Urology Services Inquiry

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

Melanie McClements
Director of Acute Services
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

4 May 2022

Dear Madam,

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

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

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

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

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

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

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

Issued by Urology Services Inquiry on 4 May 2022. Annotated by the Urology Services Inquiry.

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

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

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

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

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

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

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

Issued by Urology Services Inquiry on 4 May 2022. Annotated by the Urology Services Inquiry.

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 53 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:

Melanie McClements
Director of Acute Services
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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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 15th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

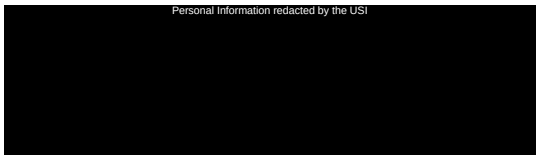
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

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 8th June 2022**.

Issued by Urology Services Inquiry on 4 May 2022. Annotated by the Urology Services Inquiry.

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 4th May 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Issued by Urology Services Inquiry on 4 May 2022. Annotated by the Urology Services Inquiry.

Urology Services Inquiry

SCHEDULE

[No 53 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. 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.

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.

The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel not referenced by the Inquiry but which you are aware of.

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

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality

standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

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

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any subsequent protocol (please specify) provided to or disseminated in any way to you or 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 that protocol or any subsequent 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, if any, with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role, if any, in that process?
    IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

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14. As far as you are aware, 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 urology unit was adequately staffed and properly resourced during your tenure? 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 during your tenure? 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. Did your role change in terms of governance during your tenure? If so, explain how and why it 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 during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff

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allocation provided to the medical and nursing staff. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do 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 concerns from 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.

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.

Issued by Urology Services Inquiry on 4 May 2022. Annotated by the Urology Services Inquiry.

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. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

31. 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

32. What was your role in relation to the Directors of Human Resources and Organisational Development, the Assistant Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in the urology unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

33. 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? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

34. 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?

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

36. 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?

37. 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?

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

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

40. 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?

41. 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.

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

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

44. 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.

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

46. 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.

47. Did you feel supported in your role by general management and 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

48. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

    (i) The Chief Executive - the Inquiry understand the post holder to have been Shane Devlin;
    (ii) the Medical Director(s) - the Inquiry understand this to have been Maria O'Kane;
    (iii) the Assistant Directors - Heather Trouton, Ronan Carroll and Barry Conway;
    (iv) the Associate Medical Directors - the Inquiry understand this to have been Mark Haynes and Damian Scullion;
    (v) the Clinical Directors - the Inquiry understand this may have been Colin Weir/Ted McNaboe;
    (vi) the Head of Service, namely Martina Corrigan, and
    (vii) the consultant urologists in post.

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 urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (vii) above but with whom you interacted on matters falling within the Inquiry's Terms of Reference.

49. During your tenure, 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 and how was this done? Please provide all relevant documents.

(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, please name those individuals and set out the assurances they provided to you. 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.

50. 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?

51. 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. (Q65 will ask about any support provided to Mr O'Brien).

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

Mr. O'Brien

53. 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)?

54. 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.

55. 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?

56. 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.

57. 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.

Issued by Urology Services Inquiry on 4 May 2022. Annotated by the Urology Services Inquiry.

58. 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.

59. 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.

60. 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?

61. 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?

62. 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?

63. 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?

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64. 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?

65. 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.

66. 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 raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

67. 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.

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

69. 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?

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70. 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.

71. 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?

72. 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?

73. 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

UROLOGY SERVICES INQUIRY

USI Ref: Notice 53 of 2022

Date of Notice: 4th May 2022

An Addendum amending this Section 21 Statement can be found at WIT-96844 to WIT-96847.

Witness Statement of: Melanie McClements, Director Acute Services

I, Melanie McClements, will say as follows:-

General

Q1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1. I have been the Director of Acute Services since 7 June 2019 to current day (due to retire 31 August 2022). My job role and function is to operationally manage the vast array of acute services and maximise the collective working arrangements of Divisional Medical Directors, Assistant Directors, Heads of Service and their operational multi-disciplinary teams. I describe in my response to Questions 7 and 49, the various one to one (1:1) and group approaches that I mobilise to ensure the services delivered are in line with the Trusts objectives of delivering safe, quality, patient centred care and improving services. The detailed description of the issues raised, the meetings that I attended and the decisions that I took to address these concerns are described in my response to sections ***Concerns regarding the urology unit and Mr O'Brien*** of this notice

2. Another important function relates to the requirement to liaise with the Medical Director and her Deputy Directors, the Executive Nurse for Nursing, Midwifery & Allied Health Professionals, the Executive Director of Social Work and Director of Human Resources & Organisational Development, as appropriate, to consider and effectively deal with all work related and professional issues. As a member of the Trust Senior Management Team and Trust Board, I am

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required to escalate areas of concerns, plans to resolve those and offer assurances regarding ongoing patient safety and safe quality services.

3. With regard to the Terms of Reference of the Inquiry, I specifically reference Urology services and Cancer & Clinical Services as they are inextricably linked. I have detailed under each section my involvement in and knowledge of all matters falling within the scope of those terms. I have detailed my roles, responsibilities and duties and provided detailed description of any issues raised with me and actions and decisions taken by me and others to address those concerns.

Q2. 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. 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.

Q3. 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.

The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel not referenced by the Inquiry but which you are aware of.
Your position(s) within the SHSCT

Q4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

4. I completed **a Diploma in Community Nursing** in December 1991 from University of Ulster, Jordanstown.

5. I obtained a **Post Graduate Diploma and Master of Science in Health Promotion** in November 2005 from University of Ulster, Jordanstown.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Registered General Nurse (RGN) (January 1986)

6. I trained in October 1982 – January 1986 in Mater Infirmorum Hospital Belfast (Now Belfast Health & Social Care Trust).

