting lists of high acuity patients who are deteriorating while waiting for investigation and treatment and exhausted staff. In addition to this the Senior

				Management Team is changing in that 2 senior members the previous Chief Executive and Performance Director in the last few months have moved to other posts, the Finance Director has been newly appointed 6 months ago from a different sector having never worked in HSC previously, the Director for Acute Services is being replaced in the next month and is being replaced by 2 interim directors, the Mental Health and Disability Director is now in post 4 months and the other operational directors in children's and older people's services also hold interim posts. The Director for Performance and planning is interim in the last few weeks. The role of Medical Director is being covered by a Deputy Medical Director. I have now been in post as Chief Executive for 7 weeks since the 1st of May. In addition to this there are a number of changes at the Assistant Director level who are retiring imminently. All of these concerns have been identified on the Trust Corporate Risk Register.

ATTACHMENT – CHIEF EXECUTIVE JOB DESCRIPTION (2022) document can be located at S21 No 29 of 2022, 10. Chief Executive Job Description 2022

ATTACHMENT – MEDICAL DIRECTOR JOB DESCRIPTION (2018) document can be located at S21 No 29 of 2022, 11. Medical Director MARIA O'KANE JD

ATTACHMENT – DIRECTOR MENTAL HEALTH AND DISABILITY JOB DESCRIPTION (2021) document can be located at S21 No 29 of 2022, 12. Director of MHD JD

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.

Medical Director 1st December 2018 – 30th April 2022

6.1 As Medical Director my reporting arrangements were as follows:

Role	Reported to	Comments
Medical Director	Chief Executive	As Medical Director I also provided a verbal assurance report to Trust Board at each monthly meeting on matters relating to Professional Medical Governance

6.2 As Medical Director my line management arrangements were as follows:

Name	Position	Roles	Date Commenced Post	Date Ended
Dr Damian Scullion	Deputy Medical Director	Appraisal and Revalidation	22/11/2021	Ongoing
Dr Aisling Diamond	Deputy Medical Director	Workforce and Education	06/04/2020	Ongoing
Dr Damian Gormley	Deputy Medical Director	Quality, Safety and Governance	01/04/2021	Ongoing
Simon Gibson	Asst Dir Medical Directorate	Professional Governance and Education	01/04/2016	Ongoing
Trudy Reid	Asst Dir Clin & Soc Care Gov	Corporate Clinical and Social Care Governance	07/01/2019	23/03/2020
Stephen Wallace	Asst Dir Clin & Soc Care Gov	Corporate Clinical and Social Care Governance	23/03/2020	31/01/2021
Caroline Doyle	Asst Dir Clin & Soc Care Gov	Corporate Clinical and Social Care Governance	01/02/2021	Ongoing
Trudy Reid	Asst Dir Infection Prevention and Control	Infection Prevention and Control	23/03/2020	Ongoing
Stephen Wallace	Asst Dir Systems Assurance	Public Inquiry Support and Assurance	31/01/2021	Ongoing

6.3 As Medical Director the services I had responsibility for were as follows:

a) Infection Prevention and Control

b) Corporate Clinical and Social Care Governance

c) Medical Education

d) Research and Development

e) Medical Professional Governance (including Medical Appraisal and Revalidation)

f) Emergency Planning

Mental Health and Disability Director 1st April 2021 - 14th February 2022

6.4 As Mental Health and Disability Director my reporting arrangements were as follows:

Role	Reported to
Mental Health and Disability Director	Chief Executive

6.5 As Mental Health and Disability my line management arrangements were as follows:

Name	Position	Roles	Date Commenced Post	Date Ended
Lynn Woolsey	Interim Assistant Director Inpatients	Mental Health Inpatients Services	2018	31/12/2021
Joe Walker	Interim Assistant Director Inpatients	Mental Health Inpatients Services	03/01/2021	Ongoing
Jan McGall	Assistant Director Community Mental Health Services	Community Mental Health Services	2019	Commenced as Director of MHD 14th February
John McEntee	Assistant Director Disability Services	Disability Services	2018	Ongoing

ATTACHMENT – JOB DESCRIPTION DMD APPRAISAL & REVALIDATION document can be located at S21 No 29 of 2022,13. Deputy Medical Director Medical Appraisal and Revalidation

ATTACHMENT – JOB DESCRIPTION DMD WORKFORCE & EDUCATION document can be located at Relevant to HR, reference no 2b, 20191000 - REF2b - DEPUTY MD Education Workforce Development Job Description

ATTACHMENT – JOB DESCRIPTION DMD QUALITY, SAFETY AND GOVERNANCE document can be located at S21 No 29 of 2022, 14. Deputy Medical Director Governance Safety and QI

ATTACHMENT – JOB DESCRIPTION AD MEDICAL DIRECTORS OFFICE document can be located at S21 No 29 of 2022, 15. Assistant Director MD Office JD

ATTACHMENT – JOB DESCRIPTION AD CLINICAL & SOCIAL CARE GOVERNANCE document can be located at S21 No 29 of 2022, 16. AD Clinical and Social Care Governance JD

ATTACHMENT – JOB DESCRIPTION AD INFECTION PREVENTION AND CONTROL document can be located at S21 No 29 of 2022, 17. Assistant Director Infection Prevention and Control JD

ATTACHMENT – JOB DESCRIPTION AD MENTAL HEALTH INPATIENTS document can be located at S21 No 29 of 2022, 18. JOB DESCRIPTION AD MENTAL HEALTH INPATIENTS

ATTACHMENT – JOB DESCRIPTION AD COMMUNITY MENTAL HEALTH SERVICES document can be located at S21 No 29 of 2022, 19. Assistant Director of Mental Health Band 8C

ATTACHMENT – JOB DESCRIPTION AD DISABILITY SERVICES document can be located at S21 No 29 of 2022, 20. JOB DESCRIPTION AD DISABILITY SERVICES

ATTACHMENT – ORGANOGRAMS OF MANAGEMENT STRUCTURES MEDICAL DIRECTORS OFFICE document can be located at S21 No 29 of 2022, 21. Medical Directorate Organisational Chart at January 2021 and 21a, Medical Directorate Organisational Chart April 2022

ATTACHMENT – ORGANOGRAMS OF MANAGEMENT STRUCTURES MENTAL HEALTH AND DISABILITY document can be located at S21 No 29 of 2022, 22. MHD Gov Structure Updated 2021

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

7.1 Corporate Governance should be an integrated function of the Southern Health and Social Care Trust but, in practice, was defined in a delineated structure delivered through operational and clinical professional directorates. The structure that has supported the delivery of this in the Southern Trust until now is that the Executive Directors lead and are accountable for professional standards and behaviours of registered staff in their professional areas and the Operational Directors have been responsible for the operational delivery of governance. Governance assurance and lead responsibility for Patient Safety is additionally the responsibility of the Medical Director.

7.2 In practice these different functions have been arbitrary at times and not clearly delineated.

7.3 As Medical Director (1st December 2018 – 30th April 2022) although I did not have any operational responsibility for delivery of Urology Services, however, I had responsibility for professional medical standards and behaviour.

7.4 Professional medical lines of responsibility for management and accountability were from Consultant to Clinical Director to Associate Medical Director (later Divisional Medical Director) to Medical Director. Service operation and the Clinical Governance of the Urology Unit were, and currently remain, as the responsibility of the Director of Acute Services. This is explained further in my answer to question 21.

7.5 As indicated above, the Trust to this point has operated a distributed Clinical and Social Care Governance system where each operational director is responsible for activity and Clinical Governance within their operational services.

7.6 My role as Medical Director included responsibility for Trust Corporate Clinical and Social Care Governance which provided assurance regarding clinical and social care governance mechanisms. A more detailed description of the interfaces around this governance model is provided in my answer to Question 8.

7.7 My Medical Director job description (2018) states *"(the)…..Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place".*

7.8 The following specific items are noted in my job description regarding clinical governance. For ease of reference, I have included all relevant job descriptions as attachments.

Medical Director (2018) Job Description Extract
CLINICAL GOVERNANCE 1. As a member of the Senior Management Team and Trust Board, assume corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds. 2. Provide professional advice to the Senior Management Team as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of Senior Management Team Governance, to regularly review this information, and to provide assurance or expert input into necessary next steps to address any issues arising from same.

3. Work with other professional Directors to lead multidisciplinary teams to ensure there is a system for audit of clinical practice that assesses and reviews the quality of services provided and ensures that any learning is incorporated into professional practice and systems.

4. While the operational responsibility and accountability for patient safety rests with operational Directors, assume responsibility for:

    a) Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.

    b) Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by Senior Management Team, within the wider Clinical and Social Care Governance arrangements of the Trust.

    c) Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to Senior Management Team, Governance Committee and Trust Board.

5. Ensure the development and maintenance of professional standards and education liaising with professional and education bodies as necessary

6. Provide advice on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to patients and clients

7. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC's guidance "Good Medical Practice" and the GDC's "Standards for Dental Professionals"

8. Set up systems for meeting and liaising with Associate Medical Directors and Clinical Directors in the Trust to ensure appropriate arrangements are in place for securing patient and client safety.

9. Ensure effective systems of clinical risk management and adverse event reporting are in place demonstrating trend analysis and processes to share learning.

10. Support the development and implementation of the Trust's Audit Strategy.

11. Ensure compliance with relevant assurance standards.

12. Provide arrangements for the clinical scrutiny of claims and litigation.

13. Ensure that there are effective systems in place to support the Trust's research governance arrangements.

14. Act as the designated lead Director for strategic management of patient safety initiatives, and the link Director with the Patient Safety Forum and other regional fora.

7.9 In delivering on these responsibilities, I had oversight of the following Governance processes, each addressed in turn below:

	ELEMENT	DESCRIPTION	REPORTING ARRANGEMENTS / FREQUENCY	IMPROVEMENTS INTRODUCED DURING MY TENURE
CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE	**Adverse Incidents**	I had responsibility for the oversight and management of the Trust incident reporting system (DATIX). This includes coordination and production of trend and activity reports for Trust Governance Committee. I provide challenge and scrutiny to directorate teams on incidents reported via the weekly governance debrief meeting, DivMD 1-1s and Trust Senior Management Teams	• Weekly Governance Debrief meeting • Quarterly Corporate Clinical and Social Care Governance Trust Board Report	• Upgrade of DATIX system • Weekly Challenge function introduced via the Governance Debrief meeting • Appointment of a DATIX systems manager
	Serious Adverse Incidents (SAIs)	I provided coordination of the Trust SAI processes. This includes monitoring of regional timescales and managing corporate supports to assist with SAI completion including the Family Liaison Team and use of the SAI Corporate Chair resource. All completed SAIs are currently approved by the operational Director who commissioned the review. I provide challenge and scrutiny to directorate teams on Serious Adverse Incidents reported via the weekly governance debrief meeting, Divisional Medical Director 1-1s and Trust Senior Management Teams	• Weekly Governance Debrief meeting • Quarterly Corporate Clinical and Social Care Governance Trust Board Report	• Introduction of Family Liaison Officer Role • Introduction of Corporate SAI Chair role • Introduction of Corporate Clinical and Social Care Governance Officer role • Pending introduction of Executive Director SAI Oversight Group • Weekly Challenge function introduced via the Governance Debrief meeting
	Clinical Audit	I was the lead director for Clinical Audit within the Trust. To date the Trust Clinical Audit function has been significantly understaffed. This has been referenced in the Trust Clinical Audit Strategy 2018.	• Annual National Audit Report to Trust Governance Committee • Weekly Governance Debrief	• Renewed Clinical Audit Strategy due for launch Summer 2022 • Additional funded secured to rebuild

				clinical audit function
	Patient Safety	I was Trust lead for patient safety. This includes developing a Trustwide Patient Safety Strategy, coordinating and overseeing Trust participation in patient safety initiatives. I also to lead on the development and implementation of mechanisms to improve patient safety data and data collection.	• Weekly Governance Debrief meeting • Quarterly Corporate Clinical and Social Care Governance Trust Board Report	• Creation of the first Patient Safety Strategy due for publication August 2022 • Introduction of Temporary Head of Service to implement recommendations from the Regional Public Inquiry into Hyponatraemia Related Deaths
	Complaints	I was Trust lead for corporate complaints management which includes coordination of complaints to directorate governance offices and collation of statistics and information relating to complaints Each Complaint response to coordinated by operational governance teams and approved by the service operational director. I provide challenge and scrutiny to directorate teams on incidents reported via the weekly governance debrief meeting, DivMD 1-1s and Trust Senior Management Teams	Weekly Governance Debrief meeting Corporate Clinical and Social Care Governance Trust Board Report	• Introduction of Corporate Clinical and Social Care Governance Officer • Introduction of new Complaints Manager post
	Medical Oversight of Litigation	Litigation Claims and Coronial outcomes were presented to me for review and assurance. This took the form of me being provided with details of the case and taking action to address any service deficiencies / areas for improvement with the relevant Divisional Medical Director / Operational Director	• Attendance at Litigation / DLS oversight meetings • Discussion with DivMD 1-1s	• Incorporation of learning into Medical Education programmes
	Mortality and Morbidity	I was Trust lead for the implementation and assurance surrounding M&M Processes. As part of this the Trust operates a Urology Patient Safety Meeting and specific	• M&M Oversight Group • Trust Governance Committee (Mortality Report)	• Relaunch of M&M Oversight Group • Introduction of quarterly mortality

		Surgery Mortality and Morbidity Meeting. I also oversee the production of a quarterly mortality report that is produced for Trust Governance Committee		reporting to Trust Governance Committee
	Learning from Experience	I was Trust lead for Learning from Experience which focuses on learning from Experience	• Trust Governance Committee	• Relaunch of the Trust learning from Experience Group
This attachment can be found at: WIT-54640 to WIT-54661	**Whistleblowing**	As professional lead for Medicine in the Trust I was a point of escalation for reporting whistleblowing concerns ATTACHMENT : TRUST WHISTLEBLOWING POLICY) document located at *Relevant to HR/reference no 2i/20180401 ref 2i/ Regional Your Right to Raise a Concern Policy and Procedure*	Trust Governance Committee	• Engagement with GPs to develop systems for reporting concerns in progress • Co-signatory on Medical Director letter regionally to remind all doctors or responsibility and pathways for raising concerns.
	Being Open	I was Trust lead for the implementation of the Being Open strategy	• Trust Governance Committee	• Establishment of Trust Being Open Group
MEDICAL PROFESSIONAL GOVERNANCE	**Maintaining High Professional Standards**	As Medical Director, I was responsible for oversight of concerns about the performance of doctors and ensuring they were identified and managed under the Department of Health (NI) Maintaining High Professional Standards in the Modern HPSS	• Discussed and monitored with GMC Employer Liaison Advisor	• Establishment of the Trustwide Doctors and Dentists Oversight Group
	Medical Appraisal	As Medical Director I was Trust lead for the medical appraisal process that facilitates self-review supported by information gathered from the full scope of a doctor's work.	• Annually to Trust Board	• Review of Appraisal Structure • Appointment of Temporary Divisional Medical Director for Appraisal and Revalidation

	Medical Revalidation	As Medical Director I was also Responsible Officer for the Southern Health and Social Care Trust. As Responsible Officer I held a statutory role in medical regulation. As a Responsible Officer I was accountable for the local clinical governance processes in the Trust that related to the conduct and performance of doctors. This included evaluating doctor's fitness to practise, and liaising with the GMC over relevant procedures and making recommendations on doctors revalidation.	• Annually to Trust Board	• Establishment of the Trustwide Revalidation Oversight Group • Appointment of Temporary Divisional Medical Director for Appraisal and Revalidation
	Job Planning	As Medical Director I had oversight of the Medical Job Planning processes	• 1-1 DivMD meetings	• Job planning moved from 75% in 2019 to 88% in 2021
	Private Practice / Paying Patients	As Medical Director I had oversight of the processes regarding private practice (as part of appraisal and revalidation whole practice appraisal) and along with the Director of Finance implemented Regional and Trust Paying Patients Guidance.	• Plans to develop a Report for Trust Governance Committee	• Revision of Trust Paying Patients Guidance to be published quarter 4 2022 •Requested Internal Audit on Paying Patients / Private Practice
	Medical Education	As Medical Director I was responsible for in conjunction with NIMDTA the coordination and delivery of the Trust Medical Education programme (undergraduate and postgraduate)	• Reports provided to Trust Board via Medical Director reports	•Significant improvement National Training Survey outcomes for the Southern Trust
SERVICE DELIVERY	**Infection Prevention and Control**	I was nominated Director with responsibility for Infection Prevention and Control (DIPC) with operational responsibility for the Infection Prevention and Control Team	• 6/12 month reporting to Trust Performance Committee • Report to quarterly to Trust Strategic Forum	• Provided support the management of Patient Safety throughout COVID-19 Pandemic
	Research and Development	I was lead director with responsibility for Research and Development within the Trust	• Annual report to Trust Board	• Trust led the SIREN study for the Trust regarding COVID-19
	Emergency Planning /	I was lead director with responsibility for Emergency	• Reports provided to Trust Board	• Quality Assurance

	Business Continuity	Planning and Business Continuity across the Trust	via Medical Director reports	programme of business continuity processes

Assurance Mechanisms

7.10 In my role as Medical Director (1st December 2019 -30th April 2022) I obtained assurances regarding the effectiveness of Clinical Governance via the following mechanisms.

MORBIDITY AND MORTALITY MEETINGS **These attachments can be found at:** **WIT-45406 to WIT-45408** **WIT-45409 to WIT-45450** **WIT-45451** **WIT-45452 to WIT-46613** **WIT-46614 to WIT-46615**	As per previous I was Trust lead for the implementation and assurance surrounding M&M Processes. To provide assurance regarding oversight I operated an M&M Strategic Oversight Group. The purpose of the M&M Strategic Oversight Group is to: • Provide high level oversight and assurance that effective systems and processes are in place for review of mortality and morbidity. • Ensure the capturing, sharing and implementation of learning and good practice arising from M&M meetings Consider mortality reports i.e. Summary Hospital-level Mortality Indicator (SHMI) / Risk Adjusted Mortality Index (RAMI) to identify early alerts or areas where more detailed review is required. This has proved challenging to establish during the COVID-19 pandemic to gain quorum attendance. Currently the terms of reference remain in draft format. *ATTACHMENT – M&M STRATEGIC OVERSIGHT GROUP document can be located at S21 No 29 of 2022, 23. M and M Strategic Oversight Group TOR* *ATTACHMENT – GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY (M&M) PROCESS document can be located at S21 No 29 of 2022, 24.GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY MM PROCESS* *ATTACHMENT – COMINBED SURGERY PATIENT SAFETY MEETING AGENDA SAMPLE document can be located at S21 No 29 of 2022, 25. 20220311 Combined Surgical Anaesthetics MM Patient Safety Agenda* *ATTACHMENT – UROLOGY PATIENT SAFETY MEETING AGENDA SAMPLE document can be located at S21 No 29 of 2022, 26. 20220218 Patient Safety Meeting MM Meeting Urology Agenda – 54* *ATTACHMENT: REGIONAL MEDICAL DIRECTORS' LETTER RE RAISING CONCERNS document can be located at S21 No 29 of 2022, 27. REGIONAL MEDICAL DIRECTORS' LETTER RE RAISING CONCERNS*
MORTALITY REPORTING	Since 2019 as Medical Director I instated a quarterly mortality report based on CHKS data with Trust performance benchmarked against peers and presented this to Trust Governance Committee. Quarterly mortality reports consider data relating to Trustwide • Risk Adjusted Mortality Index

This attachment can be found at: WIT-46616 to WIT-46656	• Specialist mortality indicator review which include:
	  o Rate of deaths within 30 days of an emergency admission with a myocardial infarction
	  o Rate of deaths in hospital within 30 days of an emergency admission with a stroke
	  o Rate of deaths for non-elective surgical patients within 30 days of surgery
	  o Rate of deaths for elective surgical patients within 30 days of surgery
	  o Rate of deaths in low mortality groups
	• ICNARC Data (Intensive Care Unit Mortality)
	• Summary Mortality Hospital Information (SHMI)
	• Variable Life Adjusted Displays (VLADS)
	
	ATTACHMENT – QUARTERLY MORTALITY REPORT - JULY 2020 – JUNE 2021 document located at *S21 No 29 of 2022, 28. QUARTERLY MORTALITY REPORT - JULY 2020 – JUNE 2021*

WEEKLY GOVERNANCE DEBRIEF **This attachment can be found at: WIT-46657 to WIT-46694**	Since 2019 the Trust has held a Weekly Governance Debrief that was chaired by me as Medical Director, the purpose of this group is the following: • To promote incident reporting safety culture across the organisation in order to reduce avoidable harm • To review Directorate patient safety concerns which emerged in the week prior to the meeting of the group • To identify learning from the events surrounding these concerns • To identify opportunities for improvement based on a thorough understanding of the issue which caused the concern; ensuring the application of systematic quality improvement tools and methods • To provide a Weekly Governance paper to SMT detailing the issues/concerns of the previous week. A standard weekly agenda comprises of the following items • Status of ongoing SAIs and SAI Notifications • Intertrust and Interface Incidents • Focus on Incidents Graded as Catastrophic • Early Alerts • Never Events • Directors Oversight Groups • RQIA Recommendations • Litigation Information on Clinical Negligence and Coronial Matters • Medication Incidents • Safeguarding • Information Governance • Standards and Guidelines • Clinical Audit • Internal Audit • Focus on falls, pressure ulcers and violence and aggression incidents • Approval status on reported incidents *ATTACHMENT – WEEKLY GOVERNANCE REPORT EXAMPLE document located at S21 No 29 of 2022, 29. WEEKLY GOVERNANCE REPORT EXAMPLE*
GOVERNANCE COMMITTEE REPORT	As Medical Director I led on the production of a quarterly Trust Governance Committee Report. The Trust Governance Committee Report provides information to Trust Governance Committee regarding the Clinical and Social Care Governance performance indicators agreed by the Trust Senior Management Team:

This attachment can be found at: WIT-46695 to WIT-46729	• Incident monitoring to include Serious Adverse Incident and reporting timeframes • Patient safety & quality measures • Complaint monitoring • Compliment monitoring ATTACHMENT – CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE document located at *S21 No 29 of 2022, 30. CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE – App3*
DEPUTY AND DIVISIONAL MEDICAL DIRECTOR MEETINGS	As Medical Director I chaired a fortnightly Deputy and Divisional Medical Director meetings. As a standing item on the agenda I receive 'governance reports' from each of the Divisional Medical Directors present. This offered the opportunity to raise with me directly and my Deputy Medical Directors any issues that may be causing concern regarding professional governance of patient safety. *ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE document located at S21 No 29 of 2022, 31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1* *ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE document located at S21 No 29 of 2022, 33. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2*

1-1 DIVISIONAL MEDICAL DIRECTOR MEETINGS	Since 2019 as Medical Director I scheduled monthly 1-1 meeting with each of the operational Divisional Medical Directors. In 2021 these meetings have commenced following a templated format. The following items are discussed. Each Divisional Medical Director has the opportunity to raise any issues that may be causing concern regarding professional governance of patient safety.
	• Professional Governance
	  o Job Planning
	  o Medical Appraisal
	  o Revalidation
	  o Medical Workforce
	  o Doctors and Dentists Oversight Issues
	• Clinical and Social Care Governance
	  o Adverse Incidents
	  o Serious Adverse Incidents
	  o Complaints
	  o Litigation and Claims Management
	  o Standards and Guidelines
	  o Coronial Matters
	  o Morbidity and Mortality
	  o Clinical Audit and Quality Improvement
	  o Patient Safety
	• Medical Education
	• Research and Development
	
	This format is a work in progress and replaces a programme of 1-1 meetings with divisional medical directors / associate medical directors which followed an informal structured format.

	ATTACHMENT - DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE document can be located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*
CLINICAL AUDIT	Clinical Audit information features as part of both Divisional Medical Director 1-1 meetings and as part of the weekly Governance De-Brief meeting. Clinical Audit information in both fora is largely focused on National Audit information available. The Trust Clinical Audit function has been listed as a priority area for strengthening in 2022/23. A draft Clinical Audit strategy has been produced with a targeted approval date for this Summer. ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY 2022 document located at *S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022* ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022 document can be located at *S21 No 29 of 2022, 38. DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022*
NURSING QUALITY INDICATORS	As Medical Director I received reports on Nursing Quality Indicators (NQIs) which are used to monitor compliance with nursing and midwifery care processes and the impact on patient safety and quality of care. Safety audit data contained includes the following: • National Early Warning Score (NEWS) • FallSafe Compliance • SKIN Audits • Malnutrition Universal Screening Tool Audits (MUST) • Omitted Medicines • Blank Omitted Medicines • Critical Line Labelling (Quarterly) • NOAT Record Keeping Audits The NQI Summary Reports are sent each month to Chief Executive, Directors, ADs, Relevant Heads of Service, Lead Nurses, Ward (Deputy) Sisters, Clinical Educators, Nurse Governance Co-ordinators, Tissue Viability Nurses and Trust Patient Safety Manager. ATTACHMENT – NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE document located at *S21 No 29 of 2022, 39. NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE*
REVALIDATION OVERSIGHT MEETING	As Medical Director I chaired a monthly meeting of the Trust Medical Revalidation Group. This group was formed in 2021. The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership contributes towards the following: • Providing assurance that opportunities for reflection, learning and development e.g. significant events and complaints have been adequately discussed and reflected on appropriately at appraisal • Ensure there is has been a formative approach taken to the doctors appraisal process and there has been an appropriate level of engagement by the doctor

	• Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the Responsible officer's decision prior to the revalidation recommendation date • Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the responsible officer allowing for an informed decision to be made regarding a recommendation for revalidation ATTACHMENT – TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP document can be located at *S21 No 29 of 2022,40. TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP*
INFORMAL DISCUSSIONS / SAFETY WALKS	As Medical Director I engaged with a range of staff 'on the ground' via informal leadership walks and discussions with staff. Notably during COVID-19 these were focused on areas under the highest pressures (Emergency Departments, Medical Wards and Critical Care areas).
PROFESSIONAL GOVERNANCE ISSUES	As Medical Director, I was responsible for oversight of concerns about the performance of doctors and ensuring they were identified and managed under the Department of Health (NI) Maintaining High Professional Standards in the Modern HPSS - A framework for the handling of concerns about doctors and dentists in the HPSS (MHPS) (2005). This framework outlines areas for triangulation of information in relation to Medical clinicians and includes: • Concerns expressed by other HSC staff; • Review of performance against job plans and annual appraisal; • Monitoring of data on clinical performance and quality of care; • Clinical governance, clinical audit and other quality improvement activities; • Complaints about care by patients or relatives of patients; • Information from the regulatory bodies; • Litigation following allegations of negligence; • Information from the police or coroner; • Court judgements; • Following the report of one or more critical clinical incidents or near misses. ***Doctors and Dentists Oversight Group*** As Medical Director I chaired the Doctors and Dentists Oversight Group (DDOG). The purpose of the DDOG is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is: • A process for review of all cases where a practitioners practice, conduct or health gives cause for concern • Regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS) • Regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or and national professional regulatory body of another sovereign state • No undue delays in addressing practitioner performance issues • Adequate support, guidance for clinical managers and individual practitioners • Consistency in approach and decision making where appropriate across the organisation ATTACHMENT - DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE document located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*

SERIOUS ADVERSE INCIDENT OVERSIGHT GROUP	As Medical Director in April 2022 I commenced establishing an oversight group to support the quality assurance and learning from the Trust SAI process. The function of the group is planned as follows: • To review each completed SAI reviews prior to same being released to the Department of Health SPPG to ascertain if these are consistent with expected quality standards and if required, refer the report back to the relevant clinical governance team / officer • To identify any areas where professional issues are present and if required initial processes to address these at a systematic level • To provide assurance to Trust Senior Management Team and Trust Board that Serious Adverse Incident reports are subject to a robust quality assurance review • Assist in the identification of significant risks to service users and services associated with the quality of the delivery of patient care are identified and appropriately escalated The group will consist of the following members • Executive Medical Director (Chair) • Executive Director of Nursing, Midwifery and Allied Health Professionals • Executive Director Social Work The group is planned to formally meet for the first time in August 2022. ATTACHMENT – DRAFT TERMS OF REFERENCE SERIOUS ADVERSE INCIDENT OVERSIGHT GROUP document located at *S21 No 29 of 2022, 41..SERIOUS ADVERSE INCIDENT EXECUTIVE DIRECTOR OVERSIGHT GROUP TOR*

CHIEF EXECUTIVE (1st May 2022 – CURRENT)

7.11 As Chief Executive (1st May 2022 – Current) in addition to the assurances set out above the descriptions below set out further assurances provided in my role as Chief Executive.

INDIVIDUAL PERFORMANCE REVIEWS	I have commenced a process to establish a programme of Individual Performance Reviews for each of the Trust Directors. This will take the form of considering outcome measures for activities in each director's areas of responsibility. 1-1 meetings are scheduled to take place commencing in August 2022.
SENIOR MANAGEMENT TEAM GOVERNANCE INFORMATION	As an output of the Weekly Governance Debrief meetings SMT receive a summary report for discussion and if required escalation of actions required to maintain patient safety. This is also shared with Divisional Medical Directors. ATTACHMENT – WEEKLY SUMMARY SMT GOVERNANCE REPORT document located at *S21 No 29 of 2022, 42. WEEKLY SUMMARY SMT GOVERNANCE REPORT*
TRUST BOARD	As Chief Executive I have weekly 1:1 meetings with the Chair of the Trust Ms Eileen Mullan and monthly meetings with the Non –Executive Directors. These meetings together with monthly Trust Board and Quarterly Governance, Performance, Audit and Patient and Client Experience Committees provide assurances to the Trust Board of the Trusts' governance concerns.

RQIA REPORTS	As Chief Executive I receive copies of reports directly from RQIA of both announced and unannounced visits to any Trust location. As Medical Director there was previously no established line of communication on this. RQIA reports now when received are issued to the Medical Director, Executive Director of Nursing and Executive Director of Social Work along with the relevant operational director for consideration and action.
INTERNAL AUDIT REPORTS	As Chief Executive I receive copies of Internal Audits directly from Business Services Organisation that involve any internal audit review of Trust services. The internal audit function is oversaw by the Executive Director of Finance who operates an Internal Audit Oversight Meeting that reports to SMT and Trust Audit Committee.

ATTACHMENT - ACUTE DIRECTOR JOB DESCRIPTION document located at Relevant to HR, reference no 2b, SMT JDs, Director Acute Services JD

ATTACHMENT - ASSISTANT DIRECTOR OF SURGERY JOB DESCRIPTION document located at S21 No 29 of 2022, 43. AD of Surgery Elective Care Band 8C

ATTACHMENT - HEAD OF SERVICE UROLOGY, ENT AND OUTPATIENTS JOB DESCRIPTION document located at S21 No 29 of 2022, 44. Head of Urology and ENT Job Description

ATTACHMENT - ASSOCIATE MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE document located at Relevant to HR, reference no 2b, 20170600 - REF2b - AMD SEC Job Description

ATTACHMENT - CLINICAL DIRECTOR (PREVIOUS), UROLOGY AND ENT document located at Relevant to HR, reference no 2b. 20160600 - REF2b - CD SEC CAH Job Description

ATTACHMENT - CLINICAL DIRECTOR (CURRENT), UROLOGY AND ENT document located at S21 No 29 of 2022, 45. CLINICAL DIRECTOR (CURRENT), UROLOGY AND ENT

ATTACHMENT - DIVISIONAL MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE document located at S21 No 29 of 2022, 46. DIVISIONAL MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE

ATTACHMENT - DIVISIONAL MEDICAL DIRECTOR, UROLOGY IMPROVEMENT document located at S21 No 29 of 2022, 47. DIVISIONAL MEDICAL DIRECTOR UROLOGY IMPROVEMENT

ATTACHMENT – M&M STRATEGIC OVERSIGHT GROUP document can be located at S21 No 29 of 2022, 23. M and M Strategic Oversight Group TOR

ATTACHMENT – GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY (M&M) PROCESS document can be located at S21 No 29 of 2022, 24. GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY MM PROCESS

ATTACHMENT – COMINBED SURGERY PATIENT SAFETY MEETING AGENDA EXAMPLE document located at S21 No 29 of 2022, 25. 20220311 Combined Surgical Anaesthetics MM Patient Safety Agenda

ATTACHMENT – UROLOGY PATIENT SAFETY MEETING AGENDA SAMPLE document located at S21 No 29 of 2022, 26. 20220218 Patient Safety Meeting MM Meeting Urology Agenda

ATTACHMENT – QUARTERLY MORTALITY REPORT - JULY 2020 – JUNE 2021 document located at S21 No 29 of 2022, 28. QUARTERLY MORTALITY REPORT - JULY 2020 – JUNE 2021

ATTACHMENT – WEEKLY GOVERNANCE REPORT EXAMPLE document located at S21 No 29 of 2022, 29. WEEKLY GOVERNANCE REPORT EXAMPLE

ATTACHMENT – CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE document located at S21 No 29 of 2022, 30. CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE – App3

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE document located at S21 No 29 of 2022, 31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE document located at S21 No 29 of 2022, 33. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2

ATTACHMENT - DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE document located at S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE

ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY 2022 document located at S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022

ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022 document located at S21 No 29 of 2022, 38. DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022

ATTACHMENT – NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE document located at S21 No 29 of 2022, 39. NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE

ATTACHMENT – TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP document located at S21 No 29 of 2022, 40. TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP

ATTACHMENT – DRAFT TERMS OF REFERENCE SERIOUS ADVERSE INCIDENT OVERSIGHT GROUP document located at S21 No 29 of 2022, 41. SERIOUS ADVERSE INCIDENT EXECUTIVE DIRECTOR OVERSIGHT GROUP TOR

ATTACHMENT – WEEKLY SUMMARY SMT GOVERNANCE REPORT document located at S21 No 29 of 2022, 42. WEEKLY SUMMARY SMT GOVERNANCE REPORT

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

8.1 As Medical Director (1st December 2018 – 30th April 2022), although I did not have any operational responsibility for delivery of Urology Services, I had responsibility for professional medical standards and behaviour. I have outlined corporate governance responsibilities in the previous question (Question 7) and refer to the outlined Job Description for the Medical Director role. Operational Services and Clinical Governance of the Urology Unit were, and currently remain, as the responsibility of the Director of Acute Services.

8.2 As mentioned in the previous answer, the Trust operates a distributed Clinical and Social Care Governance system where each operational director is responsible for activity and Clinical Governance within their operational services.

8.3 The table below sets out the responsibilities regarding clinical governance as extracted from the respective job descriptions.

8.4 **Corporate Clinical and Social Care Governance Roles (During my tenure as Medical Director and Chief Executive 1st December 2018 – Present)**

	8.5 Key Clinical Governance Responsibilities
Medical Director ***Post-holder*** *Currently Vacant – Deputy Medical Directors providing cover)*	I refer to my answer given in question 7
Deputy Medical Director Safety, Quality and Governance ***Post-holder*** *Dr Damian Gormley* *New Post Established 01/04/2020*	The Deputy Medical Director (Governance, Safety and Quality Improvement) role is focused on providing strong leadership, systems and processes to lead on clinical standards and governance across the organisation, providing expert advice, lead on strategy implementation, support the development of clinical governance, safety and improvement plans, and participate in education and training programmes as required. This includes the following: • Providing professional leadership to medical staff, communicating the organisation's perspective to clinicians and building commitment among clinicians to achieve the Trust's objectives and overall aim of safe, high quality and responsive services in line with HSC values. • Providing advice to the medical director and clinical colleagues on clinical standards, guidelines and priorities. • Supporting the development of robust multidisciplinary systems to ensure clinical and social care governance processes are adhered to and services are equitable across all Trust services. • Promoting a culture of patient safety and facilitate the delivery of agreed safety, learning and improvement goals. • Deputising for the Medical Director, where required, and take a lead role in developing links between the Medical Director's office and the wider organisation in respect of clinical standards and governance. • To support Divisional Medical Directors, Associate Medical Directors, alongside the Executive Director of Nursing and AHP and Operational Directors to ensure the delivery of safe, responsive and effective clinical services.

	• Support, where appropriate, investigations, including analysis of clinical and other incidents, review research and national guidelines to improve practice and provide judgment where medical practice may differ. • Provide leadership on the management of reviews and investigations of a clinical nature, such as those arising from complaints or adverse events where service users are involved. • Supported by Morbidity and Mortality chairs, oversee and provide assurance on Trust Morbidity and Mortality processes and highlight areas where further investigation / analysis may be required • Refer concerns to the Executive Medical Director and, if required, involve the appropriate responsible director (e.g. Executive Director of Nursing or Operational Director). • Support Trust implementation of the recommendations contained in the Inquiry into Hyponatraemia related Deaths
Assistant Director Clinical and Social Care Governance ***Post-holders*** *Trudy Reid 07/01/2019-23/03/2020* *Stephen Wallace 23/03/2020-31/01/2021* *Caroline Doyle 01/02/2021-Ongoing*	The Assistant Director Clinical and Social Care Governance post is responsible for developing and implementing effective systems to assure the Trust Board and Senior Management Team that robust Clinical and Social Care Governance (CSCG) arrangements are in place and are working effectively across the Trust. This includes the following: • Responsibility for Corporate Clinical Audit Function (2018 – September 2021 when this transferred to the Assistant Director Systems Assurance) • Responsibility for the administration and support for the Trust Mortality and Morbidity functions • Develop, implement and lead structures, systems and processes to assess the robustness of clinical and social care governance systems and processes throughout the Trust • Lead and develop the Trust's Risk Management systems and processes to ensure that the organisations risks are properly identified and managed • Lead on the development, implementation and monitoring of effective systems • Work with the Trust's operational, executive and corporate governance leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care. • Provide leadership to ensure a systematic approach to the reporting of clinical and social care incidents and near misses and a culture of appropriate and timely reporting • Management of the Trust corporate patient safety function
Corporate Clinical and Social Care Governance Coordinator ***Post-holder*** *Connie Connolly (01.10.2020 - 01.08.2021)*	This role is designed to take the lead within the Medical Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Medical Director and the organisation. Lead on ensuring that at each level of the Medical Directorate, staff have access to timely, high quality and appropriate information in relation to incidents, complaints, audit, clinical indicators, litigation and risk.

Stacey Heatherington (03.10.2021 until current)	To provide support and guidance to Directorate governance teams to support timely and appropriate responses to both incidents and complaints and to ensure standards of response times and patient / client satisfaction in the complaints process is maintained. This will include providing to directorate teams through: • Support and guidance of reviews in progress • Support for teams conducting reviews to advise on review technical issues • Provision of corporate tracking of review progress • Provision of bespoke training / guidance to local teams in the conduct of review elements including where appropriate, systems analysis, root cause analysis, human factors training • Provision of guidance to assist with the coordination of cross directorate / cross Trust or interagency reviews • Provision of guidance for developing recommendations in response to incident review findings • Provision of guidance and support to assist with the consolidation of themed recommendations across services and directorates • Development and use of Structured Clinical Reviews as appropriate • Development of an overarching Patient Safety approach to embedding learning from Serious Adverse Incidents • Measurement of impact of lessons learned from SAIs To ensure that strong links are maintained between Directorates and corporate functions such as complaints, the management of SAI's and litigation. Represent the Medical Director at directorate governance meetings providing a challenge and scrutiny function of governance information including reviews of serious adverse incidents to ensure that a consistently high standard of review and report writing is maintained at all times.
Head of Patient Safety Data and Improvement *Fiona Davidson (20.06.2019 to 25.10.2020)* *Lynne Hainey (07.10.2020 to 03.01. 2021)* *Joanne McConville (04.01.2021 - CURRENT)*	The Head of Patient Safety Data and Improvement leads on the development and implementation of the Trust's Patient Safety Strategy. This role is also responsible for the following: • The day-to-day systems and processes to support patient safety data collation, storage, analysis and reporting in line with Trust assurance structures and requirements. • Leading and overseeing participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the Trust and providing strategic and professional advice on implementation. • Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by the Senior Management Team, within the wider Clinical and Social Care Governance arrangements of the Trust. • Reviewing and monitoring the impact of Patient Safety initiatives and provide regular Patient Safety reports to Governance Committee, Trust Board and other sub-committees.

	• Leading the development, implementation and maintenance of mechanisms to improve patient safety, data collation and enhance its reporting to Senior Management, Governance Committee, other sub committees and Trust Board. Identify and oversee implementation of evidence-based models, tools and systems to enhance centralisation, storage and retrieval of safety information. • Overseeing and quality assurance of regular and ad-hoc information analyses and other management reports and dashboards on service metrics, for Senior Management Team, Governance Committee, Trust Board, Patient Safety (Morbidity & Mortality (M&M)) meetings, Patient Safety (Morbidity & Mortality (M&M)) Chair and Oversight Groups and other sub committees.
Corporate Senior Manager of Standards, Risk and Learning *Caroline Beattie (01.05.2020 (interim); appointed permanently 01.10.2021)*	The post of Senior Manager of Standards, Risk and Learning and is responsible for ensuring that the implementation of the Trust's Risk Management Strategy. The facilitation and coordination formal learning and learning from experience which compliments Trust-Wide Risk Management agenda and the delivery of safe services to patients and clients. Also the post-holder provides professional leadership to support the management and development of the Trust's Standards and Guidelines portfolio and the guidance and regulation advice necessary to enable the quality of care to be monitored and improved.
Assistant Director Systems Assurance ***Post-holders*** *Stephen Wallace New Post Established 01/02/2021*	The post holder works with Medical Director to ensure effective processes are in place spanning both clinical and medical professional governance. This includes leading on development activities to strengthening assurance across these domains. Oversee the development and implementation of strategies for clinical audit and clinical effectiveness, ensuring that these are forward thinking and challenging. Oversee the interpretation of national clinical audit and effectiveness policy and develop this locally.
Head of Service Systems Assurance and Clinical Audit *Fiona Davidson New Post Established 08/09/2021*	The post-holder is responsible for the development and implementation of audit and improvement processes to strengthen assurance in delivering improved outcomes for patients and clients. They have overall responsibility for policy and service development including the practical implementation of strategic plans, policies and procedures. They have delegated authority within his/her role and will be the organisational senior manager in respect of the services under their remit. They are responsible for the teaching and/or design and/or delivery of training and development programmes for the services under their remit.

Operational Directorate Governance Roles

8.5 All members of staff within Urology services have a role in the implementation of effective governance practices. The table below sets out the levels of responsibilities in operational teams regarding Clinical and Social Care Governance.

Director Acute Services ***Post-holders*** *Esther Gishkori 17/08/2015 - 30/04/2020* Personal information redacted by USI *Melanie McClements 07/06/2019 – 31/10/2020 (Interim)* *Melanie McClements 01/11/2020 – Current (Permanent)*	The Director of Acute Services has been Melanie McClements since June 2019. Esther Gishkori occupied this role prior to June 2019. The Director of Acute Services is the point of escalation for governance, operational and performance issues for the Assistant Director of ATICS and SEC and the AMD of SEC. The Director of Acute Services reports Clinical Governance issues to the Medical Director while being accountable to the Trust Chief Executive. The Director of Acute Services would work collectively with the operational teams and the Acute Governance team to ensure the delivery of safe and effective services across all areas within the directorate.
	The Assistant Director of ATICS and SEC has been Ronan Carroll since 2016. Roles incorporated within the governance and operational management include: • Collaborative working with all ATICS/SEC managers (Medical and non-Medical) to ensure the delivery of high quality, safe services to the Southern Trust population area. • Responsible for effective resource and financial management for the ATICS/SEC division • Monitor available workforce across all ATICS/SEC service areas collectively with Head of Service, AMD for SEC, AMD for ATICS, and Assistant Directors for Nursing Workforce. • Responsible for performance management and escalation of all ATICS and SEC target areas. • Monitor in collaboration with Heads of Service, AMD and CDs all risks within area of responsibility, escalating to appropriate risk registers (Directorate or Corporate). • Monitor governance data to identify trends and potential safety concerns. • Ensure appropriate processes are in place to reduce and manage risk. • Chair regular Divisional meetings where performance and governance are core agenda items. • Attend Acute Governance meetings within the directorate as the Divisions representative including fortnightly Standards and Guidelines meetings, monthly Clinical Governance meeting, Monthly Clinical Governance forum, monthly Nursing Clinical Governance meeting. • Attends weekly Screening meetings where incidents, complaints, litigation and M+M cases with potential need for advanced review (e.g. SAI) are discussed and assessed with AMDs, CD and members of the Acute Governance Team. • Regular meetings with Director of Acute Services to discuss operational, performance and governance within the Division.

	The point of escalation for operational and governance is the Director of Acute Services.
Head of Service ENT and Urology ***Post-holder*** *Martina Corrigan 2009 - October 2020* *Wendy Clayton October 2021 – Current (Acting)*	The Head of Service who operationally managed Urology Services has changed since 2020. Initially Martina Corrigan was Head of Service undertaking this position from 2009 until October 2020. Since October 2020 Wendy Clayton has been the Acting Head of Service role for Urology Services. The Head of Service for Urology Services include governance and operational roles such as:- • Working with all members of Urology Services workforce (Medical, Nursing, Admin, etc.) to ensure delivery of the safe Urology Service • Monitor performance targets for Urology Services collectively with SEC Operational Support Lead (Jane Scott). When deficits identified collective engagement with Clinical Director for Urology Services, Associate Medical Director for SEC and Assistant Director. • Chair operational meeting covering both governance and performance for Urology Services which includes the CNS, Medical teams, OSL, etc. • Monitor the delivery of Urology Services while encouraging modernisation. Implement initiatives to improve service delivery and adapt service to the changing needs of the Southern Trust population. • Monitor risks within the Service area and ensure there accurate recording and controls within the Divisional and Directorate risk registers. • Monitor and assist in investigation process for complaints, Datix investigation and SAIs within Urology Services, monitoring for trends and safety concerns within the service area. • Collectively with the Assistant Director for ATICS and SEC, Divisional Medical Director, CD for Urology Services, Lead Nurse and Assistant Director for Nursing Workforce monitor the Urology Services workforce (Nursing and Medical) • Review resource requirements for Urology Services and assist with the financial management of the speciality collectively with the AD for ATICS and SEC. • Medical professional issues are escalated through the Clinical Director and Divisional Medical Director professional lines and the Medical Directors office. • Work collectively with the Clinical Director for Urology Services to ensure effective job planning of medical staff. • Nursing professional issues would be escalated by the lead Nurse to both the Head of Service for Urology Services and the SEC professional Head of Service who is Brigeen Kelly (Head of Service for T+O) and actioned in collaboration with the Assistant Director for ATICS and SEC and the Nursing Governance Team, (Nurses in Difficulty). The point of escalation for operational and governance matters is the Assistant Director of ATICS and SEC.