7. I worked as a Staff Nurse in Mater Infirmorum Hospital Belfast from January 1986 until May 1987.

8. I worked as a Staff Nurse in Downe Hospital from May 1987 until November 1987 (now South Eastern Trust).

I registered as a Midwife (RM) (June 1989)

9. I entered Midwifery training in November 1987 – June 1989 in Royal Maternity Hospital (Now Belfast Health & Social Care Trust).

10. I worked as a temporary Staff Nurse in Downe Hospital for 3 months June 1989 – August 1989 (now South Eastern Trust).

11. I then took 10 months off (Maternity Leave).

12. I subsequently worked as a Staff Midwife June 1990 – September 1990 in Downe Maternity Hospital (now South Eastern Trust).

I registered as a Health Visitor (RHV) in December 1991.

13. I commenced Health Visitor training in September 1990 in University of Ulster, Jordanstown and completed in December 1991.

14. I worked as a Health Visitor in North & West Belfast Trust 1991 – 1994 (now Belfast Health & Social Care Trust).

15. I subsequently worked as a Health Visitor in Down & Lisburn Unit of Management 1994 – 2000 (now South Eastern Trust).

16. I moved into a Health Promotion Specialist post in Down Lisburn Trust 2000-2004 (now South Eastern Trust).

17. I then was promoted to Health Development Manager 2004 – 2007 in Down Lisburn Trust (now South Eastern Trust).

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Q5. 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.

Assistant Director Promoting Wellbeing

18. I moved to SHSCT as **Assistant Director Promoting Wellbeing** (AD PWB) in 06 August 2007 – 31 May 2012.

19. The main duties of the role and responsibilities of the post were to:
    - develop and deliver on the Trust's Promoting Wellbeing Strategy embracing health improvement, health promotion and community development within the Southern Trust area;
    - provide strategic leadership for the development of health-and wellbeing policy, strategy, service development and delivery across Trust Directorates and Divisions ensuring adherence to regional priorities, local need and clinical governance standards for health and wellbeing;
    - lead the development and implementation of the Trust's Personal and Public Involvement (PPI) policy, strategy and action plan across Directorates and with stakeholder organisations;
    - have a lead role in representing the Trust at local, area and regional levels, ensuring effective working of cross-sectoral partnerships and synergy across the policies, strategies, funding direction and service development of external partners, agencies and community organisations in line with the objectives of the Trust's Corporate Plan;
    - be responsible for effective financial management, efficient use of the PWB resource and the external commissioning of services to meet this agenda;
    - be a member of the Directorate's senior management team and contribute to policy development and the achievement of its overall objectives;
    - ensure the Trust delivered its wellbeing and PPI services in accordance with DHSSPS *Quality Standards for Health and Social Care, Regional PPI Guidelines* and professional standards for wellbeing and other relevant requirements;
    - ensure high standards of governance were compliant with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework;
    - ensure performance management arrangements were implemented and the defining and monitoring of performance standards in contracts/service level agreements for Directorates and with independent service providers;
    - ensure the management of complaints within the division complied with HPSS and Trust complaints procedures and were underpinned by transparency and a culture of continuous improvement;
    - Lead on the implementation of quality initiatives.

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20. **I believe the job description was an accurate reflection of the duties and responsibilities of the post.** 1.*20070801 Q5.20 JD - AD - Promoting Wellbeing located in S21 53 of 2022 Attachments.*

Assistant Director Older People Services

21. **I was Assistant Director for Older Peoples Services** (AD OPS) 01 June 2012– 01 October 2017.

22. The main duties of the role and responsibilities of the post were to:

- be responsible to the Director of Older People and Primary Care for the delivery of high-quality community-based care to older people in the Southern Trust area;
- be responsible for the operational management of all services within the division which included directly managed domiciliary/home care, residential and day-care services;
- ensure the objectives of the "Trust's Delivery Plan" for older people were successfully implemented through effective multidisciplinary working;
- provide clear leadership to all staff in the division and to be responsible for effective financial management and the efficient use of all resources;
- support the Director of Older People and Primary Care with long term planning and service reform initiatives;
- be a member of the directorate's senior management team and to contribute to policy development in the directorate and the achievement of its overall objectives;
- ensure that the needs of older people and their carers were at the core of how the division delivered its services and were in accordance with DHSSPS Quality Standards for Health and Social Care and other relevant requirements;
- ensure high standards of governance in the division including compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's Safety First framework;
- liaise closely with senior professional/governance staff to ensure the division complied with the standards and codes of practice of the relevant professional bodies such as NMC, NISCC and HPC;
- ensure all recommendations from the RQIA and other regulatory bodies were implemented within requisite timescales;
- ensure performance management arrangements were implemented and the defining and monitoring of performance standards in contracts/service level agreements with independent service providers;
- ensure the management of complaints within the division complied with HPSS and Trust complaints procedures and were underpinned by transparency and a culture of continuous improvement;
- Lead on the implementation of quality initiatives.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

23. I believe the job description was an accurate reflection of the duties and responsibilities of the post. 2. *20120901 Q5.23 JD - AD - Older People Services located in S21 53 of 2022 Attachments*

Director Older People and Primary Care

24. I was **Director of Older People & Primary Care** (OPPC) service, as Acting Director from 02 October 2017, then substantively from 19 September 2018 – 06 June 2019.