Associate Medical Director (Later Divisional Medical Director)	The AMD for SEC was Mr Mark Haynes until December 2021 when he was appointed the Divisional Medical Director for Urology Service Improvement. Mr Ted McNaboe has occupied the role of DMD for SEC since December 2021. The AMD roles has been replaced throughout the Trust by the Divisional Medical Director Role which is now a standardised Job Description (JD) with an increased clarity in relation to governance, responsibility and accountability functions. (DMD) works collectively with the Assistant Director and Medical Directors Office to ensure the safe delivery of services. This post and that of CD are important bridges between the operational and corporate governance functions of doctors within operational directorates. The AMD (DMD) works collectively with the Assistant Director and Medical Directors Office to ensure the safe delivery of services. Their responsibilities cover roles such as Medical staffing, revalidation, medical job planning, operational and governance service delivery. This role has a direct line of accountability to Director of Acute Services. The role also is directly accountable to the Medical Director for Medical Professional Governance issues and maintains reporting function to the Medical Director regarding patient safety and governance. agenda items. ATTACHMENT – ASSOCIATE MEDICAL DIRECTOR ACUTE SEC JD document can located at *Relevant to HR, reference no 2b, 20170600 - REF2b - AMD SEC Job Description*
Clinical Director	The Clinical Director for ENT and Urology Services was Mr Ted McNaboe since 2018 until December 2021. The Clinical Director post for ENT and Urology Services has been vacant since December 2021. The Clinical Director for Urology Services works collectively with the Head of Service, AD for ATICS and SEC and AMD to ensure the safe delivery of services under his level of responsibility. Operational, performance and governance aspects are collectively managed with the operational management structure. Professional issues pertaining to Medical staff are escalated through the professional structures, DivMD and Medical Directors Office.
Urology Consultants	There were no specific lead roles for Urology Consultants regarding Governance prior to 2021 outside of those that relate to medical professionals responsibilities. 1Pprogrammed Activity (PA) is equal to 4 hours if undertaken between 7am-7pm Monday – Friday and 3 hours if taken outside of this timeframe. Since 2021 the following formal roles have been agreed • Mr John O'Donoghue – Patient Safety Lead 0.485PA • Mr Tony Glackin – Cancer MDT lead 1.0PA • Mr Matthew Tyson – S&G clinical lead 0.5PA and Quality Improvement lead 0.5PA • Mr Michael Young – Rota clinical lead 0.5PA • Mr Mark Haynes – NICAN Chair 0.5PA • Ms Laura McAuley - Education Lead 0.5PA

Lead Nurse Surgery	The Lead Nurse who operationally managed Urology Services has changed since 2018. Initially Gillian Henry was Lead Nurse until 2018. Linda Hamilton undertook this role in 2018 until March 2019, Sarah Ward continued this from March 2019 until November 2021. Paula McKay has occupied this position since November 2021. Governance is central to the Lead Nurse's role as they would:- • Work collectively with the service area to ensure processes are in place that enable risks to be identified and managed accordingly. • Be involved within the review of complaints, Datix and Serious Adverse reviews (SAIs). • Link with Acute Governance team to identify trends or patient safety issues. • Facilitate monthly "Ward Sisters" meetings were governance is be a core agenda item. • Monitor performance of staff under their responsible areas, escalating performance or professional concerns operationally or professionally (Head of Service/ SEC Professional Head of Service/ Assistant Director/ Nursing Governance Team). • Monitor Nursing workforce within each clinical area under their responsibility and work to ensure safe staffing levels for each area. • Ensure effective operational bed flow and management within clinical areas under their responsibility. • Attend the "Acute Professional Leads Forum" chaired by Acute Clinical Governance to assist with the implementation of new and outstanding standards and guidelines applicable to their service area. The point of escalation for operational and governance is the relevant Head of Service.
Acute Clinical and Social Care Governance Coordinator	The Head of the Acute Governance Team is the Acute Clinical and Social Care Governance Coordinator (CSGC). This post of Acute CSCG was occupied by Trudy Reid from 2018 – 2019. In 2019, Patricia Kingsnorth fulfilled the role of acting Acute CSCG until July 2021. Since July 2021, Chris Wamsley has occupied the Acute CSCG position.

Comments on Interfaces between Corporate and Clinical Governance

8.6 Question 7 paragraph x-xi details the interfaces for assurance on the quality of operationally led clinical and social care governance

8.7 The Duffin Report, undertaken by the Leadership Centre through Mr Molloy in October 2017, raised concerns about how Adverse Incident reporting was being managed in the Trust. An assurance was given and an action plan enacted before I arrived in the Trust

in December 2018. This highlighted at that time the confusion in roles and responsibilities in clinical leadership and management roles which have now been addressed through the Review of Medical Leadership which was introduced in 2019 and is now in the final stages of implementation.

ATTACHMENT – DONAL DUFFIN GOVERNANCE REVIEW document located at Relevant to MDO, reference no 42, 2017_18 Duffin Report_management actions annotatedATTACHMENT- ACTIONS IN RESPONSE TO WHISTLEBLOWING REPORT D DUFFIN document located at S21 No 29 of 2022, 48. ACTIONS IN RESPONSE TO WHISTLEBLOWING REPORT for LNC 17.5.18

ATTACHMENT _ACTIONS REQUIRED FROM GOVERNANCE COMMITTEE MEETING ON 6TH DECEMBER 2018 document located at S21 No 29 of 2022, 49. 20190131 Actions Required from Governance Committee Meeting on 6th December 2018

ATTACHMENT – medical leadership review June 2019 document located at S21 no 29 of 2022, 50. Medical Leadership review June 2019

ATTACHMENT – MEDICAL LEADERSHIP REVIEW MARCH 2020 document located at S21 No 29 of 2022, 51. MEDICAL LEADERSHIP REVIEW MARCH 2020

ATTACHMENT – MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021 document located at S21 No 29 of 2022, 52. MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021

8.8 The Champion Review outlined the concerns in 2019 as to the roles, responsibilities and assurance systems in place across corporate governance systems. Following this, a response and action plan were developed which has gradually been rolled out as time,

finance and expertise has allowed in the course of the COVID 19 Pandemic in the last 27 months. In recent weeks the Senior Management Team has had a workshop to develop its understanding of the linkages and communication across this system and this will be further developed with Trust Board at an August 2022 Governance Workshop.

ATTACHMENT – CHAMPION GOVERNANCE REVIEW 2019 document located at S21 No 29 of 2022, 53. CHAMPION GOVERNANCE REVIEW

ATTACHMENT – JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS document located at S21 No 29 of 2022, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMENDATIONS

ATTACHMENT – DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW document located at S21 No 29 of 2022, 55. DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW

General Comments on Differences and Overlap of Roles Between Operational and Medical Directorates

8.9 Governance, Corporate Governance and Clinical and Social Care Governance are difficult concepts to articulate.

8.10 Governance provides the general regulatory framework and the cultural environment necessary for facilitating the functions of the organisation. It is applied to the entire organisation.

8.11 The purpose of the processes of Governance in Health and Social Care is to maintain / improve Patient (Service User) Safety

8.12 Governance is not an endpoint, it is a scaffolding.

8.13 The end point of Governance processes at all levels is “all things Patient Safety”.

8.14 There is no absolute single measure of “Patient Safety”

8.15 The underlying assumption is always that Governance processes are evidence based (expert experience / research) and that measurement of adherence to these processes is a useful proxy for the delivery of safe health care.

8.16 The next underlying assumption is that, if we are providing safe health care, we are reducing potential harm to patients - either from their disease progression or as a result of our care.

8.17 Typically, we do not usually measure adherence to only one parameter but to a number for the purposes of increasing the 360 degree view on the provision of health care.

8.18 The aim of good governance is to increase the sensitivity (identifying those it effects) and thus the specificity (identifying those it doesn’t effect) and to avoid giving “False Assurances”.

8.19 In most health care organisations, the aspect that guides the corporate/ business functions is termed as ‘Corporate Governance’ and that for operational directorates involving clinical/social care is called ‘Clinical/Social Care Governance’.

8.20 The purpose of clinical and social care governance is to create and maintain an environment that is conducive to achieving the goals of safe health and social care.

8.21 The purpose of corporate governance is to quality-assure the governance processes within the operational directorates to ensure patient safety.

8.22 Patient safety is everyone's concern.

8.23 In the Southern Trust the Medical Director is also Corporate lead for Patient Safety.

8.24 Governance is only possible if the people involved can adhere to a (typically evidence-based) uniform set of rules, ethical principles, policies and procedures by virtue of belonging to an organisation or a regulated professional group.

8.25 The number of reviews and the changing views on where CSCG sits within the organisation have made it difficult to embed a consistent model.

8.26 A number of recommendations made in the 2019 Governance Review are being progressed and form the basis of the Governance Action Plan for the short to medium term.

8.27 In an effort to address clarity around functions, roles and responsibilities and following on from the Champion Governance review carried out for the Trust in 2019, thought has been given to the structures that support the delivery of CSG / Corporate Governance functions within the Trust.

8.28 Currently, the Operational Directorate Governance Coordinators and their supporting teams are placed within each Operational Directorate.

8.29 Currently, their reporting structure has been via each Operational Directorate. They do not have a recognised reporting line to Corporate Governance.

8.30 As a consequence of this there may have been a lack of shared understanding and standardised practice across the Trust.

8.31 These coordinators are an essential part of the healthy functioning of clinical teams and the relationships with the clinicians and managers in the teams.

Other Considerations

8.32 The previous Trust AMD role in Surgery and Elective Care was described as playing an active role in contributing to the strategic direction and provision of safe, efficient, high-quality services. The role reported operationally to the Acute Director and professionally to the Medical Director.

8.33 Under Clinical Governance Responsibilities at page 3 of the AMD job description ('JD'), the post describes that the AMD will be directly responsible to the Director of Acute Services for patient safety. This JD appeared to create a sense that patient safety escalations sat exclusively with the Director for Acute Services and did not automatically recognise the need for the AMD to give clinical governance assurance to the Medical Director. In the revised Divisional Medical Director Job Description, which outlines the roles and responsibilities of the Divisional Directors, this is recognised as having a lead responsibility for the delivery and assurance of all aspects of Professional and Clinical and Social Care Governance.

8.34 There is an expectation in this now that the Divisional Medical Director will now report on not just professional concerns to the Medical Director but also in her role

as Director for Patient Safety and Clinical and Social Care Governance Assurance, any concerns and assurances that they have in relation to governance processes in place to deliver on patient safety.

8.35 The Medical Staff are accountable to the Clinical Director. The Clinical Director post has been developed in line with the Divisional Medical Director post to ensure clear lines of accountability and responsibility through the Divisional Medical Director and Assistant Medical Director and mirrors that in place for the Divisional Medical Director in relation to the Medical Director.

8.36 The Lead Nurses report through the Heads of Service who in turn report through the Assistant Directors to the Acute Director, for Governance and operational issues.

8.37 When I commenced as Medical Director there was not a clear governance assurance connectivity and understanding between this post and the operational directors despite being included in my Job Description. Over time, the understanding of the roles and responsibilities has developed through the use of Directors' Oversight meetings involving the Operational, Medical and Nursing Directors in relation to any patient safety and governance processes' concerns within each of the operational directorates.

8.38 This, together with the involvement of the governance co-ordinators, clinical professional directors and divisional medical directors at the weekly governance meeting chaired by the Medical Director, has improved the communication, learning and development of the understanding of patient safety and governance processes. This is consolidated weekly when this report and its summary are reviewed at the Senior Management Team and through the Chief Executive with the Non-Executive

Directors monthly to provide ‘Bed to Board’ assurance on governance systems and processes in place to ensure patient safety.

ATTACHMENT – JOB DESCRIPTIONS

DIVISIONAL MEDICAL DIRECTOR SAFETY, QUALITY AND GOVERNANCE document located at *S21 No 29 of 2022, 14. Deputy Medical Director Governance Safety and QI*
ASSISTANT DIRECTOR CLINICAL AND SOCIAL CARE GOVERNANCE document located at S21 No 29 of 2022,16. *AD Clinical and Social Care Governance JD*

CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE COORDINATOR document located at *S21 No 29 of 2022, 56a. Corporate Clinical Social Care Governance Coordinator*

HEAD OF PATIENT SAFETY DATA AND IMPROVEMENT document located at *S21 No 29 of 2022, 56b. HEAD OF PATIENT SAFETY DATA AND IMPROVEMENT*

CORPORATE SENIOR MANAGER OF STANDARDS, RISK AND LEARNING document located at *S21 No 29 of 2022, 57. CORPORATE SENIOR MANAGER OF STANDARDS, RISK AND LEARNING*

ASSISTANT DIRECTOR SYSTEMS ASSURANCE document located at *S21 No 29 of 2022, 58. Assistant Director Systems Assurance*

HEAD OF SERVICE SYSTEMS ASSURANCE AND CLINICAL AUDIT document located at *S21 No 29 of 2022, 59. HEAD OF SERVICE SYSTEMS ASSURANCE AND CLINICAL AUDIT BAND 8B JD*

DIRECTOR OF ACUTE SERVICES document can be located at *Relevant to HR, reference no 2b, SMT JDs, Director Acute Services JD*

ASSISTANT DIRECTOR SURGERY AND ELECTIVE CARE document can be located at 21 No 29 of 2022, 43. *AD of Surgery Elective Care Band 8C*

HEAD OF SERVICE ENT AND UOLOGY document can be located at *S21 No 29 of 2022, 45. Head of Urology and ENT Job Description*

ASSOCIATE MEDICAL DIRECTOR SURGERY AND ELECTIVE CARE document located at *Relevant to HR, reference no 2b, 20170600 - REF2b - AMD SEC Job Description*

CLINICAL DIRECTOR ENT AND UROLOGY (OLD) document located at *Relevant to HR, reference no 2b. 20160600 - REF2b - CD SEC CAH Job Description*

CLINICAL DIRECTOR ENT AND UROLOGY (NEW) document located at *S21 No 29 of 2022, 45. CLINICAL DIRECTOR (CURRENT), UROLOGY AND ENT*

UROLOGY CONSULTANTS document located at *Relevant to HR, reference no 15, 19971200-REF15-Mr M Young UROLOGY Job Description, 20120306 - REF15 - MR A GLACKIN Job Description, 20131000 - REF15 - MR J O'DONOGHUE Job Description, 20131000 - REF15 - MR M HAYNES Job Description*

ACUTE CLINICAL AND SOCIAL CARE GOVERNANCE COORDINATOR document located *at S21 No 29 of 2022, 60. Acute Governance Coordinator Job Description*

ATTACHMENT – DONAL DUFFIN GOVERNANCE REVIEW document located at *Relevant to MDO, reference no 42, 2017_18 Duffin Report_management actions annotated*

ATTACHMENT – MEDICAL LEADERSHIP REVIEW JUNE 2019 document located at *S21 No 29 of 2022, 50. MEDICAL LEADERSHIP REVIEW JUNE 2019*

ATTACHMENT – MEDICAL LEADERSHIP REVIEW MARCH 2020 document located at *S21 No 29 of 2022, 51. MEDICAL LEADERSHIP REVIEW MARCH 2020*

ATTACHMENT – MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021 document located at *S21 No 29 of 2022, 52. MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021*

ATTACHMENT – CSCG REVIEW (CHAMPION REVIEW) document located at *S21 No 29 of 2022, 53. CHAMPION GOVERNANCE REVIEW 2019*

ATTACHMENT – LOCATED IN S21 29 OF 2022, 1. *MEDICAL DIRECTOR HANDOVER FROM DR KHAN*

ATTACHMENT – JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS document located at *S21 No 29 of 2022, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS*

ATTACHMENT – DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW document located at *S21 No 29 of 2022, 55. DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW*

Urology services/Urology unit – staffing

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

9.1 I cannot respond as the timeframe was not within my tenure.

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

10.1 I cannot respond as the timeframe was not within my tenure.

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

11.1 I cannot respond as the timeframe was not within my tenure.

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

12.1 The purpose of the Integrated Elective Access Protocol (IEAP) is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It is a step-by-step guide to staff, and acts as a reference work, for the successful management of patients waiting for hospital treatment.

12.2 The Protocol describes how the patient, from referral onwards, should move through the secondary care system. It does not describe how clinical decisions are reached, nor does it describe the quality of the clinical care provided.

12.3 Following correspondence from the HSCB in December 2021 this guidance has been altered.

ATTACHMENT : INTEGRATED ELECTIVE ACCESS PROTOCOL 30th April 2008 document can be located at *Relevant to Acute, Document Number 6, 20080430 No. 6 - Integrated Elective Access Protocol*

ATTACHMENT : LETTER SHARON GALLAGHER 081221 RE REVISED IEAP document can be located at *S21 No 29 of 2022, 61. 20211208 IEAP June 2020*

ATTACHMENT : NORTHERN IRELAND CANCER ACCESS STANDARDS – A GUIDE 2008 document can be located at Relevant to Acute, Document Number 11, 20080102 A guide to cancer waiting times - January 2008

12.4 Within the Trust this Protocol has been operationally managed since its inception in 2008, and during my tenure since 2018, by Acute Services.

12.3 The implementation and monitoring of this, in keeping with all other Trusts throughout Northern Ireland, is an operational function and, unless doctors are not compliant with work required, this is not usually brought to the attention of medical managers.

12.4 Since the beginning of my tenure, I have been aware that there have been chronic challenges in responding to the volumes of demand on the urology service.

ATTACHMENT LESLEY'S RECENT DATA ON UROLOGY documents can be located at *S21 No 29 of 2022, 62. Urology Outpatient Total Waits April 18 Onwards, 63. Urology Red Flag Referrals April 18 onwards, 64. Urology Outpatient Longest Waits April 18 onwards,*

65. Urology IP Longest Waits April 18 onwards, 66. Urology Inpatient Total Waits April 18 onwards, 67. Urology Day Case Total Waits April 18 onwards, 68. Urology Day Case Longest Waits April 18 onwards, 69. SPC UROLOGY REVIEW BACKLOG, 70. Urology mentions in CPD report

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

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

13.1 I cannot respond as this timeframe was not within my tenure.

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

14.1 I cannot respond as this timeframe was not within my tenure.

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

15.1 Unfortunately, the Team South Plan does not, in my view, describe the issues that it was formulated to address. Therefore, I cannot be clear if these issues still exist as this was developed before my tenure began.

ATTACHMENT TEAM SOUTH UROLOGY PLAN document can be located at S21 No 29 of 2022, 71. Team South Implementation Plan v0.3, HM700 - ltr to Trust Dir Acute re Urology Review Implementation, Urology Review Recommendations for stocktake April 2014 V1

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

16.1 I cannot respond as this timeframe was not within my tenure.

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

17.1 As I understand, previously and during my tenure, the Urology Service has been perceived as never having been adequately commissioned, based on the demands placed on the service. This has led to extensive waiting lists over the last number of years.

17.2 During my tenure as Medical Director (1st December 2018 – 30th April 2022), the difficulties with waiting lists were compounded by staffing shortages which were brought to my attention by various staff via informal mechanisms, however, none being raised as specific patient safety issues.

17.3 The Trust recognised it was under-commissioned in terms of the number of consultants compared to service demand. The limited commissioning of services resulted in inadequate funding to provide sufficient staff to meet the demand.

17.4 The table below shows the post holders within the urology medical workforce during my tenure.

Name of Doctor	Start Date	End Date	Position	Comments
Aidan O'Brien	01/07/1992	20/07/2020	Permanent Consultant	Retired still not replaced
Michael Young	01/07/1998	27/05/2022	Permanent Consultant	Retired still not replaced
Anthony Glackin	01/08/2012	Still in Post	Permanent Consultant	
Mark Haynes	14/05/2014	Still in Post	Permanent Consultant	
John O'Donoghue	01/08/2014	Still in Post	Permanent Consultant	
Matthew Tyson	07/02/2020	Still in Post	Permanent Consultant	
Laura McAuley	01/01/2017	Still in Post	Permanent Staff Grade (0.44 WTE)	
Sabahat Hasnain	01/01/2019	Still in Post	Permanent Staff Grade	
Personal Information redacted by the USI			Temporary Agency Consultant	Backfill vacant post
			Temporary Agency Consultant	Backfill vacant post
			Temporary Agency Consultant	Backfill vacant post

Shawgi Razig Omer	21/09/2020 16/08/2021	30/06/2021 30/10/2021	Temporary Agency Consultant	Backfill vacant post
Saifeldin Elamin	19/07/2021	02/08/2021	Temporary Agency Consultant	Review Backlog Clearance clinics only
Nasir Khan	02/11/2020	Still in post	Temporary Agency Consultant	Backfill vacant post

17.5 The below table shows the consultant posts funded *vs*. those occupied during my tenure. Where there were vacancies, these were actively advertised and, where possible, pursued via locum backfill. However, it is recognised that there is a regional shortage of urologists which has resulted in too few Doctors to provide urology services across Northern Ireland. Typically then, when demand has outstripped capacity, the most severely ill patients are prioritised which has added to the intensity and complexity of the surgeon's work.

YEAR	CONSULTANTS FUNDED BY COMMISIONNER	CONSULTANT POSTS OCCUPIED
2018	6	• 4 substantive filled. • 1 Locum fill (Mar- Dec). • 1 Vacant unable to recruit following advertisement.
2019	6	• 4.6 Substantive posts filled until July 2019 when M Tyson went on sabbatical. • 1 Vacant post unable to recruit to and 2 locums for a few months. • Note Mr Haynes works 3 days for Southern Trust and 2 for Belfast Trust.
2020	7	• 4.6 substantive posts up until July 2020 (Mr O'Brien retired so down to 4 substantive). • 2 locum fill from September and November 2020.

		• And advertised two posts with Mr Omer successful but asked for the Trust to wait until he got on the specialist register before taking up post – to note he never did as he requested to remain as a locum due to family. • Note Mr Tyson was due back from sabbatical in August 2020 but only was able to return January 2022 [redacted]
2021	7	• 3.6 substantive posts. • 2 locums. • And advert as per below table.
2022	7	• As of 11th July there are 3.6 substantive posts and 1 locum. • However, the Trust has appointed 2 consultant urologists who are awaiting registration with the GMC and will serve their notice thereafter.

17.6 The below table shows the SAS grade posts funded *vs*. those occupied during my tenure.

YEAR	SAS FUNDED BY COMMISIONNER	SAS POSTS OCCUPIED
2018	2	0.44 Plus 1 locum
2019	2	1.44 substantive (additional hours are used to fund the out of hours rota)
2020	2	1.44 substantive (additional hours are used to fund the out of hours rota)
2021	2	1.44 substantive

		(additional hours are used to fund the out of hours rota)
2022	2	1.44 substantive (additional hours are used to fund the out of hours rota)

17.7 The below table shows the attempts to recruit to consultant posts during (broadly) my tenure.

NO. OF TIMES ADVERTISED	**DATE ADVERTISED**	**NORMAL ADVERTISING**	**APPLICATIONS RECEIVED**	**ENHANCED ADVERTISING**
Consultant Urologist	10/01/2017		No Applicants	
Consultant Urologist	02/10/2018		Mr Matthew Tyson Started post 25/02/2019	
1	March 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	
2	May 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
3	October 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	

4	February 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	➢ BMJ website – Top Job
5	April 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	Closing date: 10 May 2022	➢ Irish Medical Times ➢ BMJ website enhancements Top Job Premium job Promoted Job Target email to 150 registered candidates CV database search ➢ BMJ website in Australia & New Zealand

18. Were there periods of time when any posts within the unit remained vacant for a period of time?

If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

18.1 As Medical Director (1st December 2018 – 30th April 2022), I did not have any operational responsibility for delivery of Urology Services. However, I had responsibility for professional medical standards and behaviour, integrated corporate governance and patient safety.

18.2 I refer to the tabular answers given in my response to question 17 in terms of the identification of posts that were vacant during my tenure.

18.3 I also refer to the tabular answers given in my response to question 17 regarding staffing challenges and vacancies. As Medical Director I did not have operational responsibility for management of the vacancies or remedies regarding same but did share the concern for the potential impact of these vacancies on the other staff and on patient safety.

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

19.1 Any Trust service with sub-optimal staffing has the potential to impact on the capacity of the service to provide care for patients. In terms of the governance processes that surround any given service, these should still exist. However, it can be challenging to deliver where there is inadequate staffing.

19.2 As a result, Governance processes in Urology were not as well developed as they required to be. As outlined in detail in my answer to Question 21 below, they are being developed to address shortcomings.

19.3 Staffing shortages led to further lengthening of Waiting Lists.

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

20.1 Aside from the changes made to the Medical Leadership Structures referenced in answer 21 below, I am unaware of changes in medical roles, duties and responsibilities in the unit.

20.2 The table featured at 17 (iii) above describes the staffing changes within the unit during my tenure.

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

21.1 My role and responsibilities as Medical Director did not change during my tenure however I have strengthened and improved mechanisms to obtain assurances regarding clinical and professional governance activity during this time.

Medical Professional Governance Improvements

21.2 During my tenure, and as previously referenced in my answer to question 7 above, I sought to bring about more robust scrutiny and challenge to medical professional governance processes via the introduction of the following:

Appointment of Head of Service for Appraisal and Revalidation **This attachment can be found at: WIT-47249 to WIT-47265**	The post holder is responsible for designing, developing and implementing specific programmes in order to support the implementation of professional governance arrangements within the Trust. S/he will initiate and lead the planning, implementation, monitoring and progression of a range of initiatives on behalf of the Medical Director, Executive Director of Nursing. This will be realised through his/her leadership of a Revalidation Team. A key responsibility will be to evaluate the effectiveness of the initiatives and provide assurances to the Medical Director, Executive Director of Nursing and Assistant Director of Clinical and Social Care Governance on same. The postholder also provides assurances on the efficient management of the team budget and other resources. The postholder is responsible for developing collaborative working channels and have subject expertise in order to provide expert advice and guidance to General Medical Council (GMC) and Nursing and Midwifery Council (NMC) registrants, senior managers and others. ATTACHMENT – HEAD OF SERVICE FOR APPRAISAL AND REVALIDATION JOB DESCRIPTION document can be located at S21 No 29 of 2022, 72. HEAD OF SERVICE FOR APPRAISAL AND REVALIDATION JOB DESCRIPTION

These attachments can be found at: WIT-46730 to WIT-46731; WIT-46733 to WIT-46734; WIT-46735; and WIT-46736 to WIT-46753	**DEPUTY AND DIVISIONAL MEDICAL DIRECTOR MEETINGS** As Medical Director I chaired a fortnightly Deputy and Divisional Medical Director meetings. As a standing item on the agenda, I receive 'governance reports' from each of the Divisional Medical Directors present. This offered the opportunity to raise with me directly and my Deputy Medical Directors any issues that may be causing concern regarding professional governance of patient safety. These pre-existed as monthly AMD meetings prior to my tenure however the frequency of these previously was once per month. ATTACHMENT – DEPUTY AND DIVISIONAL MEDICAL DIRECTOR AGENDA SAMPLE document can be located at S21 No 29 of 2022, *31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1* ATTACHMENT – DEPUTY AND DIVISIONAL MEDICAL DIRECTOR MINUTES SAMPLE document can be located at S21 No 29 of 2022, 33. *DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2*
This attachment can be found at: WIT-46754 to WIT-46773	**1-1 DIVISIONAL MEDICAL DIRECTOR MEETINGS** Since 2019 as Medical Director I scheduled monthly 1-1 meetings with each of the operational Divisional Medical Directors. These include Clinical and Social Care Governance information as follows: • Job Planning • Medical Appraisal • Revalidation • Medical Workforce • Doctors and Dentists Oversight Issues • Medical Education • Research and Development This format is a work in progress and replaces a programme of 1-1 meetings with divisional medical directors / associate medical directors which followed an informal structured format. ATTACHMENT - DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE document can be located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE* **INITIATION OF REVALIDATION OVERSIGHT MEETING** As Medical Director I chaired a monthly meeting of the Trust Medical Revalidation Group. This group was formed in 2021. The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership contributes towards the following: • Providing assurance that opportunities for reflection, learning and development e.g., significant events and complaints have been adequately discussed and reflected on appropriately at appraisal.

This attachment can be found at: WIT-46802 to WIT-46803	• Ensure there is has been a formative approach taken to the doctor's appraisal process and there has been an appropriate level of engagement by the doctor. • Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the Responsible Officer's decision prior to the revalidation recommendation date. • Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the Responsible Officer allowing for an informed decision to be made regarding a recommendation for revalidation. ATTACHMENT – TERMS OF REFERENCE MEDICAL REVALIDATION OVERSIGHT MEETING document located at S21 No 29 of 2022, 40. TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP **ESTABLISHMENT OF THE DOCTORS' AND DENTISTS' OVERSIGHT GROUP** As Medical Director I established and chair the Doctors and Dentists Oversight Group (DDOG). The purpose of the DDOG is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is: • A process for review of all cases where a practitioners practice, conduct or health gives cause for concern. • Regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS). • Regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or and national professional regulatory body of another sovereign state. • No undue delay in addressing practitioner performance issues. • Adequate support, guidance for clinical managers and individual practitioners. • Consistency in approach and decision making where appropriate across the organisation.
This attachment can be found at: WIT-47266 to WIT-47269	ATTACHMENT – TERMS OF REFERENCE DOCTORS AND DENTISTS OVERSIGHT GROUP document can be located at *S21 No 29 of 2022, 73. TERMS OF REFERENCE DOCTORS AND DENTISTS OVERSIGHT GROUP*

Clinical and Social Care Improvements

21.3 There have been significant changes towards strengthening the Trust Clinical and Social Care Governance model during my tenure. These are set out in the table below.

External Review of Trust Clinical and Social Care Governance	In 2019 I commissioned an independent review of Clinical and Social Care Governance via the HSC Leadership Centre. This review which produced a draft report with 48 recommendations. A copy of the review and current progress report is provided.

These attachments can be found at: WIT-46954 to WIT-47014; and WIT-47015 to WIT-47021	ATTACHMENT CHAMPION GOVERNANCE REVIEW 2019 document can be located at *S21 No 29 of 2022, 53. CHAMPION GOVERNANCE REVIEW 2019* ATTACHMENT JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS document can be located at S21 No 29 of 2022, *54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS*
New Corporate Posts Developed	In 2019 I undertook a review of Corporate Clinical Social Care Governance Functions and Structures and developed a proposal paper with the purpose being as follows: • To outline the Trust vision to become a top performing organisation in the UK as a consequence of Learning from Experience, Improvement and providing Safe Patient and Service User Care • To detail the elements of continuous improvement in Clinical and Social Care Governance including upholding of standards, embedding learning from experience and improving overall patient and staff experience • To provide an overview of Trust-wide Clinical and Social Care Functions, Structure and Resourcing required to deliver the vision • To set out two proposals in response to the Trust governance review 2019 and CSCG work scoping exercise 2020 - Proposal to Realign Clinical and Social Care Governance Structures - Proposal to Increase Resourcing in the Trust Clinical and Social Care Governance Function • To provide outline details of the functions and benefits of the proposed additional resourcing and revised structures • To provide details on costing of the proposal • To provide details on a phased approach to implementation of the proposals
This attachment can be found at: WIT-47270 to WIT-47293	ATTACHMENT – CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE FUNCTIONS PAPER 2019 document can be located at *S21 No 29 of 2022, 74. CLINICAL AND SOCIAL CARE GOVERNANCE RESTRUCTURE PAPER 2020* Recruitment of posts highlighted is in progress, the following posts have been recruited: • Family Liaison Officer (2 posts) • Corporate SAI Chairs (3 posts) • Corporate Clinical and Social Care Governance Coordinator • Head of Patient Safety Data and Improvement • Corporate Senior Manager Standards, Risk and Learning • Clinical and Social Care Governance Risk Manager
This attachment can be found at: WIT-47043 to WIT-47054	**Key New Positions Created** **Corporate Clinical and Social Care Governance Coordinator** This role is designed to take the lead within the Medical Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Medical Director and the organisation. ATTACHMENT - CORPORATE CLINCAL AND SOCIAL CARE GOVERNANCE COORDINATOR JOB DESCRIPTION document can be located at *S21 No 29 of 2022, 56a. Corporate Governance Coordinator Band 8B JD*

	Head of Patient Safety Data and Improvement The Head of Patient Safety Data and Improvement leads on the development and implementation of the Trust's Patient Safety Strategy. The postholder also leads on the day-to-day systems and processes to support patient safety data collation, storage, analysis and reporting in line with Trust assurance structures and requirements and leading and overseeing participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the Trust and providing strategic and professional advice on implementation.
This attachment can be found at: WIT-47055 to WIT-47068	ATTACHMENT – HEAD OF PATIENT SAFETY DATA AND IMPROVEMENT JOB DESCRIPTION document can be located at *S21 No 29 of 2022, 57. HEAD OF PATIENT SAFETY DATA AND IMPROVEMENT*
	Corporate Senior Manager of Standards, Risk and Learning The post of Senior Manager of Standards, Risk and Learning is responsible for ensuring that the implementation of the Trust's Risk Management Strategy, the facilitation and coordination formal learning and learning from experience which compliments Trust-Wide Risk Management agenda and the delivery of safe services to patients and clients. Also the post-holder provides professional leadership to support the management and development of the Trust's Standards and Guidelines portfolio and the guidance and regulation advice necessary to enable the quality of care to be monitored and improved.
This attachment can be found at: WIT-47069 to WIT-47082	ATTACHMENT – CORPORATE SENIOR MANAGER OF STANDARDS, RISK AND LEARNING JOB DESCRIPTION document can be located at S21 No 29 of 2022, *57. CORPORATE SENIOR MANAGER OF STANDARDS, RISK AND LEARNING*
	Family Liaison Officer Role The post holder has responsibility for management of the proactive liaison service for service users, relatives and carers who have had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety. The post holder is the key central point of contact between the affected service users, relatives and carers and will ensure they remain fully supported, including pastoral and tangible supports where required, throughout and following any Trust review processes.
This attachment can be found at: WIT-47294 to WIT-47306	ATTACHMENT – FAMILY LIAISON OFFICER JOB DESCRIPTION document can be located at S21 No 29 of 2022, *75. FAMILY LIAISON OFFICER JOB DESCRIPTION*
	SAI Chair The Serious Adverse Incident Chairperson is responsible for leading and overseeing the serious adverse incident review process from commencement to conclusion for individual incident reviews. The chairperson will be responsible for ensuring that serious adverse incident reviews under their oversight is carried out in a thorough, systematic, fair and transparent manner and that recommendations and learning from each review are clearly identified to facilitate service improvements.
This attachment can be found at: WIT-47307 to WIT-47314	ATTACHMENT – SAI CHAIR JOB DESCRIPTION document can be located at S21 No 29 of 2022, *76. SAI CHAIR JOB DESCRIPTION*

This attachment can be found at: WIT-47315 to WIT-47327	**Corporate Complaints Manager** The post holder is responsible for screening service user contacts and determining if these are enquiries or complaints. They facilitate either resolution of the enquiry or complaint following de-escalation to an informal enquiry/complaint or they will facilitate the service user in the process of the HSC formal complaints procedure. The post holder also provides significant support to the Directorate Governance offices in the management of complaints, alerting them to significant issues at an early stage and resolving those that can be managing through local clinical teams or provision of information. The postholder also produces a suite of Complaints and Compliment reports from the Clinical and Social Care Governance reporting system and Care Opinion. ATTACHMENT – CORPORATE COMPLAINTS MANAGER JOB DESCRIPTION document can be located at S21 No 29 of 2022, *77. CORPORATE COMPLAINTS MANAGER JOB DESCRIPTION*
Moves to Establish a Stronger Corporate Model for Clinical and Social Care Governance **This attachment can be found at: WIT-47270 to WIT-47293**	As part of the 2020 proposal paper regarding Corporate Clinical Social Care Governance Functions and Structures I proposed a realignment of clinical governance coordinator posts. Each operational directorate (Acute, Children and Young People, Older People and Primary Care and Mental Health and Disability Services) has a governance coordinator which reports to and is accountable to the service Director. My proposal was to retain the reporting arrangements to the operational director while developing a corporate oversight of each of these roles to ensure consistency of approach, ability to share governance team resources and pool knowledge and expertise of Governance functions. This realignment is continuing in 2022 with an expected end date of December 2022. ATTACHMENT – CLINICAL AND SOCIAL CARE GOVERNANCE RESTRUCTURE PAPER 2020 document can be located at *S21 No 29 of 2022, 74. CLINICAL AND SOCIAL CARE GOVERNANCE RESTRUCTURE PAPER 2020*
Clinical Audit and Patient Safety Functions	I have sought to build the Trust Clinical Audit function; this is an organisational priority for 2022/23. A draft Clinical Audit strategy has been produced with a targeted approval date for this Summer. In addition, a proposal paper regarding strengthening both the Clinical Audit and Patient Safety functions has been developed and is being worked through to identify funding streams. A senior manager, Head of Clinical Audit has been appointed to coordinate the rebuilding of the Trust clinical audit function. The posts related to patient safety and clinical audit noted in the Patient Safety & Clinical Audit Resourcing Proposal supersede those requirements for those particular functions as noted in the 2020 Corporate Clinical Social Care Governance Functions and Structures proposal.

These attachments can be found at: WIT-46774 to WIT-46791; WIT-46792 to WIT-46800; and WIT-47328 to WIT-47409	ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY 2022 document can be located at S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022 ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022 document can be located at S21 No 29 of 2022, 38. *DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022* ATTACHMENT – PROPOSAL PAPER ON STRENGTHENING CLINICAL AUDIT FUNCTION document can be located at *S21 No 29 of 2022, 78. PROPOSAL PAPER ON STRENGTHENING CLINICAL AUDIT FUNCTION*
Introduction of Additional Assurance Mechanisms	As previous provided in my answer to question 7 the following assurance mechanisms have been introduced during my tenure: • Morbidity and Mortality Oversight Group • Establishment Of Quarterly Mortality Reporting • Establishment Of A Weekly Governance Debrief • SAI Executive Director Oversight Group • Deputy And Divisional Medical Director Meetings • Divisional Medical Director 1-1 Meetings

Strengthening of Medical Leadersip

21.6 There have been significant changes towards strengthening the Trust Medical Leadership Model during my tenure

21.7 In 2020 in my role as Medical Director, I initiated a change in the Trust Medical Leadership Structure that oversaw a move to standardise, strengthen and increase clinical and professional governance oversight of medical leaders within Directorate teams.

21.8 A Medical Leadership paper was presented and approved by the Trust Senior Management Team and commenced on a phased basis across all Associate Medical Director positions in 2021.

21.9 In 2022, as a second phase Trust Clinical Director roles have been revised and strengthened to include more allocated time along with a stronger clinical governance role.

21.10 The table below lists the elements that now feature in both Divisional Medical Director and Clinical Director job descriptions.

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

21.11 In support of these changes three new Deputy Medical Director positions were created to both strengthen the medical governance function and improve coordination of information flows regarding same.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
22/11/2021	CURRENT	Dr Damian Scullion	Deputy Medical Director - Appraisal and Revalidation
06/04/2020	CURRENT	Dr Aisling Diamond	Deputy Medical Director - Workforce and Education
01/04/2021	CURRENT	Dr Damian Gormley	Deputy Medical Director - Quality, Safety and Governance

ATTACHMENT – JOB DESCRIPTIONS FOR THREE DEPUTY MEDICAL DIRECTORS document can be located *at S21 No 29 of 2022, 13. Deputy Medical Director Medical Appraisal and Revalidation, 15. Deputy Medical Director Governance Safety and QI* and *Relevant to HR, reference no 2b, 20191000 - REF2b - DEPUTY MD Education Workforce Development Job Description*

Specifically With Reference to Urology

21.12 The above sections refer to Trustwide strengthening of my role with regards to clinical governance as Medical Director. With specific regard to Urology the following improvements have been made.

Urology Medical Leadership Posts

21.13 Mr Mark Haynes was incumbent Associate Medical Director upon my appointment in December 2018. As part of the aforementioned Medical Leadership strengthening programme the post of Divisional Medical Director Surgery and Elective Care was created which was competitively internally advertised and appointed to with Mr Haynes being the successful applicant.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
2016	2 August 2021	Mr Mark Haynes	Divisional Medical Director Surgery and Elective Care (Replacing former Associate Medical Director Surgery and Elective Care post)

21.14 As a result of work to strengthen Urology services an additional post was created in 2021 which Mr Mark Haynes was transferred to from his Divisional Medical Director, Surgery and Elective Care, post for an initial period of 2 years. The job description for the post of Divisional Medical Director Urology Improvement is attached. The focus of

this post is to strengthen professional medical standards and behaviour. The existing Divisional Medical Director post was subject to a further internal competitive recruitment process for backfilling purposes; this post was again temporary for an initial period of 2 years.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
1 December 2021	CURRENT	Mr Ted MacNaboe	Divisional Medical Director Surgery and Elective Care (Temporary 2 years)
1 December 2021	CURRENT	Mr Mark Haynes	Divisional Medical Director Urology Improvement (Temporary 2 years)

21.15 To support the Associate Medical Director Surgery and Elective Care / Divisional Medical Director Surgery and Elective Care a Clinical Director post was present. The role description for this was also subject to revision to increase clinical and professional governance oversight of medical leaders within directorate teams. The Clinical Director roles and responsibilities have been revised and strengthened to incorporate overall professional medical standards and behaviour oversight (Outlined in viii).

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
D17th December 2018	30th November 2021	Mr Ted MacNaboe	Clinical Director
NA	NA	Post currently vacant following advertisement – post being re-advertised	Clinical Director

New Specific Urology Lead Posts

21.16 The following lead posts have been aligned to specific doctors within Urology Services since 2021 (unless otherwise noted below):

a) Mr John O'Donoghue – Patient Safety Lead 0.485PA

b) Mr Tony Glackin – Cancer MDT lead 1.0PA

c) Mr Matthew Tyson – S&G clinical lead 0.5PA and Quality Improvement lead 0.5PA

d) Mr Michael Young – Rota clinical lead 0.5PA

e) Mr Mark Haynes – NICAN Chair 0.5PA

f) Ms Laura McAuley – Education Lead 0.5PA

ATTACHMENT – MEDICAL LEADERSHIP REVIEW JUNE 2019 document can be located at *S21 No 29 of 2022, 50. MEDICAL LEADERSHIP REVIEW JUNE 2019*

ATTACHMENT – MEDICAL LEADERSHIP REVIEW MARCH 2020 document can be located at *S21 No 29 of 2022, 51. MEDICAL LEADERSHIP REVIEW MARCH 2020*

ATTACHMENT – MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021 document can be located at *S21 No 29 of 2022, 52. MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021*

ATTACHMENT – ACUTE DIRECTOR JOB DESCRIPTION document can be located at *Relevant to HR, reference no 2b, SMT JDs, Director Acute Services JD*

ATTACHMENT – ASSISTANT DIRECTOR OF SURGERY JOB DESCRIPTION document can be located at *S21 No 29 of 2022, 43. AD of Surgery Elective Care Band 8C*

ATTACHMENT – HEAD OF SERVICE UROLOGY, ENT AND OUTPATIENTS JOB DESCRIPTION document can be located at *S21 No 29 of 2022, 44. Head of Urology and ENT Job Description*

ATTACHMENT – ASSOCIATE MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE document can be located at *Relevant to HR, reference no 2b, 20170600 - REF2b - AMD SEC Job Description*

ATTACHMENT – CLINICAL DIRECTOR (PREVIOUS), UROLOGY AND ENT document can be located at *Relevant to HR, reference no 2b. 20160600 - REF2b - CD SEC CAH Job Description*

ATTACHMENT – CLINICAL DIRECTOR (CURRENT), UROLOGY AND ENT document can be located at *S21 No 29 of 2022, 45. CLINICAL DIRECTOR (CURRENT), UROLOGY AND ENT*

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE document can be located at *S21 No 29 of 2022, 46. DIVISIONAL MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE*

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR, UROLOGY IMPROVEMENT document can be located at *S21 No 29 of 2022, 47. DIVISIONAL MEDICAL DIRECTOR UROLOGY IMPROVEMENT*

ATTACHMENT – M&M STRATEGIC OVERSIGHT GROUP document can be located at *S21 No 29 of 2022, 23. M and M Strategic Oversight Group TOR*

ATTACHMENT – GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY (M&M) PROCESS document can be located at *S21 No 29 of 2022, 24.GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY MM PROCESS*

ATTACHMENT – COMINBED SURGERY PATIENT SAFETY MEETING AGENDA EXAMPLE document can be located at S21 *No 29 of 2022, 25. 20220311 Combined Surgical Anaesthetics MM Patient Safety Agenda*

ATTACHMENT – UROLOGY PATIENT SAFETY MEETING AGENDA SAMPLE document can be located at *S21 No 29 of 2022, 26. 20220218 Patient Safety Meeting MM Meeting Urology Agenda – 54*

ATTACHMENT – QUARTERLY MORTALITY REPORT – JULY 2020 – JUNE 2021 document can be located at *S21 No 29 of 2022, 28. QUARTERLY MORTALITY REPORT - JULY 2020 – JUNE 2021*

ATTACHMENT – WEEKLY GOVERNANCE REPORT EXAMPLE document can be located at *S21 No 29 of 2022, 29. WEEKLY GOVERNANCE REPORT EXAMPLE*

ATTACHMENT – CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE document can be located at *S21 No 29 of 2022, 30. CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE – App3*

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE document can be located at *S21 No 29 of 2022, 31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1*

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE document can be located at *S21 No 29 of 2022, 33. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2*

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE document can be located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*

ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY 2022 document can be located at *S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022*

ATTACHMENT – DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022 document can be located at *S21 No 29 of 2022, 38. DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022*

ATTACHMENT – NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE document can be located at *S21 No 29 of 2022, 39. NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE*

ATTACHMENT – TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP document can be located at *S21 No 29 of 2022, 40. TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP*

ATTACHMENT – DRAFT TERMS OF REFERENCE SERIOUS ADVERSE INCIDENT OVERSIGHT GROUP document can be located at *S21 No 29 of 2022, 41. SERIOUS ADVERSE INCIDENT EXECUTIVE DIRECTOR OVERSIGHT GROUP TOR*

ATTACHMENT – WEEKLY SUMMARY SMT GOVERNANCE REPORT document can be located at *S21 No 29 of 2022, 42. WEEKLY SUMMARY SMT GOVERNANCE REPORT*

ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE document can be located at S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE

ATTACHMENT – CHAMPION GOVERNANCE REVIEW 2019 document can be located at *S21 No 29 of 2022, 53. CHAMPION GOVERNANCE REVIEW 2019*

ATTACHMENT – JUNE 2022 UPDATE ON GOVERNANCE REVIEW Recommendations document can be located at *S21 No 29 of 2022, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS*

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

22.1 Mrs Anita Carroll, Assistant Director for Support Services, is best placed to provide this information.

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

23.1 I refer to my answer to question 22 above.

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

24.1 I do not believe that there were ever any concerns raised with me by this staff grouping.

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

25.1 With regard to the overall change of the day to day running of the urology unit and to whom that person or persons answered, the following applies.

25.2 The Director Acute Services is responsible for the management and oversight of the unit on behalf of the Trust Chief Executive.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
17.08.2015	30.04.2020 [redacted] from 06.06.2019)	Esther Gishkori	Director Acute Services
07.06.2019	CURRENT	Melanie McClements	Director Acute Services

25.3 The Director of Acute Services was, and is currently, supported in this task by the Assistant Director Surgery Elective Care and Head of Service Urology, ENT and Outpatients.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
2016	CURRENT	Ronan Carroll	Assistant Director Surgery and Elective Care
2009	October 2020	Martina Corrigan	Head of Service Urology, ENT and Outpatients
October 2020	CURRENT	Wendy Clayton	Head of Service Urology, ENT and Outpatients

25.4 In terms of medical oversight of clinical governance arrangements, I refer to my answer given to question 21 above.

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

26.1 I was not involved in Urology staff activity performance reviews.

26.2 As Medical Director, I had oversight of the Appraisal and Revalidation of Urologists which draws on Safety and Quality Data from doctors' performance. Copies of documentation governing this process are enclosed.

26.3 The first table below provides information on appraisal completion rates across all doctors who require appraisal. The second table provides the same information; however, it focuses on Urology alone.

26.4 Appraisal performance was slower during 2020 and 2021 due to COVID-19 pressures these are being actively followed up and completed currently.

a.

Year	All Doctors Requiring Appraisals	Appraisal Complete	Appraisal in Progress	Appraisal Not Complete
2018	307	307 (100%)	0 (0%)	0 (0%)
2019	356	343 (96%)	4 (1%)	9 (3%)
2020	409	352 (86%)	17 (4%)	40 (10%)
2021	483	36 (7%)	14 (3%)	433 (90%)

b.

Year	Urology Doctors Requiring Appraisals	Appraisal Complete		Appraisal in Progress		Appraisal Not Complete	
2018	6	6	100.0%	0	0.0%	0	0.0%
2019	7	5	71.4%	1	14.3%	1	14.3%
2020	7	5	71.4%	0	0.0%	2	28.6%
2021	9	3	33.3%	0	0.0%	6	66.7%

ATTACHMENT – DOH CIRCULAR ANNUAL APPRAISAL FOR CONSULTANTS AND STAFF AND ASSOCIATE SPECIALIST MEDICAL STAFF IN HSC TRUSTS document can be located at S21 no 29 of 2022, 79. DOH CIRCULAR ANNUAL APPRAISAL FOR CONSULTANTS AND STAFF AND ASSOCIATE SPECIALIST MEDICAL STAFF IN HSC TRUSTS

ATTACHMENT – SHSCT APPRAISAL SCHEME GUIDANCE document can be located at Relevant to MDO, Reference No 2t, 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff

ATTACHMENT – GMC GOOD MEDICAL PRACTICE FRAMEWORK FOR APPRAISAL AND REVALIDATION document can be located at S21 No 29 of 2022, 80. GMC GOOD MEDICAL PRACTICE FRAMEWORK FOR APPRAISAL AND REVALIDATION

ATTACHMENT – GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION document can be located at S21 No 29 of 2022, 81. GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION

ATTACHMENT – MEDICAL STAFF APPRAISAL AIDE MEMOIRE AND QUALITY ASSURANCE AUDIT TOOL document can be located at S21 No 29 of 2022, 82.

MEDICAL STAFF APPRAISAL AIDE MEMOIRE AND QUALITY ASSURANCE AUDIT TOOL

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

27.1 Yes; my role was subject to annual medical appraisal and this was undertaken annually by Mr Charlie Martyn, Medical Director, South Eastern Health and Social Care Trust.

27.2 As Medical Director I was not subject to Individual Performance Reviews in keeping with the other Directors, however, I did participate in 1-1 meetings with the Chief Executive, Mr Shane Devlin. During these meetings I presented updates on my current priorities, detailing issues and concerns and potential solutions. These meetings did not follow a structured format and the list of discussion items was provided by me for each meeting. Available records of these meetings have been included.

ATTACHMENT – DOH CIRCULAR ANNUAL APPRAISAL FOR CONSULTANTS AND STAFF AND ASSOCIATE SPECIALIST MEDICAL STAFF IN HSC TRUSTS document located at S21 no 29 of 2022, 79. DOH CIRCULAR ANNUAL APPRAISAL FOR CONSULTANTS AND STAFF AND ASSOCIATE SPECIALIST MEDICAL STAFF IN HSC TRUSTS

ATTACHMENT – GMC GOOD MEDICAL PRACTICE FRAMEWORK FOR APPRAISAL AND REVALIDATION document located at S21 No 29 of 2022, 80. GMC GOOD MEDICAL PRACTICE FRAMEWORK FOR APPRAISAL AND REVALIDATION

ATTACHMENT – GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION document located at S21 No 29 of 2022, 81. GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION

ATTACHMENT –1-1 AGENDAS WITH CHIEF EXECUTIVE document located at S21 No 29 of 2022, 83. 20201218 CX 1-1 – A10, 84. 20210308 CX 1-1 – A16, 85. 20210505 CX 1-1 – A16, 86. 20210608 CX 1-1 – A19

Engagement with unit staff

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

28.1 The Urologists form approximately 1% of the Medical Workforce in the Southern Trust.

28.2 Prior to the concerns that were raised in June 2020 in relation to Mr O'Brien, I had limited engagement with all of the staff in the Urology Unit.

28.3 My main points of contact in relation to Urology Services were with the 1:1 and monthly AMD Group meetings with the then AMD for all Surgical Specialities, and now DivMD for Urology Improvement, Mr Mark Haynes.

28.4 I had regular weekly contact with the Director for Acute Services through the Senior Management Team Meeting and intermittent contact with the Assistant Director of Surgery, Mr Ronan Carroll, and the Head of Service, Mrs Martina Corrigan.

28.5 Since the Ministerial announcement of the Public Inquiry (24th November 2020) and the out-workings of the Lookback Review, I have had more frequent and focused contact.

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

29.1 I refer to my answer for question 28.

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

30.1 From my limited interactions with them, my sense is that they did and do work well together, with the exception of the working relationship with Mr O'Brien.

30.2 My impression is that the remaining staff had the greatest respect for each other, regardless of discipline, and were very professional in their interactions with their patients and each other. They appeared to work well together outside the challenges of having to manage and work with Mr O'Brien.

30.3 My impression (based upon reading the MHPS papers – including witness statements – and SAI documents) was that, over the years, Mr O'Brien's colleagues had developed ways of not confronting him for fear of having to deal with unpleasantness but had found ways of constantly working around him to avoid antagonising him and to get the work of treating patients done.

30.4 I was also aware that Mr O'Brien had the support of the Chair of the Trust, Mrs Roberta Brownlee. At my first meeting with her after taking up post as Medical Director, on the 11th January 2019, she advised me against pursuing him in the way that she believed my predecessors had done and she intimated that she believed that he was an excellent surgeon and that he had saved her life.

Governance – generally

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

31.1 I refer to my answers for Questions 7, 8 and 21 in answer to this Question.

32. WHO OVERSAW THE CLINICAL GOVERNANCE ARRANGEMENTS OF THE UNIT AND HOW WAS THIS DONE? AS RELEVANT TO YOUR ROLE, HOW DID YOU ASSURE YOURSELF THAT THIS WAS BEING DONE APPROPRIATELY?

Who oversaw the Clinical Governance arrangements of the unit?

32.1 The overall clinical governance of the unit was, and is currently, overseen by the Director of Acute Services.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
17.08.2015	30.04.2020 Personal information redacted by USI from 06.06.2019)	Esther Gishkori	Director Acute Services
07.06.2019	CURRENT	Melanie McClements	Director Acute Services

32.2 The Director of Acute services was and is currently supported in this task by the Assistant Director Surgery Elective Care and Head of Service Urology, ENT and Outpatients.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
2016	CURRENT	Ronan Carroll	Assistant Director Surgery and Elective Care
2009	October 2020	Martina Corrigan	Head of Service Urology, ENT and Outpatients
October 2020	CURRENT	Wendy Clayton	Head of Service Urology, ENT and Outpatients

32.3 In terms of medical oversight of clinical governance arrangements, I refer to the answer I gave to question 21.

32.4 In terms of the arrangements for oversight of Clinical Governance and how this was conducted operationally Melanie McClements, Director of Acute Services is best placed to provide this information.

AS RELEVANT TO YOUR ROLE, HOW DID YOU ASSURE YOURSELF THAT THIS WAS BEING DONE APPROPRIATELY?

MEDICAL DIRECTOR (1st December 2018 – 30th April 2022)

32.7 In my role as Medical Director, I obtained assurances regarding the effectiveness of Clinical Governance via the below mechanisms. I continue to utilise these mechanisms through the Deputy Medical Director Quality, Safety and Governance until the point a substantive Medical Director is appointed.

a) Urology Patient Safety Meetings fortnightly
b) Morbidity and Mortality Oversight Meetings monthly
c) Mortality Reporting quarterly
d) Weekly Governance Debrief weekly
e) Governance Committee Report quarterly
f) Deputy and Divisional Medical Director Meetings fortnightly
g) Divisional Medical Director 1-1 Meetings monthly
h) Clinical Audit being developed
i) Nursing Quality Indicators monthly
j) Revalidation Oversight Meeting as and when Urology consultants are due for revalidation
k) Informal Discussions / Safety Walks suspended during Covid 19 Pandemic
l) Professional Governance Issues monthly in Doctors' and Dentists' Oversight Group

32.8 Currently as Chief Executive, until the recently appointed Medical Director arrives in the Trust in early October 2022, I am continuing to receive updates from these assurance groups in order to assure myself of proper oversight.

32.9 As indicated above and at Question 31, further details are provided in my answers to questions 7, 8 and 21.

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

33.1 As mentioned in my response to Question 7 above, Corporate Governance should be an integrated function of the Trust but, in practice, it has been defined in a delineated structure delivered through operational and clinical professional directorates. The structure that has supported the delivery of this in the Trust until now is that the Executive Directors lead and are accountable for professional standards and behaviours of registered staff in their professional areas and the Operational Directors have been responsible for the operational delivery of governance. Governance assurance and lead responsibility for Patient Safety is additionally the responsibility of the Medical Director.

33.2 In practice, these different functions have been arbitrary at times and not clearly delineated.

33.3 In my role as Medical Director, I did not have responsibility for the operational oversight of the quality of Urology Services. In delivering on other aspects of integrated clinical and social care governance my role as Medical Director was to Quality Assure the systems and processes in place which captured patient safety data and then to provide assurances in relation to these.

33.4 Prior to the 2019 CSCG review (see Question 21 above) and the development of robust interfaces between the operational and corporate governance reporting structures (as well as the developing restructuring of Governance), the reporting structures relied on reporting by exception or escalation of concerns from Urology Services to corporate

governance. A copy of the Review, the Trust response and updated action plan is enclosed. For more detail on these structures, I refer to my answer to Question 7 above.

33.5 In the interim period since the Review the Trust has been implementing a programme of strengthening operational and CSC Governance as described in the CSCG Review and the updated workplan included.

33.6 Previously, as Medical Director I was not a member if the Trust Performance Accountability meetings as these meetings were in relation to performance only and involved the CEO, Director of Performance and Reform, and the Operational Director for Acute Services.

33.7 Accountability meetings regionally were stood down as part of the regional response to the Covid 19 Pandemic and, since the beginning of the financial year 2022, are now being reinstated within the Trust and regionally.

33.8 Learning from our experiences throughout the pandemic and the Inquiry is reshaping the Trust's approach to these Accountability meetings.

ATTACHMENT – CSCG REVIEW (CHAMPION REVIEW) document can be located at S21 No 29 of 2022, 53. CHAMPION GOVERNANCE REVIEW 2019ATTACHMENT – Document located at S21 29 OF 2022, 1. MEDICAL DIRECTOR HANDOVER FROM DR KHAN

ATTACHMENT – JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS document can be located at S21 No 29 of 2022, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS

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

34.1 As Medical Director (1st December 2018 – 30th April 2022), I did not have oversight of activity performance metrics in urology services. I had oversight of quality and safety metrics through governance processes and these have been described in my answers to Questions 7, 8, and 21 above.

34.2 Activity performance metrics were overseen by the Director of Acute Services and were corporately reported via the Trust's recently established Performance Committee (October 2019).

ATTACHMENTS – PERFORMANCE COMMITTEE AGENDAS AND MINUTES document can be located at S21 No 29 of 2022, 87. 20191017 Performance Committee Agenda, 88. 20191209 Performance Committee Agenda, 89. 20200319 Performance Committee Agenda NO MEETING, 90. 20200521 Performance Committee Agenda, 91. 20200903 Performance Committee Agenda, 92. 20201203 Performance Committee Agenda, 93. 20210318 Performance Committee Agenda, 94. 20210520 Performance Committee Agenda, 95. 20210902 Performance Committee Agenda, 96. 20211202 Performance Committee Agenda, 97. 20220310 Performance Committee Agenda, 98. 20220519 Performance Committee Agenda, 99. 20191017 Approved Performance Committee Minutes, 100. 20191209 Approved Performance Committee Minutes, 101. 20200319 Feedback questions and answers Marsh 2020 Performance Committee_ Final NO MEETING, 102. 20200319 Performance Committee_ Chair Report, 103. 20200521 Approved Performance Committee Minutes, 104. 20200903 Approved Performance Committee Minutes, 105. 20201203 Approved Performance Committee Minutes, 106. 20210318 Approved Performance Committee Minutes, 107. 20210520 Approved Performance Committee Minutes, 108. 20210902 Approved Performance Committee Minutes, 109. 20211202 Approved Performance Committee Minutes, 110. 20220310 Approved Performance Committee Minutes

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained? Refer to answer to Q7.

35.1 I refer to my answers to Questions 7, 8 and 21 above in this regard.

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

36.1 Medical Professional Governance Improvements are outlined in my answer to Question 21.

36.2 The following systems were available for identifying concerns and bringing them to my attention as Medical Director:

a) Medical Appraisal (Internal);
b) Divisional Medical Director 1-1 (Internal);
c) Divisional Medical Director Meetings (Internal);
d) Weekly Governance Debriefs (Internal);
e) Whistleblowing (Internal or External);
f) Morbidity and Mortality Meetings (Internal);
g) Serious Adverse Incidents (Internal or External if interface incident);
h) Adverse Incidents (Internal);
i) Complaints (External);
j) Litigation and Coronial Matters (External);
k) Concerns from General Practitioners (External);
l) Concerns from Elected Representatives (External).

36.3 The systems for dealing with concerns are set out in the table below, along with my views on the efficacy of these systems.

Systems in Place	Views of the efficacy of those systems for identifying concerns
Medical Appraisal (Internal)	Until recently the Trust was following the 2014 policy on Appraisal. The process of implementation of this has now been updated in the recently devised 2022 Policy as described in the Attachments provided. I did not believe that the 2014 Appraisal Policy was as efficacious as it required to deliver on a meaningful Appraisal process. ATTACHMENTS : 2014 Appraisal Policy document located at *Relevant to MDO, reference 2t, 20140701 Policy - Southern Trust Appraisal Scheme for Medical Staff* 2022 Appraisal Policy document located at *S21 No 29 of 2022, 111. Medical Staff Appraisal and Revalidation Policy 2022* Appraisal and Revalidation Changes from 2019 to current document located at *S21 No 29 of 2022, 112. MOK PI Appraisal Revalidation Narrative 13062022*
Divisional Medical Director 1-1 (Internal)	These meetings with the Medical Director have begun over the last 2 months as the recently appointed Divisional Medical Directors begin to come on board. They have been somewhat disrupted by the interim Medical Director arrangements currently but will be a focus for the new appointee as Medical Director and updates from these will form part of the Individual Performance Review for the newly appointed Medical Director. The format of this Divisional Medical Director meeting is being developed and refined and concentrates on professional and social and clinical care governance processes, appraisal and revalidation. Robust online real-time recording systems are being explored. ATTACHMENT –DIVISIONAL MEDICAL DIRECTOR MEETING TEMPLATE 1-1 document located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*
Divisional Medical Director Meetings (Internal)	The frequency of these has increased from monthly to fortnightly in order to develop this recently appointed team of senior medical leaders and as part of their induction over the last few months to build their confidence and intelligence as medical leaders. ATTACHMENT – DEPUTY AND DIVISIONAL MEDICAL DIRECTOR AGENDA SAMPLE document located at ATTACHMENT – *S21 No 29 of 2022, 31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1* ATTACHMENT – DEPUTY AND DIVISIONAL MEDICAL DIRECTOR MINUTES SAMPLE document located at *S21 No 29 of 2022, 33. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2*
Weekly Governance Debriefs (Internal)	These weekly online meetings have proved extremely helpful in providing almost realtime feedback on patient safety across the organisation and progress in the use of governance processes. They have provided a forum for reporting directly on patient safety concerns to the executive directors in medicine, nursing and social work and in turn a weekly report is shared with SMT and monthly with the Non

	Executive Directors as a means of proving Bed to Board assurances on patient safety across the health and social care organisation. ATTACHMENT – WEEKLY GOVERNANCE MEETING document located *at S21 No 29 of 2022, 113. Weekly Governance Report Template*
Whistleblowing (Internal or External)	This process if led by the Director of HROD, Mrs Vivienne Toal, who would be best to comment on this.
Morbidity and Mortality Meetings (Internal)	These meetings are evolving onto patient safety meetings to consider not just mortality but also morbidity across the Trust and meeting monthly for each division. They are not exclusive, however, the attendance mostly consists of Medical Staff, with a lesser representation from other clinical disciplines and managers. Doctors' attendance is recorded and reported through revalidation systems.
Serious Adverse Incidents (Internal or External if interface incident)	The process for this has been described in my answer to Question 7 vii. This process is time consuming and involves numerous participants over a period of time. The regional review of SAI led by the Public Health Agency is awaited. Action plans are formulated and implemented through operational directorates. An Executive Director Oversight Group is being established. ATTACHMENT – Executive Directors' Oversight Group (SAI) Terms of Reference document located at *S21 No 29 of 2022, 41. SERIOUS ADVERSE INCIDENT EXECUTIVE DIRECTOR OVERSIGHT GROUP TOR*
Adverse Incidents (Internal)	This process has also been described in my answer to Question 7 vii. Improvements continue to made in the use of the Datix System.
Complaints (External)	The process for this is similarly described in my answer to 7 vii. The Trust has implemented the London School of Economics HCAT tool which is a tool for extracting themes and opportunities for improvements from complaints. The learning from this will be developed through the Medical Education systems in the Trust led by the Deputy Medical Director for Workforce and Education. ATTACHMENT – HCAT TOOL document located at *Relevant to CX Chair's Office, reference no 2j, 20210211 Appendix 1 - HCAT October - December 2020*
Litigation and Coronial Matters (External)	The process for this is described in my previous answer under 7 vii. Learning from this is shared with operational governance coordinators at the weekly governance meetings and learning for improvement has been developed through Medical Education systems led by the Deputy Medical Director for Workforce and Education. ACHMENT- AGENDA MEDICOLEGAL MEETING EXAMPLE WITH DLS AND HEAD OF LITIGATION document can be located at *S21 No 29 of 2022, 114. Case Review Mr [redacted], 115. Case Review Mr [redacted]_A4, 116. Case Review Mr [redacted]_ A1, 117. Case Review Mr [redacted]_A2.1, 118. Case Review Mr [redacted]_ A2.2, 119. Case Review Mr [redacted]_ A2.3, 120. Case Review Mr [redacted]_ A2.4, 121. Case Review Mr [redacted]_ A2.5, 122. Case Review Mr [redacted]_ A2.6, 123. Case Review Mr [redacted]_ A2.7, 124. Case Review Mr [redacted]_ A2.8, 125. Case Review Mr [redacted]_ A2.9, 126. Case Review Mr [redacted]_ A2.10, 127. Case Review Mr [redacted]_ A2.11, 128. Case Review Mr [redacted]_ A2.12, 129. Case Review Mr [redacted]_ A2.13, 130. Case Review Mr [redacted]_ A2, 131. Case Review Mr [redacted]_ A3, 132. Case Review Mr [redacted]_ A4*

Concerns from General Practitioners (External)	GPs have been encouraged to directly, via telephone and email and face to face meetings, contact the Trust, principally through the Trust Associate Medical Director for General Practice, to raise concerns in relation to medical clinical practice and care. This process will be audited for efficacy in the Autumn.
Concerns from Elected Representatives (External)	Elected representatives contact the Trust Chief Executive's office through the corporate communications office on a very frequent and often daily basis to make complaints or seek information on behalf of their constituents. In addition to this, there have been regular meetings between the Chief Executive and the Elected representatives. I have not reinstated these as yet since purdah but will begin in late July. The politicians also use parliamentary Assembly Questions on a regular basis and these again are coordinated through the Corporate Communications Office and collated on a weekly basis for senior leaders in the Trust.

37. Did those systems or processes change over time? If so, how, by whom and previous to 2020 why?

37.1 I can only comment on the changes that I have introduced since taking up the post of Medical Director formally on the 1st December 2018. The table below illustrates changes over time:

i. **Systems in Place**	***Did those systems or processes change over time***	***How, by whom and why***
Medical Appraisal **This attachment can be found at: WIT-48318 to WIT-48320**	I refer to the relevant part of the table set out in my answer to Question 36.iii above. ATTACHMENT – MEDICAL ASSURANCE REPORT TO TRUST BOARD 23.06.2022 document located at *S21 No 29 of 2022, 133. Trust Board Cover Sheet Urology 23 June MO'K*	I have instigated this through the Deputy Medical Director for Appraisal and Revalidation. The previous process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Divisional Medical Director 1-1	These are now in place and take place regularly between Deputy Medical Directors and the Divisional Medical Directors on a monthly basis. This is a structured	I instigated this through the Clinical Leadership Review 2019, which implementation has been delayed by the

This attachment can be found at: WIT-46754 to WIT-46773	meeting now which focusses on all aspects of Integrated Governance. ATTACHMENT – 1-1 DIVISIONAL MEDICAL DIRECTOR TEMPLATE document located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*	Covid19 pandemic. The process this replaced with 1-1 meetings with AMDs did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Divisional Medical Director Meetings **These attachments can be found at: WIT-46730 to WIT-46731; WIT-46732; WIT-46733 to WIT-46734; WIT-46735; and WIT-46736 to WIT-46753**	As the Divisional Medical Director roles have been established over the past few months this group pf senior doctors now meets fortnightly rather than monthly amongst other agenda items to describe governance assurances in their respective areas. ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR AGENDA document can be located at – *S21 No 29 of 2022, 31. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE and 32. DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1* ATTACHMENT – DIVISIONAL MEDICAL DIRECTOR MINUTES document located at *S21 No 29 of 2022, 33. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE, 34. DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1 and 35 . DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2*	I instigated this through the development of the DivMD roles in Spring of 2022. The process this replaced with 1-1 meetings with AMDs did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Weekly Governance Debriefs **This attachment can be found at: WIT-48231 to WIT-48238**	These meet weekly and include professional directors, DivMD, governance leads in all areas, leads for Improvement and education. ATTACHMENT – WEEKLY GOVERNANCE DEBRIEF TEMPLATE document located at *S21 No 29 of 2022, 113. Weekly Governance Report Template*	I instigated this approximately 18 months ago to draw the elements of governance across the Trust in answer to the Question “Are we safe this week, will we be safe tomorrow?” The process did not exist previously and, as

		such, was not available to identify patient safety concerns identified through the Johnston and Hughes SAIs.
Whistleblowing	Have been developed in the context of the impending launch of the Trust's People Plan.	Mrs Toal, Director of Human Resources, is responsible for this policy. The process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Morbidity and Mortality Meetings **This attachment can be found at: WIT-45451**	These continue on a monthly basis for all specialties with the exception of Mental Health and Learning Disability, who instead have Patient Safety meetings. ATTACHMENT – PATIENT SAFETY MEETING MINUTES document can be located at *S21 No 29 of 2022, 25. 20220311 Combined Surgical Anaesthetics MM Patient Safety Agenda*	I have developed revised Terms of Reference and attendance at these are now recorded for the purposes of Appraisal and Revalidation for all doctors. The previous process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Serious Adverse Incidents **This attachment can be found at: WIT-47307 to WIT-47314**	Over the past year I have developed an SAI core medical team to lead in chairing SAIs. ATTACHMENT – SAI CHAIR ROLE DESCRIPTION document located at *S21 No 29 of 2022, 76. SAI CHAIR JOB DESCRIPTION*	I developed this in response to the growing numbers of SAIs as a consequence of the Covid19 pandemic and as a means of providing standardisation to this process. The process did not identify the patient safety concerns identified through the

		Johnston and Hughes SAIs previous to these.
Adverse Incidents	The Datix system for recording has been upgraded in the last 6 months and dedicated members of staff are now employed in monitoring on the quality of these.	This process was developed as part of the outworkings of the Champion review of CSCG. The previous process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Complaints **This attachment can be found at: WIT-48321 to WIT-48340**	These are processed through the Complaints Office to the relevant directorate who then resolves and communicates with the complainants. Corporate and Social Care Governance has implemented the (Health Care Complaints Analysis Tool) HCAT tool with the London School of Economics to monitor trends in complaints which then informs learning. ATTACHMENT : HCAT GUIDANCE document located at *S21 No 29 of 2022, 134. HCAT Guidance*	The staffing function in corporate governance has been strengthened through the AD for CSCG. The previous process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Litigation and Coronial Matters	The Medical Director reviews these as they arrive from litigation office. The Head of Litigation, the lead for DLS and the Medical Director meet monthly to review and update on these. Relevant lead Clinicians are contacted regularly for advice and guidance and to promote learning through their education systems.	The Director of Nursing is now included in the circulation of these from the Medical Director to expand awareness and learning. The previous process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.

Concerns from General Practitioners	The AMD for Primary Care meets with GPs on a regular basis to address concerns. She is either contacted by email or directly by mobile.	This has been in place for a number of years and has been publicised again regularly to GPs in the course of the Urology Inquiry. The previous process did not identify the patient safety concerns identified through the Johnston and Hughes SAIs.
Concerns from Elected Representatives	These are received on multiple times during the day through the Chief Executive's Office and handled by the Corporate Communications team same or next day when forwarded by the CEO PA.	This has not changed. It is used heavily by local representatives.

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

38.1 I refer to my answer given to Question 7. I also refer to the Clinical and Social Care Governance Improvements noted in my answer to Question 21.

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

39.1 I refer to my answers given to Questions 7, 8 and 21.

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

40.1 In respect of concerns identified during my tenure as Medical Director (1st December 2018 – 30th April 2022) and Chief Executive (1st May 2022 – CURRENT), the following were recorded in Trust Governance documents:

	Date	Items Discussed
Trust Governance Committee Trust Governance Committee meetings are confidential and chaired by the Trust Chair and not open to the public. These meetings are attended by Trust Directors (Executive, Non-Executive, Operational and Corporate Directors and the Assistant Director Clinical and Social Care Governance).	26th November 202 item 3 Chairs Business page 2	The Chair referred to the Statutory Public Inquiry announcement in relation to Urology.
	16th November 2021	Confidential minutes and paper re review of Mr A's compliance private work.
	10th February 2022	Ongoing demands of Urology Services Public Inquiry ('USI') impact on Trust business continuity recognised in Corporate Risk Register. Progress update on review of Mr A's private practice
Trust Board (Confidential Section) Trust Board meetings have a confidential section that is not open to the public and only Directors (Executive, Non-Executive, Operational and Corporate Directors). By way of ensuring that Board members were informed of relevant concerns I provided updates at various stages following the identification of concerns in June 2020. These summary updates informed Trust Board of progress on the Urology Lookback, Communications with Mr O'Brien's representatives, Department of Health, Health and Social Care Board, and GMC.	Update 23rd June 2022	Outlined the work of the USI to date, including 56 S21, site visit, progress of lookback exercise, letter from Ms Smith QC 130622.
	Update 26th May 2022	Minutes recognise arrival of independent advisor, Margaret O'Brien and the impact of demand on system capacity. 7. Update to Board on the incorrect letters sent to patient in Dec 2021 and the process in place to understand and correct and improvement on this.
	Update 31st March 2022	Minutes note the plan to set up Quality Assurance oversight group; Jane McKimm appointed as USI lead to replace Mrs Trouton. 10.outline of progress on group structures and patients. 8. Plans to develop programme board to assure Trust Board and update on progress to date.
	Update 27th January 2022	Minutes outline grievance update, DLS training, Internal Audit recommendations, improvements being made in relation to the MDM findings.
	Update 28th October 2021	papers outline progress and update for families and task and family group re SAIs. Minutes update provided by Mrs Trouton and outlines concerns re 74 patients and Internal Audit report.
	Update 30th September 2021	Minutes outline progress of review, staff concerns, update on grievance. 5. Update outlines progress in relation to SAI and private practice.
	Update 27th May 2021	Minutes outline progress of review, staff concerns, update on grievance. 5. Update outlines progress and Mrs Trouton taking on lead for process currently.

	Update 25th March 2021	Minutes outlined concern re visiting clinicians' escalation of concerns. 5 Update on Urology review progress
	Update 10th December 2020	3. outlining progress with review to date.
	Update 12th November 2020	6. outlining progress with review to date.
	Update 22nd October 2020	7b. Paper outlining the clinical concerns being identified as review of Urology patients continues; 7c update on history of Mr O'Brien.
	Update 24th September 2020	Update in relation to SAI provided in section 7. Paper submitted outlining recent concerns highlighted since the 7th June 2020 and outlining restrictions on practice as a result.
	Any Other Business : 28.08.2020	I brought to the Board's attention SAI reviews involving a recently retired urologist. Members requested a written update for the next confidential TB meeting.
Trust Senior Management Team (SMT)	*This is summarised in the SMT Summary of minutes (ATTACHED) and spans the time from 29th January 2019 until 21st June 2022. Document located at S21 no 29 of 2022, 135.SMT Agenda Notes – Re Urology*	*The themes within this document hold all references that were made to Urology at SMT during my time as Medical Director and since the 1st May during my time as Shief Executive and include updates on the Public, Inquiry, SAI, SCRR, demands on staff and Trust, and lack of identified budget.*
Early Alerts (To the Department of Health and Health and Social Care Board) The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or may require urgent	31st July 2020 onwards	Original Early Alert re Aidan O'Brien. On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns, a lookback exercise of the Consultant's work was conducted to ascertain if there were wider service impacts.
	15th October 2020	Further to Early Alert dated 31st July 2020 relating to the provision of Trust Urology Services additional significant concerns have been brought to the attention of the Trust regarding prescribing practices regarding the medication Bicalutamide by the individual consultant who is no longer employed by Health and Social Care Services.
	23rd July 2021	Early Alert re number of medical staffing gaps across a range of specialties including - Medicine, Trauma Orthopaedics & Urology this weekend.

regional action by the Department.		

40.2 In respect of the Acute Directorate Risk Register the following entries relating to urology service concerns more generally (i.e., as distinct from concerns related to Mr O'Brien) were recorded:

Risk Register	Risk Description	Date Added
Acute Directorate Risk Register *ATTACHMENT ACUTE DIRECTORATE RISK REGISTER* document located *at S21 No 29 of 2022, 136. Acute Directorate Risk Register April 2022*	**62 Day Cancer Performance** *Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.*	03/09/2012
Surgery and Elective Care Risk Register *ATTACHMENT SURGERY AND ELECTIVE DIVISIONAL RISK REGISTER* document located at *S21 No 29 of 2022, 137. SEC ATICS Divisional HoS Risk Register April 2022*	**Inpatient / Daycase Planned Backlog** *Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.*	15/10/2016
	Access Times (Outpatients) - General (not inclusive of visiting specialties) *Increase in access times associated with capacity gaps and emergent demand*	12/04/2019
	Capacity gap in RF, urgent and routine. *Reduction in elective capacity due to COVID-19 restrictions- Urology ENT, Gen Surgery, Gynae and Orthopaedics*	03/12/2020

ATTACHMENT - S21 No 29 of 2022, 136. Acute Directorate Risk Register April 2022

ATTACHMENT - S21 No 29 of 2022, 137. SEC ATICS Divisional HoS Risk Register April 2022

ATTACHMENT – TRUST GOVERNANCE COMMITTEE MINUTES, documents located at RELEVANT TO CX CHAIR'S OFFICE, REFERENCE NO 2K, 20201126 Approved Governance Committee Minutes 26.11.20, S21 NO 29 OF 2022, 138. 20211116 GOVERNANCE COMMITTEE MINUTES, 139. REVIEW OF MR A's PRIVATE PRACTICE, 140. REVIEW OF MR A's PRIVATE PRACTICE 2

ATTACHMENT – TRUST GOVERNANCE COMMITTEE TERMS OF REFERENCE document located at S21 No 29 of 2022, 141. Approved Governance Committee Terms of Reference Feb 2022

ATTACHMENT – TRUST BOARD CONFIDENTIAL MINUTES document located at S21 No 29 of 2022, 142. 20220526 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS, 143. 20220331 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS, 144. 20220127 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS

ATTACHMENT – TRUST SENIOR MANANGEMENT TEAM MINUTES document located at S21 No 29 of 2022, 135. SMT Agendas Notes - Re Urology

ATTACHMENT – TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS – RELEVANT TO CX CHAIR'S OFFICE, REFERENCE NO 52, 20200924 Trust Board Urology Report, 20201022 Trust Board Urology Report, 20201112 Trust Board Urology Report, 20201210 Trust Board Urology Report, 20210325 Trust Board Urology Report, 20210527 Trust Board Urology Report, 20210930 Trust Board Urology Report, 20211028 Trust Board Urology Report, RELEVANT DOCUMENTS LOCATED IN S21

NO 29 OF 2022, 144. 20220127 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS, 143. 20220331 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS, 142. 20220526 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS

ATTACHMENT – EARLY ALERTS RELEVANT TO CONCERNS document can be located at Relevant to MDO, reference no 76 (ii), 20200826_HIGH IMPORTANCE Early Alert SHSCT_ATTACHMENT, 20210723 Early Alert Medical Staffing Gaps and 20210723 Early Alert Medical Staffing Gaps A1

ATTACHMENT: SMT SUMMARY OF MINUTES Jan 2019 – June 2022 document located at S21 No 29 of 2022, 135. SMT Agendas Notes - Re Urology

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

41.1 During my tenure as Medical Director (1st December 2018 – 30th April 2022) and Chief Executive (1st May 2022 – CURRENT) the following systems were in place to collect patient data in the unit.

41.2 The below table illustrates a list of Assurance Systems used for collecting patient data that were available to me and / or that I had knowledge of through Governance Assurance systems. Melanie McClements, Director Acute Services, and Mr Mark Haynes, Divisional Medical Director Urology Improvement, are better placed to provide additional details.

System Name	Function	How this was used to identify concerns

NICAN Peer Review / MDT Audit	Dr Shahid Tariq, Divisional Medical Director Cancer and Clinical Services holds information relating to this	
Clinical Audit	Dr Mark Haynes, Divisional Medical Director Urology Improvement, holds information relating to this	
Adverse Incidents	The Trust operates the DATIX adverse incident reporting system which allows any member of staff to log patient or staff safety incidents	When staff or patients or carers raise concerns these are recorded as incidents on Datix. These Incidents are then reviewed by service managers and assigned a risk rating depending on severity. This system allowed the recording and review of all of the SAIs dealt with to date through the Johnston and Hughes SAIs.
Serious Adverse Incident	The Trust adheres to the Regional Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016) and conducts Serious Adverse Incident reviews as per guidance in this document.	Serious Adverse Incident reports detail patient harm or potential harm and can assist with the identification of underlying issues that may cause concern. The panel takes a root cause analysis approach (RCA) to understand the contributory factors in producing an SAI and from this then generates recommendations for learning for improvements. This process has been used in the course of the Johnston and Hughes SAIs and the recommendations are being acted upon to improve the system.

Complaints	The Trust adheres to the Department of Health Guidance In Relation To The Health and Social Care Complaints Procedure (2022) when handling and responding to patient and service user complaints.	Complaints are recorded on the Datix system and are reviewed and responded to at Directorate level. Corporately, these are reported on a trend basis to support the identification of potential issues of concern. These unfortunately did not serve as a robust governance 'smoke signal', other than generically in relation to waiting times mainly
Litigation and Coronial Matters	Reports are received by the Medical Director on matters relating to litigation and coronial matters.	Issues identified by either the Coroner or the Courts are dealt with through professional and operational management and can identify areas of concern including systematic patient safety issues. As with complaints, to date these have not served as robust smoke signals.
Appraisal and Revalidation	Concerns may be identified during the course of the medical appraisal process or medical revalidation process.	Issues identified by either appraisal or revalidation will be dealt with via professional and operational management. Unfortunately, previously this process depended on the appraisee brining information to the appraiser whom they selected. This process

		then operated in isolation. This has now been made more secure.
Urology Morbidity and Mortality Meeting	The Urology Service operates a urology patient safety meeting, which meets in 2 of every 3 months (the third month this is replaced by the overarching surgical M&M meeting) and considers a range of patient safety information streams; examples of these are detailed below: • Deaths within 30 days Discharge • Mortality Reporting • Morbidity • Local incident themes : Ward / Unit issues • Pharmacy issues, incidents and medicine safety alerts • Shared learning from Complaints / SAI/ IR1 forms / Other meetings / Learning Letters • Shared learning from Litigation / Coroners cases / PM reports / Ombudsman • Safety alerts and Circulars (Safety Quality Reminder) sent to M&M chairs • Local Audit reports/Quality Improvement • Consultant outcome data (NCEPOD / National / Regional / Speciality) This meetings' outcomes are used to input into the wider Surgery Mortality and Morbidity Meetings.	Morbidity and Mortality Meetings via the case review approach can identify concerns in relation to patient care and treatment. These rely on complaints, SAI, Datix, deaths, medicolegal and coroners' processes etc. as outlined and are unable to pick up morbidity and mortality outside these processes.
Performance Metri	Ronan Carroll, Assistant Director. Surgery and Elective Care holds information relating to this	
Structured Clinical Record Reviews (SCRR)	In agreement with the Department of Health the Structured Clinical Record Review Process was created to provide an alternative, proportionate and robust review structure to SAI that can be utilised to review SAIs in a timely manner. The SCRR process is	SCRRs are conducted on incidents discovered as a result of urology lookback activity which are found to have met the threshold for and

	designed and unpinned by the Royal College of Physicians Structured Judgement Review methodology. The SCRR is undertaken in place of SAIs and conducted currently by subject matter experts who are independent to the Southern Trust. Where appropriate, the process considers the following care elements: triage; initial assessment or review; review of diagnostics; ongoing outpatient care; admission and initial management; ongoing inpatient care; care during a procedure; perioperative care and discharge plan of care.	SAI as set out in the Regional Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016). The SCRR method looks for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. SCRRs provide information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

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

42.1 My views on the efficacy of these systems, as well as a summary of any changes to them during my tenure as Medical Director (1st December 2018 – 30th April 2022) and Chief Executive (1st May 2022 – CURRENT), are set out in the table below.

System Name	My Views on the Efficacy of the Systems	Changes of these Systems over time
NICAN Peer Review / MDT Audit	Dr Shahid Tariq, Divisional Medical Director Cancer and Clinical Services holds information relating to this.	
Clinical Audit	Clinical audit present in full function and capacity would	An investment proposal in building a robust clinical audit

	have supported more detailed triangulation of governance data to provide assurance. However, the Trust clinical audit function has not been resourced adequately to support a full Trustwide clinical audit programme.	function is being progressed during 2022/23.
Adverse Incidents	Adverse incidents are a useful tool to identify trends and use to improve services. Challenges remain in ensuring that staff use the system to report all incidents and ensuring that full required details are provided.	Datix adverse incident recording system has received a significant update in 2022 that will enhance its reporting functionality.
Serious Adverse Incident	The SAI process can be useful, however, also lengthy and learning is potentially delayed in its identification compared to other available tools such as Structured Judgement Reviews.	The Regional guidance on conducting SAI reviews has not changed during my tenure. I have sought to appoint additional SAI chairs as detailed in my answers to Questions 21, 41 and 42.
Complaints	Complaints are a useful source of feedback for improvement as they can identify concerns that are invisible to other methods of identification, particularly those that relate to access and discharge from care. The complaints processes in the Trust are undergoing work to assist the standardisation of response pathways.	The Regional guidance on managing complaints has not changed during my tenure. I have sought to appoint a corporate complaints manager as detailed in my answer to question 21. I have also championed the introduction of the Healthcare Complaints Analysis Tool (HCAT) to assist with using complaint data more effectively.
Litigation and Coronial Matters	Litigation and coronial feedback is a useful form of external assurance to the system. Currently dissemination is the responsibility solely of the Medical Director. The Trust is seeking to appoint medical leads for both litigation and coronial matters to support the integration of learning.	Learning from litigation and coronial matters is used to inform education and training of medical staff.
Appraisal and Revalidation	I refer to my answers to Questions 21 (paras i and ii), 7, 8, and 68 (paras 16-20).	

Urology Morbidity an Mortality Meeting	The Trust adheres to the Guidance For The Regional Mortality and Morbidity Processes. From my personal experience, attending this meeting I felt this was useful in identifying learning and areas for service improvement.	The Guidance For The Regional Mortality and Morbidity Processes has remained the same during my tenure.
Performance Metrics	Ronan Carroll, Assistant Director. Surgery and Elective Care holds information relating to this	
Structured Clinical Record Review	Structured Clinical Record Reviews provide a methodology for incident review that is validated and can be completed in a less resource intensive manner than SAIs. I feel that, moving forward, the underpinning methodology of Structured Judgement Reviews can be wider applied to improve our adverse incident reviews across multiple programmes of care.	The SCRR process has not changed, however, it is subject to review by RQIA who will produce a review report on this, expected in Summer 2022.

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

43.1 In my role as Medical Director (1st December – 30th April 2022) I did not have a role in setting performance objectives for medical staff that related to service delivery matters. I was responsible for setting performance objectives with regards to medical professional governance via Medical Appraisal and Revalidation. I was responsible for assurance around monitoring the safety and quality in relation to Medical activity. I refer to my answer given to Question 26.

43.2 Outside of any performance criteria set in job plans and monitored by operational managers, I am not aware of performance objectives as I was not involved in monitoring these. As such I do not have an informed and reasoned view on how well these were set for consultants and specialty teams.

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

JOBPLANNING

44.1 Job planning statistics over my tenure as Medical Director (1st December 2018 – 30th April 2022) are provided for all Trust Doctors (in the first table below) and Urology Doctors only (in the second table below).

Years	Number Job Plans Required (Trustwide)	Number Completed	% Completed	Number in Progress not completed
2018	344	259	75%	85
2019	362	272	75%	90
2020	410	277	68%	133
2021	413	365	88%	48
2022	426	138	32%	288

Years	Number Job Plans Required (Urology)	Number Completed	% Completed	Number in Progress not completed
2018	5	2	40%	3

2019	6	1	17%	5
2020	7	3	43%	4
2021	7	7	100%	0
2022	7	2	29%	5

44.2 The ongoing challenges of the COVID-19 pandemic have placed enormous pressure on all the Southern Trust Urology staff to adapt and provide services in the context of contingent Infection Prevention Control restrictions over the past 27 months. This has necessitated a number of job plan changes for individuals within each annual cycle. Despite this the urology team achieved 100% in the last calendar year. This is now reported on a monthly basis and across the Trust is at its highest level since its introduction.

MEDICAL APPRAISAL

44.3 Medical appraisal statistics over my tenure as Medical Director (1st December 2018 – 30th April 2022) are provided below. The first table below provides information on Appraisal completion rates across all doctors who require appraisal. The second table provides the same information focusing on Urology alone.

Year	All Doctors Requiring Appraisals	Appraisal Complete	Appraisal in Progress	Appraisal Not Complete
2018	307	307 (100%)	0 (0%)	0 (0%)
2019	356	343 (96%)	4 (1%)	9 (3%)
2020	409	352 (86%)	17 (4%)	40 (10%)

2021	483	36 (7%)	14 (3%)	433 (90%)

Year	Urology Doctors Requiring Appraisals	Appraisal Complete		Appraisal in Progress		Appraisal Not Complete	
2018	6	6	100.0%	0	0.0%	0	0.0%
2019	7	5	71.4%	1	14.3%	1	14.3%
2020	7	5	71.4%	0	0.0%	2	28.6%
2021	9	3	33.3%	0	0.0%	6	66.7%

44.4 My opinion regarding the cycle of appraisal is summarised in my answer to Question 68, at paras 16-20.

ATTACHMENT – MOK PI Appraisal & RevalidationNarriative13062022 document can be located at *S21 No 29 of 2022, 145. MOK PI Appraisal Revalidation Narrative 13062022*

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose.

Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1 I refer to my answers for Questions 7, 8 and 21 in answer to this question.

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

46.1 When I commenced as Medical Director, Medical Leaders (Associate Medical Director and Clinical Director) had limited time in their respective job plans to deliver on their areas of responsibility. There has been a constant tension between the delivery of medical leadership and management and the demands of their clinical roles. Medical leaders also had not traditionally had much in the way of formal training or induction to their roles and as such at times have struggled to provide leadership. This has been developed over the last 3 years but progress has been greatly hampered by the Covid19 pandemic.

46.2 In addition to this, doctors tend to be hesitant to speak up or give an opinion unless they are very fully informed and can formulate their thoughts, for fear of giving a wrong opinion. As a result, they often have to be encouraged to speak up.

46.3 Within these limitations, I felt that Medical Leaders have supported me as best they could while I was Medical Director and also, currently, as Chief Executive.

46.4 Furthermore, when concerns were raised they were very receptive and supportive in exploring these further and implementing improvement. In particular, Mr Mark Haynes was the medical leader who brought the initial concerns regarding Urology assurance to my attention in June 2020 and he has been very constructive throughout in relation to developing solutions albeit that, given the pressures in his speciality, he is always under time constraints.

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

(i) The Chief Executive(s);

(ii) the Director(s) of Acute Services;

(iii) the Assistant Director(s);

(iv) the Clinical Director

(v) the Associate Medical Director;

(vi) the Head of Service;

(vii) the Clinical Lead;

(viii) the consultant urologists.

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

47.1

	Governance Generally	***Specifically regarding urology concerns***	***Frequency of Meetings***
The Chief Executive(s)	Range of issues discussed related to my role as Medical Director are detailed in my answer to question 27.	Specific discussions regarding urology concerns included: •Maintaining High Professional Standards processes in relation to Mr O'Brien; •Progress in relation to the lookback; •Discussions regarding both sets of SAIs (2016 and 2020); •Quality Improvement in Urology Services.	Monthly meeting, unstructured format. Items for discussion generated by myself. ATTACHMENT: 1-1 CEO PLANS INCLUDED IN DOCUMENTATION document located at *S21 No 29 of 2022,83. 20201218 CX 1-1 – A10, 84. 20210308 CX 1-1 – A16, 85. 20210505 CX 1-1 – A16, 86. 20210608 CX 1-1 – A19*
Director(s) of Acute Services	Range of issues discussed related to my role as Medical Director including the following: • Infection Prevention and Control; • Adverse Incidents; • Serious Adverse Incidents (SAIs); • Clinical Audit; • Patient Safety; • Complaints; • Litigation; • Mortality and Morbidity; • Learning from Experience; • Maintaining High Professional Standards.	Specific discussions regarding urology concerns included: •Maintaining High Professional Standards processes in relation to Mr O'Brien; •Progress in relation to the lookback; •Discussions regarding both sets of SAIs (2016 and 2020); •Quality Improvement in Urology Services.	No formal 1-1 meetings; meetings were mostly as part of Urology Oversight Group, weekly Senior Management Team Meetings or Trust Committee meetings. TRUST UROLOGY OVERSIGHT MINUTES document located at *Relevant to PIT, Evidence Added or Renamed 19 01 2022, No 76 – minutes and agendas with attachments, Internal Meetings*

Assistant Director(s)	No formal set meetings; however, discussions, when they did take place, would form a subset of those that were held with the Director of Acute Services.	Specific discussions regarding urology concerns included: •Maintaining High Professional Standards processes in relation to Mr O'Brien; •Progress in relation to the lookback; •Discussions regarding both sets of SAIs (2016 and 2020); •Quality Improvement in Urology Services.	No formal 1-1 meetings; meetings were mostly as part of Urology Oversight Group, weekly Senior Management Team Meetings or Trust Committee meetings. AS ABOVE
Clinical Director	No formal set meetings; however discussions, when they did take place, would form a subset of those that were held with the AMD / Divisional Medical Director.	AMD meetings	No set scheduled individual meetings. NONE UNDERTAKEN
Associate Medical Director (Later Divisional Medical Director)	As per my answer to question 7, regarding Deputy and Divisional Medical Director Meetings and 1-1 Divisional Medical Director Meetings.	Specific discussions regarding urology concerns included: •Maintaining High Professional Standards processes in relation to Mr O'Brien; •Progress in relation to the lookback; •Discussions regarding both sets of SAIs (2016 and 2020); •Quality Improvement in Urology Services.	Monthly meetings. ATTACHMENTS : MONTHLY AMD MEETINGS MINUTES MONTHLY DIV MD MEETINGS MINUTES documents located at *S21 No 29 of 2022, 146.* AMD MEETINGS MINUTES – 18th January 2019, 147. AMD MEETINGS MINUTES – 15th February 2019, 148. AMD MEETINGS MINUTES – 26th April 2019, 149. AMD MEETINGS MINUTES – 24th May 2019, 150. AMD MEETINGS MINUTES – 26th July 2019, 151.