25. The main duties of the role and responsibilities of the post were to:

- be a key member of the Trust's Senior Management Team and be accountable to the Chief Executive for leading the delivery of safe, effective and high-quality services within the portfolio of the Trust's Older People and Primary Care Directorate;
- play a key strategic role in leading and managing the transformation of services for older people and others in line with the principles and strategic direction for health and social care contained in *Health and Wellbeing 2026: Delivering Together;*
- engage with external stakeholders to enhance local partnerships and new and innovative collaborative approaches to enable and support people living in the Trust's area to achieve their full health and wellbeing potential;
- provide exemplary and visible leadership and be a member of the Trust's Senior Management Team and have both an individual and a corporate leadership responsibility to contribute fully to the development, delivery and achievement of the Trust's corporate objectives;
- represent the Trust on regional work streams, which include influencing policy direction, contributing to and / or leading on strategic development, implementation, review and evaluation of transformation plans for older people and primary care services;
- Lead the development and implementation of the Older People & Primary Care/Directorate's strategic plan in line with Health and Wellbeing 2026 - Delivering Together and other key strategic reforms;
- Work collaboratively with regional colleagues to strengthen the achievement of scale and spread of evidenced based local service improvement models;
- Lead and be accountable for having effective arrangements in place in the Trust to enable as many older people as possible to be cared for safely in their own homes or return there as soon as possible following a hospital admission or care episode.
- Ensure a close interface between Trust Directorates ensuring early intervention to promote an upstream approach to prevention,

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

rehabilitation, optimum health and wellbeing for efficient patient flow and patient experience.

- Shape and develop the implementation of evolving Primary Care models including Trust managed GP Services;
- Lead and be accountable for active engagement with primary care providers, GP Federations, commissioners, user groups and the voluntary and independent sectors in the design and delivery of services in order to inform service improvement;
- Influence and work collaboratively with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets;
- Lead and be accountable for the development and implementation of the Trust's Personal Public involvement (PPI) and Promoting Health and Wellbeing Strategy, and maximize the co-production model in service development and delivery;
- Ensure that the needs of older people and their carers were at the core of how the Directorate delivered its services and were in accordance with DOH Quality Standards for Health and Social Care and other relevant requirements. This included driving up the quality of care, improving outcomes and enhancing the patient/client experience in line with the principles for change contained in Health and Wellbeing 2026: Delivering Together;
- Lead and be accountable for ensuring excellent standards of governance in the Directorate to include compliance with all relevant professional requirements and standards, adult safeguarding policies and procedures, the assessment and management of risk and the implementation of all relevant learning and best practice;
- Ensure ongoing, critical evaluation of the Directorate's performance, taking corrective action as required, to maximize performance against specific Objectives & Goals for Improvements (OGIs) and agreed trajectories for improvement;
- Lead the defining and monitoring of performance standards in contracts/service level agreements with independent service providers and oversee arrangements;
- Ensure the management of complaints and SAI's within the Directorate complied with DOH, HSCB and Trust complaints procedures / SAI procedures and were underpinned by candour, transparency and a culture of continuous improvement;
- Be accountable for the management of the Directorate's budget (pay and non-pay) and the meeting of all financial targets by each division and service.

26. I believe the job description was an accurate reflection of the duties and responsibilities of the post. 3. *20170901 Q5.26 JD - Director - Older People and Primary Care located in S21 53 of 2022 Attachments*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Director Acute Services

27. I was interim **Director of Acute Services** from 07 June 2019 – 31 October 2020, and thereafter transferred to the post substantively up to present day. My planned retirement date is 31 August 2022.

28. I commenced the Acute Director post on an interim basis on 10th June 2019 to cover Personal Information redacted by the USI for Esther Gishkori. This was initially meant to be for approximately six weeks. I had redeployed temporarily from my substantive post of Director of Older People & Primary Care. Following a prolonged period of absence by Mrs Gishkori, I agreed to remain in the Acute Services Director post in October 2020 (same Director level post as Director OPPC).

29. The Director is responsible operationally for Medicine, Unscheduled Care, Integrated Maternity & Women's Health Services, Cancer and Clinical Services, Surgery and Elective Care, Anaesthetics, Theatres and Intensive Care Unit, Pharmacy services and Functional Support Services including Hospital Records, Administration staff and Consultant Secretaries, catering, domestic services, portering, sterile supplies department and Laundry. I oversee a budget of approximately £315 million and have 5200 staff. The four key areas that I have operational oversight for are workforce, performance, governance and finance.

30. The Director of Acute Services is responsible through the Chief Executive for the development and delivery of safe**,** high-quality emergency and elective hospital care within the Southern Trust. I lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. I provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, I have a corporate role as a member of the Trust's senior management team, including helping to shape the Trust's overall objectives.

31. The main duties of the role and responsibilities of the post are to:

- Ensure the co-ordination of multidisciplinary teams to deliver safe, high-quality and equitable emergency and elective hospital care to the Trust's population and lead the effective and efficient deployment of all resources to achieve all relevant targets. This will include delivering against Ministerial and commissioning standards and targets;
- Be accountable to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the successful delivery of agreed Patient Safety Programmes and the reporting of appropriate safety and quality indicators to provide assurance to the Chief Executive and Trust Board;