			AMD MEETINGS MINUTES – 23rd August 2019, 152. AMD MEETINGS MINUTES – 27th September 2019, 153. AMD MEETINGS MINUTES – 25th October 2019, 154. AMD action notes 22nd November 2019 v2, 155. AMD Meeting Minutes – 31 January 2020, 156. AMD Meeting Minutes – 28th February 2020, 157. AMD Meeting Minutes – 27th March 2020, 158. AMD Meeting Minutes – 22nd May 2020, 159. AMD Meeting Minutes – 26th June 2020, 160. AMD Action notes 28th August 2020, 161. AMD Action notes 23rd October 2020, 162. AMD Minutes 27th November 2020, 163. AMD Action notes 22nd January 2021, 164. AMD Action notes 26th February 2021, 165. AMD Action notes 26th March 2021, 166. AMD Action notes 23rd April 2021, 167. AMD Action notes 28th May 2021, 168. AMD Action notes 25th June 2021, 169. AMD Meeting Minutes – 28th June 2021, 170. AMD Action Notes 23rd July 2021, 171. DivMD. AMD meeting minutes 22.10.21, 172. DivMD.AMD meeting minutes 19.11.21, 173. DivMD meeting 03.12.21
Head of Service	No formal set meetings; however discussions, when they did take place, would form a subset of those that	Specific discussions regarding urology concerns included: •Maintaining High Professional Standards	No formal 1-1 meetings; meetings were mostly as part of Urology Oversight Group.

	were held with the Director Acute Services.	processes in relation to Mr O'Brien; •Progress in relation to the lookback; •Discussions regarding both sets of SAIs (2016 and 2020); •Quality Improvement in Urology Services.	MONTHLY DIV MD MEETINGS MINUTES
Clinical Lead	*Clinical Lead was AMD / DivMD*	*Clinical Lead was AMD / DivMD*	*Clinical Lead was AMD / DivMD*
Consultant Urologists	No scheduled meetings regarding general governance.	Supportive meetings to discuss progression of urology lookback.	Meetings occurred on an ad hoc basis. NO ACTIONS RECORDED AS MEETING WERE FOR INFORMATION

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

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

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

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

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

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

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

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

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

48.1

QUESTION	RESPONSE For the purpose of the answers to Question 48, I will address only urology concerns outside those which relate to Mr. O'Brien. I will deal with these Mr O'Brien concerns separately from Question 52 onwards.
48A. What were the concerns raised with you, who raised them and what, if any, actions did you or others, please name direct, to be taken as a result of those concerns? Please provide details of all meetings including dates, notes, records etc and attendees and detail what was discussed and what was planned as a result of these concerns?	I was aware of issues relating to capacity and demand in Urology in the context of service pressures since my arrival in December 2018. I had understood these were longstanding since 2009 in the Trust area. Mrs Corrigan has recently outlined to me when she took up post in September 2009 as Head of Service (HoS) that the waiting time for outpatient urology was 9 weeks and within IEAP guidance but that the that waiting time for inpatient and daycase was 26 weeks. This has continued to deteriorate since then. Red Flag referral patients were assessed within a few days in 2009 but in recent times for some the waiting time has reached as high as 60 weeks. These were not raised with me as specific concerns in relation to individual patient's safety although I have been acutely aware throughout that long waits for patients in receiving care and investigation is harmful, as these conditions can be time critical. There were frequent discussions formally and informally in relation to the demand in Urology and active steps put in place to manage waiting lists locally and regionally through initiatives such as Team South. I had not been part of the development of these as they predated my tenure. Mrs Corrigan and Mr Carroll as HoS and AD (Assistant Director) respectively will have access to this data in a more complete form. On my arrival I was aware that for patients about whom there were concerns these could be placed in "hot clinics" (same or next day clinics Monday to Friday). Consultants had the opportunity to use these hot clinics on their weeks as Urologist of the Week (UoW) to review any patients about whom there were imminent concerns. These patients came either through the Emergency Department as urgent new referrals or as patients who had been on waiting lists and had deteriorated, patients who rang the consultants' secretaries to raise concerns about their conditions and who were booked in for review and patients about whom the consultant or their secretary was contacted by the patient's GP raising concern about deterioration in a patient's condition and requesting for them to be seen. It would appear that despite having long waiting lists with the propensity then for patients to deteriorate these Hot Clinics were not used as intensively by Mr O'Brien as they were by other consultants.

	Arguably, in retrospect these Hot Clinics if enacted through a standardised approach might have been a temperature check on the safety of the system as they may have been a useful proxy for measuring patient acuity and responsiveness. This is an approach we will take as a Trust going forward. ATTACHMENT : HOT CLINIC ACTIVITY DATA document located at *S21 No 29 of 2022, 174. 20220626 E re HOT Clinics* ATTACHMENT: PERFORMANCE DATA UROLOGY SINCE 2009 documents located at *S21 No 29 of 2022, 175. Urology Board paper v2 1 Sept, 62. Urology Outpatient Total Waits April 18 Onwards, 63. Urology Red Flag Referrals April 18 onwards, 64. Urology Outpatient Longest Waits April 18 onwards, 65. Urology IP Longest Waits April 18 onwards, 66. Urology Inpatient Total Waits April 18 onwards, 67. Urology Day Case Total Waits April 18 onwards, 68. Urology Day Case Longest Waits April 18 onwards, 69. SPC UROLOGY REVIEW BACKLOG, 70. Urology mentions in CPD report* I was also aware that discussions were taking place between the Trust Directorate and Acute Performance and Planning and the Associate Medical Director for Surgery in regard to this with the Health and Social Care Board (HSCB). I was aware that commissioned capacity vis-à-vis demand and short supply of staff was a longstanding and perennial problem. This was mirrored in complaints from patients who referred to long waits. (ATTACHMENT : UROLOGY COMPLAINTS SINCE 2009) document located at *S21 No 29 of 2022, 176. UROLOGY COMPLAINTS SINCE 2009* On reflection I now believe that this was not only problematic for patients on the long waiting lists and the staff responding. Unfortunately the long waits “hid” in plain sight the issue that was uncovered on the 7th June 2020 when Mr O’Brien emailed Mr Haynes re placing patients on surgical waiting lists. This revealed that patients had not been place on waiting lists at all after their initial consultation or following investigations or a cancer MDM (Multi-Disciplinary Meeting). As such they had an elongated care pathway which was assumed initially to be due to the long waiting lists rather that to the delays incurred because they had not actually been placed on a waiting list or had referrals made. This problem that on the

	face of it then presented as a problem of long waits also masked governance failings in relation to patients who had not been placed on lists when they should have been. ATTACHMEN : EMAIL MR O'BRIEN TO MR HAYNES 06.06.20 document located at *Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, no 77 – emails Mr Mark Haynes – AMD and Consultant Urologist, 20200611-email patients to be added to urgent bookable list – att9* Because I have not been in the Trust for the duration of the development of Urology services, I have asked those involved in Urology and Planning to develop a comprehensive timeline in relation to the genesis of the Urology Service in the Southern Trust and the changes in approach, waiting lists and times and staff involved since its inception in 2007. This will be supplied at a later date to the Inquiry once it is complete. This development of Urology involved various approaches to managing capacity through the independent sector, a blue sky thinking plan which eventually generated BlueSky Vision Model for Urology / Team South Model (2014) which could not be fully enacted because of staff shortages and was led by Mr. Dean Sullivan and Mr. Michael Bloomfield at the Health & Social Care Board. This predated my tenure by a number of years and I was not involved in the planning and discussions in relation to this. (ATTACHMENT: BLUESKY / VISION MODEL UROLOGY) document located at, *S21 No 29 of 2022, 177. the vision 1 Sept 14* (ATTACHMENT: TEAM SOUTH MODEL) document located at *S21 No 29 of 2022, 71. Team South Implementation Plan v0.3, 175. Urology Board paper v2 1 Sept, 178. ST Urology Benchmarking - Updated 6.7, 179. 20100603 Urology Benchmarking* In addition to this there was a Cancer Urology Group regionally at times chaired by Mr. Haynes and concerns about waiting times and demand and capacity were raised through this forum with the commissioners. ATTACHMENT : UROLOGY PIG MINUTES/ AGENDAE document located at *S21 No 29 of 2022, 180. 20201207 - Agenda PIG meeting example*
48B. What steps were taken (if any) to risk assess the potential impact of the	In relation to those capacity and demand concerns (i.e., the concerns other than the specific concerns raised in relation to Mr O'Brien's performance which are addressed later in this statement), it was recognised that these concerns could impact on patient safety. In the circumstances, there were a number of initiatives implemented over the years to address the risks identified through waiting list management, staff recruitment, governance monitoring.

concerns once known?	These will be summarised in more detail in the Urology Services Timeline referenced above. For present purposes, I offer the summary below. Over the years, **WAITING LIST MANAGEMENT** included 1. Saturday waiting list initiatives,) 2. Use of Independent Sector (IS) providers including employing a team of staff from Australia; 3. Waiting list validation processes; 4. Weekly reports run by urology managers to monitor those patients waiting longest (Mrs Corrigan holds data on this process); 5. Weekly Monday evening meetings circa 2014/15 to address over 18 months (Mrs Corrigan holds data on this process); I am led to believe that these meetings were chaired by the Director of Acute Services and attended by the consultants and others managing the urology service and aimed to address urology waiting lists and the structures required to address these long waits. 6. Monthly performance discussions with consultants, and with managers weekly, to address imbalance in waiting lists and prioritise the patients most in need across the service (Mrs Corrigan holds data on this process); 7. Urology was added to the Acute Governance Risk Register in 2014/15 and has been monitored on this monthly by Acute Governance leads; (ATTACHMENT: ACUTE GOVERNANCE MEETINGS SINCE 2014) document located at Relevant to Acute, Document No 2L folder) *8.* Urology performance data is included in Trust Performance committee meetings (ATTACHMENT: PERFORMANCE COMMITTEE MINUTES/ AGENDA/ PAPERS) document located at *S21 No 29 of 2022, Question 34 folders, PERFORMANCE COMMITTEE AGENDAS AND MINUTES)* *87. 20191017 Performance Committee Agenda, 88. 20191209 Performance Committee Agenda, 89. 20200319 Performance Committee Agenda NO MEETING, 90. 20200521 Performance Committee Agenda, 91. 20200903 Performance Committee Agenda, 92. 20201203 Performance Committee Agenda, 93. 20210318 Performance Committee Agenda, 94. 20210520 Performance Committee Agenda, 95. 20210902 Performance Committee Agenda, 96. 20211202 Performance Committee*

	Agenda, 97. 20220310 Performance Committee Agenda, 98. 20220519 Performance Committee Agenda, 99. 20191017 Approved Performance Committee Minutes, 100. 20191209 Approved Performance Committee Minutes, 101. 20200319 Feedback questions and answers Marsh 2020 Performance Committee_ Final NO MEETING, 102. 20200319 Performance Committee_ Chair Report, 103. 20200521 Approved Performance Committee Minutes, 104. 20200903 Approved Performance Committee Minutes, 105. 20201203 Approved Performance Committee Minutes, 106. 20210318 Approved Performance Committee Minutes, 107. 20210520 Approved Performance Committee Minutes, 108. 20210902 Approved Performance Committee Minutes, 109. 20211202 Approved Performance Committee Minutes, 110. 20220310 Approved Performance Committee Minutes **RECRUITMENT:** In addition to this there were ongoing attempts to recruit staff as outlined in my response to Question 17. **GOVERNANCE PROCESSES**: These are outlined in my answer to Question 21. My reflection on the capacity *vs*. demand concern is that there have been a number of approaches taken over the years to reduce waiting times for patients with varying degrees of success. These approaches over time have not always been consistent and the frequent changes in personnel involved contributed to this. Typically success in waiting list management has been considered in terms of numbers waiting over different measures of time and their impact on patient experience. As such typically routine waiting lists have been viewed as performance rather than patient safety or governance concerns, except for the sickest patients where the time critical nature of their condition is most obvious.

	Thus governance processes and patient safety measures have not always been considered, developed in tandem or sufficiently integrated to consider "How can we assure ourselves that this change in performance creates a measureable improvement in patient safety in addition to patient experience?". Another major concern that has come to light since the publication of Dr Hughes' SAI findings (in 2021) is that there has been a disconnect between the multidisciplinary meeting in relation to Uro-oncology and Urology Services line management. Although the Urology Service forms part of the multidisciplinary meeting (MDM) it has been chronically short of pathology, radiology and oncology expertise. A further complicating factor has been that the Clinical Nurse Specialists (CNS) have reported to and been accountable to Cancer Services. This is changing so that these CNS also now report to Urology Services so that there is a free flow of information sharing across the system. In addition the absence of key clinical cancer consultants in oncology, radiology and pathology has meant limited clinical challenge either internally or in relation to their own decision making or internally to the Urology clinicians. In addition to this their absence is a loss of expertise in the clinical care of patients. In recent months this position has improved in relation to pathology and radiology. The Uro-oncologist has been provided by the Belfast Trust since the introduction of the Regional Cancer MDM around 2013. As those oncologists are managed by Belfast Trust their line management escalation tends to be through that system. There are significant advantages to holding specialist services together in one Trust. However the disadvantage with these consultants not being part of the local Urology system is that concerns have not always been escalated other than through a direct communication with Mr. O'Brien. As a result of this discovery we are now putting systems and processes in place to ensure that clinicians from other Trusts who provide services into the Southern Trust are clear about the routes of escalation should they have concerns about clinical practice.
48C. Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what	I refer to my answer at 48B above and the measures implemented in relation to waiting list management, staffing, and governance. In addition to this, the SAIs chaired by Dr Johnston and later Dr Hughes generated action plans which I have enclosed. In addition to this, I enclose correspondence from Mr Barry Conway outlining the improvements in Uro-oncology services. ATTACHMENT _ SAI ACTION PLAN Personal Information redacted by JOHNSTON SAI REPORT document located at *Relevant to Acute, Document Number 54, 20210722 Approved final action plan Urology*

steps, if any, did you take to mitigate against this? If not, why not?	ATTACHMENT - 2020 SAI Recommendation Action plan INCORPORATING THE 2016 RECOMMENDATIONS document located at *S21 No 29 of 2022, 181. Action Plan Update June 2022 – A53* ATTACHMENT:URO-ONCOLOGY IMPROVEMENT document located at *S21 No 29 of 2022, 182. Uro Oncology Improvements 2022*
48D. If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?	I refer to my answers at 48B and 48C above and to the measures implemented in relation to waiting list management, staffing, and governance.
48E. How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?	I refer to my answer in Questions 7, 8 and 21 which describes the processes and systems in place. In addition, to support the changes required in Urology the governance systems and process in place have been strengthened through secondment and appointment of a number of key staff to identify concerns and drive improvement ATTACHMENT : DESCRIPTION OF UROLOGY ACCOUNTABILITY (mo'b) document located at *S21 No 29 of 2022, 183. Briefing Paper on new structure and process for Urology Lookback Review v2 9th June 2022* The patient safety system in Urology is monitored through local Governance meetings and concerns are escalated through the Director of Acute Services and the Divisional Medical Director for Urology to the Medical Director and, through the governance coordinators, to the Assistant Director for Governance and in turn to the Assistant Director for Quality Assurance for discussion with the Medical Director. Governance data is considered and acted upon through the process of Data Triangulation to improve the level of assurance in relation to this.

	ATTACHMENT : TRIANGULATION OF PATIENT SAFETY DATA) document located at *S21 No 29 of 2022, 184. slides-su2s-triangulating-data*
48F. If you were given assurances by others, how did you test those assurances ?	I refer to my answer at 48E above. In addition to this the Trust is developing its Clinical Audit function. (ATTACHMENT : CLINICAL AUDIT STRATEGY) document located at *S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022)* Through Internal Audit the Trust has undertaken a number of 2nd and 3rd line assurances audits in Urology to test the robustness of systems and processes in place. These will continue in the next Internal Audit cycle. ATTACHMENT: INTERNAL AUDITS document located at *Relevant to PIT, reference no 76, 20201007 Report Internal Audit PreOpandConsent19-20, 20201007 Report Internal Audit Management of Private and Paying Patients 19-20, 20200909 Report Internal Audit Mgt of Referrals 19-20 and Internal Audit Mr A Private Work* Recent assurance processes in relation to communicating with patients affected in the course of the Inquiry Lookback have been tested and strengthened. ATTACHMENT: MARGARET O'HAGAN: PAPERS ON UROLOGY LOOKBACK PROCESS document located at *S21 No 29 of 2022, 185. 20220531 - review of urology letters investigation action plan and 186. 20220531-final report of review of urology letters investigation and Relevant to MDO, Evidence after 4 November MDO – reference no 76 (i) – DOH SW, 20210429_RE IHRD - LOOKBACK REVIEW GUIDANCE AND POLICY_ATTACHMENT 1, 20210429_RE IHRD - LOOKBACK REVIEW GUIDANCE AND POLICY_ATTACHMENT 2*
48G. Were the systems and agreements put in place to rectify the problems within urology services successful?	Waiting times remain extremely concerning within Urology Services as outlined and concerted efforts continue to address these internally as well as externally (e.g., with the commissioner). Governance processes within Urology services have been strengthened as described in my answers to Questions 7, 8 and 21. Internal Audit plans, learning in particular from the Dr Johnston and Dr Hughes' SAIs are being implemented and monitored and all show improvement. ATTACHMENT: UROLOGY PERFORMANCE document located at S21 No 29 of 2022, *175. Urology Board paper v2 1 Sept S21, 62. Urology Outpatient Total Waits April 18 Onwards, 63. Urology Red Flag*

	Referrals April 18 onwards, 64. Urology Outpatient Longest Waits April 18 onwards, 65. Urology IP Longest Waits April 18 onwards, 66. Urology Inpatient Total Waits April 18 onwards, 67. Urology Day Case Total Waits April 18 onwards, 68. Urology Day Case Longest Waits April 18 onwards, 69. SPC UROLOGY REVIEW BACKLOG, 70. Urology mentions in CPD report ATTACHMENT : UROLOGY INTERNAL AUDIT ACTION PLANS document located at *Relevant to PIT, reference no 76, 20201007 Report Internal Audit PreOpandConsent19-20, 20201007 Report Internal Audit Management of Private and Paying Patients 19-20, 20200909 Report Internal Audit Mgt of Referrals 19-20 and Internal Audit Mr A Private Work* ATTACHMENT : ACTION PLANS FROM SAIS (DR JOHNSTON, DR HUGHES) document located at *S21 No 29 of 2022, 181. Action Plan Update June 2022 – A53)*
48H. If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.	These are outlined in the attachments to my answer at 48G above. *ATTACHMENT : MONITORING PROCESS IN RELATION TO 2017 ACTION PLAN MHPS document located at S21 No 29 of 2022, 187. Detail of monitoring of 2017 action plan*

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

(a) properly identified,

(b) their extent and impact assessed,

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

49.1 I refer to my answer to Question 48 in respect of the general urology concerns (i.e., not specific to Mr O'Brien).

49.2 The concerns relating specifically to Mr O'Brien are addressed in Questions 52-65. However, my considered view on the issues raised by Questions 49a to 49c in respect of these particular concerns can be expressed as follows:

49.3 I believe that the issues of concern were eventually properly identified and fully acknowledged, but not all at the same time. Until 2019 and the referral to the GMC, I think that the system as a whole found it difficult to identify the seriousness of the concerns, despite the fact that a number of individuals over the previous 10 years in particular had been trying to draw attention to these. In the context of the prevailing view that Mr O'Brien was a good surgeon, it was difficult for the system to believe that his behaviours could be causing harm. This view of his ability appears to have been driven by the long hours he spent on the ward with some of his patients and his helpfulness towards some staff rather than being evidence-based in relation to patient outcomes. Based on their interaction with him, patients appear to have believed that he had saved their lives although I am not clear what the actual outcomes evidence for this was. In addition, because there was the perception that he was a "good surgeon" who appeared to make himself indispensable at times, his failings were not then robustly challenged. This perception seemed to resonate

NOTE: As per email received by the Inquiry on 12 June 2024 located at TRU-309844 the reference to 'IV antibiotics and opiates' highlighted below should read "IV antibiotics and fluids'. Annotated by the Urology Services Inquiry.

with a rather outdated archetype of the brilliant but flawed doctor who has to be tolerated and forgiven readily because of their special status. When their concerns were not taken seriously enough by the system, and in particular by Mr O'Brien, the colleagues had to resort to workarounds to make the process work for patients. This had the unfortunate and unintended impact (I believe) of helping to minimise the impact of the behaviours and governance failings and thus inadvertently hiding and prolonging the difficulties in plain sight as various personnel changed and the narrative and memory of the concerns were thus diluted as a result. The next stepwise change was following Mr O'Brien's email to Mr Haynes on 7th June 2020. Until this point, the intelligence was that the difficulties were in relation to non-triage, non-dictation, withholding of clinical information and records, and prioritisation of private patients, and also that there had been time-limited difficulties in the past with prescribing of IV antibiotics and opiates, an episode of throwing charts in the bin, and concerns re cystectomies. The 7th June 2020 email led to a review of clinical practice and then a Lookback helped further identify difficulties with preoperative assessment, non-dictation and non-referral to and from MDM, non-engagement with MDM, and non-involvement of CNSs.

49.4 Through the process of Lookback, the clinical extent and impact have been identified in the areas of concern outlined in my answer to Question 54 below.

49.5 The potential risk to patients is being identified increasingly as we progress through the last 18 months of Mr O'Brien's clinical practice. Up to 11th July 2022, 82 patients from within this cohort meet the criteria for SAI and are being managed through the SCRR process.

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

50.1 I refer to my answer to Question 48.

50.2 I have had a number of informal meetings with Mrs Melanie McClements (Director of Acute Services), the Urology Consultants, Clinical Nurse Specialists and managers in the urology service to make them aware of the Minister's announcements in relation to the Urology Inquiry. The meetings took place on 24th November 2020, 25th November 2020 and 8th December 2020.

50.3 All of the staff have been made aware of the psychological support available for them through the Trust's Occupational Health Service.

50.4 In addition to this, organisational support is being accessed through an Organisational Consultant formerly from the Tavistock Clinic, London, planned to start over Summer 2022.

50.5 The governance and medical management processes have been strengthened through the out workings of the Medical Leadership Review, the development of the Divisional Medical Director post for Urology Improvement, and Clinical Leads within the service.

ATTACHMENT MEDICAL LEADERSHIP REVIEW document located at *S21 No 29 of 2022, 52. MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021*

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

51.1 Mrs Melanie McClements, Director Acute Services, will hold information relating to this issue operationally as will Mrs Paula Tally, Assistant Director for QI.

51.2 The majority of the improvements implemented have been as Systems Improvement at relative speed in the context of improving governance and patient safety within the

restrictions of the Covid19 pandemic which continues to limit staff availability and patient access to services.

51.3 These System Improvements, unlike specific smaller scale Quality Improvement (QI) projects, have not been subjected to the absolute rigours of specific data gathering and PDSA (Plan Do Study Act) cycles as is a necessary prerequisite of QI Methodology. They have however included the general underlying principles of Quality Improvement in that any change aims to be an improvement and is not carried out in isolation.

51.4 These can be considered under the following headings: Professional Governance Improvements, Clinical and Social Care Governance improvements and Quality Assurances

Professional Governance Improvements	Refer to Answers 7, 8, 21i, and 21ii above.
Clinical & Social Care Governance Improvements	Refer to Answers 7, 8, and 21iii- xiv above.
Quality Assurances	Refer to Answers 31-46 and in Amended responses to Section 21 Notices Nos. 1 and 1a of 2022.

51.5 Not all of these systems improvements have been subjected to audit or review to provide second and third line assurances but these are planned for Autumn 2022 and will be shared when approved by Trust Board.

51.6 The Project Board is being developed to provide Assurance to Trust Board on Service Improvements and will be commenced in September 2022.

51.7 The Permanent Secretary, Mr May, has written to the Trust on 7th July 2022 outlining that an independent review of Trust processes will be undertaken by RQIA following on from the letter from the Inquiry Chair, Ms Smith, in May 2022.

ATTACHMENT PERM SEC LETTER JULY 2022 document located at *S21 No 29 of 2022, 188. 07072022 Letter to Maria O'Kane from Perm Sec*

51.8 I have outlined in response to Questions 7, 8 and 21 the Systems Improvements in relation to Medical Management and Governance monthly communications to Divisional Medical Directors in relation to complaints involving doctors throughout 2021 and since.

ATTACHMENT : MONTHLY UPDATE TO DIVISIONAL MEDICAL DIRECTORS ; DIVISIONAL MEDICAL DIRECTORS' MONTHLY TEMPLATE document located at *S21 No 29 of 2022, 36. DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE*

51.9 Changes to appraisal and revalidation processes have been undertaken and have been implemented.

ATTACHMENT: Appraisal and Revalidation Developments document located at S21 No 29 of 2022, *112. MOK PI Appraisal Revalidation Narrative 13062022*

51.10 In conjunction with and following on from the Review of Private practice processes and the Internal Audit recommending changes to this system, improvements have been made.

ATTACHMENTS: IA, PRIVATE PRACTICE DOCUMENTATION, ACTION PLAN , MEMOS , LNC MINUTES documents located at *Relevant to PIT, reference no 76, 20210424 Report Internal Audit Private Medical Practice 2011-12*,

51.11 Governance reporting / triangulation of data in keeping with format of weekly Trustwide Governance meeting including complaints, SAI, medico legal, coroners, performance and reported weekly to SMT and monthly to Non-Executive Directors.

ATTACHMENTS: INTERNAL AUDIT REPORTS AND ACTION PLAN UPDATES/ RAG RATINGS : PRIVATE PRACTICE, PREOPERATIVE ASSESSMENT, MR O'BRIEN'S WORK documents located at *Relevant to PIT, reference no 76, 20210424 Report Internal Audit Private Medical Practice 2011-12, Relevant to PIT, reference no 76, 20201007 Report Internal Audit PreOpandConsent19-20,*

51.12 Reporting and Accountability with respect to MHPS is in the process of being developed as the new permanent Medical Director comes into post.

51.13 Other Systems' Improvements have been developed following the Johnston and Hughes' SAIs as outlined in the Action Plans attached and from SCRR in the interim.

ATTACHMENT: HUGHES' AND JOHNSTON SAIS AND ACTION PLANS document located at *S21 No 29 of 2022, 181. Action Plan Update June 2022 – A53*

51.14 I have attached the Administration Action Plan developed following the review by Anita Carroll. Document can be located at *Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 67, 20211122-Admin Review Process (67) and S21 No 29 of 2022, 189. Admin Review Process - Triage Process April 21, 190. Admin Review Process - Consultant to Consultant Referrals SOP, 191. Admin Review Process - Guide to Paying Patients, 192. Admin Review Process - Services not using e-triage, 193. Admin Review Process - PAS OP Referral Source Code Private to NHS*

51.15 I have attached the Actions undertaken in Uro- oncology to progress MDM working ATTACHMENT URO-ONCOLOGY JUNE 2022 UPDATE PAPER document located at S21 No 29 of 2022, 182. *Uro Oncology Improvements 2022*

ATTACHMENT - SAI ACTION PLAN Personal Information redacted by USI *JOHNSTON SAI REPORT document located at Relevant to Acute, Document Number 54, 20210722 Approved final action plan Urology*

ATTACHMENT - 2020 SAI RECOMMENDATION ACTION PLAN INCORPORATING THE 2016 RECOMMENDATIONS WHERE APPLICABLE document located at S21 No 29 of 2022, 181. Action Plan Update June 2022 – A53

Mr. O'Brien

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

52.1 I refer also to my answer at Question 7(i) and (ii).

52.2 From January 2019 until his retirement on 17th July 2020, I was Mr O'Brien's Responsible Officer and Medical Director. Since his retirement, the function of his Responsible Officer has moved to the GMC.

52.3 I have never met Mr O'Brien and communications with him were through his operational and professional line managers, namely, the Director for Acute Services and Assistant Director for Surgical Services, as well as his Clinical Director and Associate Medical Director. Currently, communications with him are by email through his legal team. The GMC continues to request information in relation to Mr O'Brien and this has been provided.

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

53.1 Mr O'Brien's Job Plans were formulated and agreed with the Operational Manager, Clinical Director and Associate Medical Director.

53.2 Currently, the process for second signoff on Job Plans sits with the Medical Director / Operational Director.

53.3 It was reported to me in October 2019 that the first sign off of Mr O'Brien's Job Plan was not completed in a timely fashion as Mr O'Brien would not agree what was being offered, despite the fact he was given the administration time on a Tuesday morning that he requested. He was also described as spending long hours on the ward at times that he was neither required nor expected to be there and then was asking for additional payment recognition for this. By the time I arrived in 2018, there was a pattern of him agreeing to sign off Job Plans and then not following through. When I specifically requested that this was done, he agreed with Mr McNaboe in November 2019 that this would be done but then only signed these before he retired to allow his pension to be finalised. There was limited process for escalation across the Trust because this was not clearly delineated in the Clinical Director and Associate Medical Director job descriptions across the Trust which were not standardised and so escalation was difficult to enforce for one doctor when the levels of job planning were not optimal across the Trust. With the review of medical management structure, there is now greater clarity in the CD and DivMD posts in relation to responsibility for this and, now that these posts are in place and the Deputy Medical Director for workforce has been able to establish oversight at my request, the level of Job planning has markedly increased.

ATTACHMENT: 23062022 MEDICAL DIRECTOR'S REPORT TO TRUST BOARD document located *at S21 No 29 of 2022, 133. Trust Board Cover Sheet Urology 23 June MO'K*

53.4 As a result, the process is being strengthened with timescales and processes for escalation and mediation if these are not achieved to reduce the likelihood of this recurring for other doctors in the future and the protocol for this is being agreed with the BMA and reviewed by SMT.

53.5 In the circumstances, the level of job-planning (despite the impact of the pandemic on this process) has improved markedly.

53.6 Furthermore, reporting on progress on Job Plans has now been developed to report monthly to the Medical Director through the 1:1 with Divisional Medical Directors and in the HROD – Medical Director meetings. A report on job planning, appraisal and revalidation is being more fulsomely developed to provide to the Senior Management Team and Trust Board.

53.7 In addition, an oversight group reviewing those on more than 12 PAs has been established.

ATTACHMENT: Job planning oversight group data documents located at S21 No 29 of 2022, 194a. Workforce Metrics Feb 22 – Apr 22, 194b. Workforce Metrics Nov 21 – Jan 22, 194c. Workforce Metrics 250621, 194d. Job Planning Guidance Final Agreed with LNC April 19

ATTACHMENT: MEDICAL DIRECTOR SUBMISSION TO TRUST BOARD 23.06.22 document located at *S21 No 29 of 2022, 134. Trust Board Cover Sheet Urology 23 June MO'K*

ATTACHMENTS –20190131 Action Notes, document located at S21 No 29 of 2022,195. 20190131 Action Notes.pdf,

20190502 AGENDA - HR & Medical Directorate Meeting, document located at S21 No 29 of 2022, 196. 20190502 AGENDA - HR Medical Directorate Meeting.pdf,

20190718 AGENDA - HR Medical Directorate Meeting, document located at S21 No 29 of 2022, 197. 20190718 AGENDA - HR Medical Directorate Meeting.pdf,

20191015 AGENDA - HR Medical Directorate Meeting, document located at S21 No 29 of 2022, 198. 20191015 AGENDA - HR Medical Directorate Meeting.pdf,

20200709 Medical Directorate and HR Meeting, document located at S21 No 29 of 2022, 199. 20200709 Medical Directorate and HR Meeting.pdf,

20200820 AGENDA - HR Medical Directorate Meeting, document located at S21 No 29 of 2022, *200. 20200820 AGENDA - HR Medical Directorate Meeting.pdf,*

20201001 ACTION NOTES HR & Medical Directorate Meeting, document located at S21 No 29 of 2022, *201. 20201001 ACTION NOTES HR Medical Directorate Meeting.pdf,*

20201105 AGENDA HR & Medical Directorate Meeting, document located at *S21 No 29 of 2022, 202. 20201105 AGENDA HR Medical Directorate Meeting.pdf,*

20201217 AGENDA HR & Medical Directorate Meeting, A1 and A2, document located at S21 No 29 of 2022, *203. 20201217 AGENDA HR Medical Directorate Meeting, 203.1 20201217 AGENDA HR Medical Directorate Meeting A1 and 203.2 20201217 AGENDA HR Medical Directorate Meeting A2,*

20210414 ACTION NOTES HR & Medical Directorate Meeting, A1, A2, A3, A4 and A5, document located at *S21 No 29 of 2022, 204. 20210414 ACTION NOTES HR Medical Directorate Meeting, 204.1 20210414 ACTION NOTES HR & Medical Directorate Meeting A1, 204.2 20210414 ACTION NOTES HR & Medical Directorate Meeting A2, 204.3 20210414 ACTION NOTES HR & Medical Directorate Meeting A3, 204.4 20210414 ACTION NOTES HR & Medical Directorate Meeting A4 and 204.5 20210414 ACTION NOTES HR & Medical Directorate Meeting A5*

20210616 AGENDA HR & Medical Directorate Meeting and A, document located at S21 No 29 of 2022, 205. *20210616 AGENDA HR Medical Directorate Meeting and 205.1 20210616 AGENDA HR Medical Directorate Meeting A*

20211008 AGENDA HR & Medical Directorate Meeting, A1, A2 and A3, document located at S21 No 29 of 2022, 206. *20211008 AGENDA HR Medical Directorate*

Meeting, 206.1 20211008 AGENDA HR Medical Directorate Meeting A1, 206.2. 20211008 AGENDA HR Medical Directorate Meeting A2 and 206.3. 20211008 AGENDA HR Medical Directorate Meeting A3,

20211208 AGENDA HR & Medical Directorate Meeting, A1, A2, A3 and A4, document located at *S21 No 29 of 2022, 207. 20211208 AGENDA HR Medical Directorate Meeting, 207.1 20211208 AGENDA HR & Medical Directorate Meeting A1, 207.2 20211208 AGENDA HR & Medical Directorate Meeting A2, 207.3 20211208 AGENDA HR & Medical Directorate Meeting A3 and 207.4 20211208 AGENDA HR & Medical Directorate Meeting A4*

20220414 HR medical directorate meeting, document located at *S21 No 29 of 2022, 208. 20220414 HR medical directorate meeting,*

20210205 AGENDA OF MEDICAL HR MEETING, A1, A2, A3 and A4, document located at *S21 No 29 of 2022, 209. 20210205 AGENDA OF MEDICAL HR MEETING,209.1 20210205 AGENDA OF MEDICAL HR MEETING A1, 209.2 20210205 AGENDA OF MEDICAL HR MEETING A2, 209.3 20210205 AGENDA OF MEDICAL HR MEETING A3 and 209.4 20210205 AGENDA OF MEDICAL HR MEETING A4,*

20210205 NOTES OF MEDICAL HR MEETING. Document located at *S21 No 29 of 2022, 210 20210205 NOTES OF MEDICAL HR MEETING*

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

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please

name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

55.1 I have addressed Questions 54 and 55 together because of the overlap between them.

When were you first aware of issues related to Mr O'Brien? What were those issues of concern and when and by whom were they first raised with you?

55.2 The answer to this question includes a chronology of events and a description of my developing awareness and understanding of the concerns which had to be dealt with, not in isolation, but in the context of what had occurred before; hence the rather large amount of information provided.

55.3

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
I first became aware during a meeting with GMC during which Mr O'Brien's case was mentioned.
What were those issues of concern and when and by whom were they first raised with you?
I was an observer at the meeting and became aware that concerns about a urologist had been discussed with the GMC but that Mr O'Brien had not been identified to the GMC.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
Mr O'Brien's care was first raised as a "local concern" at a Trust RO/ELA meeting on 8.2.17.
Please provide any relevant documents
ATTACHMENT GMC – ELA MEETING 04.12.18 with corrections email The minute records (since corrected) that I was wrongly identified as RO. Document located at S21 No 29 of 2022, *2. 20220616 E GMC Meeting Minutes and Corrections, 3. 20220616 E GMC Meeting Minutes and Corrections 2, 4. 20220616 E GMC Meeting Minutes and Corrections 2 A1*

55.4

Date of discussions	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
4.12.18	Meeting with GMC (as described above)	On 4th December 2018, a few days after I commenced in the Southern Trust as Medical Director, and before I assumed the role of Responsible Officer on the 1st January 2019, I attended a meeting between the GMC Employment Liaison Adviser (note: the ELA is a GMC employee who provides liaison between the Trust and the GMC – he/she can be medical, legal or lay) and Dr Ahmed Khan, Responsible Officer. It was advised during this meeting that the MHPS and SAI investigations had been completed and reports were finalised and would arrange for the final MHPS Report and final SAI Report to be sent to Joanne Donnelly. A Trust Disciplinary Hearing was to take place in early January 2019. Mr Gibson reported that the doctor still had local restrictions on his practice, the 2017 Action Plan, and these were being kept under review. Mr Gibson was to update Joanne Donnelly on the Trust Disciplinary Hearing. Because of local restrictions and changes to local systems he stated that there were no patient safety concerns and gave an assurance the doctor did not do any work outside of SHSCT	Joanne Donnelly Dr Ahmed Khan Simon Gibson

55.5

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
MHPS update meeting with Mrs Vivienne Toal
What were those issues of concern and when and by whom were they first raised with you?

My understanding of the issues was, in terms, that Mr O'Brien had not been compliant with a number of patient administration processes identified in the course of 2015 and 2016 resulting in 4 main concerns as outlined in the February 2017 Return to Work Action Plan. This Action Plan had been formulated by Dr Richard Wright, then Medical Director, and others, and was summarised through the 4 main concerns (which I shall outline in detail later). The 5 Terms of Reference for the investigation of Mr O'Brien under the Maintaining High Professional Standards Framework addressed these 4 broad concerns namely, Untriaged Letters, Current Backlog Review until 29th February 2016, Patient Centre Letters and recorded outcomes from clinics (this was in response to reports by frustrated consultant colleagues that they were concerned that there was often no record of consultations/ discharges made by Mr O'Brien on Patient Centre or on Patient notes) and Patient Charts at Mr O'Brien's home. They also addressed whether Mr O'Brien had prioritised private patients and determined to what extent any of the above matters were known to line managers prior to December 2016 and actions taken to manage concerns.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
I learned then that some had been in existence since 2015.
Please provide any relevant documents
ATTACHMENT: MAINTAINING HIGH PROFESSIONAL STANDARDS INVESTIGATION COMPLETED SEPTEMBER 2018 document located at *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, no 77 Dr Khan and Dr Wright emails, 20180928 Email Case Manager Determination AO'B FINAL 280918 attachment*

55.6

Date of discussions	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
10th December 2018	Meeting with Mrs Vivienne Toal Director HROD	On reviewing the MHPS information with the awareness that there had been patient safety concerns in relation to Mr O'Brien's administrative processes, I contacted Mrs Vivienne Toal Director for HROD on the 8th December 2018 and we met on the 10th December so that Mrs Toal could provide me with a brief outline of the history which led to the MHPS investigation.	Mrs Vivienne Toal

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?

Meeting with Chair of Trust during which Mr O'Brien's case was mentioned.

What were those issues of concern and when and by whom were they first raised with you?

Do you now know how long these issues were in existence before coming to your or anyone else's attention?

Mrs Brownlee volunteered to me that Mr O'Brien had saved her life, that she hoped I wouldn't raise concerns about Mr O'Brien as had been her experience previously with medical managers, that she thought he had been poorly treated through the MHPS process, and that he was an excellent surgeon.

Please provide any relevant documents

Date of discussions	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
11.01.2019	Meeting with Chair	As above. I spoke to Mr Devlin explaining that if there were concerns about any doctor I had a professional responsibility to pursue these concerns to assure patient safety. He agreed.	

55.7

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
On 19th February 2019, Mr Haynes brought SAI Personal Information redacted by to my attention. On the same date, I contacted Mrs Gishkori, Director for Acute Services, about my concerns, based on my review of the SAI and MHPS paperwork. She did not identify any ongoing concerns and expressed the view that he was a "well respected surgeon".
What were those issues of concern and when and by whom were they first raised with you?
Concerns were raised in relation to lack of perioperative assessment, lack of cardiology workup and procedural consent not clearly documented. There was no specific criticism of Mr O'Brien but the patient had been under his care.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
Patient's admission was 9th May 2018.
Please provide any relevant documents
Attachment: sai Personal Information redacted by document located at *Relevant to Acute/Document Number 54/*Personal Information *20190409 Final Report*

55.8

Date of discussions	Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien	Name those present
19th February 2019	Concerns arising from SAI as outlined above. Mr Haynes and I discussed the current difficulties generally in accessing timely preoperative assessment and the complexity of the consent process. We discussed the limitation of CHKS data in relation to identifying trends in perioperative blood loss. We discussed whether there were other specific concerns outside the comments made in the SAI and at that point could not identify further outside what was known already through MHPS.	Mr Haynes
19th February 2019	Concerns arising from SAI as outlined above in the context of previous MHPS process	Mrs Gishkori

55.9

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
11th March 2019, I received Mr O'Brien's appraisals for 2014-2016.
What were those issues of concern and when and by whom were they first raised with you?
I ascertained that, in the course of these, he had not raised reflections about the concerns raised about him leading to MHPS and the recent SAIs involving his patients.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
There was no clear evidence in the Appraisals that his appraiser had been made aware of any concerns. In addition to this, his 2017 Appraisal had not been completed nor had his 2018 Appraisal (for which 360 degree feedback was required) and his Revalidation date was due for renewal on the 4th April 2019. I requested any complaints, SAIs, and medicolegal and coroners' court involvement in relation to Mr O'Brien since his last revalidation. These did not appear to indicate any specific clinical concerns that could be differentiated from long waits at that time.
Please provide any relevant documents
Attach medicolegal excel spreadsheet emailed 8.7.22. Document located at *S21 No 29 of 2022, 211. 20211005 Open Urology Claims* ATTACH COMPLAINTS EXCEL SHEET. Document located at S21 No 29 of 2022, 176. *UROLOGY COMPLAINTS SINCE 2009*

55.10

Date of discussions	Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien	Name those present
11th March 2019	Discussion with Dr Scullion appraiser by phone to confirm that what was contained in the Appraisals was what was known to him and to ascertain whether he had patient safety or other concerns on the basis of the appraisals. He stated that he did not. Received and reviewed all complaints in relation to Mr O'Brien- theme in relation to waiting list Appraisals 2014,15,16 received - Failure to mention and reflect on complaints concerns re probity, insight.	Dr Damian Scullion

55.11

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
On 13th March 2019, Mr Haynes raised concern re SAI by phonecall.
What were those issues of concern and when and by whom were they first raised with you?
Late Diagnosis identified through SAI process
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
This SAI Personal Information redacted by had been approved by Acute Governance at the same time as Mr Haynes had contacted me. The SAI had developed following an IR1 on the 9th May 2018.
Please provide any relevant documents
SAI Personal Information redacted by; This SAI forms part of the Hughes' SAI. *Document located at Relevant to Acute/Evidence Added or Renamed 19 01 2022/Acute/Acute Governance Office/Document No 54/*Patient 92*/20210120 E SAI Final report* Patient 92 Personal Information redacted by

55.12

55.6 Date of discussions	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	**Name those present**
13th March 2019	Mr Haynes contacted me to state that an SAI had been completed in relation to Mr O'Brien's patient. This had not criticised Mr O'Brien but had raised concerns in relation to delays in reaching diagnosis. We discussed the overall waiting times in Urology which were continuing to grow. We discussed whether there were other specific concerns outside the comments made in the SAI and at that point could not identify further outside what was known already through MHPS. We discussed the limitations of CHKS data in identifying surgical concerns.	Mr Haynes

55.13

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
On the 28th March 2019, I referred Mr O'Brien to the GMC, discussion with NHS Resolutions and a deferral in date for revalidation.

What were those issues of concern and when and by whom were they first raised with you?
Despite the determination (not to refer him) following the MHPS Investigation, I had ongoing concerns about these recent SAIs in the context of this doctor's long history of behaviours with the potential to cause patient harm. This referral was also made in the context of the usual governance parameters namely Appraisal, Administrative processes not specifically identifying concerns and before the Hughes SAIs in particular were undertaken.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
Review of MHPS data, including interviews, suggested to me that that these concerns had been known since at least 2015 and it was intimated in the MHPS witness statements that concerns about Mr O'Brien's conduct had been around for a number of years before this, albeit unquantified.
Please provide any relevant documents
ATTACHMENTS : GMC MINUTES AND EMAILS DECEMBER 2018 ONWARDS, *Documents located at S21 No 29 of 2022, 2.* 20220616 E GMC Meeting Minutes and Corrections, 3. 20220616 E GMC Meeting Minutes and Corrections 2, 4. 20220616 E GMC Meeting Minutes and Corrections 2 A1, *Documents located at Relevant to HR, Evidence after 4 November HR, Reference 77, S Hynds no 77, 20181218 - Email - FW SHSCT - "Dr Urology Consultant", 20181218 - Attachment - Email - FW IMPORTAN - Redacted MHPS investigation into AOB, 20190109 - Email - RE SHSCT - "Dr Urology Consultant"- advice to refer, 20190320 - E-mail FW SHSCT - Dr Urology Consultant- advice to refer doctor, 20190322 - Email - RE SHSCT - "Dr Urology Consultant"- advice to refer doctor - Mr Aidan O'Brien - GMC No. 1394911, 20190402 - Email - FW GMC Referral, 20190402 - Attachment - Case Manager Determination AO'B FINAL 280918, 20190402 - Attachment -Return to Work Action Plan February 2017 FINAL, 20190402 - Attachme -December 2016, 20190402 - Attachment -September 2018, 20190402 - Attachment -March 2019 and S21 No 29 of 2022 attachment 5. 20190402 AO'B fitness-to-practise-referral-form*

55.14

	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
14/03/2019	Dr O'Kane discussion with Joanne Donnelly (JD) GMC	Conversation with Joanne Donnelly outlined history and recent concerns in relation to 2 failures, SAIs, pervasive, lack of remorse, guilt and concerns and tendency to blame others including for his own behaviours.	Joanne Donnelly, GMC
28/03/2019	GMC Referral for Mr O'Brien	GMC referral for Mr O'Brien made.	
12/04/2019	GMC ELA Meeting	JD advised and discussed: Learning from this case - During our call we discussed that there may be systems learning opportunities in respect of the approach in this case to the escalation and management of concerns about this doctor and the approach to management of non-participation in appraisal. I am available to support you in your consideration of such learning – we have a routine ELA/RO meeting scheduled for 29 March 19, however if you feel it would be helpful to meet to discuss before then I can make myself available. And please feel free to contact me on my mobile at any time.	JD
29/05/2019	Mr O'Brien Litigation Records	Mr O'Brien litigation history requested and supplied by Trust litigation team.	Litigation Department
20/06/2019	FOI Request to Trust re NCAS	Request for information held by practitioner performance advice service.	NCAS
24/06/2019	Litigation Report re Patient Personal	Litigation Report re Patient Personal received by Trust.	DLS
06/09/2019	Deferral of Mr O'Brien revalidation date by GMC	Email from Dr Scullion informing of GMC decision to defer Mr O'Brien revalidation.	GMC

29/05/2019	Mr O'Brien Litigation Records	Mr O'Brien litigation history requested and supplied by Trust litigation team.	Litigation Department
20/06/2019	FOI Request to Trust re NCAS	Request for information held by practitioner performance advice service.	N C A S
24/06/2019	Litigation Report re Patient Pers onal	Litigation Report re Patient Pers onal received by Trust.	D L S
06/09/2019	Deferral of Mr O'Brien revalidation date by GMC	Email from Dr Scullion informing of GMC decision to defer Mr O'Brien revalidation.	G M C
16/09/2019	Non-compliance with locally agreed action plan (incident outlined 54.8)	until November 2018 when this was stood down by Dr Khan who requested reporting by exception only.	Deviation from Return to work Action Plan as part of MHPS
26/09/2019	Response to GMC – Joanne Donnelly re Request for Further Information	Response Issued to GMC detailing answers to further questions.	
16/10/2019	Appraisal 2018	Appraisal 2018 documentation.	Dr Scullion

22/10/2019	Telephone call to Joanne Donnelly GMC from Dr O'Kane, Medical Director	Telephone conversation with Joanne Donnelly I advised that Mr O'Brien revalidation date is 4 Nov 19. I also advised that Dr O'Brien is engaging in local revalidation processes appraisal. I asked whether a decision has been made yet in relation to referral of Dr O'Brien – as this is potentially relevant to consideration as to whether a deferral recommendation is necessary. Joanne advised that a decision had not as yet been made.	G M C

55.15

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
Monitoring of 2017 Return to Work Action Plan - 16th September 2019
What were those issues of concern and when and by whom were they first raised with you?
Mrs Corrigan made me aware that on she had noted a discrepancy in outpatient dictation and triage.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
This had occurred throughout the period June to September 2019.
Please provide any relevant documents
ATTACHMENT: Email Martina Corrigan 16.09.2019. Document can be located at *Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Martina Corrigan/20190916-email AOB concerns – escalation, 20190916-email AOB concerns - escalation attachment 1 – 6*

55.16

Date of discussions	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
16/09/2019	Non-compliance with locally agreed action plan	Brought to Mrs Corrigan's attention that the assurance she was depending on from Mr O'Brien's PA, Ms Elliott, was not robust as it did not accurately record clinic letters against actual patients seen. Mr O'Brien's compliance with the local agreed action plan was monitored on a weekly basis, with a summary compliance email issued by the service manager to the Case Manager by exception.	Deviation from Action Plan following MHPS.

55.17

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
Absence of Job Plan
What were those issues of concern and when and by whom were they first raised with you?
8th October 2019 – This was raised through a meeting in relation to deviation from Return to Work Plan. This was again raised in an oversight meeting on the 12th February 2020 . Mr O'Brien then announced his plan to retire on the 13th February 2020 and Job planning was pursued to finalise his pension.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
A number of years.
Please provide any relevant documents
ATTACHMENT : Mr O'Brien's Job Planning History. Documents located at *S21 No 29 of 2022, 212. 20060718 Ltr to J Templeton re ex gratia payment, 213. 20111110 E re Amended Job Plan 11-12, 214. Outcome of facilitation process, 215. Job plans and summary screenshot, 216. JobPlan - Mr Aidan O'Brien - 01.01.2020, and Relevant to HR, reference no 15, 20110401-Ref15-AO'Brien-Urology-JobPlan, 20120401-Ref15-AO'Brien-Urology-JobPlan, 20130401-Ref15-AO'Brien-Urology-JobPlan, 20180401-Ref15-AO'Brien-Urology-JobPlan*

55.18 There has been quite a history with this one – with none of the CD's or DMD's able to get a job plan signed off with Mr O'Brien.

55.19 Back in 2006, when the new contract was introduced, Mr O'Brien didn't accept the Trust offer and proceeded to Facilitation. In the end the MD settled with an offer to him of 15.5 PA's plus an extra payment.

55.20 **April 2006 –1 October 2011: Paid 15.5 PA's** Plus an extra payment (This was agreed after a Facilitation meeting with the MF/CX at the time as he didn't sign the job plan offer at the time).

55.21 In an attempt to get updated job plans signed, it proceeded to a facilitation meeting when he didn't agree to his online job plan, quite some time later in October 2011. This resulted in a reduction to **12.75 PA's** via a facilitation meeting with Dr Murphy.

55.22 **October 2011 – 1 March 2012: Paid 12.75 PA's 8% on-call**

55.23 As part of the original facilitation, it had been agreed the job plan would reduce down to 12 PA's from 1 March 2012. You will see from attached documents; time for administration is mentioned a lot by Mr AOB.

55.24 **1 March 2012 – 11 May 2014**: **Paid 12 PA's 8% on-call** (As per previous Job Plan Facilitation)

55.25 In 12 May 2014, there was just a change to the on-call frequency outside of normal job planning process, which resulted in all consultants being reduced from 8% on-call to 5% on-call.

55.26 1 March 2012 until he retired; he was paid 12 PA's. He didn't engage with the job planning system - from the attached job plans and summary screenshot none were signed off by Mr O'Brien.

55.27

55.9 Date of discussions	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
8th October 2019	Discussion re deviation from 2017 Action Plan	Review of concerns in relation to deviation from Action Plan . Mrs Corrigan and Mr McNaboe were made aware that this had to be undertaken and arranged to meet with Mr O'Brien who then stated that he did not want to have a discussion in the middle of a clinic. Mr McNaboe then met him informally and he gave an undertaking he would complete Job Planning. ATTACHMENT : EMAILS OUTLINING CONCERNS AND AGENDA FOR MEETING/ EMAIL WITH Melanie's minute. Documents located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20191004 Email from Dr O'Kane re AOB escalation concerns, Attachment 1 to Email from Dr O'Kane re AOB escalation concerns, Attachment 2 to Email from Dr O'Kane re AOB escalation concerns, Attachment 3 to Email from Dr O'Kane re AOB escalation concerns, Attachment 3(i) to Email from Dr O'Kane re AOB escalation concerns. Relevant to Acute/Evidence after 4 November Acute/Document No 77/Melanie McClements/20191030 AOB Notes	Meeting with Siobhan Hynds, Ronan Carroll, email communication with Mr Haynes
12th February 2020	Discussion re deviation from 2017 Action Plan	Directors' Oversight meeting noted that this had not been completed and Mr Haynes and Mr McNaboe were asked by me to take this forward.	

55.28

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
Concerns re discrepancy in Patient Administration System records of patients on waiting list and those being placed on a surgical theatre list by Mr O'Brien
What were those issues of concern and when and by whom were they first raised with you?
The concerns were brought to my attention by Mr Haynes on the 11th June 2020 at 12.47 by email following an email to him on the 7th June at 22.35 from Mr O'Brien. Mr Haynes had recognised that there was a discrepancy between those patients on PAS and those on theatre lists and realised, as a result, that patients had not been referred in a timely fashion. This led to a review outlined below, discussions with and notifications to the Department of Health, NHS Resolutions, HSCB and the GMC. Mr O'Brien then wanted to retract his decision to retire and challenged the Trust decision not to invite him to work part-time on retirement. This decision was made on the basis of concerns in relation to potential patient safety issues. This series of events then led to the announcement of a Public Inquiry into Urology Services.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
Unknown at the time of discovery but throughout current Lookback timeframe since January 2019 in first instance.
Please provide any relevant documents
ATTACHMENT : Emails Mr Haynes. Document located at Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, no 77 – emails Mr Mark Haynes – AMD and Consultant Urologist, 20200611-email patients to be added to urgent bookable list – att9 Most recent Lookback submission to USI. Document located at *S21 No 29 of 2022, 217.Lookback Review Letter Update 180722* ALL OF THE ATTACHMENTS OUTLINED BELOW

55.29

Date of discussions	Event	Details **Detail content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
11/06/2020	Email to Mr Mark Haynes from Mr O'Brien 07/06/2020	Patient Lists (dealt with in more detail in answer to question 57).	Maria O'Kane

12/06/2020 - 15/06/2020	Review of Mr O'Brien Elective Practice 1st January 2019 – 31st May 2020	**Review of emergencies surgeries** **Concerns and or follow-up** There are 11 patients who have been readmitted but I am not able to determine if they had stent removed as there is no letter dictated on NIECR (I will have to request notes for these 11 patients) I have highlighted in RED 11 patients who I need to get notes for as no plan or they are not appearing on either PAS or NIECR so need looked at in more depth 9 patients will need followed up due to only having had their stent done or have no date yet (now I know about them) **Other issues** Patients being brought in electively and being operated on the emergency list Other patients admitted for issues not relating to stents (e.g. and no letters dictated or on PAS) Delay in dictation from clinics/theatres until letter was completed	Martina Corrigan ATTACHMENTS. Documents located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Melanie McClements/20200615 AOB elective emerg – A4 Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20200616 Email from M Corrigan re Emergencies Jan 19 to Jun 2020. S21 No 29 of 2022, 20200616 Email from M Corrigan re Emergencies Jan 19 to Jun 2020 A1, A2 Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20200703 Email from R Carroll

		LPP Information redacted by the USI [redacted]	June Turkington, DLS
05/07/2020	Email re concerns of current outstanding cases	Vivienne Toal and Melanie McClements discussion re position on patients from a clinical perspective	Martina Corrigan ATTACHMENTS. Document located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20200706 Email from R Caroll 2
06/07/2020	Email commentary on cases	Comments on identified cases from Mr Mark Haynes	Mr Mark Haynes, Martina Corrigan, Ronan Carroll, Melanie McClements, Vivienne Toal ATTACHMENTS. Document located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20200706 Email from Mr Haynes

Donnelly 06/07/2020	Review of Mr O'Brien's Elective Practice 1st January 2019 – 31st May 2020	**Emergencies** *As discussed this was a quick exercise just to determine if patients had stents or not and then I had picked up a few other issues and noted these down.* *There were 147 emergencies during the period 1 January 2019 until end of May 2020 (these were filtered for the times that that he was on call)* *There were 60 patients NOT requiring a stent in their procedure* *There were 41 patients who had their stent removed and I have got this information from NIECR* *No concerns flagging with these 101 patients* **Electives** As discussed – 334 <u>elective in-patients</u> records looked at: 1- 36% 120 patients - had a delay in dictation – (delay ranged from 2 weeks – 41 weeks) 40% had no concerns (48 patients) 2- 11% 36pts - had no entries in NIECR 1- <u>60% of delayed dictation patients had an issue (72 patients)</u>	Martina Corrigan ATTACHMENTS. Document located at Relevant to HR/Evidence after 4 November HR/Reference 77/V Toal no 77/20200706 Email from Mr Haynes

08/07/2020	Zoom call with Joanne Donnelly	Discussion of Mr O'Brien information with Joanne Donnelly, ELA, GMC.	Joanne, Dr Maria O'Kane, S Wallace ATTACHMENTS. **Document located at** S21 No 29 of 2022, 218. 20200708 Note of Zoom Mtg with Joanne Donnelly

Date of discussions	Event	**Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien**	Name those present
29/05/2019	AOB Litigation Records	AOB litigation history requested and supplied by Trust litigation team	Litigation Department ATTACHMENTS. Document located at *S21 No 29 of 2022, **219**.AOB Litigation History*
20/06/2019	FOI Request to Trust re NCAS	Request for information held by practitioner performance advice service	NCAS ATTACHMENTS. Document located at Relevant to MDO/Evidence Added or Renamed 19 01 2022/No 77/Zoe Parkes additional evidence/20190620 FOI letter from NCAS July 19 re Dr A OBrien
24/06/2019	Litigation Report re Patient Personal Info	Litigation Report re Patient Personal Info received by Trust	DLS ATTACHMENTS. Document located at S21 No *29 of 2022, 220. 20190629 Litigation Report re* Personal Info
06/09/2019	Deferral of AOB revalidation date by GMC	Email from Dr Scullion informing of GMC decision to defer AOB revalidation	GMC ATTACHMENTS. Document located at S21 No 29 of 2022, ***221. 20190906 E re AOB Appraisal-Revalidation from D Scullion S***
26/09/2019	Response to GMC – Joanne Donnelly re Request for Further Information	Response Issued to GMC detailing answers to further questions	Dr Maria O'Kane ATTACHMENTS. Document located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no%2077/20191008%20 Attachment - 20190926_LtrJD_AOB_InformationRequest
16/10/2019	Appraisal 2018	Appraisal 2018 documentation	Dr Scullion ATTACHMENTS. Document located at Relevant to HR/Evidence Added or Renamed 19 01 2022/No 77/Zoe Parkes Appraisal email/2018 Appraisal Mr A O'Brien (Dr D Scullion) 161019, S21 *No 29 of 2022, 222. Job Plan 05 4 18 AOB, 223. Case review structured reflective template*

22/10/2019	Telephone call to Joanne Donnelly GMC from Dr O'Kane, Medical Director	Telephone conversation with Joanne Donnelly Dr O'Kane advised that AOB revalidation date is 4 Nov 19. Dr O'Kane also advised that Mr O'Brien is engaging in local revalidation processes appraisal. Dr O'Kane asked whether a decision has been made yet in relation to your referral of Mr O'Brien – as this is potentially relevant to your consideration as to whether a deferral recommendation is necessary. Joanne advised that a decision has not as yet been made.	GMC ATTACHMENTS. Document located at S21 No 29 of 2022, *224. 20191024 E from JD SHSCT Dr O'Brien GMC No 1394911*
12/02/2020	Meeting of Oversight Group - MHPS case AOB	To have a meeting / conversation with Ted McNaboe, Clinical Director regarding him meeting with AOB regularly and seeking assurances through that supervisory process that AOB was working in accordance with the triage process, was not holding notes at home and was undertaking all digital dictation immediately following each individual clinical contact with a patient.	ATTACHMENTS. Documents located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20200214 Email Meeting of Oversight Group – MHPS case Mr A O'Brien Relevant to HR/Reference no 1/2020 _Retirement Resignation/2020 2.13 Email trail between AOB and Medical Staffing re retiring return

		MOK spoke with Mr Ted McNaboe and Mr Mark Haynes to ensure an agreed job plan is in place for AOB as a matter of priority or to escalate to the next stage of the job planning process. (In the interim Mr O'Brien announced his retirement on the 13th February 2020) Maria to seek assurance from Damien Scullion that AOB is completing annual appraisals. MO'K responded to GMC and RQIA in respect of their recent correspondences to the Trust seeking additional information about the case. SH to draft a terms of reference for the independent review of the SAI recommendations and the MHPS review recommendation. Terms of reference to go to the Group for agreement. MMcC to share SAI reports and recommendations with Siobhan for drafting of the TOR. Maria spoke to Dr Rose McCullough (GP) to undertake the independent review. This was hard to	

		establish and was subsequently undertaken by Mrs Anita Carroll. Maria to update Shane VTto progress AOB's Grievance process.	
13/04/2020	Email from Martina Corrigan to Medical HR	Email from Martina Corrigan to Zoe Parks attaching copy of AOB's retirement letter which was emailed to her on 26 March 2020 @ 23:17, *"Each day my intent to send you a 'Letter of Retirement' has fallen by the wayside. I have managed to remember to do so this evening. It's a surreal moment, after 28 years!"*	Martina Corrigan, Zoe Parks ATTACHMENTS. Document located at Relevant to HR/Reference no 1/2020 _Retirement Resignation/2020 4 13 Letter and Email between AOB and Martina Corrigan
15/04/2020	Malcolm Clegg email to HoS Surgery	Malcolm Clegg responded to Martina's email advising that AOB's application for pension benefits is in hand and will be processed as a leave from 30 June 2020. Also advised that Martina would need to inform HR if it has been agreed for Dr O'Brien to return to work following his retirement so he can be reinstated on the payroll.	Martina Corrigan, Malcolm Clegg ATTACHMENTS. Document located at Relevant to HR/Reference no 1/2020 _Retirement Resignation/2020 3 26 Email AOB and Martina Corrigan re notice of Retirement
08/06/2020	AOB Contact to Medical HR	Medical HR took a call from AOB – he wanted a copy of correspondence from HR acknowledging his retirement letter. No	Niamh O'Hanlon

		formal acknowledgement letter issued to AOB as all HR processes in relation to his pension application had been completed on 6 March 2020 and a copy of his retirement letter was not received until 13 April 2020.	
09/06/2020	Letter to AOB from Medical HR	Letter issued to AOB from Medical HR advising that all HR processes had been completed in relation to his pension application. Follow up email from AOB to AMcN following telephone call requesting a copy of his AW6 form – copy sent @ 12:47. "In Confidence" email sent from ZP to Mr Haynes	Medical HR Zoe Parks
09/06/2020-12/06/2020	Letter from AOB to Director HROD	Letter from AOB to Vivienne Toal – letter of notification of revocation of application for retirement and of indication of withdrawal from full time employment.	Vivienne Toal ATTACHMENTS. Document located at Relevant to HR, Evidence after 4 November HR, Reference 77, V Toal no 77, 20200609 Email from Mr AOB to VToal with letter att, 20200609 Ltr attachment to email from Mr AOB to VToal
11/07/2020	Letter to AOB from Mr Mark Haynes, AMD SEC	Letter to AOB from Mr Mark Haynes outlining a summary of concerns identified from scoping exercise	Mr Mark Haynes ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/reference 51 (k)/AOB Tughans SW/20200711 AOB Attachment Letter to AOB from MHaynes FINAL, 20200711 Mr

			O'Brien Attachment Mr A OB Summary of
16/07/2020	Letter from Tughans to Trust	Response from Tughans to letter from Mr Mark Haynes	Tughans ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/reference 51 (k)/AOB Tughans SW/20200716 FW
17/07/2020	**Mr O'Brien retires.**		
24/07/2020	AOB Internal Oversight Meeting	SH – requests to go through solicitors to collect Trust equipment and any personal items that require returned. Grievance is proceeding next Thursday, expect that this will continue. MOK – how long will outcome take. SH – longer than one day, given complex elements it will take longer, uncertain how long this will take. MOK – Admin Review – Rose McCullagh – clear description of what is required from the admin process – this point going forward. Requirement for a tor to be formed and agreed with Ahmed Khan. SH – LPP Information redacted by the USI [redacted]	Siobhan Hynds, Ronan Carroll, Maria O'Kane, Martina Corrigan, Mark Haynes, Stephen Wallace ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Meeting Notes Jul 20-Oct 21 SW/20200724 MNOTES - 24.07.2020 1315pm AOB Internal Local Meeting

		LPP Information redacted by the USI [redacted] MOK – requirement for RCS to advise on any potential lookback exercise. Actions: SW agree ToR with AK re Admin Review RC MC – screen SAIs LPP Information redacted by the USI [redacted] SW – contact RCS	
28/07/2020	Call with RCS Invited Review Service (IRS)	Maria O'Kane Mark Haynes Martina Corrigan Stephen Wallace Lorraine Hart (Royal College IRS Lead) MOK and MH gave background to AOB, advised of retirement 17th July. Advised of email from AOB to MH asking for patients to be added to urgent bookable list. Advised of lookback carried out by Martina – some patients who hadn't been added to waiting lists. CT scan results not actioned, pathology required action. Two patient interactions flagged which flagged MDT outcomes not being enacted and processes. MOK advised that AOB is being investigated by	Maria O'Kane Mark Haynes Martina Corrigan Stephen Wallace Lorraine Hart (Royal College IRS Lead) ATTACHMENTS. **Document located at** Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Meeting Notes Jul 20-Oct 21 SW/20200728 MNOTES - 28.07.2020 1230pm IRS RCollege Surgery

		GMC. MC advised of the lookback parameters already carried out. MOK – we have been in contact with NCAS also, deficit of previous clinical practice. MOK – requirement for support from IRS to identify scale of clinical lookback required. LH to discuss with RCollege colleagues on potential for IRS input	
31/07/2020	Early Alert Issued to DoH	Early Alert issued to the DoH	Dr Maria O'Kane ATTACHMENTS. **Document located at** Relevant to MDO, reference no 76 (ii), 20200826_HIGH IMPORTANCE Early Alert SHSCT_ATTACH MENT
05/08/2020	Call with RCS Invited Review Service	MOK gave background to DOH Early alert, PH confirmed LH IRS had briefed him on the background to the case. MOK confirmed AOB had retired and MOK has made contact with GMC and NHS Resolutions. Initial conversation with RQIA. MOK advised we are currently progressing 6 SAI's. MOK identified that a lookback should be	Phil Higgs – HoS IRS Jessica Govier-Speirs – Administrator IRS Maria O'Kane Melanie McClements Ronan Carroll Martina Corrigan Stephen Wallace ATTACHMENTS. **Document located at** Relevant to MDO/Evidence after 4 November MDO/reference no 76 (vi)/RCS SW/20200508 MNOTES - 05.08.2020 1130am – RCS IRS

		undertaken, limited lookback at this time. PH RCS link with British Association Urology Surgeon society, 5 years is likely appropriate, a sample will be required. PH 10% /15%. MOK what is the timeframe for a review – Oct to Nov. PH – can do a sample of notes then advise if need to go further. 2 day review 40 cases costs £18k then expenses and VAT.	
06/08/2020	Telephone Call with Deputy Chief Medical Officer	Summary of discussion 1. Described Early Alert and concerns re extent of patient safety / SAI – potentially six cases identified 2. Summarised discussion with IRS, GMC,NHS Resolutions 3. Advised PHA as below 4. Asked for critical friend support from DOH/PHA ,	Dr Maria O'Kane ATTACHMENTS. **Document located at** : S21 No 29 of 2022, *6. 20200811 E Discussion with Naresh Chada*

		advice re extent of look back, any blindspots – stated would consider and come back to me.	
17/08/2020	Email update to GMC	Updated information sent to GMC	Chris Brammall, Maria O'Kane, Stephen Wallace ATTACHMENTS. Document located at S21 No 29 of 2022, *225. 20200817 E to General Medical Council - Mr O'Brien Encryption and 226. 20200817 E to General Medical Council - Mr O'Brien Encryption A1* also Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20200817 Attachment – Appendix 1 (i) Job_Plan_View_-_Mr_O'Brien_Aidan_-_01_Apr_2018, 20200817 - Attachment - Appendix 1 (ii) Job_Plan_View_-_Mr_O'Brien_Aidan_-_01_Apr_2013, 20200817 - Attachment - Appendix 2 Report to HSCB 29.5.2020, 20200817 - Attachment - Appendix 3 (i) The Northern Ireland Cancer Network, 20200817 - Attachment - Appendix 3 (ii) Revised Prostate Diagnostic Pathway December 2019, 20200817 - Attachment - Appendix 4 (i) Service User A Notes, 20200817 - Attachment - Appendix 4 (ii) Service User B Notes
24/08/2020	Meeting with SHSCT and DoH	MOK gave background on case dating from AOB's offer of retirement. Had already had a MHPS investigation	Jackie Johnston Maria O'Kane Stephen Wallace

		on the back of 6 SAIs previously. Background given regarding oversight committee process, background given regarding the GMC made. MOK gave background to the email trail which alerted the latest concerns regarding his practice. A quick snapshot of roughly 400 patient records which identified more areas of concern. MOK – had a conversation with DLS re not being his RO. GMC have stated that we should follow MHPS currently, advice obtained from NHS Resolutions, communicated with PHA and HSCB. • Question re Panel composition • Question re Communications • Question re Communicating with families • Question re lookback on patients - PHA to advise on developing the terms of reference, Paul Cavanagh Commissioner will also have a role in this. • Jackie will consider further re MHPS	ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/reference no 76 (i)/DOH SW/20200824 MNOTES - 24.08.2020 1400pm AOB DoH

		Contact Brid re terms of reference or Olive, Paul Cavanagh	
27/08/2020	HSCB / PHA Call	MOK gave background to case. AMD SEC found delays relating to patient management from email issued from clinician. A short review of cases was conducted of cases since Jan 2019 which identified approx. 30% of cases. SAI's have been identified via MDT processes also, Dermot Hughes has agreed to conduct these as an external chair. MOK gave additional details on case including initiatives to support review patients. MOK explained that clinician is no longer connected to the organisation or RO. BF – SAI level 3 SAI, IRS in parallel and review of urology cancer patients MC – gave details of clinicians activity over the last 5 years including outpatients, inpatients and surgeries. BF – could the operative procedures be taken from electronic records, MC – yes	Martina Corrigan Melanie McClements Ronan Carroll Maria O'Kane Stephen Wallace Brid Farrell Paul Cavanagh ATTACHMENTS. **Document located at** Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Meeting Notes%20Jul%2020-Oct 21 SW/20200827 MNOTES - 27.08.2020 1400pm AOB Paul Cavanagh – Brid Farrell

		they can. PC need to discuss potential risks with private patients with DoH tomorrow. BF can BAUS or other subject matter	
28/08/2020	DOB/PHA/HSCB/SHSCT meeting	JJ – not sure if there is a process regarding MHPS for retired doctor, referral to the GMC. MOK confirmed AOB disconnected on 29th July via GMC / RO. MOK asked should a formal alert be made to the DoH. JJ agreed to respond to MOK to notify of required actions. JJ potential lookback exercise. MOK 30% of work we have looked at since Jan 2019 we are not happy with. BF Is there anything we can say with confidence that we have no concerns regarding. RC we can describe to date what we have found cases with varying degrees of Ca. MOK there has been no discernible pattern to this. Sample size of 80 can be supported by the RCS IRS. BF – Level 3 is appropriate, stay with the policy which does	Jackie Johnston Maria O'Kane Stephen Wallace Martina Corrigan Paul Cavanagh Ronan Carroll Brid Farrell ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/Reference no 77/Meeting Notes Jul 20-Oct 21 SW/20200828 MNOTES - 28.08.2020 1400pm AOB DoH

		JJ – Agree a date when we go public on this, DoH decide if a statement to the assembly is required. SAI terms of reference could reference potential systems failure in identifying non-compliance. PC implications for private patients, is there responsibility for those patients. Do we have specific responsibilities regarding this.	
09/09/2020	Tughans to DLS	Letter confirming AOB will not be partaking in MHPS process	Tughans Letter to Trust September 2020 ATTACHMENTS. **Document located at** Relevant to MDO/Evidence after 4 November MDO/reference 51 (k)/AOB Tughans SW/20200909 Letter from Tughans to Trust
29/09/2020	Vivienne Toal, Director HROD to Tughans	Response from the Trust regarding MHPS process	Tughans ATTACHMENTS. **Document located at** Relevant to HR/Reference no 1/2020 Tughans related correspondence/2020 09 SEPT.29th.Response to TUGHANS ltr 9th Sept.sent 29092020
16/10/2020	Department of Health	Alert Letter	CMO ATTACHMENTS. **Document located at** Relevant to MDO/Evidence after 4 November MDO/reference no 73/20201127 Alert Letters Xerox Scan_22102020084453 Attachment 2
25/10/2020	DLS to Tughans	Letter increasing scale of concerns which continue to come to light as a	DLS ATTACHMENTS. **Document located at** Relevant to HR/Reference no 1/2020

		result of the review exercise currently ongoing within the Trust regarding AOB practice.	Media Interest/25.10.20 Letter to Tughans Mr A O'Brien
30/10/2020	Tughans to DLS		ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/reference 51 (k)/AOB Tughans SW/20201029 Letter from Tughans to DLS
9/11/2020	Stephen Wallace to GMC	Updated communication	Stephen Wallace Chris Brammall Maria O'Kane ATTACHMENTS. Document located at S21 No 29 of 2022, *227. 20201109 General Medical Council - Mr O'Brien – A6*
24/11/2020	CMO to Regional CX's regarding cancellation of professional alert letter	Communication from CMO regarding the cancellation of the professional alert letter issued on 16th October 2020.	CMO ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/reference no 73/20201127 Alert Letters Item 4392 – Cancellation NI Alert Letter AOB 24 November 2020 Attachment 1
24/11/2020	DLS to Tughans	Letter detailing supports available to patients impacted. Request to speak to MOK directly included in body of letter	DLS ATTACHMENTS. Document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Melanie McClements/20201124 AOB from DLS and A1
24/11/2020	Ministerial Statement	Statement re: Covid-19	DoH ATTACHMENTS. Document located at S21 No 29 of 2022, *228. Health Minister's Statement re Covid-19*
29/11/2020	Response from MOK to CB, Investigation officer of GMC, information request	'Raising additional fitness to practise concerns' form re: AOB (dated 27/11/20), 'MRI Pelvis prostate Report'(dated 27/05/2020) and accompanying letter which highlights reports that AOB	MOK ATTACHMENTS. Document located at Relevant to MDO/Evidence after 4 November MDO/reference no 73/20201129 RE Mr O'Brien (GMC reference C1-2598136964) Encryption, 20201129 RE Mr O'Brien (GMC reference C1-2598136964) Encryption LtrGMC-AOB Attachment 1, 20201129 RE

		continues to actively practice privately.	Mr O'Brien (GMC reference C1-2598136964) Encryption DC9662 Attachment 2, 20201129 RE Mr O'Brien (GMC reference C1-2598136964) Encryption MRI Pelvis prostate report Attachment 3
03/12/2020	Notes shared with GMC	Patient notes requested by GMC (13/11/2020) Summary of SAIs shared within body of the email. Patients Patient 14, Patient 11, Patient 13, Patient 12 and Patient 10	Attachments. Document located at Relevant to MDO/Evidence after 4 November MDO/reference no 73/20201203 Urology – Copies of SAI Notes Encryption, 20201203 Urology - Copies of SAI Notes Encryption Patient 13 copy notes, 20201203 Urology - Copies of SAI Notes Encryption Patient 10 copy notes, 20201203 Urology - Copies of SAI Notes Encryption Patient 11 copy notes, 20201203 Urology - Copies of SAI Notes Encryption Patient 14 copy notes, 20201203 Urology - Copies of SAI Notes Encryption Patient 12 Copy notes
07/2022	Ongoing updates to GMC	Outlines progress to date	Will be shared as available

ATTACHMENTS : GMC MINUTES AND EMAILS DECEMBER 2018 ONWARDS documents located at *S21 No 29 of 2022, 2. 20220616 E GMC Meeting Minutes and Corrections, 3. 20220616 E GMC Meeting Minutes and Corrections 2, 4. 20220616 E GMC Meeting Minutes and Corrections 2 A1, Documents located at Relevant to HR, Evidence after 4 November HR, Reference 77, S Hynds no 77, 20181218 - Email - FW SHSCT - "Dr Urology Consultant", 20181218 - Attachment - Email - FW IMPORTANT - Redacted MHPS investigation into AOB, 20190109 - Email - RE SHSCT - "Dr Urology Consultant"- advice to refer, 20190320 - E-mail FW SHSCT - Dr Urology Consultant- advice to refer doctor, 20190322 - Email - RE SHSCT - "Dr Urology Consultant"- advice to refer doctor - Mr Aidan O'Brien - GMC No. 1394911, 20190402 - Email - FW GMC Referral, 20190402 - Attachment - Case Manager Determination AO'B FINAL 280918, 20190402 - Attachment -Return to Work Action Plan February 2017 FINAL, 20190402 - Attachment -December 2016, 20190402 - Attachment -September 2018, 20190402 - Attachment -March 2019 and S21 No 29 of 2022 attachment 5.*

20190402 AO'B fitness-to-practise-referral-form

ATTACHMENTS: INTERNAL TRUST UROLOGY OVERSIGHT MINUTES document located at Relevant to PIT, Evidence Added or Renamed 19 01 2022, No 76 – minutes and agendas with attachments, Internal Meetings

ATTACHMENTS: UROLOGY ASSURANCE OVERSIGHT MINUTES DOH documents located at *S21 No 29 of 2022, 229. 20201030 DOH SHSCT Uro Meet, 230. 20201106 DOH SHSCT Uro Meet, 231. 20201106 DOH SHSCT Uro MEET A1, 232. 20201113 DOH SHSCT Uro Meet, 233. 20201113 DOH SHSCT Uro Meet A1, 234. 20201120 DOH SHSCT Uro Mtgs, 235. 20201120 DOH SHSCT Uro Mtgs A1, 236. 20201204 DOH SHSCT Uro Meet, 237. 20201204 DOH SHSCT Uro Meet A1, 238. 20201218 DOH SHSCT Uro Meet, 239. 20201218 DOH SHSCT Uro Meet A1, 240. 20210108 DOH SHSCT Uro Meet, 241. 20210122 DOH SHSCT Uro Meet A1, 242. 20210122 DOH SHSCT Uro Mtgs, 243. 20210111 DOH SHSCT Uro Mtgs A1, 244. 20210319 DOH SHSCT Uro Meet, 245. 20210319 DOH SHSCT Uro Meet A1, 246. 20210416 DOH SHSCT Uro Agenda, 247. 20210416 DOH SHSCT Uro Agenda A1, 248. 20210514 DOH SHSCT Uro Meet, 249. 20210514 DOH SHSCT Uro Meet A1, 250. 20210618 DOH SHSCT Uro Meet, 251. 20210618 DOH SHSCT Uro Meet A1, 252. 20210906 DOH SHSCT Uro Meet, 253. 20210906 DOH SHSCT Uro Meet A1, 254. 20210122 Urology Assurance Group minutes, 255. 20210906 Assurance Group minutes*

ATTACHMENTS: MINUTES OF MEETINGS WITH ROYAL COLLEGES OF SURGEONS, PHYSICIANS AND BRITISH UROLOGY SOCIETY document located at Relevant to MDO, Evidence after 4 November MDO, reference no 76, RCS – MOK, RCS - SW and Reference 76 (other) British Association of Urological Surgeons SW

ATTACHMENTS : EMAILS REFLECTING DISCUSSIONS WITH DR NARESH CHADA DEPUTY CMO AND JACKIE JOHNSTON DOH IN THE ABSENCE OF DR MCBRIDE CMO document located at S21 No 29 of 2022, *6. 20200811 E Discussion with Naresh Chada, Relevant to MDO/Evidence after 4 November MDO/reference no 76 (i)/DOH MOK/20200904_Fwd alert letters, 20200904_Fwd alert letters_ATTACHMENT, 20200821_RE HPRM MM 0121 2020 – Email from Maria O'Kane – CONFIDENTIAL EARLY ALERT - Urology_1, 20200903_RE Today's Zoom Meeting, 20200917_FW alert letters re SHSCT Urology EA (OFFICIAL SENSITVE) and Relevant to MDO/Evidence after 4 November MDO/reference no 76 (i)/DOH SW/20200805_Deputy CMO Call with Dr O'Kane SHSCT*

ATTACHMENT : EMAILS DR MCBRIDE document located at Relevant to MDO/Evidence after 4 November MDO/reference no 76 (i)/DOH MOK/20200819_FW HPRM MM 0121 2020 Email MOK CONFIDENTIAL EARLY ALERT – Urology, 20200819_FW HPRM MM 0121 2020 - Email MOK - CONFIDENTIAL EARLY ALERT - Urology_ATTACHMENT 20200820_FW HPRM MM 0121 2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT – Urology, , 20201014_FW VERY URGENT HPRM MM 0121 2020 – Email from Maria O'Kane – CONFIDENTIAL EARLY ALERT – Urology, 20201015_RE VERY URGENT HPRM MM 0121 2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT – Urology

ATTACHMENTS: PRACTIONERS PERFORMANCE (NCAS) SUMMARISED DISCUSSIONS document located at Relevant to MDO, Evidence Added or Renamed 19 01 2022, No 77, Zoe Parkes Additional Evidence, 20160913 NCAS ADVICE LETTER AOB, 20190620 - FOI letter from NCAS July 19 re Dr A Obrien, 20160913 -

LETO_160913_To+RB_Advice+letter_13 September 2016, 20161229 - LETO_161229_Advice+Letter_29Dec2016, 20161229- NCAS ADVICE LETTER 29 December 2016, 20181106 - NCAS ADVICE LETTER 6 November 2018, 20180921 - NCAS ADVICE LETTER 21 September 2018 and 20190719 - NCAS 18665 email re Dr AOB, Relevant to MDO, reference no 36, 20200710RE Confidential Personal – Case 18665, 20200710RE Confidential Personal – Case 18665 Attachement RE Confidential Personal – Case 18665 Attachment LETO, 20201027 FW Case 18665 – RESENDING, 20201029 MNOTES - 29.10.2020 1030am Colin Fitzpatrick - NHS Resolutions, 20201102 Letter - NCAS +to+ECO+-+advice+letter+18665, Relevant to MDO, Evidence after 4 November MDO, reference no 68, NCAS NHS Resolutions SW, 07072020 AOB, Relevant to MDO Evidence Added or Renamed 19 01 2022, No 68 (iii), NHS Resolutions MOK, 20200711_RE Confidential Personal – Case 18665

Reflections on what I know now compared with what I knew at in Spring 2019

55.30 The Serious Adverse Incidents chaired by Dr Johnston (where harm had been caused to patients as a result of these failings) were progressing before I arrived and were reported in May 2020. These worked to clearly defined Terms of Reference and Dr Johnston did not report any patient concerns directly to me while the SAIs were being completed. In retrospect, I believe that the MHPS determinations inadvertently gave the system a false assurance about Mr O'Brien's practice as it was unaware of the difficulties in the Uro-oncolgy system which were not fully known to the staff interviewed in the course of this and were not identified as part of the Johnston SAIs.

55.31 When I reviewed Mr O'Brien's Appraisals, Complaints, Serious Adverse Incidents and Medicolegal cases available for the previous 5 years at that time, in addition to CHKS data, (as outlined in answer to question 55) these did not suggest to me that there had been concerns raised about Mr O'Brien's actual clinical ability and were thought to be largely in relation to waiting list management. ATTACHMENTS 20211005 Open Urology Claims. Document located at *S21 No 29 of 2022, 211. 20211005 Open Urology Claims.*

55.32 Given what was uncovered subsequently following June 7th 2020 in relation to Mr O'Brien's prescribing practices of Bicalutamide and his clinical management of patients who required further investigation or surgery, I regret that I accepted these assurances and did not ask for a more comprehensive review of his clinical work at that time.

55.33 Knowing what I know now, I would have asked for a comprehensive review of the parameters mentioned in (ii) including a consideration as to the quality and robustness of the Appraisals, Complaints' responses and the SAIs and ask for a sample of his clinical work to be undertaken, potentially using Clinical Audit and Structured Clinical Review Process or Global Trigger Tool, by a group of senior medical leaders and directors. This process is now developing through the Doctors' and Dentists' Oversight Group and a Governance Trigger Tool addressing concerns is being developed alongside A Just Culture Guide to managing doctors in difficulty together with the Directors' SAI Oversight Group. I would also have sought robust feedback from GPs and the MDM in addition to the Urology Service.

ATTACHMENTS: TOR DDOG document located at S21 No 29 of 2022, 74. TERMS OF REFERENCE DOCTORS AND DENTISTS OVERSIGHT GROUP
DIRECTORS' OVERSIGHT GROUP document located at S21 No 29 of 2022, 41. SERIOUS ADVERSE INCIDENT EXECUTIVE DIRECTOR OVERSIGHT GROUP TOR
A Just Culture Guide document located at S21 No 29 of 2022, 256. A Just Culture Guide
S21 No 29 of 2022, 20200701 Newsletter Summer ed. Medical Appraisal and Revalidation

55.34 The MHPS investigation case managed by Dr Khan and SAIs chaired by Dr Johnston did not raise any of the concerns about Multidisciplinary Team (MDT) working, Preoperative assessment, Prescribing, Investigation and Patient Follow-up, failures that were later identified in the SAIs chaired by Dr Dermot Hughes, following the discrepancy in theatre and PAS discovered in the email sent from Mr O'Brien to Mr Haynes on the 7th June 2020.

55.35 On review of the witness statements that formed part of the MHPS investigation, I was also concerned by Mr O'Brien's attitude to the SAIs and this was reflected in the

report that Dr Chada had submitted as Case Investigator which I discussed with her in the course of January 2019 to check that my understanding of her report was correct. I have not noted the date. ATTACHMENT: Dr Chada MHPS Case Investigator Report. document located at *Relevant to HR, Reference No 1, MHPS Investigation Report, MHPS Investigation, Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018*

55.36 Mr O'Brien's responses to concerns raised about patients and his behaviours appeared to be minimised and tardy. ATTACHMENT: SUMMARY OF MR O'BRIEN'S RESPONSES TO SERIOUS ADVERSE INCIDENTS 2020 REPORT WITNESS STATEMENTS AND MAINTAINING HIGH PROFESSIONAL STANDARDS INVESTIGATION 7: PAGE 21- 30. *Document located at Relevant to HR, Reference no 1, MHPS Investigation Report, Mr O'Brien response to the MHPS investigation – APP15*

55.37 From my review of these, my perception was that Mr O'Brien had a tendency to blame others, particularly managers, rather than to accept any responsibility for his actions and their impact on patient care, suggesting lack of insight. He did not appear to express any concern or remorse that patients had come to harm or be concerned about the impact of his actions on the psychological safety of his colleagues. He did not appear curious about the process for the patients that he had not triaged or dictated. He failed to acknowledge that part of the reason his case load was high, and he had more surgical lists and thus more work, was because he was admitting private patients onto his NHS waiting lists. It was clear from his narrative that he had been aware that he had not been triaging patients and, although he had protested reportedly about this, he does not appear to have informed anyone that he had not been doing this. Dr Chada comments on this in her report. He stated that the process for undertaking this was not clear to him, yet he had not appeared to approach others for help in defining. He stated that he believes it was better to talk to patients than to tick boxes but, unfortunately for a significant number of patients, it appears he did neither. When asked about storing patient records at home, he stated that this did not disadvantage other specialties. There appeared to be a lack of concern about the inappropriateness of this and the impact this could have potentially on patient care and the additional burden of work for his colleagues as a result. There was suggestion in his response that his processing of

patients was 62% and that he prioritised the most urgent. Given that, in his response, he had vastly underestimated the numbers of patients and clinics undictated, this seemed implausible. In addition to this, his sense that "he had a frustration with the preoccupation about dictating at the end of clinics by some colleagues" and that he found the "allegation deplorable" in relation to prioritising private patients, I was concerned that Mr O'Brien had not grasped the seriousness of the professional concerns and their impact on patient and staff. He did not appear to be at all embarrassed, ashamed or anxious about the situation in which he found himself, rather he appeared dismissive and defensive. On reviewing the information my impression was that his actions sat at odds with the actions of a doctor concerned about patients' welfare despite his rhetoric about immorality.

55.38 In addition, Mr O'Brien's apparent tendency to avoid dealing with concerns by delaying meetings and submitting long responses that did not always address the concerns raised Iso delayed implementation of the Conduct Panel recommended by Dr Khan which, in retrospect, did not then bring the MHPS proceedings to a close and allowed the 4 Concerns' monitoring to be continued. Mr O'Brien was of the view that, in keeping with the comments made in the 2017 Action Plan, these should come to an end in September 2018 with the MHPS Case Determination despite his awareness that he was significantly non-compliant in the period June to September 2018 and then again in June to September 2019.

55.39 In addition to this, my observation was that a pattern had emerged in the MHPS process whereby his delays in responding to concerns over many months and his tendency to deviate from the foci of the concerns raised together served as a powerful distraction which reduced his managers' and colleagues' ability to manage the cardinal issues. He appeared to lack concern about the impact of his actions on his patients' welfare or his colleagues' workload.

55.40 To compensate, his colleagues described in their witness statements in the course of the MHPS investigation and the SAIs that they had found ways of working around him over the years for expediency. There were suggestions in the witness statements that

he was unpleasant and patronising when challenged. The witness statements suggested that he was frustrating of others' efforts and that some had been effectively stalled from managing him effectively, particularly when Mr O'Brien suggested through others that these colleagues were bullying him. While the managers changed and moved on, the decay in memory and continuity of what had occurred diluted attempts in managing him. Mr O'Brien remained the constant throughout.

55.41 Typically in my experience, senior consultants have well established patterns and relationships over long periods of time with relatively settled teams. Managers, as in this case, often change more frequently than clinical team members. This can mean that teams and individual consultants can potentially have developed their own culture and an ability to be very resistant to change or challenge and can find ways to obfuscate until the manager "moves on ". Likewise, when managers are repeatedly rendered impotent by resistance to change, staff can become demoralised so that managers then can't manage to change their systems. This effectively "freezes" the system in a dynamic that can be difficult to manage and change.

55.42 I was concerned when I read the MHPS report and the appendices that these concerns had been known about for a long time, although not the extent of them, that various interventions had been tried but either failed or did not succeed. In addition to this the default system put in place in 2015 by Ms Burns in relation to Waiting List management to provide a safety net for patients who were not triaged inadvertently helped mask the problem.

Relevant document located in *S21 29 OF 2022, 1. MEDICAL DIRECTOR HANDOVER FROM DR KHAN*
ATTACHMENTS: FOLDERS 1-3 MHPS INVESTIGATION
Attachment: LETTER 06.02.2017 from AHMED KHAN document located at *Relevant to HR/reference no 33/GRIEVANCE PANEL 1/20170206 Grievance Panel 1Tab 34 Letter Dr Khan to AOB CC decision*

ATTACHMENT: case investigation report for consideration on 26.01.2017. *Relevant to HR, Reference No 1, MHPS Investigation Report, MHPS Investigation, Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018.*

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

56.1 I refer to my answers to Questions 54 and 55 above.

56.2 In summary, I have set out below in table form the concerns, the actions taken in respect of them, and the rationale for them.