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- Work closely with other Directors to secure an integrated approach to managing demand on hospital services, reducing admissions where appropriate and minimising length of stay including the effective management of discharge planning in liaison with community services in line with benchmarked best practice;
- Actively promote the development of clinical and professional networks across the Trust;
- Lead the strategic development and integration of specialty and sub-specialty services across the Trust's hospital network, ensuring implementation of an effective and efficient service configuration in line with Commissioner intent;
- Ensure that the needs of patients and their carers are at the core of the way the Trust delivers acute hospital care;
- Ensure high standards of governance including the effective assessment and management of risk;
- Ensure the Trust's acute care services comply with all professional regulatory and requisite standards and the discharge of statutory functions;
- Ensure that robust performance management arrangements are developed and implemented within the directorate;
- Lead innovation and change to underpin the modernisation of acute hospital care in the Trust;
- Lead quality initiatives in the Directorate to improve the patient experience;
- Ensure the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies, Ministerial and HSCB priorities;
- Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets;
- Be responsible for the management of the Trust's acute services budget and ensure the meeting of all financial targets within the directorate;
- Participate in contract and service level negotiations with commissioners;
- Provide clear and strategic leadership to staff within the directorate and ensure the Trust has a highly skilled, flexible and motivated workforce to provide high-quality acute hospital care;
- Ensure that staff working in Acute Hospital Care are trained and developed in line with professional standards as defined by the relevant Executive Director for that professional workforce and as agreed by the Senior Management Team;
- Lead the development and implementation of workforce modernisation initiative;
- Ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation;
- Ensure the full engagement of all professional staff working in acute services;

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- Contribute to the Trust's corporate planning, policy and decision-making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated;
- Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board;
- Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions;
- Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability;
- Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers;
- Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training;
- Review the organisation plan and levels of the service I am responsible to ensure they are consistent with achieving objectives and recommend change where appropriate;
- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision-making, while retaining overall responsibility and accountability for results;
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

32. I never received a Job Description for this post due to the manner in which I was redeployed to cover Personal Information redacted by the USI. As the leave extended, I was in post 16 months and I had then the choice to remain or return to Director of Older People and Primary Care. I have sourced the Job Description in preparation for submitting this response and have read it. It is similar to my previous Director Job Description in many ways in terms of breadth of remit and level of corporate responsibility, albeit applied to an acute setting. Thus,

33. **I believe the job description is an accurate reflection of the duties and responsibilities of the post.** 4. *20190610 Q5.33 JD - Director - Acute Services located in S21 53 of 2022 Attachments*

Q6. 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.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Role	Line Manager description/reported to	Managed / Responsible for
Assistant Director Promoting Wellbeing (PWB)	Line managed by: - Dr Gillian Rankin and then - Angela McVeigh Both in their capacity as Director Older People & Primary Care - (PWB) was within their portfolios.	Responsible for the Promoting Wellbeing Team within Directorate of OPPC and responsibility to embed and deliver on the Health Improvement, Personal & Public Involvement (PPI) and Community Development (CD) work streams across the Trust Directorates. I line managed: - Gerard Rocks, Head of Service, Promoting Wellbeing; - Carolyn Agnew, Head of Service, Community Development/ Personal and Public Involvement.
AD OPS	Line managed by Angela McVeigh Director of OPPC	Responsible for planning, developing and overseeing workforce, performance, governance and Financial issues across staff and services in the Older Peoples division. I line managed Heads of Service for Community-based services all delivering care services, predominantly for older people and vulnerable groups, namely: - Claudine McComiskey, Head of Service, Domiciliary Care; - Jane Greene, Consultant Nurse, Care Home Support Team; - Tierna Armstrong, Head of Service, Statutory Residential Homes and Day-care.
Director OPPC	Line managed by Chief Executive – Francis Rice initially then Stephen McNally and subsequently Shane Devlin.	Strategic development and delivery of older people and primary care services across the Trust. I line managed: - Brian Beattie, Assistant Director, Primary Care; - Roisin Toner, Assistant Director, Enhanced Services; - Monica McAlister, Assistant Director, Older Peoples Services; - Gerard Rocks, Assistant Director, Promoting Wellbeing.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Director Acute Services	Line managed by Shane Devlin and since February 2022 Dr Maria O'Kane (interim and then substantive)	Responsible for safe, effective, quality Acute service delivery across Craigavon Area Hospital, Daisy Hill Hospital, South Tyrone hospital (theatres) and related outpatient services. I line manage: - Anne McVey, Assistant Director, Medicine; - Mary Burke, Assistant Director Unscheduled Care; - Barry Conway, Assistant Director Cancer and Clinical Services (previously also held responsibility Assistant Director for Integrated Maternity and Women's Health, within his post); - Wendy Clarke acted into Interim ADS IMWH for 4 months as Mr Conway was on leave; - Caroline Keown, Assistant Director Integrated Maternity and Women's Health, (commenced October 21 when this became a standalone post); - Ronan Carroll, Assistant Director, Surgery & Elective Care / Anaesthetics, Theatre and Intensive Care (SEC/ATICS) – Urology is within this portfolio; - Anita Carroll, Assistant Director Functional Support Services (includes Administrative services including Health Records, Consultant Secretaries, Domestics, Porters, Catering, Laundry and Sterile Supplies); - Dr Tracey Boyce, Director of Pharmacy - now Ann McCorry Pharmacy Head of Service since Tracey retired 31/1/22); - Patricia Kingsnorth, Coordinator for Clinical & Social Care Governance from I commenced on 10 June 2019 until July 21 when she retired; During a period of Personal Information redacted by Inquiry leave in October 2019 Mrs Connie Connolly covered the CSCG coordinator post until February 2020;

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

		- Chris Wamsley took up post of Coordinator for Clinical & Social Care Governance in July 2021. - There is also a Human Resources Assistant Director who is a Business Partner within Acute Services. This post in directly managed by Vivienne Toal, Director of Human Resources and Organisational Development and the post holder has a direct relationship with the Acute Director. Since my tenure I have offered additional supervision/support to Helen Walker, Assistant Director (in post when I commenced and retired in March 2022) and subsequently Assistant Director Fiona Stevenson has taken up the post. - In addition, the Associate Medical Directors (now entitled Divisional Medical Directors – DMD's) report operationally to me from all specialities (accountable to Medical Director). With respect to this Section 21 notice, I include Mr Mark Haynes (from commencement of my tenure and still in post) and Mr Edward McNaboe since November 2021 (DMD's in Surgery and Elective Care including Urology) And Mr Shahid Tariq DMD due to interface with Cancer And Clinical Services.

Q7. With specific reference to the operation and governance of urology services, please set out your roles and responsibility and lines of management.

34. None of my previous posts had any role or responsibility for the operation and governance of urology services. When I joined the Senior Management Team as Director of Older People and Primary Care, I had corporate insight to the breadth of operational and governance challenges that were escalated to Performance Committee, Governance Committee and Trust Board. I do not recall having any detailed discussions about specific issues within urology services.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Line Management

35. In my role as Director of Acute Services from 10 June 2019, I am responsible to ensure that the urology service within the Southern Area is delivered in line with Commissioner Intent with respect to workforce, performance, governance and finance. To deliver on these, I line manage Mr Ronan Carroll, Assistant Director (AD) for Surgery and Elective Care (SEC) and Anaesthetics, Theatre and Intensive Care (ATICS), who has direct operational and governance responsibility for the urology service. As line manager to Mr Carroll, I offer supervision, and the opportunity to discuss options, situations and make decisions when he escalates areas of concerns where all operationally appropriate approaches have already been taken. If necessary, I also escalate situations and issues of concern within Mr Carroll's Division to agree a way forward with the Chief Executive, Senior Management and Trust Board. An example of this is the escalations regarding workforce and equipment which resulted in inclusion in the Corporate Risk Register and funding from the Capital Allocation Group. *5. 20220512 Q7.35 Summary Corporate Risk Register to Governance Committee located in S21 53 of 2022 Attachments*

36. Mr Carroll works collectively with the Divisional Medical Director for Surgery and Elective Care (Mr Mark Haynes, and since November 2021, Mr Edward McNaboe is also co-Divisional Medical Director with Mr Haynes), Clinical Director for ENT and Urology (previously Mr McNaboe until November 2021, post vacant since) and Head of Service for Urology (Mrs Martina Corrigan until October 2020, presently Ms Wendy Clayton) to plan, implement and oversee service delivery, addressing ongoing challenges in terms of capacity outstripping demand, lack of workforce capacity or daily operational issues to be addressed.

37. The Divisional Medical Director of Surgery and Elective Care (DMD, previous title was Associate Medical Director - AMD) who is accountable to the Medical Director also reports to and is operationally managed by me as the Acute Services Director. The DMD has responsibility within the aligned Division for the delivery and assurance surrounding all aspects of professional and Clinical and Social Care Governance. In partnership with the Assistant Director, Clinical Directors and Heads of Service, the DMD is also responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

38. From the commencement of my post as Acute Director, I met with the DMD, (formerly Mr Mark Haynes, Consultant Urologist, and now Mr Edward McNaboe, ENT Consultant) every 1-2 months to discuss issues and to escalate any concerns from a medical perspective. With respect to urology services, the discussion between myself and Mr Haynes and now Mr McNaboe focused on

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

the lack of capacity in urology services and inability to recruit Consultant Urologists, despite repeated recruitment efforts to fill gaps. Mr Haynes remains a DMD in Urology with a focus on service improvement, with a lead role in ensuring the division maintains high-quality, safe and effective services and works alongside Mr McNaboe. 6. *20190704 Q7.38 A1, 7. 20200127 Q7.38 A2, 8. 20200529 Q7.38 A3, 9. 20201220 Q7.38 A4 located in S21 53 of 2022 Attachments*

39. The DMDs are also supported by the Clinical Directors (CD) who sit at Divisional Management Teams and Directorate Senior Management Team. The CD reports to the DMD and has a lead role in ensuring their Division maintains high-quality, safe and effective services and contributes to the Division's strategic direction. They hold delegated responsibility on behalf of the DMD within their areas Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

40. Urology services are also interlinked with Cancer and Clinical Services Division. Consequently, I offer the same supervision and oversight arrangement to Mr Barry Conway, Assistant Director, Cancer and Clinical Services and Dr Shahid Tariq, Divisional Medical Director, Cancer and Clinical Services.

Roles and Responsibilities for the Operation of Urology Services

Workforce

41. My responsibility for the urology workforce is to oversee delivery of safe, effective quality service delivery for patients and to support staff health and wellbeing. Since my tenure as Director of Acute Services, Urology services in the Southern Trust area has been run by a small multidisciplinary team of Consultant Urologists (Mr Mark Haynes, Mr John O'Donoghue, Mr Michael Young (now retired May 2022), Mr Anthony Glackin, Mr Matthew Tyson and Mr Aidan O'Brien (retired July 2020)), Clinical Nurse Specialists (Kate O'Neill, Jenny McMahon, Leanne McCourt, Patricia Thompson and Jason Young), and the operational management team of Assistant Director, Head of Service, Clinical Director and Divisional Medical Director as named above. They cover the diagnosis and treatment of urinary tract conditions including kidneys, ureter, bladder and urethra, as well as male genital conditions. There are now 7 funded Consultant Urologists with currently 3.5 in post (Mr Mark Haynes, Mr Anthony Glackin, Mr John O'Donoghue, Mr Matthew Tyson, in addition, to the 3.5, Mr Nasir Khan is a locum consultant). They are supported by 5 Clinical Nurse Specialists and 1 Lead Nurse (Paula McKay from November 2021, previously Sarah Ward).