CONCERNS	***ACTIONS TAKEN***
4 CONCERNS • **TRIAGE** • **DICTATION/RECORD KEEPING** • **RETENTION OF RECORDS** • **PRIORITISATION OF PRIVATE PATIENTS**	ATTACHMENT : ACTION PLAN 2017 document located at *Relevant to HR/reference no 33/GRIEVANCE PANEL 1/20170200 - Return to Work Action Plan DR AOB* ATTACHMENT : SUMMARY OF DISCUSSIONS (2019) IN RELATION TO DEFAULT ON ACTION PLAN 2017 document located at SUMMARY OF DISCUSSIONS (2019) IN RELATION TO DEFAULT ON ACTION PLAN 2017 *Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20191025 Email – FW Return to Work Action Plan February 2017 FINAL and 20191025 Attachment UROLOGY, Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/no*

	77 emails Mr Mark Haynes –AMD and Consultant Urologist/20191118-email backlog report This has resulted in improvements on the whole in Mr O'Brien's triage of GP referrals, dictation, non retention of medical records and non prioritisation of private patients.
SERIOUS ADVERSE INCIDENT JOHNSTON & HUGHES	ATTACHMENTS : ACTION PLANS FROM SAI 2020, 2021 documents located at *S21 No 29 of 2022, 183. Action Plan Update June 2022 – A53* ATTACHMENT URO-ONCOLOGY IMPROVEMENTS JUNE 2022 document located at *S21 No 29 of 2022, 182. Uro Oncology Improvements 2022* This has resulted in improvements on the whole in Mr O'Brien's triage of GP referrals, dictation , non retention of medical records and non prioritisation of private patients. The outworkings of the Hughes' SAI have led to reduced silo working between urology and uro -oncology, increased governance and attendance at MDM, enhanced monitoring of cancer patients and greater awareness of NICE guidance in relation to Urology prescribing.
TO MHPS MANAGEMENT REVIEW CONCERNS	ATTACHMENTS : CLINICAL LEADERSHIP REVIEW AND RECOMMENDATIONS document located at *S21 No 29 of 2022, 52. MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021* This review has led to a strengthening in medical management and medical professional governance process through improvement appraisal and revalidation processes and live monitoring of professional governance concerns and triangulation.
MHPS ADMINISTRATION REVIEW CONCERNS	ATTACHMENT : ANITA CARROLL REVIEW AND PLAN documents located at *Relevant to PIT, Evidence after 4*

	November 2021 PIT, Reference 67, 20211122-Admin Review Process (67) and S21 No 29 of 2022, 189.Admin Review Process - Triage Process April 21,190. Admin Review Process - Consultant to Consultant Referrals SOP, 191. Admin Review Process - Guide to Paying Patients,192. Admin Review Process - Services not using e-triage, 193. Admin Review Process - PAS OP Referral Source Code Private to NHS This administration review explored the process for patients moving through the administration system in Urology and has resulted in changes to process to prevent patient referrals by GPs not bring triaged at the point of referral in the future.
CONCERNS OUTLINED IN REFERRAL TO GMC	ATTACHMENT: MINUTES OF DISCUSSIONS WITH GMC GMC REFERRAL 28TH MARCH 2019. Document located at *Relevant to HR, Evidence after 4 November HR, Reference 77, S Hynds no 77, 20181218 - Email - FW SHSCT - "Dr Urology Consultant", 20181218 - Attachment - Email - FW IMPORTANT - Redacted MHPS investigation into AOB, 20190109 - Email - RE SHSCT - "Dr Urology Consultant"- advice to refer, 20190320 - E-mail FW SHSCT - Dr Urology Consultant- advice to refer doctor, 20190322 - Email - RE SHSCT - "Dr Urology Consultant"- advice to refer doctor - Mr Aidan O'Brien - GMC No. 1394911, 20190402 - Email - FW GMC Referral, 20190402 - Attachment - Case Manager Determination AO'B FINAL 280918, 20190402 - Attachment -Return to Work Action Plan February 2017 FINAL, 20190402 - Attachment -December 2016, 20190402 - Attachment -*

	September 2018, 20190402 - Attachment -March 2019 and S21 No 29 of 2022 attachment 5. 20190402 AO'B fitness-to-practise-referral-form In January to 28th March 2019 these discussions led to a referral to the GMC the details of which are outlined in the referral documentations.
7th June2020 SURGICAL LIST DISCREPANCY CONCERNS	ATTACHMENTS: DISCUSSIONS WITH ROYAL COLLEGES document located at Relevant to MDO, Evidence after 4 November MDO, reference no 76, RCS – MOK, RCS - SW and Reference 76 (other) British Association of Urological Surgeons SW, BAUS, located at *Relevant to MDO, Evidence after 4 November MDO, reference no 76, RCS – MOK, RCS - SW and Reference 76 (other) British Association of Urological Surgeons SW* DEPUTY CMO, *located at S21 No 29 of 2022, 6. 20200811 E Discussion with Naresh Chada* CMO, located at *Relevant to MDO/ Evidence after 4 November MDO/ reference no 76 (i)/ DOH MOK/ 20200819_ FW HPRM MM 0121 2020 Email MOK CONFIDENTIAL EARLY ALERT – Urology, 20200819_FW HPRM MM 0121 2020 - Email MOK - CONFIDENTIAL EARLY ALERT - Urology_ATTACHMENT 20200820_FW HPRM MM 0121 2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT – Urology, 20201014_FW VERY URGENT HPRM MM 0121 2020 – Email from Maria O'Kane – CONFIDENTIAL EARLY ALERT – Urology, 20201015_RE VERY URGENT HPRM MM 0121 2020 - Email from Maria O'Kane - CONFIDENTIAL EARLY ALERT - Urology* UAG , documents located at *S21 No 29 of 2022,*

	229. 20201030 DOH SHSCT Uro Meet, 230. 20201106 DOH SHSCT Uro Meet, *231. 20201106 DOH SHSCT Uro MEET A1, 232. 20201113 DOH SHSCT Uro Meet, 233. 20201113 DOH SHSCT Uro Meet A1, 234. 20201120 DOH SHSCT Uro Mtgs,* *235. 20201120 DOH SHSCT Uro Mtgs A1, 236. 20201204 DOH SHSCT Uro Meet, 237. 20201204 DOH SHSCT Uro Meet A1, 238. 20201218 DOH SHSCT Uro Meet,* *239. 20201218 DOH SHSCT Uro Meet A1, 240. 20210108 DOH SHSCT Uro Meet, 241. 20210122 DOH SHSCT Uro Meet A1, 242. 20210122 DOH SHSCT Uro Mtgs, 243. 20210111 DOH SHSCT Uro Mtgs A1, 244. 20210319 DOH SHSCT Uro Meet,* *245. 20210319 DOH SHSCT Uro Meet A1, 246. 20210416 DOH SHSCT Uro Agenda, 247. 20210416 DOH SHSCT Uro Agenda A1, 248. 20210514 DOH SHSCT Uro Meet,* *249. 20210514 DOH SHSCT Uro Meet A1, 250. 20210618 DOH SHSCT Uro Meet, 251. 20210618 DOH SHSCT Uro Meet A1, 252. 20210906 DOH SHSCT Uro Meet, 253. 20210906 DOH SHSCT Uro Meet A1, 254. 20210122 Urology Assurance* *Group minutes, 255. 20210906 Assurance Group minutes and* TRUST OVERSIGHT MEETINGS located at *Relevant to PIT, Evidence Added or Renamed 19 01 2022, No 76 – minutes and agendas with attachments, Internal Meetings* These discussions led to the development of the SCRR with the RCP, the involvement of subject matter experts through the RCS – BAUS to advise on clinical concerns

	and also to advise on risk stratification, time frames to be considered , identification of concerns, and the eventual formal Look back processes.
DEVELOPMENT OF UROLOGY LOOKBACK FOLLOWING DISCREPANCY 06.06.20	ATTACHMENTS: AS ABOVE These discussions led to the development of the SCRR with the RCP, the involvement of subject matter experts through the RCS – BAUS to advise on clinical concerns and also to advise on risk stratification, time frames to be considered , identification of concerns, and the eventual formal Look back processes.
DISCUSSIONS WITH CEO	ATTACHMENTS : 1-1 MEETINGS WITH CEO. Documents located at *S21 No 29 of 2022, 83. 20201218 CX 1-1 – A10, 84. 20210308 CX 1-1 – A16, 85. 20210505 CX 1-1 – A16, 86. 20210608 CX 1-1 – A19* During these meetings I made him aware of my concerns in Spring 2019 that resulted in referral to the GMC, updated him of any concern that arose in relation to monitoring in September 2019, the results of the Johnston SAIs, the concerns discovered in June 2020 and in the interim until he left the post, the emerging picture in relation the patients who have been part of the Lookback exercise in Urology.
UPDATES TO TRUST BOARD	ATTACHMENTS : CONFIDENTIAL AND PUBLIC TRUST BOARD MINUTES This has been described in the answer to question 40. Document located at *142. 20220526 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS,* 143. *20220331 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS, 144. 20220127 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS*

UPDATES TO DOH, PI, TRUST BOARD FOLLOWING INACCURACIES IN RELATION TO PATIENT LETTERS DEC 2021	ATTACHMENT : MARGARET O'HAGAN DIAGNOSTIC AND ACTION PLANS. Documents located at *S21 No 29 of 2022, 185. 20220531 - review of urology letters investigation action plan and 186.20220531-final report of review of urology letters investigation* This has led to enhanced management of the process of communication to patients and external agencies, the secondment of an experienced Director from the Northern HSC Trust Margaret O'Hagan to provide oversight to the process of the Urology Lookback and the ongoing development of a Urology Programme Board to assure Trust Board.

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

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

57.1 I have addressed these issues in my answers to Questions 48 and 54 above and previously in my responses, on behalf of the Trust, to Section 21 Notices Nos.1 and 1a of 2022. In addition, I would offer the following.

57.2 The main process available to me as Medical Director to manage doctors is through MHPS.

57.3 A formal standardised framework for Risk Assessment does not exist for these scenarios but is being developed in the context of the Governance Trigger Tool which will be implemented through the Doctors' and Dentists' Oversight Group when it is developed and will consider the impact of different aspects of governance on patient safety for each individual about whom there are concerns. .

57.4 The approach that was used considered the areas of concern raised through the 2017 Return to Work Action Plan and the MHPS process.

57.5 Risks were considered as they were identified in relation to ongoing patient safety and action plans put in place to mitigate as they arose, for example, the 2017 Action Plan, the outworkings of the Johnston and Hughes' SAIs, the outworkings of the Lookback Review in relation to prescribing, MDM, involvement of CNS, preoperative assessment, dictation, the outworkings of the communications failures with patients in December 2021, changes within Appraisal and Revalidation Systems, development of more robust medical management systems, and Doctors and Dentists oversight processes, management of private patients, Project Board oversight and the development of new Corporate Governance Structures and the development of a more comprehensive Bed to Board approach to CSCG on a live and weekly basis across the Trust

57.6 In summary, the original risks identified before I arrived were managed through the 2017 Action Plan and the management plan from MHPS developed in 2018.

57.7 When further difficulties with failure to triage were identified in June to September 2019 these were monitored and managed

57.8 When difficulties were identified on the 7th June 2020, following Mr O'Brien's email to Mr Haynes, Mr O'Brien was asked not to take on clinical work (theatre lists, day

procedures and new patient clinics had been stood down largely other than for emergencies in March 2019 due to the Covid19 Pandemic) other than finishing administrative work and tending to his review backlog virtually (something that he had started) so that there was no further exposure to new patients while we reviewed the extent and impact of the concerns on patient safety.

57.9 Throughout this process he was asked to give assurances that he was not seeing private patients.

ATTACHMENTS: AGREEMENT 2017 ACTION PLAN/ TUGHAN'S LETTER/ PROFESSIONAL ALERT. Document located at *Relevant to HR/reference no 33/GRIEVANCE PANEL 1/20170200 - Return to Work Action Plan DR AOB / Relevant to MDO, Evidence after 4 November MDO, reference 51 (k), AOB Tughans SW, 20201025 Letter to Tughans*

57.10 Concerns throughout were conveyed to NHS Resolutions, the GMC and the Chief Medical Officer's office. To support this the Chief Medical Officer issued a Professional Alert in relation to private practice which was later cancelled (ATTACHMENT : GREY LETTERS). Document located at *Relevant to MDO/Evidence after 4 November MDO/reference no 73/20201127 Alert Letters Xerox Scan_22102020084453 Attachment 2 and 20201127 Alert Letters Item 4392 – Cancellation NI Alert Letter AOB 24 November 2020 Attachment 1*

57.11 The GMC suspended Mr O'Brien for 18 months until May 2022, revised in June 2022 allowing for nonclinical practice related to medicolegal work.

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

58.1 When I arrived in the Trust in December 2018, Mr O'Brien was being actively managed already through the Action Plan agreed following the Maintaining High Professional Standards process in March 2017 following a decision by the Case Conference on 26th January 2017 to lift the immediate exclusion which was in place from 30th December 2016.

58.2 This 2017 action plan formed the basis for Mr. O'Brien's return to work at that time and was to be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

58.3 The decision of the members of the case conference in January 2017 was for Mr. O'Brien to return as a Consultant Urologist to his full job role as per his job plan and to put safeguards and monitoring around the four main issues of concern under investigation.

58.4 An urgent job plan review was to be undertaken to consider any workload pressures to ensure appropriate supports can be put in place.

58.5 It goes on to describe that Mr. O'Brien's return to work is based on -

(1) strict compliance with Trust policies and procedures in relation to triaging of referrals, contemporaneous note keeping, storage of medical records and private practice

(2) agreement to comply with the monitoring mechanisms put in place to assess his administrative processes.

58.6 It states that the work would be monitored by the Head of Service and reported to the Assistant Director in relation to managing clinical activity.

58.7 It outlines the concerns and in relation to :

a) Concern (1) - it states all referrals received by Mr. O'Brien will be monitored by the Central Booking Centre in line with timescales and a report will be shared with the assistant director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets are met.

b) Concern (2) - that notes must not be stored in Mr. O'Brien's office and should be tracked out to him for the shortest period of time for the management of the patient.

c) Concern (3) - that a plan or record for each clinic attendance must be recorded for each individual patient and this should include a letter for any patient who did not attend as there must be a record of this back to the G.P. and that in relation to

d) Concern (4) - the scheduling of the patients must be undertaken by the secretary who will check the list with Mr. O'Brien and then contact the patient for their appointment.

58.8 This process was in keeping with the practices established within the Urology team.

58.9 It also then states that any deviation from compliance with this action plan must be referred to the MHPS case manager immediately.

How did I know this was working as it should?

58.10 When Mr O'Brien was found to have defaulted on aspects of the Action Plan on the 16th September 2019, he was offered support in clearing the backlog and it was understood that this had come about at a time he had been [redacted] when [redacted].

58.11 When he was carefully monitored throughout this process he appeared to be able to comply with what was required and did not ask for any help and this was offered.

58.12 Previously, there had been extra administrative time provided on a Tuesday morning in his Job Plan and Mr Young had taken on some of his triage as had the others on occasion.

58.13 When the Covid19 pandemic was announced in March 2020, and the Trust moved to pandemic measures, the level of surgical activity fell to emergency only and there were fewer patients to monitor as a result. That said, Mrs Corrigan maintained weekly monitoring where required and sought accurate assurances from Mr O'Brien's secretary and her line managers that the activity submitted was accurate to ensure that the oversight that was discovered in September 2019 was not repeated. Assurances of this were sought at Oversight meetings in relation to Urology from the MHPS case manager.

Did the processes work and, if not, why not?

58.14 What I was not aware of at that point (as it predated my arrival) was that there had been a period of time between June and September 2018 when Mrs Corrigan had been on leave Personal information redacted by USI when the monitoring was not undertaken and, on her return, she uncovered that there were discrepancies in these which were subsequently addressed.

58.15 I think, in retrospect, that these 2 times of deviation (both from June to September, but in different years - 2018 and 2019) were confused in the discussions and not clearly articulated in writing. Those who had been involved in both time frames potentially assumed others, including me, knew that both had occurred rather than just the latter.

58.16 This lack of clarity was important as, when I gave assurance to the GMC and others in Autumn 2019, I did so in the belief that the 2019 lapse had been the only lapse in Mr O'Brien's behaviours as I was not aware of that in 2018.

58.17 Had I been fully aware of both, I believe I would have given different feedback to the GMC and others and this would have further heightened my levels of concerns about his behaviours and the robustness of the monitoring systems.

58.18 The monitoring of the Action Plan was overseen by Dr Khan as Case Manager. A job plan review had been offered throughout but Mr O'Brien was reticent to engage.

58.19 Mr Haynes had not been involved in the oversight of the Return to Work Action Plan before I arrived and I was not aware of this for a significant period of time as I assumed that he had been as this would be usual for an AMD. The rationale for this has not been described in the paperwork to which I have had access, but appears to be linked to Mr Haynes having been involved in raising concerns in the first place. Another urologist had not been nominated to provide this function alongside Mrs Corrigan in Mr Haynes' place, as would have been typical had Mr Haynes been involved from the outset.

58.20 On reflection, the potential unintended consequences of this were that, from a clinical oversight perspective, information was not being sought automatically from Mr Haynes or his agent which might have assisted Mr Corrigan in her operational monitoring. That said, when Mr Haynes noted discrepancies, he did raise these which helped greatly in identifying difficulties in 2019 and 2020, despite not having access to information in relation to changes in approach to the monitoring of the Action Plan, for example, in November 2018 the decision to move from routine reporting to reporting by exception only.

58.21 Mr Haynes recorded in an email dated 31st May 2019 at 9.08am to me and others that Mr O'Brien did not have a signed Job Plan. Discussion had occurred and the job plan has been "awaiting doctor agreement" since November 2018. An update on the process had been requested from the relevant Clinical Director. This situation continued until Mr O'Brien

completed these before his retirement and, despite attempts at engagement by Mr McNaboe, Clinical Director, including in a discussion he had with Mr O'Brien in November 2019, after Mr O'Brien defaulted on the 2017 Action Plan between June and September 2019.

58.22 In his email referenced above, Mr Haynes went on to state that he is aware of instances where the actions regarding Concern 1 have not been met, specifically "triage of all referrals must be completed on the Friday after Mr O'Brien's Consultant of the Week ends. Red Flag referrals must be completed daily".

58.23 Mr Haynes goes on to state "Given that I am aware of aspects of the action plan not being met, I am concerned to see the statement that there have been "no exception reports flagged to case manager" the implication being that there has been an agreed deviation from the action plan and monitoring is now occurring against different standard, or that the monitoring and /or escalation process has not functioned as it should". He expresses the concern that the reporting process appears to have failed to flag these to the case manager.

58.24 Mr O'Brien's case was discussed regularly through the Doctors' and Dentists' Oversight Group for Doctors in difficulty involving senior HR personnel and with the GMC. In addition to this, he was supported throughout the MHPS process and Action Plan by Mr John Wilkinson as Non -Executive Director.

What could have been done differently?

58.25 When Mr O'Brien returned to work he was monitored on the four elements of the 2017 Return to Work Action Plan. As I now know there were other areas that should have been monitored but which were not included (discharges from Day Surgery/theatre notes, MDM follow-up, prescribing, preoperative assessment, follow-through of outcome from the dictation - e.g. adding to waiting list, F/U appts, ordering of tests/reviewing results, etc) so

all patient administration processes should have been monitored, not just those that were on the 2017 Return to Work Plan.

58.26 In retrospect, knowing what I know now, I believe that, as well as the breadth of what was monitored, the depth of monitoring of Mr O'Brien should have been more robust and proactive than it was and that there should have been a nominated clinician to work alongside Mrs Corrigan. To drive this, I now believe that the oversight should not have depended on escalation of default from the 2017 Action Plan but that information should have been more proactively sought, audited and assured on a regular basis.

58.27 I think that I and others failed to realise that the usual approaches to monitoring that typically work for other doctors in similar situations would not work for Mr O'Brien and his secretary who had a history of knowingly or unknowingly withholding, or at least not sharing, information. In 30 years of clinical practice and 15 years of senior medical management I had not encountered this before in a doctor's work but I should have been cognisant of the fact that this was possible. This has resulted in a more proactive approach to monitoring doctors through the development of the Doctors' and Dentists' Oversight Group in the Trust.

ATTACHMENT – *RELEVANT TO PIT, EVIDENCE AFTER 4 NOVEMBER 2021 PIT, REFERENCE 67, 20211122-Admin Review Process (67), and S21 No 29 of 2022, 192. Admin Review Process - Triage Process April 21, 195. Admin Review Process - Services not using e-triage, 193. Admin Review Process - Consultant to Consultant Referrals SOP, 194. Admin Review Process - Guide to Paying Patients, 196. Admin Review Process - PAS OP Referral Source Code Private to NHS*

ATTACHMENT – Relevant to HR, Reference No 33, Grievance Panel 1, 20170200 - Return to Work Action Plan DR AOB

ATTACHMENT: DOCTORS' AND DENTISTS' OVERSIGHT MINUTES IN RELATION TO MR O'BRIEN. Document located at *Relevant to Hr, Reference no 1, Oversight documentation Mr O'Brien folder*

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

59.1 Following the MHPS determinations, a workplan including a number of measures against the 4 main concerns was developed against which Mr O'Brien was monitored. In this answer I have outlined these and the progress against them. They did not change throughout monitoring until November 2018, when they were reported by exception rather than as an automatic weekly report as had been the case when they were introduced originally in April 2017.

Attachment Action Plan 2017

ATTACHMENT – *S21 No 29 of 2022, 257. Handbook - Effective Clinical Governance for the Medical Profession*

ATTACHMENTS – S21 No 29 of 2022, *195. 20190131 Action Notes, 196. 20190502 AGENDA - HR & Medical Directorate Meeting, 197. 20190718 AGENDA - HR Medical Directorate Meeting, 198. 20191015 AGENDA - HR Medical Directorate Meeting, 199. 20200709 Medical Directorate and HR Meeting, 200. 20200820 AGENDA - HR Medical Directorate Meeting, 201. 20201001 ACTION NOTES HR & Medical Directorate Meeting, 202. 20201105 AGENDA HR & Medical Directorate Meeting, 203. 20201217 AGENDA HR & Medical Directorate Meeting, 203.1 20201217 AGENDA HR & Medical Directorate Meeting A1 and 203.2 20201217 AGENDA HR & Medical Directorate Meeting A2, 204. 20210414 ACTION NOTES HR & Medical Directorate Meeting, 204.1 20210414 ACTION NOTES HR & Medical Directorate Meeting A1, 204.2 20210414 ACTION NOTES HR & Medical Directorate Meeting A2,*

204.3 20210414 ACTION NOTES HR & Medical Directorate Meeting A3, 204.4 20210414 ACTION NOTES HR & Medical Directorate Meeting A4 and 204.5 20210414 ACTION NOTES HR & Medical Directorate Meeting A5, 205. 20210616 AGENDA HR & Medical Directorate Meeting and 205.1 20210616 AGENDA HR & Medical Directorate Meeting A, 206. 20211008 AGENDA HR & Medical Directorate Meeting, 206.1 20211008 AGENDA HR & Medical Directorate Meeting A1, 206.2 20211008 AGENDA HR & Medical Directorate Meeting A2 and 206.3, 20211008 AGENDA HR & Medical Directorate Meeting A3, 207. 20211208 AGENDA HR & Medical Directorate Meeting, 207.1 20211208 AGENDA HR & Medical Directorate Meeting A1, 207.2 20211208 AGENDA HR & Medical Directorate Meeting A2, 207.3 20211208 AGENDA HR & Medical Directorate Meeting A3 and 207.4 20211208 AGENDA HR & Medical Directorate Meeting A4, *208. 20220414 HR medical directorate meeting, 209. 20210205 AGENDA OF MEDICAL HR MEETING, 209.1 20210205 AGENDA OF MEDICAL HR MEETING A1, 209.2 20210205 AGENDA OF MEDICAL HR MEETING A2, 209.3 20210205 AGENDA OF MEDICAL HR MEETING A3 and 209.4 20210205 AGENDA OF MEDICAL HR MEETING A4, 210. 20210205 NOTES OF MEDICAL HR MEETING.*

ATTACHMENT: SUMMARY OF SHSCT IEAP PROCESS document located at S21 No 29 of 2022, *258. Summary of IEAP PROCESSES ST*
Attachment RATIONALE FOR TRAIGE AND METRICS IEAP document located at S21 No 29 of 2022*, 259. Rationale for Triage IEAP*

ATTACHMENT: Detail of monitoring of 2017 action plan document located at *S21 No 29 of 2022,* 187. *Detail of monitoring of 2017 action plan*

59.2 The outworkings of the MHPS investigation into Mr O'Brien's conduct developed in an Action Plan enacted in 2017 outlined that facets of his administrative practices would be monitored namely

1. Triage

2. Retention of Charts in his office and home- checked against assigned chart lists on a weekly basis
3. Delays in dictation- assurance given by Mr O'Brien's secretary to Head of Service weekly and escalated by secretarial line management when delays of more than a few days occurred
4. Preferential management of private patients on surgical waiting lists – monitored by the Head of Service on a weekly basis to ensure that private patents were not being added to lists out of sequence for clinical priority.

Action plan and any variation of same

59.3 The Action Plan continued as that devised in February 2017 as follows. Variations are described in the following points.

59.4 The metrics against which this was judged was against the requirements of the IEAP attached and the requirements of the Action Plan

59.5 The monitoring was undertaken as described within the Action Plan.

59.6

CONCERNS	METRICS DEVELOPED AND IN PLACE FROM APRIL 2017 UNTIL END JULY 2020 FOLLOWING CONCERNS MONITORED AND TO BE REPORTED WEEKLY UNTIL NOV 2018 WHEN CHANGED TO MONTHLY BY EXCEPTION TO MHPS CASE MANAGER	EFFECTIVENESS OF MEASURES NOT MONITORED JUNE – NOV 2018 WHEN MRS CORRIGAN [redacted] FALSE ASSURANCES GIVEN, JUNE TO SEPT 2019, MRS CORRIGAN NOTED AS BELOW On 16th September 2019 at 16:37 Martina Corrigan noted:	HOW DID THESE MEASURES DIFFER FROM WHAT EXISTED BEFORE
NON -TRIAGE	All referrals received by Mr. O'Brien will be monitored by the Central Booking Centre in line with timescales and a	Not adhered to; Mr. O'Brien has 26 paper referrals outstanding and only triaged 19 routine and 8 urgent referrals.	In all domains, Mrs Corrigan continued weekly monitoring and reporting by exception if necessary from

	report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery, at the end of each period to ensure all targets are met.		September 2019 until Surgery and Clinics and procedures effectively being stood down mod-March 2020 until Mr O'Brien retired in July 2020. Discussed at monthly DDOG meetings.
RETENTION OF RECORDS	Notes must not be stored in Mr. O'Brien's office and should be tracked out to him for the shortest period of time for the management of the patient.	Adhered to; no notes are stored off premises nor in his office (this is only feasible to confirm as there have been no issues raised regarding missing charts that Mr. O'Brien had).	
DICTATION/ CLINICAL RECORDING	A plan or record for each clinic attendance must be recorded for each individual patient and this should include a letter for any patient who did not attend as there must be a record of this back to the G.P.	Not adhered to - Mr. O'Brien continues to use digital dictation for SWAH clinics what I have done is spot checked today and clinics in SWAH, 22 on 12th August, all patients have letters on NIECR. Clinics held in Thorndale Unit, Craigavon Hospitals 20th August 2019, 12 booked to clinic, 11 attendances and 1 CND but no letters at all. • 23rd August 2019 10 attendances and one letter on NIECR • 30th August 2019 12 booked to clinic, 1 CND, 1 DNA and no letters on NIECR	

		• 3rd September 2019 8 booked to clinic, no letters on NIECR.	
CLINICAL SCHEDULING	The scheduling of the patients must be undertaken by the secretary who will check the list with Mr. O'Brien and then contact the patient for their appointment. This process is in keeping with the practices established within the Urology team. It also then states that any deviation from compliance with this action plan must be referred to the MHPS case manager immediately.	Adhered to – no more of Mr. O'Brien's patients that have been seen privately as an outpatient have been listed	

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

60.1 This process is outlined in the summary of correspondence above in the response to Question 59 using the point of reference in the 2017 Action Plan, namely *Summary of Return to Work Plan Monitoring Arrangements Meeting 9th February 2017 in relation to Mr. A. O'Brien, Consultant Urologist*

60.2 My view of the Action Plan was that it worked in part in that it outlined the parameters identified as a result of the initial review of cases undertaken in 2016 but that it failed through its focus to identify other failings which were then identified in June 2020.

60.3 The reasons for its partial success were that the implementation of this was not as clearly defined in the plan as it should have been in retrospect and that also too much assurance lay with secretarial staff who had not highlighted difficulties in the past.

60.4 In addition to this the burden of this fell mainly to Mrs Martina Corrigan on top of an already very busy job and was not covered then by others when she was on leave.

60.5 I also think that involving Mr Haynes in the oversight of the 2017 Action Plan from the outset of its implementation rather than from early 2019 would also have made its implementation more robust as he had an excellent working knowledge of the system.

60.6 When he was not included the rationale being that he had raised the IR1s, he was not replaced by another consultant urologist who would understand the nuances of the impact of systems.

60.7 In addition to this a fulsome handover should have been provided to me or sought by me at an earlier stage as I was not aware of the entire history of this until a number of months into a new post in a Trust I hadn't worked in before and assumptions were made.

60.8 The monitoring of the plan did miss concerns that became obvious at a later stage post 7th June 2020. Its focus was narrow and did not consider all of practice. In fairness, it concentrated on the areas that had been raised in the course of the MHPS investigation.

60.9 It also became clear that Mr O'Brien was ambivalent about the plan, did not adhere to it at times, did not make others aware of whether he was adhering or not, and relied upon the decision by the Case Conference on 26th January 2017 (that this action plan for Mr. O'Brien's return to work would be in place pending conclusion of the formal investigation process under MHPS) in support of his belief that it only extended to

September 2018, when later challenged regarding non-compliance in 2019, despite having followed it in part in 2019.

60.10 In addition to this, what was discovered as (what amounted to) a false assurance being given by his secretary that all dictation was being done until September 2019, led to false assurances then being given by others in turn and undermined the monitoring of the action plan as a result. This is explored further in my answer to Question 61 below.

60.11 As such, the system that was implemented delivered on what it was set up to deliver albeit what was implemented was not all of what was intended or assumed was in place at the outset.

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

61.1 This answer should be read in conjunction with my answer to Questions 58 to 60 above as the areas covered overlap.

61.2 The agreements and systems that were put in place through the 2017 Action Plan from the MHPS early findings of Summary of Concerns identified deficits in triage, dictation, inappropriate retention of patient records and giving preferential treatment to previously private patients added to NHS waiting lists.

61.3 I am recently aware that there were concerns about compliance with the monitoring system in 2018 prior to my arrival in the Trust in the period from June to September 2018.

61.4 I was aware of similar concerns then in June to September 2019 when they occurred.

61.5 As mentioned above, I think that the symmetry in the dates has led to confusion in discussions across those involved in this process.

61.6 Despite assurances being given by administration staff to Mrs Martina Corrigan who in turn assured the case manager that monitoring was being adhered to, it came to light to her on the 16th September 2019 when another secretary was covering for Mr O'Brien's secretary's annual leave that there were discrepancies in the backlog reporting.

61.7 This has been simply described to me that, for example, if Mr O'Brien had reviewed 8 patients at a clinic there will have been 8 letters on the system but what this will not have revealed was that there may have been 3 letters dictated on one patient and none on 2, so that although the total number of letters being identified on the patient system correlated with the number of patients seen even though each patient may not actually have had dictation completed and, as such, may not have been progressed in the system as a result.

61.8 In retrospect, Dr Chada makes 3 points in her narrative in response to Terms of Reference 5 in point 8 of page 43 of the MHPS report, namely, that: "**1.** Senior managers appear not to have known about the undictated letters. 2. Reliance on a medical secretary to flag that dictation was not being done was not appropriate or sufficient. 3. This is now hopefully addressed through use of digital dictation".

61.9 The hope was that digital dictation would address points 1 and 2 but, unfortunately, these assumptions were not audited after digital dictation was implemented and, in retrospect, should have been earlier. Eventually, these were addressed when Mrs Corrigan discovered the discrepancy in September 2019.

61.10 Under point 8 page 31 of the MHPS Investigation report Dr Chada highlights that the issue in relation to patient recording had been challenging for a period of time :"The investigation further highlighted that it was a widely known fact among some staff within the Acute Services Directorate, that Mr O'Brien's triage was often not returned to the Referral and Booking Centre. Mrs Katherine Robinson, Referral and Booking Centre Manager reported that she had been aware over a number of years that Mr O'Brien had not returned triage decisions as was the expected practice. She reported raising the concern at Acute Services meetings and directly with 2 Directors dating back to 2014. Mrs Robinson reported that the problem only existed with Mr O'Brien and all other Urology consultants completed triage. There were periods of time when Mrs Robinson and others chased up the triage from Mr O'Brien however she reported that in 2014 she was advised to book the longest waiting patients onto the lists. She advised in 2015 a default system was set up such that if triage was not returned within 3 days the R&B Centre staff added the patients to the waiting lists according to the GP prioritisation".

61.11 On page 36 of her report Dr Chada states that "Mrs Robinson reported that she became aware in December 2016 from Noeleen Elliott, Mr O'Brien's secretary, that there were clinics which had not been dictated by Mr O'Brien. She reported this to be unusual for a Consultant. Mrs Robinson reported that Ms Elliot as Mr O'Brien's secretary would have known the extent of dictation not completed and that she should have been raising this with managers in the Acute Services Directorate. Ms Elliott, indicated that when she arrived to work with Mr O'Brien, the lack of clinics being returned seemed to be a long-standing way he worked and therefore she felt this issue was known. She therefore did not raise or report the issue."

61.12 Given this it is curious then that the assurance was given by Ms Elliott to Mrs Corrigan that dictation was being done given that Ms Elliott was aware that this was an area previously in relation to Mr O'Brien's practice and patient safety about which senior managers were concerned.

61.13 As outlined in answer to question 58, when Mr O'Brien returned to work he was monitored on the four elements of the 2017 Return to Work Action Plan. As I know now, there were other areas that should have been monitored but not included, so all patient administration processes should be monitored not just those that were on the 2017 Return to Work Plan. As also outlined in my answer to Question 58, both the breadth and depth of monitoring ought to have been greater.

61.14 In addition to this, the assumption was that, after digital dictation was implemented for Mr O'Brien as per Dr Chada's recommendation in the MHPS Case Investigator's report, this would remedy this situation. Dr Chada considered the role of Mr O'Brien's secretary in recording, recognising and escalating concerns but, in retrospect, there was not full recognition of her absolutely essential role in all of this and the risks and consequences of Ms Elliott not fulfilling this role for any reason.

61.15 As mentioned above, I think that I and others failed to realise that the usual approaches to monitoring would not work for a doctor and his secretary who had a history of knowingly or unknowingly withholding, or at least not sharing, information. However, there is now in a more proactive approach to monitoring doctors through the development of the Doctors' and Dentists' Oversight Group in the Trust.

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

62.1 Mr O'Brien has never been in contact with me about matters of patient safety, care, risk, governance or administration.

62.2 I am not aware of Mr O'Brien raising any specific patient concerns in relation to patient care, risk, governance or administration.

62.3 His appraisals document that he raised concerns about workload and administration time. This was dealt with through Job Planning when he engaged with this.

62.4 I am led to believe that In the course of the development of the 2017 Action Plan Mr Obrien was given a Tuesday morning 4 hours as extra Supporting Programmed Activity (SPA) to allow him time to complete his dictation from the Enniskillen clinic on a Monday.

62.5 In addition to this he was repeatedly encouraged to engage in job planning through his clinical director Mr McNaboe throughout 2019.

62.6 As outlined in my response to question 65 concerns about waiting lists were recorded on the Acute and Corporate Risk Registers, and have been brought to the attention of the SPPG currently and the HSCB previously.

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

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not.

63.1

Nature of Concern	***Raised With and When***	***Actions Taken***	***Outcome***
Mr O'Brien deviated from the 2017 action plan formulated following MHPS investigation (as referred to in my answer to Q54)	• MHPS Case Manager (16.09.2019) • NHS Resolutions • Directors' Oversight Group • Chief Executive • Oversight Group • GMC • Trust Board	Dr Khan Case Manager discussed with those involved including Mr O'Brien, Dr Grainne Lynn NCAS and the GMC on 24.09.2019 who asked for update by 07.10.19 This was discussed at an oversight group on the 03.10.19 and updated by Mr Haynes by email on 07.10.19. This in turn was discussed with the Chief Executive at 1-1 meetings and at Trust Board Confidential Sections as outlined in answer to question 40.	Before my tenure, a decision was made that monitoring using the MHPS Action Plan would continue with recognised additional time for Mr O'Brien to complete triage following his Surgeon of the Week. It was understood that he had deviated from the plan following the email of the 16th September 2019 time because [redacted]
Patients found to not have been added to lists for required surgery 07.06.2020	• Trust Board • HSCB / SPPG • Directors' Oversight Group for Doctors in Difficulty	When this was discovered a review of Mr O'Brien's clinical work was immediately commenced by Mrs Corrigan to determine the extent of this problem. Ongoing discussions were	The developing awareness of the issues discovered as a result of the email of the 7th June 2020 and summarised in my

	• GMC • Chief Executive • Deputy CMO	held with the relevant directors throughout the summer until Mr O'Brien retired on the 17th July. Progress to date in the time frame 1st January 2019 until the 31st May 2020 was formally reviewed by Directors' oversight on the 6th July 2020. I discussed the unfolding concerns with Joanne Donnelly, GMC, on the 8th July 2020, the Deputy CMO on the 6th August 2020, with DOH on 24th August 2020, with PHA and HSCB on 27th August 2020 and with HSCB, DOH and PHA on 28th August 2020.	answer to Question 57 eventually led to the Ministerial announcement of a Public Inquiry on 31st August 2020.

ATTACHMENTS – Relevant to MDO, Evidence Added or Renamed 19 01 2022, No 77, Zoe Parkes Additional Evidence, 20160913 NCAS ADVICE LETTER AOB, 20190620 - FOI letter from NCAS July 19 re Dr A Obrien, 20160913 - LETO_160913_To+RB_Advice+letter_13 September 2016, 20161229 - LETO_161229_Advice+Letter_29Dec2016, 20161229- NCAS ADVICE LETTER 29 December 2016, 20181106 - NCAS ADVICE LETTER 6 November 2018, 20180921 - NCAS ADVICE LETTER 21 September 2018 and 20190719 - NCAS 18665 email re Dr AOB.

Attachment : 1-1 with ceo document located at S21 No 29 of 2022, 83. 20201218 CX 1-1 – A10, 84. 20210308 CX 1-1 – A16, 85. 20210505 CX 1-1 – A16, 86. 20210608 CX 1-1 – A19

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

64.1 When I arrived in the Trust in December 2018, Mr O'Brien was being actively managed already through the Action Plan agreed following the Maintaining High Professional Standards process in March 2017 following a decision by the Case Conference on 26th January 2017 to lift the immediate exclusion which was in place from 30th December 2016.

64.2 An urgent job plan review was to be undertaken to consider any workload pressures to ensure appropriate supports could be put in place. Mr O'Brien had been allocated Non Executive support through Mr John Wilkinson.

64.3 Mr O'Brien had been afforded additional administration time in his Job Plan on a Tuesday morning to accommodate clinic dictation and in addition, at the time it was realised in September 2019 that he was struggling to complete triage during his turn as Urologist of the Week, the deadline for return of triage was extended from Friday at 5pm to the following Tuesdays at 5pm.

64.4 When he was found to have defaulted on aspects of the Action Plan on the 16th September 2019 he was offered support in clearing the backlog and it was understood that this had come about at a time [redacted] [redacted] When he was carefully monitored throughout this process he appeared to be able to comply with what was required and did not ask for any help although this was offered. Previously there had been extra administrative time provided on a Tuesday morning in his Job Plan (as above) and Mr Young had taken on some of his triage as had the others on occasion.

64.5 His case was discussed regularly through the Doctors' and Dentists' Oversight Group for Doctors in difficulty involving senior HR personnel and with the GMC.

ATTACHMENT – located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Colin Weir CD, 20170315 - E meeting with Mr O'Brien and Mr Weir 9 March 2017.

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

65.1 As outlined in my answer to question 62, Mr O'Brien has never raised any concerns with me or through others to me that I am aware of and so any information I have is second hand, obtained through Appraisals.

65.2 Mr O'Brien, through his Appraisals and in the course of his responses to MHPS, has repeatedly raised concerns about lengthy waiting lists and referral times**.** These concerns raised by him and others have been brought repeatedly to the Commissioners over the years with some response but waiting lists remain long, worsened by the Covid19 pandemic.

65.3 I am not aware that Mr O'Brien raised any concerns outside of these and, as such, have not seen these reflected in any other governance documents.

65.4 During my tenure, the waiting times in urology have been monitored through the Performance Committee and are on the Acute Directorate and Trust Corporate Risk Registers.

ATTACHMENTS: ACUTE RISK REGISTER document located at S21 No 29 of 2022, 136. Acute Directorate Risk Register April 2022

SURGICAL WAITSPERFORMANCE DATA UROLOGY; documents located at S21 No 29 of 2022, 175. Urology Board paper v2 1 Sept, 62. Urology Outpatient Total Waits April 18 Onwards, 63. Urology Red Flag Referrals April 18 onwards, 64. Urology Outpatient Longest Waits April 18 onwards, 65. Urology IP Longest Waits April 18 onwards, 66. Urology Inpatient Total Waits April 18 onwards, 67. Urology Day Case Total Waits April 18 onwards, 68. Urology Day Case Longest Waits April 18 onwards, 69. SPC UROLOGY REVIEW BACKLOG, 70. Urology mentions in CPD report

APPRAISALS documents located at Relevant to MDO/evidence uploaded December 2021/no 77 appraisals/20120101 Appraisal AOB including 2012 and 2013, 20110101 Appraisal A'OB, 20100101 Appraisal AOB and Relevant to MDO/reference no 77/20140101 Appraisal Dr Aidan O'Brien Dr M Young 221215, 20150101 Appraisal Dr A O'Brien (Dr M Young), 20160101 Mr A O'Brien 2016 Appraisal Dr D Scullion, 20170101 Mr A O'Brien - 2017 Appraisal - Dr D Scullion, 20180101 Appraisal Mr A O'Brien (Dr D Scullion)

Learning

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

66.1 I am aware of governance concerns that came to light during my tenure as Medical Director from the 1st December 2018 until the 31st April 2022.

66.2 These include Professional and Clinical and Social Care Governance Concerns which have been dealt with throughout this statement particularly in my responses to Questions 7, 8, 21, 48, 54, and 60.

66.3 Specifically these include the following:

a. Professional Governance : Mr O'Brien was non-compliant with Job planning and did not undertake full disclosures in his appraisals.
b. Clinical and Social Care Governance: Mr O'Brien was inconsistent in relation to patient safety administration, namely, dictation, probity in relation to private patients, retention of records, recording, consent, prescribing, appropriately referring patients in a timely fashion or at all to the relevant health care professionals, and excluding health care professionals (in particular, other clinical consultants and the CNSs) from patients' care. In relation to Trust and HSC Values, he was not open and honest, his approach to his colleagues and some of his patients lacked compassion, and he did not always work well with other staff.

66.4 Unfortunately, within the Southern Trust our governance structures professionally and within clinical and social care governance and their application were not well developed and in some areas not sensitive or specific enough to identify and manage the difficulties at a much earlier stage. The system worked in a silo in areas. This contributed to blind

spots, particularly in relation to identifying the problems with MDMs and for cancer patients in particular.

66.5 This was compounded then by the difficulties that some persons who worked with Mr O'Brien had in speaking up for fear of being inaccurate or of reprisal.

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

67.1 I will deal with this in my answer to Question 68

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

68.1 I have a number of reflections on what has gone wrong and how we might learn from what has occurred:

1) Firstly I am deeply sorry, saddened and ashamed that people in our care have come to harm as evidenced by the Johnston and Hughes SAIs in particular. This has never been the intention of the many compassionate and skilled staff who are relentlessly patient centred and who work in Urology and in the Southern Trust.

2) In the intervening years before Mr Shane Devlin came to the Trust in April 2018 and I arrived in December 2018 there had been a period of significant instability with a number of Chief Executives and Medical Directors over a relatively short period of time.

3) In addition to this there had been significant turnover in the operational management of the Acute Medical Directorate within which Urology was nested. There was lack of robust handover and the speed of changes led to loss of continuity, and thus

consistency, in addressing difficulties and in developing a reliable organisational memory.

4) With so much change and loss, the job descriptions for clinical and operational managers were developed and enacted at times in a piecemeal fashion resulting in lack of clarity and cohesion in relation to roles, responsibilities and accountability arrangements. This resulted in a lack of consistency at times across the governance functions of the roles which is now being addressed.

5) In addition to this, there had been a piecemeal approach to the delivery of governance functions with inconsistencies across the organisation and roles and responsibilities being unclear between different professionals and directorates. The Trust is in the process of improving and strengthening Professional and Clinical and Social Care processes as evidenced in answers throughout this response.

6) Furthermore, the prevailing culture that had developed in the Southern Trust in the past appears to have been focussed on productivity and meeting the obligation to break even. It appears that as a result governance structures and the requirement to provide quality services were not developed at the same rate as for example finance, performance and patient flow teams. In a healthy, well functioning system all of these are needed and they need to be able to work in conjunction with each other. It is well recognised that value for money and patient safety go hand in hand - “Care costs and Poor Care costs more”. The learning has been that these different functions must be complementary and supportive of each other,that is we must continue to develop systems that recognise that patient waits are a safety concern and that quality care provides best value for money.

7) Urology is a high-volume specialty, often dealing with patients with cancerous conditions. This demand, together with staff shortages, has resulted in a very busy and pressurised system creating a tendency for the staff then to look in and respond

to pressures rather than be able to always to look up and out and gain oversight and plan. We are in the process of significant changes to the Senior Management Team and this will allow opportunity through induction and training to develop systems' leaders cognisant of the learning form this and other Public Inquiries. To do this we will are in the process of involving the Leadership Centre and the King's Fund. Some of this work has started.

8) Training in Group and Organisational Dynamics, that is the psychological understanding of how groups and organisations function, is required, will support the approaches mentioned in the previous paragraph, and is being explored.

9) In addition to this I am implementing operational structural changes to the Trust by changing the roles and responsibilities of the directorates and developing 2 new directorates by splitting the functions of the current acute directorate into two parts in broad terms corresponding to i. Unscheduled Services and ii. Surgical, Cancer and Laboratory Services. This should allow a greater patient safety and governance focus throughout the organisation, particularly in Urology services. These changes will also coincide with the retirement of Mrs Melanie McClements in August 2022.

10) Whilst In the past there has been a number of changes and a loss of continuity and memory, the aim of the current changes is to develop stability and governance while improving patient experience and value for money. ATTACHMENT: SMT RESTRUCTURING document located at *S21 No 29 of 2022, 260. Structure Paper final arrangements June 2022*

11) To support this and through the work already started with the Medical Governance reforms in the Trust we will develop governance accountability structures through a triumvirate structure of Divisional Nurse, Divisional Doctor and Assistant Director reporting to SMT and Trust Board through the respective directors in order to strengthen

the Bed to Board Accountability. Work on this is has begun as the new directors come into post.

12) To support this, staff require training in governance and patient safety and we are in the process of developing this throughout the Trust, not just for Urology.

13) The Southern Trust also needs to embrace a culture that empowers staff, patients and carers to “Speak Up” when they have concerns. At times there has been a sense that because of busyness and work demands, staff have found it difficult to recognise when things are going wrong or to have the confidence to trust their own eyes in relation to this . Particularly where there has been fear of litigation and fear of reputational damage, there is a sense that staff have not always felt empowered to speak up or discuss their concerns and to proactively triangulate or share. I welcome the Department of Health’s consultation on Whistle blowing and the Trust will be formulating its response in the context of best practice nationally and in relation to its experiences in relation to Urology. To date we have been undertaking developmental work through HROD with Mersey Care NHS Foundation Trust in our approach to this and Mrs Vivienne Toal will be able to provide further details of this, and as part of the response to the Hyponatraemia Inquiry I had established a “Being Open Group” in the Trust to facilitate the awareness of responding to poor and good practice. To encourage staff to Speak Up and to reinforce good behaviours we have used the learning from one of the Scottish Patient Safety Fellows in the Trust to lead on Greatix which uses the principles of Nudge theory to promote good behaviours.

14) Typically, in most NHS organisations the tenure of senior doctors and nurses tends to be for much longer than managers and each team then often develops its own implicit identity and subculture which can be difficult to understand and where necessary, address, when difficulties arise. Mr O’Brien was employed in the Trust for 27 years. Most of the senior managers who worked with him were in post for a few years only.

15) Often these team cultures are developed and led by the most senior clinicians particularly if they are charismatic.

16) In addition to this, due in part to the changes in Medical Director in recent times, the communication between the appraisal system in the medical director's office and the medical managers required to be more robust. Mr O'Brien chose his own appraiser and brought only the information he wanted to. This process has now been developed as explained in my answer to Question 36.

17) This resulted in Mr O'Brien being appraised without all of the information in relation to the concerns raised in 2015 and the ensuing Maintaining High Professional Standards Investigation not being known to the Appraiser as it was not declared during the Appraisals by Mr O'Brien. This resulted then in an inadvertent false assurance on quality and safety performance being given by the appraiser, and thus loss of the opportunity to learn for improvement.

18) In addition to this, the quality of material brought to appraisal can be variable and this requires to be standardised through the development of professional governance dashboards that allow for information to be readily available to appraisees, appraisers and line managers in real time.

19) Another potential weakness in this system was the ability of the appraisee to choose their own appraiser from within any grade of permanent medical staff including those employed as a less senior grade. This ran the risk of appraiser and appraisee appraising each other and thus limiting the ability for learning from concerns.

20) In addition to this, feedback from patients and peers was invariably positive which again limits the ability to learn from concerns. The Trust is considering how this might be undertaken more objectively.

21) Revalidation assurance in place has also been strengthened and now requires significant medical professional governance data in addition to Appraisal data and a requirement that the panel of Divisional Medical Directors now make the recommendation to the GMC Responsible Officer based on their impression that the doctor is fit to practice. This also gives the other Divisional Medical Directors together with the Deputy Medical Directors the opportunity to raise issues if there are concerns from other divisions in relation to performance. This is outlined in answer to Question 36.

22) It is concerning that, on the face of it, such a highly respected, well known and experienced surgeon could practice over an extensive period of time and could not be adequately challenged by a number of senior peers and managers over the years. It is important to understand and improve upon the conditions that allowed this to happen

23) I am concerned that, given the evidence base from the GMC of doctors who get into severe difficulties and in keeping with the findings from the Patterson Report and the recent Independent Neurology Inquiry, poor behaviour seemed to be difficult to address and to recognise across the NHS as it was in this case. The vast majority of doctors are extremely dedicated and patient-focussed and work extremely well with all colleagues and, particularly as consultants, recognise themselves to be systems leaders who must always act in the best interests of the patient even in very challenging circumstances. Part of the role as a consultant in particular can be to challenge the status quo, particularly when the doctor believes that patient care is being compromised. Although at times this can be challenging for colleagues, my experience over the years has been that on the whole this is welcomed as, although it can be uncomfortable, it often stimulates the wider system to think. Those staff who are most concerning tend to be self-interested, to blame others and to hide behind the mantra of patient care rather than working proactively to improve this and, as an NHS, we are still not very sophisticated in recognising and dealing with concerning attitudes at an early stage. I am due to meet with the President of the GMC to discuss this in more detail when she visits Belfast in October 2022.