42. Ensuring there is sufficient capacity in the team is critical to making the service work. This has been an ongoing challenge particularly with the recruitment of Consultant Urologists. As Acute Services Director, I am a panel member on all Consultant posts including urology.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

43. The impact of reduced staffing availability (medical and nursing), both ward and theatre based, had resulted before my tenure in reducing 3 South, (a ward for Urology and Ears, Nose and Throat - ENT) from 36 beds to 18 beds. This obviously resulted in reduced capacity and therefore reduced performance against required levels as expected by the Commissioner. 10. *20190904 Q7.43 3 South Trust Risk Assessment located in S21 53 of 2022 Attachments*

44. I have oversight via the Assistant Director in relation to workforce planning including rota scheduling in line with medical job plans to allow planned cover for outpatient clinics, theatre lists, "Urologist of the week", alignment for wards and Emergency Department cover, "out of hours" arrangements and triage of new referrals. From a nursing perspective, the nursing rosters are planned again to provide cover for wards, outpatients, theatres and patient support.

45. As part of the workforce stabilisation and capacity plan for Urology services, I worked with the urology team collectively to agree with the Commissioner the funding for two replacement Clinical Nurse specialist posts who commenced in August 2020 *(11. 20191001 IPT - Expansion of Urology Services - Additional Clinical Nurse Specialists located in S21 53 of 2022 Attachments),* funding for Waiting List Initiatives (WLI) to create additional capacity *(12. 20220606 Q7.45 A2 Volume and Funding Allocation – Urology located in S21 53 of 2022 Attachments),* extended role of Nurse Endoscopists and discussions regarding Agenda for Change pay scale banding evaluations (13. *20210322 Q7.45 A3 CNS AFC Discussion located in S21 53 of 2022 Attachments*). We also had regular discussions with the Commissioner about additional resource and working with the other Trusts including Western, South Eastern and Belfast Trust to deliver a range of urology services across our shared staff and funding resources.

46. I chair monthly Human Resource/ Finance meetings with all Assistant Directors in Acute present including the Business Partner from Human Resources, now Mrs Fiona Stevenson (formerly Mrs Helen Walker held this post). This forum allows discussion on any issues relating to workforce and agreed actions to be implemented and escalated as appropriate to SMT and Trust Board. *(14. 20220215 Q7.46 Agenda and Notes HR-Planning-Finance Meeting located in S21 53 of 2022 Attachments)*

Performance

47. My performance oversight of the urology service is focused on 1:1 meetings and supervision of Mr Ronan Carroll, Assistant Director. At these meetings, there is an opportunity to escalate any issues or concerns with regard to his service areas, including Urology. This allows for discussions with regard to the ability of the service to deliver against required performance levels as set out by the Commissioner. In these discussions, there is a recognition that the performance of the service is constrained by the available workforce (15.*20190718 Q7.47 A, 16. 20191016 Q7.47 A2, 17. 20200302 Q7.47 A3, 18.*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

20210215 Q7.47 1-1 Meeting - Ronan Carroll located in S21 53 of 2022 Attachments).

48. There is a daily focus on performance levels as informed by referrals in, triage, trends in cancer pathways, clinic volumes, "do not attend" rates, waiting lists and waiting times. This is monitored through the Operational Support Lead for each cancer speciality/division and liaison with the Head of Service and Assistant Director. This data is discussed in a range of multi-disciplinary meetings chaired by the Assistant Director of SEC/ATICS Mr Carroll and/or Barry Conway AD CCS, throughout the month including Speciality Tumour Site and Cancer Pathways meetings with medical colleagues in attendance (19. *20220426 Q7.48 Acute Performance Scorecard located in S21 53 of 2022 Attachments*).

49. With regard to compliance with performance targets, I chair the Acute Performance Meeting with Assistant Directors and the Assistant Director/Head of Service from the Performance and Reform Corporate team. This forum analyses and discusses compliance with a range of targets, agrees actions for implementation as appropriate and oversees service activity levels against planned clinics, theatre lists etc. It also considers the performance of the Independent Sector providers with whom we contract. It does not consider individual Clinicians' performance, rather a composite picture of all specialities including the urology service *(20. 20220322 Q7.49 A1 Acute SMT Performance Meeting Action Notes located in S21 53 of 2022 Attachments).* Performance targets from SEC and ATICS that were escalated to me as Director of Acute Services include Red Flag cancellations on the day, underutilisation of WLI funding, underperformance of Independent Sector contracts and services that are not meeting estimated activity that were part of the Rebuild plans. For Cancer Services, waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets are also escalated to me.

50. There is also a Corporate Performance Committee which is a subcommittee of the Trust Board. I am required to attend by invite when specific issues relating to the Acute Directorate are under scrutiny. The corporate suite of performance data is shared and discussed within that Committee with escalation to Trust Board as required *(21. 20220509 Q7.50 Acute Performance Report - Performance Committee located in S21 53 of 2022 Attachments).*

51. As Director I am a member of the regional interface meetings with Health and Social Care Board (HSCB now known as Strategic Planning and Partnership Group, SPPG) with Assistant Directors, Heads of Service and Operational Support Leads. These meetings consider waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets. 22. *20211122 Q7.51 HSCB-Southern Trust Directors Meeting located in S21 53 of 2022 Attachments.*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

52. I am also a Board member of Northern Ireland Cancer Network since June 2019. This is a network of professionals from across the Trust, Public Health Agency and the Board. This group strategically plans cancer services and addresses issues for action and/or priority. Service users are also members of this group to help inform the Action Plan *(23. 20211222 Q7.52 A1 NICaN Workplan 2021_22, 24. 20210630 Q7.52 A2 Minutes/ Action Notes NICaN Board located in S21 53 of 2022 Attachments).*

Finance

53. I have a budget of approximately £315 million for Acute Services and have a duty to manage available resources appropriately and to deliver on the corporate statutory duty to "break even" (the legal requirement to take reasonable actions to ensure that the Trust delivers services within the budget available). Budgets are delegated to each Assistant Director as agreed in line with the commissioned service specification and the Trust Finance Department. This includes alignment of budget into payroll and goods and services (25.-26.*20221204 Q7.53 Acute Financial Position A1-A2 located in S21 53 of 2022 Attachments).*

54. On a monthly basis, I chair an Acute Finance Meeting to oversee the efficient management of budgets, to identify pressure areas, to make decisions regarding expenditure on different service areas and to take remedial action if funds need further scrutiny, reallocation or escalation to Senior Management Team *(27. 20220412 Q7.54 Acute HR-Planning-Finance Meeting Minutes located in S21 53 of 2022 Attachments).*

55. Due to the vacant Urology posts, there were additional costs incurred for locum and agency doctors and nurses (higher costs than substantive posts) to sustain service levels. In addition, Independent Sector services have been commissioned by the Trust to assess and treat NHS patients to help reduce waiting lists and times for patients in the Southern Area.

56. I attend the Trust Audit Committee by request. I am a member on the Endowments and Gifts Committee and as a member on Senior Management Team and Trust Board, all financial reports are considered.

Governance

57. The governance of urology service is undertaken on a daily basis by the operational teams who escalate any issues of concern with regard to patient safety or staff for discussion and agreed actions.

58. When I took up the post of Director, I assumed line management of the Clinical and Social Care Governance Coordinator. Dr Tracey Boyce, Director of Pharmacy, who was also part of the Acute Management Team (until 31 January 2022) covered the Clinical and Social Care Governance Coordinator post for

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

approximately four years In addition, to her substantive role as Director of Pharmacy. Subsequently, Trudy Reid became Clinical and Social Care Governance Coordinator, then Patricia Kingsnorth and since July 2021, Mr Chris Wamsley. The role of the Clinical and Social Care Governance Coordinator is to work across the multidisciplinary senior teams in Acute Services to identify risks, develop and host Risk Registers, oversee compliments and complaints, patient and family interfaces and responses, oversight of all incidents reported and screening of serious cases of concerns against Serious Adverse Incident threshold, to progress SAI investigations/reviews and report writing with feedback to patients, families and HSCB/SPPG and deliver learning and action plans for implementation of recommendations.

59. I chair the Acute Governance monthly meetings with Assistant Directors and Clinical and Social Care Governance Coordinator (CSCG) which allows for issues to be specifically discussed. Data reports and trend analysis are provided for this meeting by the Clinical Social Care Governance Coordinator including recorded volumes and severity of Incidents, Serious Adverse Incidents (SAI's), ongoing SAI reviews and application of learning, research, audits, best practice standards and guidelines. In addition, I chair a fortnightly Standards & Guidelines meeting with the Assistant Directors, Quality & Safety Manager for Standards & Guidelines (Mr Chris Warr, previously Mrs Caroline Beattie and Mrs Joanne Bell), Governance Pharmacist (Jillian Redpath) and CSCG Coordinator *(28. 20210105 Acute Gov Notes located in S21 53 of 2022 Attachments).*

60. Since I commenced my tenure in Acute Services in June 2019, on a monthly basis, I have chaired the Acute Clinical Governance meeting with the Assistant Directors, the Clinical Social Care Governance Coordinator, Divisional Medical Directors and Clinical Directors from all specialities across Acute Services including urology. This forum allows all governance issues, data and trends on complaints, Datix Incident reports detail to be shared (Datix is the electronic system used to report and host investigation and status of all incidents until closure), best practice to be highlighted and SAI reports to be discussed, debated and approved and action plans for learning agreed. Any governance issues of concern are escalated to this meeting for discussion and action across members (29. *20210409 Clinical Gov Notes located in S21 53 of 2022 Attachments*).

61. As Director I ensured there was effective communication and support mechanisms established with those service users and families impacted by the 9 Urology SAI investigations. Family liaison was provided throughout the period from identification of the issues of concern to feedback of the outcomes of the reviews. Some family liaison support is still ongoing currently, and two families are engaged with the Trust on embedding service improvement and learning. Psychology support services was offered and facilitated for those who wished

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

to engage with this service including staff members (30. *20201020 SAI offer of support*, 31. *20210831 Q7.61 A1 Memo - Family Liaison Service, 32. 20210831 Q7.61 A2 Liaison Service Referral Pathway located in S21 53 of 2022 Attachments*)

62. As Director I directed interface meetings with the urology team to support them regarding sharing the learning and eventually the Public Inquiry Approach *(33. 20201124 Mins Incident Gp A located in S21 53 of 2022 Attachments).*

Q8. It would be helpful for the Inquiry for you to explain how those aspects of your roles 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 Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

63. My role focuses on the operational oversight of the urology service. The Urology Service is one of the portfolios of services across multiple specialties with a budget of £315 million and 5200 staff approximately. The four key areas that I have operational oversight for are workforce, performance, governance and finance.

Medical Director

64. The Medical Director is the Trust corporate lead for Clinical and Social Care Governance and also is the Responsible Officer for all Doctors to ensure professional standards are upheld, including one to one Appraisal, Revalidation, training, local regional and national benchmarking, peer review, mortality and morbidity oversight, dealing with professional concerns and working within the General Medical Council code of practice.