24) I am concerned that GPs and visiting clinicians to the Cancer MDMs who are likely to have had a helicopter view of Southern Trust Urology and Uro-oncology clinical systems (including prescribing of Bicalutamide), were not able to or did not either identify or escalate concerns or observations through the Trust operational or clinical management lines. Any queries that were raised appear to have been directly with Mr O'Brien and his secretary rather than his managers.

25) I am particularly concerned that the governance practices in place were not either sensitive or specific enough to capture at an earlier point the shortcomings in recording practices that led to the SAI chaired by Dr Hughes and the current lookback processes. The work that we have undertaken in the interim (and described throughout this statement) is to remedy these failings.

26) I am concerned that, inadvertently, "false assurances" were given by secretarial staff, presumably in good faith, that Mr O'Brien was compliant with backlog processes that were in place at the time.

27) I regret that, even in the absence of evidence that these governance processes were not working, we did not audit aspects of this in the intervening period from 2017 onwards when the Action Plan emanating from when the 2016 MHPS investigation was carried out.

28) I am concerned that any challenges to Mr O'Brien or the secretarial staff supporting him were counter challenged as bullying, and that as a result those involved were then prevented from being able to proceed in pursuing the concerns and others then felt disempowered to act. Through the work that is being undertaken with Mersey Care NHS Foundation Trust, and through the strategy being adopted through HROD's "The People Plan", we are attempting to build a culture that will address this and empower people to have the Freedom to Speak Up. Attachment: Draft People Plan document located at *S21 No 29 of 2022, 261. Draft People Plan*

29) When described as bullying, these claims were not investigated and there was no clear resolution and learning or progress as a result.

30) In retrospect, knowing what I know now, I believe that monitoring of Mr O'Brien should have been more robust and proactive than it was. To drive this, I now believe that the oversight should not have depended on escalation of default from the 2017 Action plan but that information should have been more proactively sought, audited, and assured on a regular basis.

31) I think that I, and others, failed to realise rapidly enough that the usual approaches to monitoring that typically work for other doctors in similar situations, would not work for Mr O'Brien and his secretary who had a history of knowingly or unknowingly withholding, or at least not sharing, information. As mentioned above, in 30 years of clinical practice and 15 years of senior medical management I had not encountered this before in a doctor's work but I should have been cognisant of the fact that this was possible. This has now resulted in a more proactive approach to monitoring doctors through the development of the Doctors' and Dentists' Oversight Group in the Trust where we actively encourage ourselves to challenge our own assumptions and develop and encourage a stance of curiosity.

32) I am concerned that the SAI chaired by Dr Johnston did not automatically identify the shortcomings in care and governance that came to light with the subsequent SAIs chaired by Dr Hughes and in the SCRRs since.

33) The Terms of Reference chosen appear to have fitted with the circumstances of the 2015-2016 SAIs which were very much about referral systems and processes (the "front end" of the patient journey) but did not readily anticipate the problems we uncovered later in 2020 which very much identified failures in managing patients once a diagnosis had been made (the "back end" of the patient journey). This, unfortunately, did perpetuate a blind spot in the system's understanding of the risks to patient safety.

34) The tendency towards silo working across the system perpetuated this and is now being addressed through a change of management structures and escalation processes which will be reviewed later in 2022.

35) I welcome the recent publication by RQIA in relation to SAIs (ATTACHMENT: doh-rqia-review. Document located at *S21 No 29 of 2022, 262. Doh-rqia-review*. I believe that this publication recognises the challenges in standardisation and providing meaningful SAI reports that promote learning and understanding. In the interim and until improved systems are in place, the Southern Trust has developed a core SAI team and SAI oversight through the Directors of Nursing, Medicine and Social Work to quality assure these.

68.2 In summary then, I am curious as to how in the future we prevent similar failings from recurring and particularly how the NHS and General Practice achieves the following:

a. expects and supports openness and courage in speaking up without fear of reprisal,
b. recognises better the “smoke signals” of poor governance and poor behaviours,
c. continues to develop robust governance systems that are fit for purpose and which are sensitive enough to variations in care and provide adequate intelligence for clinical and non-clinical managers to be able to robustly challenge,
d. works more robustly as a system that considers Patient Safety as a primary and single function rather than in parallel or siloed parts,
e. develops robust approaches to triangulating data and captures organisational memory in linking concerns together in a narrative rather than treating them as single isolated events,
f. identifies when inadvertently “false assurance” is given and develops intelligent and robust processes for testing these assurances in a timely fashion,
g. develops to support robust, regular feedback from staff including visiting clinicians and GPs,

h. develops a culture of curiosity that is expected/ required/ encouraged, and ensures that the system continues to try to be developed when there may be clinical concerns in a safe and confidential manner;
i. emphasises that probity is a foundation of medical practice, requiring reinforcement through role-modelling, teaching and training,
j. develops courageous and robust clinical and non-clinical managers,
k. explores the development of freedom to speak up guardians in line with NHS England
l. develops robust and fair means for dealing with senior clinicians regardless of profession who practice poorly (we have learned from other Inquiries locally and nationally the power of personality and reputation and how difficult it is then for peers and managers to have doubts or challenge and raise concerns; this is particularly difficult when the clinician works across a variety of areas that may have little or no formal or informal connection with each other and where there are numerous interactions in different geographical locations across different times; it is also particularly challenging in the current climate of significant waiting lists and staffing shortages, in a challenging financial NHS climate, and in particular in hard pressed specialities where busyness can be an inadvertent smoke screen for cutting governance corners),
m. recognises that, when a system is under pressure, governance processes to support patient safety should actually be strengthened given the greater propensity in this situation for things to go wrong,
n. develops an expert system that supports senior clinical leaders and managers to access robust, reflective expertise that can help them to access “blind spots” more readily and add to the quality assurance of their process for developing awareness and solutions particularly in complex situations such as this.

I am hopeful that all of the learning that has emerged from this can be embedded in improvement in Urology and across the NHS and General Practice as soon as possible.

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

69.1 I think that although there was an awareness of the problems in the system the extent of these was not fully recognised. Based on what I have learned to date, but remaining aware that I do not have the full facts, my sense is that over the years a culture had developed that concentrated on activity to the detriment of quality and that, when things went wrong, the system pushed itself to work harder and harder doing more of the same rather than changing its approach. Establishing these facts will, of course, be for the Public Inquiry.

69.2 Since I arrived in the Southern Trust I have been very struck by the intense diligence and professionalism of the vast majority of the staff here who have kept their heads down and kept working as best as they can, who have been aware of the difficulties but have not felt empowered to sort out or change these and have not had the time and capacity to reflect and develop.

69.3 From my own early experience in the Trust, I was also aware that questions and curiosity were sometimes experienced as an attack as some staff appeared to believe that questions constituted criticism. On reflection, this was a measure of how difficult it might have been then for others to speak up if they feared being attacked or criticised in response or even dismissed.

69.4 It seems that, as staff encountered problems, they developed workarounds for the immediate problem and so the system became increasingly reactive and did not have the capacity to take a step back, reflect on the whole picture, pull together the narrative and develop an understanding of the difficulties over the longer term. In answer to the question then I would state that, on one level, there was full engagement with the problems within Urology Services in so far as they were identified as best they could be and responded to accordingly but that, on another level, the capacity to step back, undertake a full reflection and approach the development of solutions with all of the information and history available was not possible in the past.

69.5 What perpetuated this culture as well was the difficulty that people found in being taken seriously when they spoke up about problems. Mr. Mackle for example found himself accused of bullying as a result and was placed in the position of having to step away from his responsibility for Mr. O'Brien. Others who raised concerns were moved to other areas such as Heather Trouton and her concerns not followed through. The workarounds to ensure patient safety such as the automatic default to G.P. referral level when red flag referrals weren't triaged, whilst on the face of it a solution, in fact actually helped perpetuate a problem and, once again, was symptomatic of a system not being able to take a step back and reflect on its entirety rather its separate problematic parts..

69.6 From the beginning of my tenure, Mr O'Brien was actively managed through the action plan developed in 2017 as a result of raising of concerns and the outworkings of the MHPS process.

69.7 However, I came to be aware that he had not engaged with this in June to September 2018 and then again in June to September 2019 and, on neither occasion, had he informed others, albeit that the deviation was then discovered. In addition to this, the assurances that were being given by administrative staff to managers monitoring this were not reliable,

but this was not known until September 2019, when Mr O'Brien's secretary went on leave and her replacement drew Mrs Corrigan's attention to the discrepancy in dictation between patients reviewed at clinic and those actually having a letter on each outpatient appointment. In addition to this, there were also further blind spots in the system in relation to dictation on day cases and on MDM patients which eventually led to the deficiencies in care experienced by patients which have been uncovered since the 7th June 2020 email from Mr O'Brien to Mr Haynes.

69.8 Since the point of discovery that there was a misalignment of surgical patients known to the system (as identified in the email Mr O'Brien sent to Mr Haynes on the 7th June 2020) and the subsequent SAIs chaired by Mr Dermot Hughes, my sense has been that there is full engagement with this process.

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

70.1 I came to the Trust on 1st December 2018 and was not involved in the investigations that had taken place in relation to Urology prior to this. Based on the evidence available to me at that time as a result of the investigations in relation to delays in his processing of patients in keeping with the IEAP process, monitoring processes were put in place through the Case Manager and lead for HR through the MHPS process.

70.2 On the basis of the data available at that time and in the absence of concerns being raised about prescribing or the management of patients through the cancer pathways I did not have concerns raised with me at that time in relation to Mr O'Brien's clinical performance or patient safety, but was aware that his conduct was concerning. When it was discovered on 7th June 2020 that there was a discrepancy in waiting and surgical lists, this was fully explored and the Department of Health informed.

70.3 If I had known in January 2019 what I know now (i.e., since June 2020) I would have done a number of things differently.

i. As Medical Director, I would have advised the Directors' oversight of Mr O'Brien's MHPS case and the Chief Executive that a further restriction, if not exclusion, to his clinical practice be instigated. This should have been done while we undertook a review of all of his practice and not just the practice which had been highlighted as deficit at that point, namely in relation to triage, dictation, record access and private patients.

ii. As was the case throughout the MHPS investigation and throughout Dr Johnston's SAI, the system was blind to a part of itself, namely the uro-oncology aspects of care. On reflection, this was due to the fact that this part of the system in the Southern Trust is managed separately from Urology services, including the Cancer Nurse Specialists, and also because some of the consultants as part of the MDM were either absent or employed by a separate Trust (the Belfast Trust) or both.

iii. For example, there was lack of awareness during the SAI and MHPS processes that the Clinical Nurse Specialists had been excluded from the patients' care and, as such, they were not interviewed. Had they been included, this may have given us an indication at an earlier stage that there were difficulties with cancer pathways. It was not until Mr Haynes spotted the discrepancy in patient lists and explored this that we were able to identify the range of difficulties in Mr O'Brien's care of cancer patients. Dr Hughes' SAI process and the subsequent Structured

Clinical Record Reviews have deepened our awareness of the extent of the problems.

iv. That said, the governance processes that were in place at that time did not capture the difficulties adequately to recognise the risks to patient safety. Arguably the only person who was fully cognisant of Mr O'Brien's practice at that time was Mr O'Brien and he did not raise these concerns to his medical or operational line managers.

v. In addition to this, when concerns were raised in the past it appears to have been difficult for Trust clinicians and managers to have felt supported or taken seriously in dealing with the challenges presented by Mr O'Brien. This then seems to have engendered a culture of deference, acceptance and silence. If these staff had been more fulsomely supported and the information they presented triangulated this may have addressed these concerns at an earlier stage.

vi. As outlined in previous answers when I arrived in the Trust from January 2019 onwards I worked to strengthen Corporate Clinical and Social Care Governance. As a result, I commissioned a review through the Chief Executive of CSCG and have been implementing the Action Plan from this that was developed in Autumn 2019 and throughout the course of the pandemic (which has delayed its implementation).

vii. In addition to this, I have introduced improvements into the system of Professional Governance through Appraisal and Revalidation processes and the oversight of doctors and dentists in difficulty and medical leadership development.

viii. As Chief Executive I am in the process of restructuring Operational Directorate structures to strengthen clinical and social care governance and further increase the focus on patient safety and developing mechanisms to support freedom to speak up and whistleblowing.

ix. Recently, when we discovered mistakes made in relation to patient communication from December 2021 with regards to information about the process of the Public Inquiry, I appointed an independent expert seconded from the Northern Trust and the Department of Health to oversee and quality assure our approaches in relation to the Look Back and to present challenges as a system in the process of providing assurance to Trust Board and our wider community.

x. The Permanent Secretary has approached the Trust in relation to the involvement of RQIA and has asked them to develop Quality Assurance Systems in relation to the out-workings of the Public Inquiry.

xi. We have worked with Colleges, the Invited Review Services, the British Association of Urological Surgeons, the GMC, and NHS Resolution throughout the course of the Public Inquiry and at a previous stage (when we realised that there were difficulties) to learn how we might improve. In addition to this, we have liaised with NHS Birmingham who previously dealt with Mr. Patterson, Consultant Surgeon, in relation to their processes with respect to medical appraisal and revalidation.

xii. We have striven to learn from other Inquiries and have liaised with Donna Ockendon, some of those who were involved in the Hyponatraemia Inquiry,, Birmingham NHS Foundation Trust (in relation to Mr Patterson), and have made contact with those involved with the Morecambe Bay Report (which was published in 2021 in relation to Urology Services in Morecambe Bay).

xiii. We are in the process of developing an External Programme Board involving external experts from England and Scotland to provide systemic challenge to us as a Trust and to develop the assurance we require for Trust Board and our wider community.

ATTACHMENTS : CSCG Review, document located at *S21 No 29 of 2022, 53. CHAMPION GOVERNANCE REVIEW 2019*, *S21 No 29 of 2022, 54. Action plan* Medical Leadership paper *S21 No 29 of 2022, 52. Medical Leadership Development Update November 2021 ,* Changes brought about in relation to Appraisal, Revalidation, development of Doctors' and Dentists' oversight, linking of incidents to learning through the academic programme, simulation , Learning from Experience, introduced training in MHPS document located at *S21 No 29 of 2022, 112. MOK PI Appraisal Revalidation Narrative 13062022*

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

71.1 There are a variety of descriptions of how clinical and social care governance in the NHS should be delivered. There is discrepancy between the Department of Health England and NI definitions and the RQIA definition and those provided by the Royal Colleges. As such, it can be difficult to recognise a good enough Governance system until it is tested.

71.2 In responding to this Question, I am considering these answers in the context of the current Department of Health NI's use of the HM Treasury (website) definition of governance being "the system by which an organisation directs and controls its functions and relates to its stakeholders". In other words, the way in which organisations:

i. Manage their business;
ii. Determine strategy and objectives;

iii. Go about achieving these objectives.

71.3 In its Review of Clinical and Social Care Governance Arrangements in Health and Social Care Trusts in Northern Ireland 2008: Southern Health and Social Care Trust, RQIA described CSCG as a framework within which HPSS organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment.

71.5 These definitions' emphasis is different from those described in the 2021 Department of Health (England) definition which states that:

"Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence can flourish.

Clinical governance encompasses quality assurance, quality improvement and risk and incident management".

71.6 It goes on to state that commissioning arrangements are important to good governance – ensure the quality of services are specified and that service level agreements are in place, that funding is secured, and that the system is future proofed.

71.7 I mention these discrepancies between definitions of what governance is as I think that it automatically has the potential to cause uncertainty in the system. The Northern Ireland definition does not, for example, make reference to creating an environment where clinical excellence can flourish and, as such, may create a sense that there is no expectation of this corporately.

71.8 In Northern Ireland, Clinicians are guided by Royal Colleges, NICE, their regulatory bodies, and other best practice guidance across the rest of the UK which by and large is

developed in tandem with Department of Health England guidance and have the expectation then that clinical excellence can flourish.

71.9 I am also cognisant that CSC Governance is not clearly standardised at an operational level across HSC organisations in Northern Ireland and, throughout the 30 years of working in the HSC across different Trusts, I believe it is interpreted in different settings in different ways. CSC Governance is not unique in this regard: in respect of the way clinical teams are determined and defined and thus commissioned in a modern HSC, there is no clear descriptor of how many people and at which grade are required to deliver on an agreed quota of work and evidence improvements in patient safety.

71.10 In addition to this, when clinical services are commissioned they are not required to outline fulsomely the corporate functions that are required to assure quality and governance and these are often added from existing Trust resource as an afterthought or as an extension of what exists already rather than offering the opportunity to consider something bespoke to the needs of each individual area within a system..

71.11 This means in practice that what is enacted in one Trust through systems and processes to promote patient safety can be different to those in others. Comparing the impact of the different systems is problematic as the measures of patient safety and approaches to the use of this data and triangulation are not agreed across Northern Ireland and are variable across the rest of the UK.

71.12 The underlying assumption often largely untested is that if the CSCG processes are assured to be sound then these automatically ensure good outcomes for patients. The difficulty with this assumption is that each process is usually considered in isolation and its unintended consequences as part of a system may however be problematic and largely untested before implementation.

71.13 Take, for example, the governance process that was developed circa 2015 for ensuring that patients who were GP referrals and not triaged by Mr O'Brien were

automatically placed on PAS lists depending on the GP grading of risk. On the face of it, this was a failsafe action to protect patients from being lost to follow-up.

71.14 In actual fact, what then happened was that the underlying problem was not addressed, namely the non-triage, and at the same time false assurance was given that because patients were on a list they were safe. In addition, this also served to mask who had been triaged and who hadn't and meant then that, when attempts were made to quantify the breadth and impact of the non – triage, these patients were very difficult to identify and revisit and their outcomes were potentially impacted upon as a result.

71.15 Another example of this appears to have been the limited development and ownership of CSCG processes in the Southern Trust prior to the Champion Review which then led to a system that was challenged in managing patient safety concerns in Urology and which for example had lost its functioning Clinical Audit functions and had at times rudimentary approaches to other CSCG approaches.

71.16 Moving to the specific limbs of Question 71, I address these in the table below.

	Response
Do you think, overall, the governance arrangements were fit for purpose?	I arrived in the Trust on the 1st December. The Acting Assistant Director for Governance Trudy Reid was appointed in January 2019, both of us then assuming key roles in relation to the Corporate aspects of Integrated Clinical and Social Care Governance (CSCG) at around the same time. I was completely new to the organisation and in the course of my induction and orientation was increasingly aware that some of the key functions that were required to assure governance supporting patient safety, were rudimentary. I was concerned whether some of these governance processes were fit for purpose.

	On the basis of this, I approached the Chief Executive and asked for support in commissioning a review of CSCG across the Trust. This was undertaken through the Leadership Centre by Mrs June Champion who is a highly regarded local expert in this area. She produced the Champion Report in September 2019.
Did you have concerns about the governance arrangements and did you raise those concerns with anyone?	Yes, I had concerns about the paucity of the functions usually associated with providing a robust system of governance. I brought this to the attention of the Chief Executive, Mr Shane Devlin, who supported the commissioning of Mrs June Champion to produce the Champion Report in September 2019. In addition to this, to strengthen governance assurance in the operational directorates I introduced and led the weekly Trustwide Governance Group which includes Clinical Executive Directors and Divisional Medical Directors, which reports weekly to SMT and monthly to Trust Non- executive Directors ATTACHMENTS: CHAMPION REPORT, RESPONSE, UPDATED ACTION PLAN. Documents located at S21 No 29 of 2022, *53. CHAMPION GOVERNANCE REVIEW 2019, 55. DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW, 54. JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMMENDATIONS* I also had concerns about Professional Governance in the ST and this was strengthened to address these concerns.
If yes, what were those concerns and with whom did you raise them and what, if	The concerns were that the Clinical and Social Governance systems, specifically management of complaints ,SAI, standards and guidelines, clinical audit and Datix, mortality reporting and the quality assurance of these systems and triangulation of these systems were not well enough developed to provide enough governance assurance. This was raised with Mr Devlin, SMT and Trust Board and plans and funding strategies were agreed through a programme of improvement. The first aspect of this was to develop plans for improving Standards and Guidelines, Datix and SAI in year one and mortality reporting was brought up to date. Through the relevant strategies these have been progressed following significant investment.

anything, was done?	The next phase, significantly delayed by the pandemic, has been the development of the Clinical Audit Strategy, which is currently underway (ATTACHED). Document located at *S21 No 29 of 2022, 37. DRAFT CLINICAL AUDIT STRATEGY 2022* Thus, this is still a work in progress and is being developed as described in the Action Plans and in the improvements outlined in my answers to Questions 7, 8, and 21 in relation to Professional and Clinical Social Care Governance. I am also progressing the restructuring of how governance is assured by Trust Board across the Trust through restructuring of the operational directorates in order to assure quality and safety from bed to board, second and third line assurances are being developed through use of clinical audit, use of internal audit and the changes through the Champion Report and monitoring by external agencies. Governance training is being developed for delivery throughout the Trust to strengthen awareness of speaking up, governance processes, the importance of triangulation and quality assurance across the organisation and the importance of not viewing patient safety and clinical and social care governance in isolation. All of these have been developed in relation to the concerns that have been raised in the course of maintaining high professional standards in relation to Mr. O'Brien and in the course of the Serious Adverse Incidents chaired by Drs. Johnston and Hughes and throughout the course of the Look Back exercise and with the Public Inquiry. The Professional Governance concerns to which I have referred in my answer to Question 21 in relation to the process of Appraisal, Revalidation and leadership in particular were identified as requiring improvement as part of the review of professional and medical management processes which I undertook and have developed and am in the process of embedding.

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

72.1 No

NOTE:

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

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 23 August 2022

S21 29 of 2022

Witness statement of: Maria O'Kane

Table of Attachments

Attachment	Document Name
1	MEDICAL DIRECTOR HANDOVER FROM DR KHAN
2	GMC MEETING MINUTES AND CORRECTIONS (EMAIL)
3	GMC MEETING MINUTES AND CORRECTIONS (EMAIL) 2
4	GMC MEETING MINUTES AND CORRECTIONS (EMAIL) 2 A1
5	20190402 AO'B fitness-to-practise-referral-form
6	20200811 E Discussion with Naresh Chada
7	UAG MINUTES DECEMBER 2020
8	SCRR FORM
9	GMC 1394911 Screenshot of GMC Medical Register
10	*CHIEF EXECUTIVE JOB DESCRIPTION (2022)*
11	*MEDICAL DIRECTOR JOB DESCRIPTION (2018)*
12	*DIRECTOR MENTAL HEALTH AND DISABILITY JOB DESCRIPTION*
13	*JOB DESCRIPTION DMD APPRAISAL & REVALIDATION*
14	*JOB DESCRIPTION DMD QUALITY, SAFETY AND GOVERNANCE*
15	*JOB DESCRIPTION AD MEDICAL DIRECTORS OFFICE*

16	*JOB DESCRIPTION AD CLINICAL & SOCIAL CARE GOVERNANCE*
17	*JOB DESCRIPTION AD INFECTION PREVENTION AND CONTROL*
18	*JOB DESCRIPTION AD MENTAL HEALTH INPATIENTS*
19	*JOB DESCRIPTION AD COMMUNITY MENTAL HEALTH SERVICES*
20	*JOB DESCRIPTION AD DISABILITY SERVICES*
21	*ORGANOGRAMS OF MANAGEMENT STRUCTURES MEDICAL DIRECTORS OFFICE*
21a.	Medical Directorate Organisational Chart April 2022
22	*ORGANOGRAMS OF MANAGEMENT STRUCTURES MENTAL HEALTH AND DISABILITY*
23	M&M STRATEGIC OVERSIGHT GROUP
24	GUIDANCE FOR THE REGIONAL MORTALITY AND MORBIDITY (M&M) PROCESS
25	COMINBED SURGERY PATIENT SAFETY MEETING AGENDA SAMPLE
26 (1-55)	UROLOGY PATIENT SAFETY MEETING AGENDA SAMPLE
27	REGIONAL MEDICAL DIRECTORS' LETTER RE RAISING CONCERNS
28	QUARTERLY MORTALITY REPORT - JULY 2020 – JUNE 2021
29	WEEKLY GOVERNANCE REPORT EXAMPLE
30	CLINICAL AND SOCIAL CARE GOVERNANCE REPORT TO TRUST GOVERNANCE COMMITTEE EXAMPLE
31	DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE
32	DIVISIONAL MEDICAL DIRECTOR MEETING AGENDA EXAMPLE 1
33	DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE
34	DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 1

35	DIVISIONAL MEDICAL DIRECTOR MEETING MINUTES EXAMPLE 2
36	DIVISIONAL MEDICAL DIRECTOR MEETING 1-1 TEMPLATE
37	DRAFT CLINICAL AUDIT STRATEGY 2022
38	DRAFT CLINICAL AUDIT STRATEGY PRESENTATION 2022
39	NURSING QUALITY INDICATOR SUMMARY REPORT EXAMPLE
40	TERMS OF REFERENCE MEDICAL REVALIDATON OVERSIGHT GROUP
41	DRAFT TERMS OF REFERENCE SERIOUS ADVERSE INCIDENT OVERSIGHT GROUP
42	WEEKLY SUMMARY SMT GOVERNANCE REPORT
43	*AD of Surgery Elective Care Band 8C*
44	*HEAD OF SERVICE UROLOGY, ENT AND OUTPATIENTS JOB DESCRIPTION*
45	*CLINICAL DIRECTOR (CURRENT), UROLOGY AND ENT*
46	*DIVISIONAL MEDICAL DIRECTOR, SURGERY AND ELECTIVE CARE*
47	*DIVISIONAL MEDICAL DIRECTOR, UROLOGY IMPROVEMENT*
48	ACTIONS IN RESPONSE TO WHISTLEBLOWING REPORT D DUFFIN
49	ACTIONS REQUIRED FROM GOVERNANCE COMMITTEE MEETING ON 6TH DECEMBER 2018
50	MEDICAL LEADERSHIP REVIEW JUNE 2019
51	MEDICAL LEADERSHIP REVIEW MARCH 2020
52	MEDICAL LEADERSHIP DEVELOPMENT UPDATE NOVEMBER 2021
53	CHAMPION GOVERNANCE REVIEW 2019

54	JUNE 2022 UPDATE ON GOVERNANCE REVIEW RECOMENDATIONS
55	DRAFT RESPONSE TO THE CLINICAL AND SOCIAL CARE GOVERNANCE REVIEW
56a	*Corporate Clinical Social Care Governance Coordinator*
56b	HEAD OF PATIENT SAFETY DATA AND IMPROVEMENT
57	CORPORATE SENIOR MANAGER OF STANDARDS, RISK AND LEARNING
58	ASSISTANT DIRECTOR SYSTEMS ASSURANCE
59	HEAD OF SERVICE SYSTEMS ASSURANCE AND CLINICAL AUDIT
60	ACUTE CLINICAL AND SOCIAL CARE GOVERNANCE COORDINATOR
61	LETTER SHARON GALLAGHER 081221 RE REVISED IEAP
62	Urology Outpatient Total Waits April 18 Onwards,
63	Urology Red Flag Referrals April 18 onwards,
64	Urology Outpatient Longest Waits April 18 onwards
65	Urology IP Longest Waits April 18 onwards
66	Urology Inpatient Total Waits April 18 onwards,
67	Urology Day Case Total Waits April 18 onwards
68	Urology Day Case Longest Waits April 18 onwards

69	SPC UROLOGY REVIEW BACKLOG
70	Urology mentions in CPD report
71	TEAM SOUTH UROLOGY PLAN
72	HEAD OF SERVICE FOR APPRAISAL AND REVALIDATION JOB DESCRIPTION
73	TERMS OF REFERENCE DOCTORS AND DENTISTS OVERSIGHT GROUP
74	CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE FUNCTIONS PAPER 2019
75	FAMILY LIAISON OFFICER JOB DESCRIPTION
76	SAI CHAIR JOB DESCRIPTION
77	CORPORATE COMPLAINTS MANAGER JOB DESCRIPTION
78	PROPOSAL PAPER ON STRENGTHENING CLINICAL AUDIT FUNCTION
79	*DOH CIRCULAR ANNUAL APPRAISAL FOR CONSULTANTS AND STAFF AND ASSOCIATE SPECIALIST MEDICAL STAFF IN HSC TRUSTS*
80	*GMC GOOD MEDICAL PRACTICE FRAMEWORK FOR APPRAISAL AND REVALIDATION*
81	*GMC GUIDANCE ON SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION*
82	*MEDICAL STAFF APPRAISAL AIDE MEMOIRE AND QUALITY ASSURANCE AUDIT TOOL*
83 (1-11)	*1-1 AGENDAS WITH CHIEF EXECTIVE* 20201218 CX 1-1 – A10,
84 (1-17)	*1-1 AGENDAS WITH CHIEF EXECTIVE* 20210308 CX 1-1 – A16
85 (1-17)	*1-1 AGENDAS WITH CHIEF EXECTIVE* 20210505 CX 1-1 – A16,
86 (1-20)	*1-1 AGENDAS WITH CHIEF EXECTIVE* 20210608 CX 1-1 – A19
87	*20191017 Performance Committee Agenda*

88	*20191209 Performance Committee Agenda*
89	*20200319 Performance Committee Agenda NO MEETING*
90	*20200521 Performance Committee Agenda*
91	*20200903 Performance Committee Agenda*
92	*20201203 Performance Committee Agenda*
93	*20210318 Performance Committee Agenda*
94	*20210520 Performance Committee Agenda*
95	*20210902 Performance Committee Agenda*
96	*20211202 Performance Committee Agenda*
97	*20220310 Performance Committee Agenda*
98	*20220519 Performance Committee Agenda*
99	*20191017 Approved Performance Committee Minutes*
100	*20191209 Approved Performance Committee Minutes*

101	*20200319 Feedback questions and answers Marsh 2020 Performance Committee_ Final NO MEETING*
102	*20200319 Performance Committee_ Chair Report*
103	*20200521 Approved Performance Committee Minutes*
104	*20200903 Approved Performance Committee Minutes*
105	*20201203 Approved Performance Committee Minutes*
106	*20210318 Approved Performance Committee Minutes*
107	*20210520 Approved Performance Committee Minutes*
108	*20210902 Approved Performance Committee Minutes*
109	*20211202 Approved Performance Committee Minutes*
110	*20220310 Approved Performance Committee Minutes*
111	Medical Staff Appraisal and Revalidation Policy 2022
112	Appraisal and Revalidation Changes from 2019 to current
113	WEEKLY GOVERNANCE MEETING
114	Case Review Mr Personal Infor
115	Mr Personal Infor – A4
116	Case Review Mr Personal Infor_ A1
117	Case Review Mr Personal Infor_A2.1
118	Case Review Mr Personal Infor_ A2.2
119	Case Review Mr Personal Infor_ A2.3
120	Case Review Mr Personal Infor_ A2.4
121	Case Review Mr Personal Infor_ A2.5
122	Case Review Mr Personal Infor_ A2.6
123	Case Review Mr Personal Infor_ A2.7
124	Case Review Mr Personal Infor_ A2.8
125	Case Review Mr Personal Infor_ A2.9
126	Case Review Mr Personal Infor_ A2.10
127	Case Review Mr Personal Infor_ A2.11

128	Case Review Mr [redacted]_ A2.12
129	Case Review Mr [redacted]_ A2.13
130	Case Review Mr [redacted]_ A2
131	Case Review Mr [redacted]_ A3
132	Case Review Mr [redacted]_ A4
133	MEDICAL ASSURANCE REPORT TO TRUST BOARD 23.06.2022
134	HCAT GUIDANCE
135	SMT Agendas Notes - Re Urology

136	*DIRECTORATE RISK REGISTER*
137	*SURGERY AND ELECTIVE DIVISIONAL RISK REGISTER*
138	*20211116 GOVERNANCE COMMITTEE MINUTES,*
139	*REVIEW OF MR A's PRIVATE PRACTICE*
140	*REVIEW OF MR A's PRIVATE PRACTICE 2*
141	*TRUST GOVERNANCE COMMITTEE TERMS OF REFERENCE*
142	*20220526 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS*
143	*20220331 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS*
144	*20220127 TRUST BOARD UPDATE ON UROLOGY CLINICAL CONCERNS*
145	MOK PI Appraisal & RevalidationNarriative13062022
146	AMD MEETINGS MINUTES – 18th January 2019
147	AMD MEETINGS MINUTES – 15th February 2019
148	AMD MEETINGS MINUTES – 26th April 2019
149	AMD MEETINGS MINUTES – 24th May 2019
150	AMD MEETINGS MINUTES – 26th July 2019
151	AMD MEETINGS MINUTES – 23rd August 2019
152	AMD MEETINGS MINUTES – 27th September 2019
153	AMD MEETINGS MINUTES – 25th October 2019
154	AMD action notes 22nd November 2019 v2
155	AMD MEETINGS MINUTES – 31st January 2020

156	AMD MEETINGS MINUTES – 28th February 2020 – DRAFT
157	AMD MEETINGS MINUTES – 27th March 2020
158	AMD MEETINGS MINUTES – 22nd May 2020
159	AMD MEETINGS MINUTES – 26th June 2020
160	AMD Action notes – 28th August 2020
161	AMD Action notes – 23rd October 2020
162	AMD Minutes – 27th November 2020
163	AMD Action notes – 22nd January 2021
164	AMD Action notes – 26th February 2021 (1)
165	AMD Action notes – 26th March 2021
166	AMD Action notes – 23rd April 2021
167	AMD Action notes – 28th May 2021
168	AMD Action notes – 25th June 2021
169	AMD Meeting Minutes – 28th June 2021
170	AMD Action Notes 23rd July 2021
171	DivMD.AMD meeting minutes 22.10.21
172	DivMD.AMD meeting minutes 19.11.21
173	DivMD.AMD meeting 03.12.21
174	HOT CLINIC ACTIVITY DATA
175	*Urology Board paper v2 1 Sept*
176	UROLOGY COMPLAINTS SINCE 2009
177	BLUESKY MODEL UROLOGY
178	ST Urology Benchmarking - Updated 6.7,
179	20100603 Urology Benchmarking
180	20201207 - Agenda PIG meeting example
181 (1-78)	*Action Plan Update June 2022 – A53*
182	URO-ONCOLOGY IMPROVEMENT
183	Briefing Paper on new structure and process for Urology Lookback Review v2 9th June 2022
184	slides-su2s-triangulating-data

185	Review of urology letters investigation action plan
186	20220531-final report of review of urology letters investigation
187	*MONITORING PROCESS IN RELATION TO 2017 ACTION PLAN MHPS*
188	PERM SEC LETTER JULY 2022
189	*Admin Review Process –* *Triage Process April 21*
190	*Admin Review Process - Consultant to Consultant Referrals SOP*
191	*Admin Review Process - Guide to Paying Patients*
192	*Admin Review Process - Services not using e-triage*
193	*Admin Review Process - PAS OP Referral Source Code Private to NHS*
194a.	Workforce Metrics Feb 22 – April 22
194b	Workforce Metrics Nov 21 – Jan 22
194c	Workforce Metrics 250621
194d	*Job Planning Guidance final agreed with LNC April 19*
195	20190131 Action Notes,
196	20190502 AGENDA - HR & Medical Directorate Meeting,
197	20190718 AGENDA - HR Medical Directorate Meeting,
198	20191015 AGENDA - HR Medical Directorate Meeting,
199	20200709 Medical Directorate and HR Meeting
200	20200820 AGENDA - HR Medical Directorate Meeting,
201	20201001 ACTION NOTES HR & Medical Directorate Meeting
202	20201105 AGENDA HR & Medical Directorate Meeting,
203	20201217 AGENDA HR & Medical Directorate Meeting,

203.1	20201217 AGENDA HR & Medical Directorate Meeting, A1
203.2	20201217 AGENDA HR & Medical Directorate Meeting, A2,
204	20210414 ACTION NOTES HR & Medical Directorate Meeting,
204.1	20210414 ACTION NOTES HR & Medical Directorate Meeting, A1,
204.2	20210414 ACTION NOTES HR & Medical Directorate Meeting, , A2,
204.3	20210414 ACTION NOTES HR & Medical Directorate Meeting, , A3, ,
204.4	20210414 ACTION NOTES HR & Medical Directorate Meeting, A4
204.5	20210414 ACTION NOTES HR & Medical Directorate Meeting, A5,
205	20210616 AGENDA HR Medical Directorate Meeting
205.1	20210616 AGENDA HR Medical Directorate Meeting and A
206	20211008 AGENDA HR & Medical Directorate Meeting
206.1	20211008 AGENDA HR & Medical Directorate Meeting, A1,
206.2	20211008 AGENDA HR & Medical Directorate Meeting, A2
206.3	20211008 AGENDA HR & Medical Directorate Meeting, A3,
207	20211208 AGENDA HR & Medical Directorate Meeting,
207.1	20211208 AGENDA HR & Medical Directorate Meeting, A1,
207.2	20211208 AGENDA HR & Medical Directorate Meeting, A2,
207.3	20211208 AGENDA HR & Medical Directorate Meeting, A3
207.4	20211208 AGENDA HR & Medical Directorate Meeting, A4,
208	20220414 HR medical directorate meeting,
209	20210205 AGENDA OF MEDICAL HR MEETING,
209.1	20210205 AGENDA OF MEDICAL HR MEETING, A1,
209.2	20210205 AGENDA OF MEDICAL HR MEETING, A2,

209.3	20210205 AGENDA OF MEDICAL HR MEETING, A3
209.4	20210205 AGENDA OF MEDICAL HR MEETING, A4
210	20210205 NOTES OF MEDICAL HR MEETING.
211	20211005 Open Urology Claims
212	20060718 Ltr to J Templeton re [redacted]
213	20111110 E re Amended Job Plan 11-12
214	Outcome of facilitation process
215	Job plans and summary screenshot
216	JobPlan - Mr Aidan O'Brien - 01.01.2020
217	Lookback Review Letter Update 180722
218	20200708 Note of Zoom Mtg with Joanne Donnelly
219	AOB litigation history requested and supplied by Trust litigation team
220	Litigation Report re Patient [redacted] received by Trust
221	Email from Dr Scullion informing of GMC decision to defer AOB revalidation
222	Job Plan 05 4 18 AOB,
223	Case review structured reflective template
224	20191024 E from JD SHSCT Dr O'Brien GMC No 1394911
225	20200817 E to General Medical Council - Mr O'Brien Encryption
226	*20200817 E to General Medical Council - Mr O'Brien Encryption A1*
227	20201109 General Medical Council - Mr O'Brien – A6
228	Health Minister's Statement re Covid-19
229	*20201030 DOH SHSCT Uro Meet*
230	*20201106 DOH SHSCT Uro Meet*
231	*20201106 DOH SHSCT Uro MEET A1*
232	*20201113 DOH SHSCT Uro Meet*
233	*20201113 DOH SHSCT Uro Meet A1,*

234	*20201120 DOH SHSCT Uro Mtgs*
235	*20201120 DOH SHSCT Uro Mtgs A1*
236	*20201204 DOH SHSCT Uro Meet*
237	*20201204 DOH SHSCT Uro Meet A1*
238	*20201218 DOH SHSCT Uro Meet*
239	*20201218 DOH SHSCT Uro Meet A1*
240	*20210108 DOH SHSCT Uro Meet,*
241	*20210122 DOH SHSCT Uro Meet A1*
242	*20210122 DOH SHSCT Uro Mtgs,*
243	*20210111 DOH SHSCT Uro Mtgs A1*
244	*20210319 DOH SHSCT Uro Meet*
245	*20210319 DOH SHSCT Uro Meet A1*
246	*20210416 DOH SHSCT Uro Agenda*
247	*20210416 DOH SHSCT Uro Agenda A1*
248	*20210514 DOH SHSCT Uro Meet*
249	*20210514 DOH SHSCT Uro Meet A1*
250	*20210618 DOH SHSCT Uro Meet*
251	*20210618 DOH SHSCT Uro Meet A1*
252	*20210906 DOH SHSCT Uro Meet*
253	*20210906 DOH SHSCT Uro Meet A1*
254	*20210122 Urology Assurance Group minutes*
255	*20210906 Assurance Group minutes*
256	A Just Culture Guide
257	Handbook - Effective Clinical Governance for the Medical Profession
258	SUMMARY OF SHSCT IEAP PROCESS
259	RATIONALE FOR TRAIGE AND METRICS IEAP
260	SMT RESTRUCTURING

261	Draft People Plan
262	Doh-rqia-review

Medical Director Hand over

Dec 2018

Medical Director Office Structure

- Attached
- Staffing challenges with in MD directorate

MD meetings/ commitments:

External:

- Medical director informal meeting- Quarterly
- DoH- Medical leaders forum- Quarterly
- PHA director with Med director meeting- Bimonthly
- Hyponatremia Regional oversight (DoH) forum (MD, Nursing director, CYP director)
- SAMRHAI Forum
- Revalidation Operational Group meeting- quarterly

Internal

- SMT meeting – weekly
- Trust Board- Monthly
- Gov; Committee- Quarterly
- Lesson learned Forum- Quarterly
- GMC Liaison meeting- Quarterly
- Hyponatremia oversight group meeting- Quarterly
- QI steering group meeting - Quarterly
- IPC meeting- weekly
- IPC Strategy meeting- monthly
- 1;1 with CEX
- 1;1- MM
- 1;1- SG
- 1;1 meetings with all AMDs- monthly
- 1:1 meetings with all Directors
- MD-HR liaison meeting- quarterly
- NEWS Group- Quarterly
- BCBV- Monthly
- MS LSC Meeting- Litigation – Monthly
- LNC meeting- Quarterly
- AMD meeting- Monthly
- CD Meeting- quarterly
- CAH Medical staff meeting- Quarterly

- DHH Medical staff meeting- Quarterly
- Pathfinder meeting- quarterly
- M&M chairs meeting
- M&M strategy forum
- NIECR Project board- quarterly
- D&T committee- Quarterly
- Thrombosis committee-
- PCE Steering Group mtg
- Consultant Interviews - 1-2 /month
- Urgent meeting- 2 /week (average)

Acute Directorate Issues:

- Colorectal issues
- Spinal fracture issue
- Upper GI issues
- CT scanner issue
- Paeds surgical issues
- Hyponatremia recommendation related meetings
- Elective cancellation (30%) & impact of quality of care
- Theatre availability
- USC/Resilience plan

GMC Issues:

- GMC cases
- MHPS: AOB Case

HR

- Medical workforce- Recruitment & Retention challenges
- DHH Medical consultant acute shortage
- CAH- Medical trainees shortage
- NIMTDA Allocation of trainees
- Individual HR issues:
  - Personal information redacted by USI Issue
  - Personal information redacted by USI issue

IPC:

- IPC Strategy in place- To follow up implementation
- Med staff engagement- HH Audit

Medical Leadership

- Draft paper available
- AMD /CDs involvement variablity

Stinson, Emma M

From: Claire Andrews <Personal Information redacted by the USI>
Sent: 16 June 2022 08:58
To: OKane, Maria
Cc: Wallace, Stephen; Gibson, Simon; Parks, Zoe; Support TeamELS
Subject: RE: Draft (12.12.18) SHSCT - Meeting (4.12.18) Note (for RO Comment)
Attachments: RE: Draft (12.12.18) SHSCT - Meeting (4.12.18) Note (for RO Comment)

Dear Maria,

Following a discussion with my senior colleague, as previously advised I am unable to make any changes to the original meeting note itself, however, I have noted your comments regarding factual inaccuracies and will save these alongside the record of the note.

Best wishes,

Claire Andrews

Personal Information redacted by the USI please file email and attached (please file with meeting note 4.12.2018)
DB: Southern Health & Social Care Trust
Category: Other
Sub Category: n/a
Title: Email chain with SHSCT CEO (Previous RO) re: noting factual inaccuracies in meeting note from December 2018

From: OKane, Maria <Personal Information redacted by the USI>
Sent: 10 June 2022 23:06
To: Claire Andrews <Personal Information redacted by the USI>
Cc: Wallace, Stephen <Personal Information redacted by the USI>; Gibson, Simon <Personal Information redacted by the USI>; Parks, Zoe <Personal Information redacted by the USI>
Subject: RE: Draft (12.12.18) SHSCT - Meeting (4.12.18) Note (for RO Comment)

Thank you
Working with doctors Working for patients

The General Medical Council helps to protect patients and improve medical education and practice in the UK by setting standards for students and doctors. We support them in achieving (and exceeding) those standards, and take action when they are not met.

General Medical Council

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Regents Place, 350 Euston Road, London NW1 3JN

The Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh EH8 8AE

4th Floor, Caspian Point 2, Caspian Way, Cardiff Bay CF10 4DQ

9th Floor, Bedford House, 16-22 Bedford Street, Belfast BT2 7FD

Stinson, Emma M

From: Claire Andrews <Personal Information redacted by the USI>
Sent: 10 June 2022 13:36
To: OKane, Maria
Cc: Wallace, Stephen; Gibson, Simon; Parks, Zoe
Subject: RE: Draft (12.12.18) SHSCT - Meeting (4.12.18) Note (for RO Comment)

Dear Maria,

Thank you for your email. This note has been filed as the final version and I don't believe we will be able to amend it in retrospect. I have noted your comments regarding factual inaccuracies and have sought further advice from colleagues. I will get back to you as soon as I can.

Best wishes,

Claire

From: OKane, Maria <Personal Information redacted by the USI>
Sent: 08 June 2022 14:16
To: Claire Andrews <Personal Information redacted by the USI>
Cc: Wallace, Stephen <Personal Information redacted by the USI>; Gibson, Simon <Personal Information redacted by the USI>; Parks, Zoe <Personal Information redacted by the USI>
Subject: Draft (12.12.18) SHSCT - Meeting (4.12.18) Note (for RO Comment)

Claire – this meeting was held a few days after I started in ST on 1.12.2018. Was this minute circulated at the time? . Ahmed Khan was the RO at that time. It is factually incorrect in a number of areas.

1. I was not RO until 01.01.2019
2. I was not RO in BHSCT – that was Dr Cathy Jack at that time.
3. All of the statements attributed to me are incorrect - other than the comment about Patient 10 I was not in a position to comment on the Drs in ST as I did not know any of them as was 3 days into the post .
4. Can this minute be corrected asap please ?

Many thanks Maria
Working with doctors Working for patients

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General Medical Council

Meeting note – Employer Liaison Service			
Responsible Officer	Dr Maria O'Kane		
Organisation(s) Single DB	Southern Health and Social Care Trust		
Meeting location	The Rowans, CAH site (opposite Trust HQ car park)		
Date and time	04/12/2018	11:00 – 12:30	**Meeting type:** In person
Previous meeting date	02/10/2018		
Next meeting date	Click here to enter a date.	00:00 – 00:00	Next Meeting TBC
Meeting attendees	Maria O'Kane, RO [MOK]; Joanne Donnelly, ELA [JD];Simon Gibson [SG] Zoe Park [ZP] Apologies: Norma Thompson; Ahmed Khan - outgoing RO		

Item 1 Local organisational update			
Title	**Description**	**Action for ELA or RO**	**Office use only**
	• *Senior personnel changes: Exec Board/ MD support team?* **MOK advised:** with effect from 3.12.18, she is the RO/Medical Director for the BHSCT. • *Regulatory issues: CQC / NHSI / Devolved equivalents?* **MOK advised:** Relatively recent RQIA inspection of ICU - good feedback. • *Any difficult Deanery issues / QM visits? Is the DB in enhanced monitoring, if so what progress is being made?* **MOK advised:** Not enough trainees. • *Any major service pressures currently?* **MOK advised:** Opened winter ward yesterday -		

	added 18 beds at Craigavon Hospital and 6 at Daisy Hill. • *Any strategic developments locally – including key service tendering issues / cross-Trust service developments / major service reviews?* **MOK advised:** Pathfinder Project continuing/ Outpatients at Daisy Hill Hospital has now bee moved to another location at the hospital. • *Any local commissioning relationship issues* • *Good news:* **JD advised:** Media reports today- *Newsletter* "The Southern Trust and the Public Health Agency are working with local Care Homes to help improve the experience of people living in care homes. Local care home managers have participated in a workshop hosted by the Trust in order to share best practice in enhancing the quality and safety of care for residents. The Department of Health has identified Transformation Funding to help improve the quality, safety and experience of people living in Care Homes across Northern Ireland." • *Media interest*		

Item 2a Responding to concerns locally previously discussed

Last Name	Given Name	GMC Number	Description	Action for ELA or RO	GMC category	Office use only
Dr Urology Consultant			**JD advised:** this matter was first raised as a "local concern" at a SHSCT RO/ELA meeting on 8.2.17, i.e. nearly 2 years ago. In general terms, where local investigations are protracted this can have an adverse impact on the doctor concerned, any patients involved, and on the quality and fairness of the investigation and therefore on the quality and fairness of the outcomes. Where temporary local restrictions have been placed on a doctor pending completion of local processes - it is in everyone's interests that these processes are completed expeditiously and the local restrictions reviewed (local restrictions should be reviewed periodically in line with MHPS). JD asked whether the local	**ACTION: SG to send final** MHPS and SAI Reports to JD.	**FtP** Monitor	

			investigations are nearing completion. **SG advised:** The MHPS and SAI investigations are completed and reports are finalised - SG will arrange for the final MHPS Report and final SAI Report to be sent to JD. A Trust Disciplinary Hearing is to take place in early Jan 19. The doctor still has local restrictions on his practice- these are being kept under review. SG will update JD on Trust Disciplinary Hearing. Because of local restrictions and changes to local systems - there are no patient safety concerns. Also - doctor does not do any work outside of SHSCT. **BACKGROUND FROM 8.2.17** **RW advised previously (8.2.17):** SAI almost complete and MHPS investigation in progress involving concerns about a urology consultant competence re administration of his urology clinic in the SHSCT- including timeliness of recording of patient contact, referrals, follow up testing required. No actual patient harm, but potential patient harm - the event that triggered the SAI was a late diagnosis; it was initially decided that the doctor would be excluded from work (an alert letter was sent from the Dept. of Health), while the scope of the concerns was explored however exclusion was lifted and he is permitted to work with supervision of his admin responsibilities. However- during the period of the exclusion he was off [redacted]. He does not do any other work outside the SHSCT except for seeing private urology patients in his home - first appointments only to advise the patient on whether they need referred for further testing/investigation; undertakes physical examination/takes history only - no testing/medical treatment. RW is currently satisfied that there are no patient safety issues- MHPS investigation is at an early stage. **JD/RW agreed previously (8.2.17):** that RW will send JD a copy of the SAI Report as soon as he receives it. **Agreed previously (8.2.17) - RW will also:** double-check (given ROs' responsibility for whole-practice appraisal) that he is satisfied with the nature of the assurances he has about the doctor's private work - including verification/triangulation of any information provided by the doctor himself about his private work. He will also find out whether the doctor's private clinic is/should be registered with the RQIA. **BACKGROUND FROM 25.7.17** **RW advised previously 25.7.17:** SAI Investigation is not yet complete - there had been a delay at the start because of difficulties identifying a Chair. Julian Johnston is now acting as chair. **JD asked previously 25.7.17:** whether issues re private work have been resolved to his satisfaction - do the same restrictions apply to the doctor's private work as apply to his work in the SHSCT; RW, as RO, is responsible for the FTP of the doctor irrespective of where he/she works, arguable, an RO bears a greater risk in respect of a doctor's work outside the doctor's main			

			designated body. JD asked whether RQIA regulates the private medical work that the doctor does from his home. **RW advised previously 25.7.17:** he is not aware as to whether RQIA has a role as regards this doctor's private work. RW is not sure how he would obtain objective assurances about the work the doctor does at home (first appointments only to advise the patient on whether they need referred for further testing/investigation; undertakes physical examination/takes history only - no testing/medical treatment). **JD & RW agreed previously 25.7.17:** as JD has a meeting with RQIA on Thursday 26.7.17 JD will seek confirmation from RQIA re their role re regulation of doctor's who work privately from home. **JD to update RW.** **BACKGROUND FROM 4.10.17** **RW advised (4.10.17):** There has been a delay in the SAI as there was difficulty in sourcing a Chair - expect to have the report by Christmas 17. Revalidation not imminent. **Background from 6.6.18** **AK advised (6.6.18):** There are no clinical concerns about this doctor. The concerns relate to administrative delays on his part in completing routine/urgent referral paperwork after he sees urology patients for their first triaging appointment. The problem is exacerbated by the Trust system which defaults patients to "routine referral" automatically if no referral is completed by the doctor within a certain timeframe. The combined result of: (1) delays on the part of the doctor in completing the paperwork for referrals and (2) a system which defaults patients to "routine referral" where no paperwork is received, is that there were patients, whom the doctor had decided were urgent referrals, who were erroneously added to the routine referral list. **AK advised (6.6.18):** Once the problem was identified: (1) an SAI was commenced; (2) an MHPS investigation was commenced; (3) the doctor's referral paperwork was (and still is) closely monitored to ensure that it is completed within the required time frame – this monitoring provides complete assurance that no urgent cases are defaulted into the routine case list. **AK confirmed (6.6.18):** the doctor does not work for any private organisation; however he does do some private work from his own home involving triaging and referring urology patients referred by their GP. **JD advised (6.6.18):** it would be prudent for AK to secure an undertaking from the doctor that he will not do any private work from his own home – as it is impossible for AK to monitor his work there to ensure that there are no patient safety risks around delayed urgent referrals – until AK is satisfied that the risk is removed/being managed appropriately. **AK confirmed (6.6.18):** there is no suggestion that the doctor has health issues that may be contributing to the concerns. AK does not yet have a sense of the doctor's insight, remediation, engagement – this is something the MHPS Report will deal with. AK advised that at this stage he is not able to comment on any adverse impact on patients (prior to the concern being picked up)/need for patient recall –that will be examined by the SAI. **AK confirmed:** he will update JD on the MHPS investigation as soon as he can. And on the SAI investigation as soon as he can. In the meantime AK is assured there are no patient safety risks – subject to the doctor providing a written undertaking that he will not work from his own home (or do any other private work)- which he will seek as soon as practicable. **JD asked:** that AK confirms to her, just as soon as he can, that the doctor has provided this			

			undertaking and that AK is confident that he can rely on it. AK and JD to have a threshold discussion once AK has more information from MHPS/SAI. **Background from 2.10.18** **AK advised (2.10.18):** MHPS investigation has concluded and is at factual accuracy checking stage - met with doctor yesterday. There is to be a disciplinary hearing. There is an action plan in place which is being monitored and an agreed job plan which allows more time for administration. There is no issue as regards clinical performance or ability. Issue is that he did not adhere to Trust policies/targets and procedures as regards administrative duties when triaging referrals from GPs GP referral triage. No health related concerns. There is a related SAI ongoing - involving a number of patients in respect of delayed diagnosis. There are currently no patient safety risks as doctor's work in SHSCT is monitored and the doctor does not work outside the Trust. **JD asked (2.10.18):** For more information on the nature of the incidents that gave rise to the concerns - i.e. the issues that are subject of the SAI. And for more information on the findings of the MHPS investigation. This is in order to have an informed threshold discussion. **AK advised (2.10.18):** he will provide JD with this information when he has it.			

Item 2aii Responding to concerns locally advice since last meeting

Last Name	Given Name	GMC Number		Description	Action for ELA or RO	GMC category	Office use only
Personal Information	Personal Information	Personal Information		FTP- do not refer – NIMDTA/SHSCT/BHSCT - Dr Personal Information Personal Information – GMC No. Personal Information - dishonesty concerns - on further local exploration of the facts there were no dishonesty concerns (24.10.18)		**FtP** Do not refer doctor	**Remove from list**

Item 2b New

Last Name	Given Name	GMC Number	Description	Action for ELA or RO	GMC category	Office use only
Locum doctor -			**ZP advised:** A concern has just been raised about a locum	**ACTION: MOK** to	**FtP**	**Retain for next**

probity-claims for sat/sun shifts			doctor- the concern is that he claimed on the relevant form that he worked shifts on a Saturday and Sunday that he did not work. This is at the preliminary exploration of facts stage. This doctor may also be registered with the Irish Medical Council. **MOK advised:** they will obtain more information and discuss with JD next week. **JD asked:** Has the concern been shared with the locum doctor's RO. **ZP advised:** not sure who the locum doctor's RO is. **JD advised:** the key piece of information Trusts should have about locum doctors working in their Trust is who their RO is - so that if concerns need to be shared promptly this can be done (following consideration of the GMC Information Sharing Principles - see below). **JD asked:** is appointment/recruitment of locums in the SHSCT managed/coordinated centrally by SHSCT HR - so there is good oversight. **ZP advised:** yes - there is a locum team within HR which does this.	obtain more information about Locum doctor (probity-claims for sat/sun shifts) and discuss with JD next week. **ACTION: Moiza Butt (GMC ELSA)** to set up telecom between JD and MOK.	Monitor	**meeting**
GMC Thresholds for Referral			JD explained and discussed: GMC Thresholds - May 18.pdf		**FtP** Advice	**Remove from list**
Principles of			JD explained and discussed:		**FtP**	**Remove**

a Good Local Investigation			 Principles of a good local investigation.doc		Advice	**from list**
GMC Information Sharing Principles			JD explained and discussed:  GMC Information Sharing Principles.doc		**FtP** Advice	**Remove from list**
			MOK confirmed: there are no concerns about any other doctors working in the SHSCT.		Category Sub-Category	Choose an item.

Item 3a GMC open cases

Last Name	Given Name	GMC Number	Description	Connection	Actions
Personal Information redacted by the USI	Personal Information redacted by the	Personal Information redacted by the USI	**Background** **RW confirmed**: Dr Personal Informatio has resigned from the SHSCT (with effect from Personal Information) however keep on list for discussion at this meeting for organisational learning. **JD advised:** Case opened 24/10/2014. IOT - Dr suspended- High Court Extension granted. Await a PPS update. Index allegation - sexual assault; sexual assault by penetration; rape; false imprisonment; common assault; and sexual assault. **JD advised:** so far as we are aware Dr Personal Information is still in Personal Informatio. In April 2018, the GMC obtained a High Court Extension for the Interim order of suspension -which now expires 18/5/2019. Dr Personal Information s next interim order tribunal (IOT) review date is 9/7/18. Until Dr Personal Informatio returns to the UK or NI or until he is extradited from a country with whom there is an extradition agreement this is how the situation will remain (unless the IOT might decide to conclude the order or at a future High Court hearing the High Court Judge decides not to extend the IOT). **JD advised (2.10.18):** We are making formal enquiries with the PPS to ask if they have any objection to us starting our own investigation.	**Previously discussed case –** Previously connected to DB. Referred by DB.	

			JD advised (4.12.18): Dr Personal Information redacted by is still residing in Personal Information redacted by - therefore the police investigation has not progressed. However the PSNI have recently agreed to release their investigation documents to us so we will soon be able to commence a GMC investigation - we expect to receive these this week. Once we have considered these police documents we may approach the SHSCT for more information.		
Personal Information redacted by the USI	Personal Information redacted by the	Personal Information redacted by the USI	**JD advised:** Stream 1 case opened 4.10.18. Dr Personal Information redacted by the USI was criticised by a Coroner in a report dated Personal Information redacted by the USI; however, he had failed to notify us. The report concerns an inquest into the death of baby X. Allegations relate to: • **Criticisms from the coroner for (1) failing to review a CTG himself and instead relied on another doctor's assessment, thus providing substandard level of care to the deceased; (2) for missed opportunities as a result of failing to escalate the results of a CTG scan, thus providing inadequate clinical care to the deceased, and** • **Failure to notify the GMC that he had been criticised in a coroner's report** **JD advised:** We have received the completed Expert Report. We will be sending the expert report and allegations to the doctor and asking for his comments (Rule 7). **JD advised:** The GMC investigation officer (IO) advises that he has still not received a completed Responding to Fitness to Practise Concerns Form from the SHSCT - was told that this was because the doctor was currently off Personal Information redacted by however the IO just needs the Trust to return the completed form. **SG advised:** SHSCT will be in a position to complete and return the Responding to Fitness to Practise Concerns Form within the next two weeks (as doctor is now back at work.	**New case –** Connected to DB.	

Personal Information redacted by the USI	Personal Information redacted by	Personal Information redacted by the USI	**Background** **JD advised (2.10.18):** Case opened 3.9.18. DB is SHSCT. Collection of information stage. Doctor criticised by coroner - self-referred. If any other doctors have been criticised by the Coroner this will be picked up by the GMC investigation team. **JD advised (4.12.18):** We are currently waiting for the finalised Expert Report. Once that is received it will be sent to the doctor - who will have an opportunity to respond (doctor has not sent us any comments on the allegations to date). **SG asked:** this case is linked to the Personal Information redacted by the USI case (above) in which the expert report has already been received - were different experts commissioned to provide separate reports in respect of each of these two doctors? **JD advised:** she will check the cases and update SG. **MOK asked:** what is the GMC process for quality assuring GMC expert reports - is it similar to the Royal Colleges' invited review processes whereby reports are standardised - by the involvement of at least two experts. **JD advised:** she will check the current GMC position on this also.	**Previously discussed case –** Connected to DB.	**ACTION: JD** to check whether two separate expert reports were commissioned in the linked Personal Information redacted by the USI cases. **ACTION: JD** to check GMC process for quality assuring or standardising GMC expert reports.
Personal Information redacted by the	Personal Information redacted by the	Personal Information C1- Personal Information redacted by the USI	**Doctor had worked in SHSCT as a locum. DB is the NHSCT**. **Background** **Case:** Personal Information redacted by the USI - Referral from NHSCT - allegation of sexual assault against a patient in A&E in Personal Information redacted by the USI IOT Order (conditions) in place. **JD advised (2.10.18):** The MPT hearing - 3 December 18. **JD advised (4.12.18):** The MPT hearing commenced yesterday- 3 December 18.	**Previously discussed case -** Dr Personal Information was placed at Personal Information on 23/02/2015 and at Personal Information redacted by the USI between 23/02/2015 to 08/06/2015, as a Staff Grade in	

				Personal Information redacted by the USI .	
Personal Information redacted by the	Personal Information redacted by the	Personal Information C1- Personal Information redacted by the USI	**Doctor had worked in SHSCT as a locum. DB is the NHSCT**. **Background** **Case:** Personal Information redacted by the USI Allegation - sexual assault on a patient in which the patient alleged Dr Personal Information rubbed their foot against his (Dr Personal Information) groin. IOT Order in place. Collection of information stage. **JD advised (4.12.18):** We wrote to the doctor on 28/11/12 providing the evidence in respect of the allegation - he has until 26 December 18 to provide his comments (may be extended given the holidays and his attendance at MPT this week).	**Previously discussed case -** Dr Personal Information was placed at Personal Information on 23/02/2015 and at Personal Information redacted by the USI between 23/02/2015 to 08/06/2015, as a Staff Grade in Personal Information redacted by the USI .	
Personal Information redacted by the	Personal Information redacted	Personal Information redacted by the USI	**Background** **JD advised (2.10.18):** Doctor convicted on Personal Information on two counts of voyeurism. Police investigation concerning further voyeurism charges and harassment allegation ongoing. We have contacted PSNI about timescales for ongoing investigations. Interim order conditions in place. **RW advised previously 25.7.17:** Dr Personal Information was dismissed following a Trust Investigation and was, therefore, removed from SHSCT list of connected doctors- RW is no longer his RO. However, Dr Personal Information has appealed the dismissal- appeal had been put on hold pending completion of GMC investigation however Dr Personal Information has now agreed that the appeal can go ahead. RW advised it would be useful to have information on how long it is likely to be before the GMC investigation is completed - the timeframe for the GMC investigation has a bearing on the timeframe for the SHSCT investigation. **Background:** Case opened 26/02/2015. Dr Personal Information has been charged with x3 offences (Personal Information redacted by the USI): i. Voyeurism installing equipment ii. Attempting voyeurism iii. Voyeurism recording Personal Information - Dr Personal Information pleaded guilty to x2 counts. Sentenced on Personal Information - 9 months' probation - not placed on sexual offenders register. RW advised: Doctor has withdrawn his appeal re local disciplinary processes. **JD advised (6.6.18):** The PSNI investigation continues. We also have a new allegation of	**Previously discussed case -** Previously connected to DB. Doctor was excluded by DB from current position as Consultant Radiologist.	**ACTION: JD** to relay MOK's comments on aetiology certain types of sexual offences and links with work related stress - work that could be done, by GMC and others, to identify early warning signs - so as to protect doctors and

			impairment, as Dr Personal Information did not declare an open FTP investigation to NHS when applying for a new job. He has also just appeared at an early review IOT hearing and has just had his **IOT conditions amended** so that he can obtain work from home- with no patient contact - remote radiology reports. **JD advised:** we await completion of PSNI investigations/conformation that GMC investigation can proceed. **MOK advised:** Would be interesting if GMC were to be able to commission a piece of research on these types of cases - to explore the potential mental health aspects to this type of case and any possible link to coping with working in a system under pressure- alcohol/drugs issues are known to be linked to stress/mental health issues - may be that these types of sexual offence cases may have similar aetiology. If this is the case - there may be work that could be done, by GMC and others, to identify early warning signs - so as to protect doctors and patients. **JD advised:** GMC has undertaken, and continues to undertake a lot of work on upstream regulation and issues with vulnerable doctors and doctors with health issues - led by Prof. Louis Appleby. JD will relay MOK's comment to relevant colleagues within GMC. **MOK advised:** she will also be able to speak to Louis Appleby about this.		patients. **ACTION COMPLETED**
Personal Information redacted by	Personal Information	Personal Information redacted by the HSI	**JD advised (4.12.18):** Dr Personal Information 's response to the GMC (following a letter to her giving her an opportunity to provide her perspective on the allegations/evidence) was due on 30 Nov 18 however she didn't respond. The GMC investigation officer (IO) emailed her again yesterday and gave her until Friday 6 Dec 18 to respond. If she doesn't respond by then the case will be sent to the GMC Case Examiners for a decision on how to progress the case. Dr Personal Information hasn't really engaged with the investigation so far, she took over 7	**Previously discussed case -** Connected to DB. DB was incident location. Doctor work s as	**ACTION: JD** to update the GMC IO that SHSCT will seek to engage with Dr Personal Information and will update the GMC IO by 14.12.18.

			weeks to return her Work Disclosure Form at the outset, and there has been no response to GMC emails since. Has the Trust been in contact with Dr Personal Information ? **SG advised:** he is not aware that the Trust has had much engagement with Dr Personal Information recently. **JD advised:** It is important that we establish whether there is any information that might suggest that Dr Personal Information is a vulnerable/at risk doctor -her not responding, when it is in her interest to respond, could be a warning sign that there may be issues. It would be helpful if the Trust could see if they could engage with Dr Personal Information and update the GMC IO in this regard - to facilitate this the we (GMC) will postpone referring this case to GMC Case Examiners until Friday 14 Dec. 18. **MOK advised:** they will seek to engage with Dr Personal Information and will update the GMC IO by 14.12.18. **Background** **JD advised (6.6.18):** we are in the process of finalising the expert report in relation to the clinical issues. In relation to the probity issue – i.e. that the doctor gave evidence at the inquest that when the child's mother rang back asking for further advice Dr Personal Information said she advised her to bring the child back to A&E, whereas the mother said Dr Personal Information advised her to continue to monitor the child at home (the coroner preferred the mother's account over the doctor's) –we will in due course be considering appropriate steps in relation to this. **JD advised (2.10.18) :** Following our last discussion, we now have expert's opinion - in line with the views of experts from the coroner's inquest. We are currently in the process of obtaining a witness statement from the patient's mother. This is expected towards the end of October. **SG advised (2.10.18):** His understanding is that the transcript of the inquest does not suggest that Dr Personal Information 's account and the mother's account of the phone call when the mother rang back are different. **JD advised (2.10.18)**: she will pass on SG's comment to the GMC investigation officer.	Speciality Doctor in Personal Information redacted by the USI .	**ACTION COMPLETED**
Personal Information redacted by the USI	Personal Information redacted by the	Personal Information redacted by the USI	**Stream 1 opened 4.7.18 - paused** **JD advised:** The investigation is still paused and this pause is due to be	**Previously discussed case –** Referred	**ACTION: JD** to ask the GMC IO to email SHSCT

			reviewed in mid-December 18. **JD asked:** have you, or your occupational health service had any contact with Dr Personal Information redacted by the USI? Do you still consider him to be extremely vulnerable? If the SHSCT could provide an update to the GMC IO this would be useful for the mid-Dec 18 review of the pause by a GMC Medical Case Examiner. JD advised: she will ask the GMC IO to email SHSCT to request an update. **MOK advised:** It would be useful if the GMC IO would e-mail to request an update. In the meantime, the Trust will seek again to make contact with the doctor - he was last seen by Trust Occupational Health in Aug 18 – this needs to be updated; however, it would seem that it is highly likely that the basis for the decision to pause has not changed (indeed things may well have deteriorated) - MOK would expect that it would not be appropriate to lift the pause on the investigation at this time. **Background** **JD advised (2.10.18):** We have paused the investigation - based on the information from SG and the SHSCT Occupational Health. We haven't disclosed to the Dr that there is an open investigation. "Pause' is to be reviewed mid-December time. No tasks/actions will be undertaken during the pause. **AK advised (2.10.18): :** Doctor is aware that he was referred to GMC. SHSCT will speak to him to explain that the investigation has been paused and the reasons for this. AK advised that Dr Personal Information has not paid his GMC annual registration fee - does this mean that he will be removed from the register? **JD advised (2.10.18):** where there is an open GMC investigation a doctor is highly unlikely to be removed from the register for non- payment of fees - as once a doctor is no longer on the register the GMC has no authority to investigate that doctor -and there may be reasons why an investigation needs to continue even where the doctor does not intend to work/is not working.	by DB.	to request an update on Dr Personal Information. **ACTION COMPLETED** **ACTION: MOK** to seek to make contact with Dr Personal Information to obtain an update on information relevant to the pause of the GMC investigation - and to update GMC IO
Not on list	Personal Informatio	Personal information	**JD advised:** Self –referred on 03.01.17. Case Review. Undertakings. Ongoing.	**ACTION: JD** to check how Dr	

Personal information redacted by			Revalidated on 30.6.18 following recommendation from SHSCT. However, as of 12.11.18, specialist trainee in histopathology (via NIMDTA). JD will check how doctor's connect is currently appearing on GMC records.	Personal Information's (Personal Information) is currently appearing on GMC records. **ACTION COMPLETED** **ACTION:MOK** to update Dr Personal Information's connection	

Item 3b GMC closed cases					
Last Name	**Given Name**	**GMC Number**	**Description**	**Connection**	**Actions**
			None		

Item 4a Appraisal and Revalidation				
Title	**Description**	**Action for ELA or RO**	**GMC category**	**Office use only**
	System Discussion • *AoA and Board oversight* • *IV visits* • *Appraiser support (forum, meetings, training, QA)*			
	SG advised: 93% of 2017 appraisals are completed. The remaining 17% will be completed on time.		Category Sub-Category	Choose an item.

	SG advised: The annual report that goes to Trust Board contains a section on revalidation assurance. Quarterly reports go to senior management team.			

Item 4b i. Deferrals & Non-engagement						
Last Name	**Given Name**	**GMC Number**	**Description**	**Action for ELA or RO**	**GMC category**	**Office use only**
			JD advised and discussed: **Changes to GMC Protocol for (ROs) making revalidation recommendations** *You are already aware that The GMC protocol for making revalidation recommendations (March 2018) has been updated as part of the Taking revalidation forward programme with an aim of supporting improved local governance (see ELA/RO Bulletin dated . . .). It is hoped that this new version of the GMC Protocol will provide more support to ROs/SPs. Two key changes which it is hoped will provide additional support to ROs are:* • *Para 1.2.3 – You (the RO) must contact their ELA if they plan to make a recommendation of non-engagement, or a second consecutive recommendation to defer.* • *Para 6.3 – You (the RO) must inform us if a doctor is not participating in the local processes that underpin revalidation outside the doctor's four month notice period. We will write to the doctor to remind them that they must participate in these processes to maintain their licence to practise. If the doctor continues to fail to sufficiently engage with revalidation, and all local processes have*		**Revalidation** Advice	**Retain for next meeting**

			been exhausted, you can ask us to bring forward their submission date and issue the doctor with notice. You can then make a formal recommendation of non-engagement." *Also – ROs' responsibility to ensure that the designated body checks that their doctors are completing annual appraisals is highlighted – at para 1.3.*			
			• *Doctors who have missed an appraisal by more than 15 months* - **SG advised:** there are no doctors who have missed an appraisal by more than 15 months. All doctors are up to date. • *Deferral rate-* **SG advised:** there is 1 doctor who joined the SHSCT in Aug 18 who may need to be deferred. Will discuss this with JD in due course as necessary. • *Individuals approaching or reaching non engagement /overdue appraisal without valid reason.* **SG advised:** none • *Update on licence withdrawal processes/appeals:* **None** • *Other recommendations requiring discussion, i.e. exceptions highlighted by GMC Revalidation Team.* ***None***		Category Sub-Category	Choose an item.
			JD asked: are there any SHSCT doctors who have missed more than 1 appraisal? **SG advised:** no **SG advised:** no non-engagements, no second deferrals, no deferrals on basis of involvement local investigation processes.		Category Sub-Category	Choose an item.
					Category Sub-Category	Choose an item.

4b ii. Dr's in Licence Withdrawal due to Non Engagement							
Last name	**Given name**	**GMC Number**	**Status**	**Description**			
				None		Category Sub-Category	

4b iii. Open REV 6						
			None		Category Sub-Category	

4b iv. Drs in multiple deferral cycle (multiple is defined as two or more deferrals)						
			None		Category Sub-Category	

Item 5 Themed Discussion	
	None

Item 6 GMC update		
Title	**Update**	**Action**
Human factors training	All of the GMC's fitness to practise decision makers, case examiners and clinical experts are to receive Human Factors training, and advice on modifying investigation processes, as part of a collaboration agreed with Oxford University's Patient Safety Academy. The Patient Safety Academy will work with the Employer Liaison Service and Responsible Officers to ensure that the same approaches are also consistently applied locally when they are dealing with concerns around doctors' conduct and performance, before those issues are referred to the GMC.	

Review of the GMC's decision making and consent guidance	The GMC has launched a consultation on our revised *Decision making and consent* guidance, which outlines what doctors should consider when discussing treatment and care with their patients. The updated guidance focuses on the importance of communication, personalised conversations, and doctors and patients making decisions about treatment and care together. The guidance has been restructured and made clearer, so it's easier for doctors to apply in practice. More advice has been provided, including steps to follow when making decisions in different circumstances. The guidance also reflects the law, policy and healthcare settings in all four countries of the UK. We want the final guidance to be shaped by as many views as possible, especially doctors who will use it on the frontline, as well as patients, medical leaders and healthcare organisations. Responses to the consultation can be made via the online survey tool until 23 January 2019.	
Governance handbook	On 1 November 2018, the revised Governance handbook - Effective clinical governance for the medical profession was published following recommendations made by Sir Keith Pearson in his Taking revalidation forward report. The handbook is a tool for leaders of healthcare providers in developing and maintaining the effectiveness of clinical governance arrangements for doctors and their revalidation. The revised handbook more clearly outlines the role that boards and governing bodies should play in ensuring effective clinical governance is in place for doctors and their revalidation. It provides clearer advice about the clinical governance processes that underpin the responsible officer function and revalidation for doctors including annual appraisal, managing concerns about doctors and pre-employment checks. A checklist which can support organisations to review the clinical governance systems they have in place and identify areas for further development is included within the document. Governance Handbook	

	Effective clinical governance for the me	
Credentialing	The GMC is planning to introduce a process of credentialing in 2019 which will recognise expertise and provide training opportunities in areas of practice where there may be significant patient safety issues, or where training opportunities are insufficient or do not provide adequate flexibility to support effect service delivery. It is proposed that optional components within speciality training or substantial areas existing outside training will become credentials. Like postgraduate curricula, credentials will describe the expected outcomes and capabilities doctors must demonstrate as they become experts in the field. Credentials are intended to complement existing training pathways and to help doctors develop their careers. Comments on the draft framework can be submitted via an online survey until 25 January 2019. **MOK advised:** it would be really useful to have a credential for medical management - MOK will feed this back in the online survey - JD will also mention to GMC colleagues.	**ACTION: JD** to feedback to GMC colleagues MOK's comment that it would be really useful to have a credential for medical management. **ACTION COMPLETED**
Reflection at appraisal following GMC fitness to practice investigations	We have heard through appraiser network events that some doctors may have the impression that we are advising them to share details of their recent fitness to practise investigations with their appraiser at their annual appraisal. Whilst some documentation arising from the investigation may be useful in appraisal discussions, we do not require doctors to submit this to their appraiser. Our recent guidance on reflection outlines that doctors should provide a brief description of the issue/concern and then focus on their learning and development. We are looking at how we can make that expectation clearer in any decisions and we would welcome ROs reviewing local processes to ensure this expectation is not being applied locally.	
RO e-bulletin	The September 2018 issue of the GMC RO e-bulletin is now on the GMC website. If you or your team would like to sign up to receive the bulletin by email, please contact Personal Information redacted by the USI	

Item 7 AoB	
Description	**Action**
Personal **case** **ZP advised:** Personal had worked in South Tyrone Hospital (Dungannon) in Personal Information redacted by the USI as an Personal Informatio from Personal Information redacted by the USI i.e. for approximately Personal Information redacted by the USI. She then transferred to Personal Information redacted by the USI. Further checks are to be undertaken to establish whether she did any locum work and to establish whether there had ever been any complaints/concerns about her - this may require going back through hard copy records - including records that may be in storage. **MOK advised:** she will keep oversight of this and update JD	**ACTION: MOK to update JD on** details re Personal and SHSCT - dates/capacity in which she worked there and any concerns raised.
RO Training **MOK asked:** whether GMC organises (induction) training for ROs. **JD advised:** There are various events/groups that GMC lead on/contribute to that provide useful information for ROs (for example the GMC RO Reference Group and the DH RO Forum) - however the GMC does not organise RO induction training as such- that is a matter for DH. However NHS England does run a training programme that some NI ROs have attended and found useful. Also - may be useful to observe an MPTS hearing. JD will send details.	**ACTION: JD to send MOK** details re NHS England RO training programme and information re observing MPTS hearing. **ACTION COMPLETED.**

Fitness to practise referral form

General Medical Council

This form is for Responsible Officers, Suitable Persons, employers, their nominated representatives, and those acting on behalf of organisations to send fitness to practise concerns to us.

Getting help

Guidance for completing this form is available in the referral guidance. The guidance provides assistance on making fair and accurate referrals based on GMC thresholds.

Responsible Officers, Suitable Persons and their designates can seek advice and discussion about concerns and whether they meet our threshold for investigation. For details about the employer liaison adviser for your region, please visit our website.

If you are a professional raising concerns in your individual capacity or a member of the public, please visit our website to fill in our online form.

Returning the form

Please return this form to us, using practise@gmc-uk.org. You should also copy in your employer liaison adviser into the email.

If the concerns are of a serious and urgent nature and completing the form could cause a delay, please e-mail practise@gmc-uk.org straight away with as much detail about the concern as possible.

Details about the doctor

Doctor's full name	Mr Aidan O'Brien	GMC number	1394911
Doctor's specialty	Urology		
Doctor's job title	Consultant Urologist		
Doctor's grade	Consultant		

The doctor's work details

Organisation the doctor was working for, or contracted to, or providing services for at the time the concerns arose.	Southern Health and Social Care Trust
How long have they worked here?	Appointed 6 July 1992
Other organisations where the doctor is known to work or contract with (eg independent hospital, locum agencies)	Mr O'Brien sees private patients from his home.

Your relationship to the doctor

Are you the doctor's Responsible Officer? Yes ☒ No ☐

If no, please specify your connection to the doctor.	

If no, and you have been able to identify the doctor's RO or Suitable Person, have you shared your concerns with that individual? Yes ☐ No ☐

Have you shared your concerns with the doctor ? Yes ☒ No ☐

If yes, when did you do so?	The concerns were initially shared with the doctor in March 2016 and again in December 2016 prior to commencement of a formal investigation into the concerns.

Is the doctor aware that you are making a referral to the GMC? Yes ☒ No ☐

Do you need to detail concerns about another doctor? Yes ☐ No ☒

Summary of concerns

Have you discussed your concerns with an employer liaison adviser? Yes ☒ No ☐

If yes, did the ELA advise you to make a referral to us? Yes ☒ No ☐

Please use the box below to provide the following details:

- summary of the concern(s) including location and who else was involved
- a chronology of events
- details of risk to patient safety (if applicable)
- summary of all local action taken and on-going investigations (if any)
- please indicate where you have been unable to verify information contained within this referral (eg where the information is from a source outside of your remit, where a local process is on-going or where you believe there is an evidential conflict)
- details of any other relevant concerns or previous complaints you are aware of at this time (and local actions and outcomes). This will help us assess whether this incident is part of a pattern of behaviour.

The concerns

A Serious Adverse Incident (SAI) investigation was commenced within the Trust in April 2017 in respect of a patient Patient 10, a patient of the Urology service. A referral had been received by the Trust in 2015 however the patient was not seen until February 2016. The patient was seen by Mr Mark Haynes, Consultant Urologist.

Mr Haynes reviewed the patient and the referral and was concerned about the delay for the patient. As a result Mr Haynes completed a Datix form to alert the Trust to the issue of concern.

Mr Anthony Glackin, Consultant Urologist chaired the SAI investigation which commenced in Autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged. Further assessment of the issue identified a significant number of patients who had not been triaged.

The issues of concern relating to patient Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a `red-flag' referral and prioritised as such.

The Timeline

A full chronology is within the attached formal investigation report.

March 2016
On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns.

Four broad concerns were identified:

- Untriaged outpatient referral letters - It was identified at that time that there were 253 untriaged referrals dating back to December 2014.

- Current Review Backlog up to 29 February 2016 - It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- Patient Centre letters and recorded outcomes from clinics - The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.

- Patient's hospital charts at Mr O'Brien's home - The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally.

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016 and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr Richard Wright in late December 2016. As a result of the concerns raised with Mr O'Brien on 23 March 2016 and the serious concern arising from the SAI investigation by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- 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 was for these patients, and if the plan had been actioned
- some of the patients seen by Mr O'Brien may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016
Advice was sought from the National Clinical Assessment Service on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016
Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken.

03 January 2017
Mr O'Brien met with Mrs Martina Corrigan, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr Wright on 30 December 2017.

20 January 2017
During the period of the 4 week immediate exclusion period notified to Mr O'Brien on 30 December 2016, Mr Colin Weir wrote to Mr O'Brien to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Mr O'Brien to state his case and propose alternatives to formal exclusion.

23 January 2017
On 23 January 2017, Mr Weir wrote to Mr O'Brien seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to Mr O'Brien but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017
The meeting between Mr Weir and Mr O'Brien took place on 24 January 2017.

26 January 2017
In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Mr O'Brien's immediate exclusion and to determine if, from the initial preliminary enquiries, Mr O'Brien had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting.

At the case conference meeting, it was determined by the Case Manager, Dr A Khan that Mr O'Brien had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as exclusion was not deemed to be required. Instead, Mr O'Brien's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Mr O'Brien verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017
A letter was sent to Mr O'Brien on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work.

9 February 2017
Mr O'Brien attended a meeting with the Case Manager, Dr Ahmed Khan on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period.

20 February 2017
Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Mr O'Brien was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

January and February 2017
During January and February 2017, Mr O'Brien made a number of representations to Dr Richard Wright, Medical Director and Mr John Wilkinson, Non-Executive Director in respect of process and timescale.

16 March 2017
The terms of reference for the formal investigation were shared with Mr O'Brien along with an initial witness list.

April, May and June 2017
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.

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.

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.

05 July 2017
Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017
A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern.

16 October 2017
A meeting date for the second investigation meeting was agreed for 06 November 2017.

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 term of reference 4. 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.

15 February 2018
By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore this was queried with Mr O'Brien and an update sought.

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 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.

16 March 2018
Comments on the documents were not received on 9 March 2018 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.

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

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.

30 March 2018
No comments were received from Mr O'Brien.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Mr O'Brien. Mr O'Brien also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

The Findings from the investigation

There were 783 un-triaged referrals by Mr O'Brien of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Mr O'Brien stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing but the review team is satisfied with Mr O'Brien's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. Mr O'Brien gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event.

Some of Mr O'Brien's private patients were added to the HSC waiting list ahead of HSC patients without greater clinical need by these private patients .

GMC Liaison officer recommnended referral on 19.01.19. Recently appointed MD reviewed and discussed concerns re insight.

Local restrictions

Please provide details of any restrictions on the doctor's practise at a local level:

See attached management plan in place for Mr O'Brien.

Supporting documentation

Please list in the box below any available supporting information and mark which items are included with this form. Please forward to us any further supporting information which subsequently becomes available as soon as possible and, if possible, indicate in the box below which information you expect to be able to send at a later stage.

Supporting documentation (where available) could include:

- notes, reports and transcripts of internal investigations or disciplinary documentation on this matter or related previous concerns
- complaint letter
- anonymised / redacted medical records

  Where supporting information contains patient identifiable details, we may ask you to seek consent from those individuals, where you have not done so already.
- expert report(s)
- relevant Royal College reviews
- relevant audit findings
- NCAS assessment reports and other relevant NCAS correspondence
- conviction / caution cases: criminal records check or certificate of conviction
- health cases: (1) details of any relevant sickness absence; (2) medical records and (3) notes of any meetings where the doctor's health has been discussed
- where the incident being referred is part of a pattern of behaviour - all supporting documentation relating to the other concerns.

Formal investigation report and appendices (send via post to GMC)
Case Manager's determination (attached)
Management Action Plan for Mr O'Brien (attached)
NCAS advices (attached)

Other sources of information

Please use the box below to detail any organisations and bodies (eg regulatory bodies, coroners, ombudsman, the police) that may be able to assist with providing relevant information to us. Where possible, please include the contact details of a named person within that organisation.

Patient safety concerns

To your knowledge, has the doctor whom you are referring raised concerns about patient safety with your or any other organisation that patient safety or care is being compromised by the practice of colleagues, the system, policies, procedures in the organisations in which they work?

Yes ☒ No ☐ Explanatory guidance on patient safety concerns can be found in the referral guidance.

If yes, when did the doctor raise their concern? Also, please indicate the nature of the concern.

Has raised concerns throughout about waiting lists which are well recognised

Have the concerns been investigated? Yes ☒ No ☐

Please list any supporting information available in regard to the investigation and the patient safety issues raised. If the concern was not investigated, please provide an explanation below.

Supporting documentation (where available) could include:

- Reports or notes of internal / external enquiries or investigations

To mitigate effects of this Consultant of the week with triage was introduced to identify patients who should have been red flagged at referral.

Declaration

In accordance with my duty to raise concerns about the fitness to practise of doctors, I refer the named medical practitioner(s) to the GMC. In so doing, I confirm that:

- the referral is made in good faith, based on all the information that is available to me at the present time
- I have taken reasonable steps to ensure that the referral is fair and accurate.

Signature

Date

Your full name

Dr Maria O'Kane

Your role

Medical Director

Organisation

Southern Trust
Trust Headquarters
Craigavon Area Hospital

Where you are a nominated delegate, please provide the name and role of the person you are acting on behalf of, if applicable:

Acting on behalf and with the knowledge of

Role (eg Responsible Officer, Suitable Person, Medical Director, or Chief Executive)

Organisation

Stinson, Emma M

From: OKane, Maria
Sent: 11 August 2020 13:10
To: Wallace, Stephen
Subject: DW Naresh Chada

Summary of discussion

1. Described EA and concerns re extent of patient safety / SAI – potentially 6
2. Summarised discussion with IRS, GMC,NHS Resolutions
3. Advised PHA as below
4. Asked for critical friend support from DOH/PHA , advice re extent of look back, any blindspots – stated would consider and come back to me.

From: Chada, Naresh [mailto: Personal Information redacted by the USI]
Sent: 07 August 2020 13:55
To: OKane, Maria
Cc: Wilson, Ryan (DoH)
Subject: Issue at SHCST

Maria

Following our conversation yesterday I would also suggest you speak to Professor Hugo Van Woerden Director of Public Health and Medical Director of PHA and HSCB to discuss next steps. Liz Fitzpatrick at HSCB also has a role in the SAI process.

Thanks

Naresh

Dr Naresh Chada MBChB, FFPH
Deputy Chief Medical Officer, Public Health (CMO Group, Department of Health, Northern Ireland)
Telephone Personal Information redacted by the USI

UROLOGY ASSURANCE GROUP (UAG)

Friday 18 December 2020 at 12.00, by Zoom

Draft Minutes

FOI Implications: May not be disclosed Section 22 Information intended for future publication, Section 33 audit functions, Section 35 formulation of Government policy refers.

Richard Pengelly, DoH (Chair)	Paul Cavanagh, HSCB
Michael McBride, DoH	Sharon Gallagher, HSCB
Lourda Geoghegan, DoH	Olive McLeod, PHA
Michael O'Neill, DoH	Brid Farrell, PHA
Ryan Wilson, DoH	Shane Devlin, Southern Trust
Anne-Marie Bovill, DoH	Maria O'Kane, Southern Trust
	Ronan Carroll, Southern Trust
	Stephen Wallace, Southern Trust

Apologies: Jackie Johnston, Melanie McClements, David Gordon

Welcome and apologies

1. The group was welcomed and apologies noted.

Minutes of previous meeting

2. The draft minutes of the previous meeting were agreed.

Actions from previous meeting

3. The actions arising from the previous meeting were addressed during the course of the meeting.

Patient Records Scoping Exercise – update (Southern Trust)

4. A summary of progress relating to the Patient Record Scoping Exercise, capturing details included in the update paper provided by the Southern Trust

and circulated to UAG members prior to the meeting, was presented by Maria O'Kane.

5. The group noted that the Southern Trust continue to address calls to the patient information line including a range of individual issues requiring follow up. To date 144 calls, 8 emails and 3 GP calls and 1 inquiry via the trust complaints team have been received. 21 patients who have either contacted the information line/come via MLA/MP enquiry or from the GP query have been seen at clinic to date.

6. Maria outlined that Professor Sethia, Urology Subject Matter Expert, has agreed to look at all the patients that have contacted the Information Line. The group noted that as this will take some time an acknowledgement letter is being sent out to all the patients/relatives who have phoned in advising them that their case is being looked into and that they will be contacted as soon as the review is complete.

7. The group noted that 194 management plans have been received back from Independent Sector including 121 being referred by to the care of their GP, 32 being referred back to the Trust for further care/follow-up, 38 to be independently reviewed by Professor Sethia and 3 referrals to Oncologist for urgent reassessment of treatment.

8. The group noted the draft Terms of Reference (ToR) for the Invited Review Service by the RCS provided to the UAG group for information. Brid Farrell suggested it may be beneficial for the Trust to consider creating categories of relevant clinical conditions, within the sample of 100 cases to be reviewed, to support the structure of the review.

9. Maria informed the group that the Trust continues to work at ways to ensure all staff involved are and will be supported including fortnightly team meetings with the Clinical Teams and the Chief Executive, Medical Director and Director of Acute Services.

Action: Southern Trust (Maria O'Kane) to consider categorising the cases for review into relevant clinical conditions within the Invited Review Service by the RCS.

SAIs and Structured Clinical Review

10. Maria outlined that a mid-report of early identification of learning, relating to the 9 SAIs currently under review, was shared with HSCB on 17 December 2020 and full reports are anticipated by end January 2021.

11. Maria outlined to the group that the Trust has met with the Royal College of Physicians who were supportive of the use of Structured Judgement Review methodology to develop, support and ensure an appropriate structured clinical review process for any patient cases falling outside of the 9 SAIs already under review. The Trust is agreeing a core virtual training programme with the Royal College of Physicians team for a core group of reviewers.

Independent Sector

12. The group noted that on the 15th December 2020 the GMC interim orders panel suspended Mr O'Brien from the medical register for a period of 18 months and that the consideration of the potential need to re-issue the alert letters, following concerns that Mr O'Brien may be continuing private practice, is no longer required.

13. The Trust outlined their continued efforts to engage with Mr O'Brien's legal representatives in order to establish the number of private patients which were under his care.

14. The group noted concern that the information requested regarding Mr O'Brien's private practice has not been supplied to date which could restrict progress on measures which may be required to be taken in the patient's best interest. The Trust agreed to include updates to the group on this matter going forward.

Action: Southern Trust (Maria O'Kane) to include an update at future meetings on progress and engagement with Mr O'Brien's legal representatives in gaining information on patients within his private practice.

Public Inquiry

15. Michael O'Neill outlined that finance colleagues have been alerted to the fact that there will be additional financial pressures from 2021/22 and in future financial years associated with the establishment and completion of the Public Inquiry.

16. The group noted the chronology required to establish the Public Inquiry including the first step of appointing the Chair which will allow the Terms of Reference to be agreed supported by the appropriate stakeholder and patient/family engagement.

17. The Trust outlined that a small team will be required to support the work of the Public Inquiry and to address issues and consider and implement improvements as required. The Trust and HSCB are considering additional budget requirements to support this work from 2021/22 financial year.

Communication Plan

18. The group noted the management of communications raised through queries, correspondence and engagement continues to be directed and actioned through the appropriate processes and that the next key communication should be the announcement of the Public Inquiry Chair.

Any other business

19. No other business was discussed.

Date of next meeting

20. The next meeting of the group will be on Friday 8 January 2021.

Structured Clinical Record Review title(SCRR)

Section 1

This section should be completed as soon as is possible following identification of the incident
If it is deemed appropriate to complete Section 2, it should be completed within 8 Weeks (56 days)

Patient identification number:		Gender:	
Date of birth (dd/mm/yyyy)		Age:	
Date of Incident		Date Incident Reported:	
Datix Incident Number			
Date of death (if relevant)			
Location of death (if relevant)			
Was the patient identified as being within the last 12 months of life?			
Cause of death (if known)			
Primary diagnosis, including ICD-10 code (if known)			
Co-morbidities			
Healthcare teams involved in **the patient's care at the time** of incident			
Patient summary (can be completed by the clinical team)			
Concerns from family members **or carers about the patient's** care (please outline concerns, or state if there were no concerns)			
Concerns from staff about the **patient's care (please outline** concerns, or state if there were no concerns)			

Time taken to complete Section 1 of this form (minutes): .....

Date of completion: .....

Name of person completing Section 1: .....

Job title of person completing Section 1 .....

Care Review Tool for Urology

Section 2

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Triage (where relevant) • Was triage conducted in a timely manner? • Was the triage outcome assigned an appropriate level of priority given the information available at the time? Please record your explicit judgements about the triage process and whether it was in accordance with current good practice at the time the care was provided Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.2. Phase of care: Initial assessment or review (where relevant)

- Were the investigations, prescribing, diagnosis and clinical management approach and communications with patient, primary care and MDT teams appropriate?
- Were diagnostic tests or investigations requested in a timely manner and with sufficient clinical information to allow appropriate onward prioritisation?

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.3. Phase of care: Review of Diagnostics (where relevant)

- Were diagnostic tests or investigations reviewed in a timely manner with appropriate further actions taken?
- Were any required actions adequately communicated to patient / primary care / MDT teams?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.4. Phase of care: Ongoing Outpatient Care (where relevant)

- Were ongoing reviews scheduled at appropriate intervals?
- Were referrals made to other teams / professionals appropriately and in a timely manner?
- Where any further required tests / investigations requested and performed in line with good current practice?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.5. Phase of care: Admission and Initial Management (approximately the first 24 hours) (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

2.6. Phase of care: Ongoing Inpatient Care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

2.7. Phase of care: Care during a procedure (excluding IV cannulation) (where relevant)
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