65. The relationship of the Acute Director and the Medical Director is to liaise across the operational and professional boundaries, collaborate to deliver quality, safe, effective services and to participate in joint approaches to discuss, support and agree necessary actions for Doctors in Difficulty (Doctor & Dentist Oversight meetings) and more targeted oversight meetings with Human Resource colleagues when particular issues arise which cross the threshold for disciplinary procedures. Professional issues are considered within the Medical Director remit including Professional Performance Management, Appraisal and Revalidation, Morbidity and Mortality, Medical Education in conjunction with DMD/ Dir Med Education, Medical Workforce development, Clinical Audit and Medical leadership.

Associate Medical Director/ Divisional Medical Director (AMD now retitled DMD)

66. The DMD reports operationally to the Acute Director and professionally to the Medical Director. The relationship between DMD and Acute Director is focused

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

on sharing information and guidance/advice, which is then progressed operationally with the DMD, Assistant Director (AD) and Clinical Director (CD) as appropriate.

67. Consultant Urologists report to the Clinical Director, who reports to the AMD/DMD who reports to the Medical Director on professional clinical issues.

68. I meet the DMD on a regular basis to discuss professional, clinical and operational issues. When actions are agreed at the end of the discussions, there is an expectation on my part that the DMD will take these actions forward with the operational support of the Assistant Director.

69. When issues of concern relating to performance and governance are raised by the DMD, these are co-discussed with the Medical Director and the Operational Acute Directorate. An example of this is the 11 June 2020 escalation from Mr Haynes of 10 cases added to the patient database which is unusual in one day (34.-43. *20200611 Patients to be added to UBL, A1-A9 located in S21 53 of 2022 Attachments*). On further scoping Mr Haynes was concerned that there had been some delay in entering these patients for follow-up diagnostic, treatment or care. The incident was raised directly with the Head of Service for Urology, Martina Corrigan, and the Medical Director, Dr Maria O'Kane. As Director, I liaised with the Medical Director to initiate a urology oversight meeting which subsequently resulted in a look back review *(44. 20211206 Q8.69 TOR Internal Lookback Review Group located in S21 53 of 2022 Attachments).*

70. Another example of collaborative working across our respective roles is at the Doctors and Dentists Oversight Meeting (established in August/ September 2016) (45. *20220624 Q8.70 A1 MedicalDentalOversight TOR located in S21 53 of 2022 Attachments*) which allow cases of professional concern to be discussed across individual Directorates. From my perspective I attend the acute element of the meeting with both, DMD's from the various divisions if relevant, the Medical Director, and the Human Resources Director where individual clinician's cases are discussed and actions agreed. Mr O'Brien was on the agenda of these meetings from 2016 (46. *20200212 Q8.70 A2 O&G Minutes – Case AOB located in S21 53 of 2022 Attachments*).

Clinical Director

71. The Clinical Director liaises directly with the Assistant Director and Head of Service on a range of operational, workforce, performance, governance and professional issues. Many of these issues are resolved within the operational team and for those where there are outstanding concerns are escalated to the Acute Director, DMD and/or Medical Director as appropriate.

72. In some instances, discussions take place which result in suggested resolution. Decision or agreements can be made allowing the issue to be addressed. If

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

there is a greater need for further professional support, I would involve the Medical Director as appropriate.

73. Medical staff within the Urology Service attend monthly specialty meetings, dedicated to cases being discussed, reviewed, and appropriate actions taken and planned for (Morbidity and Mortality - M&M). A combined Anaesthetics and Surgical M&M is held on a Quarterly basis. I am not a member of these.

Potential Conflict between Operational and Professional Escalation

74. On occasions, I believe medical staff can find it difficult to differentiate when they escalate to a professional line or an operational line. This can be manifest in the first approach being to the Medical Director and a resultant delay in the Acute Director being made aware of the concern or any decision made. With respect to urology, there are occasions as a result of these blurring of line management and professional accountability lines where communication and timely escalation could be improved.

75. For example, on 16 September 2019 when the breaches in Mr O'Brien's agreed administrative Return-to-Work Action Plan were escalated, an email was sent detailing the breaches from Mrs Corrigan to Dr Ahmed Khan, Case Manager and copied to Siobhan Hynds, Deputy Director of Employee Relations and Engagement (47.-50. *20191004 Q8.75 Escalation of Breaches AOB, A1-A3 located in S21 53 of 2022 Attachments*). These related to non-compliance with Trust Policies and Procedures, in relation to triaging of referrals, contemporaneous note keeping, storage of medical records and private practice, following issues originating in 2016. Mrs Martina Corrigan, HOS, was monitoring his administrative processes. In the email communication, it was highlighted that non-compliance had been identified with lack of timely triage of referrals, some of which were urgent which was in breach of his agreed action plan. The second concern related to the action on digital dictation which was not complied with.

76. A follow-up email included Mr Gibson and subsequently Dr Khan informed Dr O'Kane on 18 September 2019. By 30 September 2019, Mr Haynes was copied in and I was informed by Dr O'Kane about the breaches on 4 October 2019 as a meeting had been called to respond to the concerns (47. *20191004 Q8.75 Escalation of Breaches AOB located in S21 53 of 2022 Attachments)*.

77. Previously, on the 27th August 2019, I was copied into an email from Dr O'Kane requesting further information to be provided to GMC, after her April 2019 referral of Mr O'Brien, as a result of the MHPS Case Determination report (51.-53. *20190827 Q8.77 GMC Referral - AOB, A1-A2 located in S21 53 of 2022 Attachments*). This was the first time I was aware of and I received the MHPS Case Determination Report from Dr O'Kane, in that email.

Assistant Director

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

78. The Assistant Director has direct operational and governance responsibility for the urology service and line manages the Head of Service, working in the collective leadership team across AMD/DMD and CD. They also liaise across to Cancer and Clinical Services collective leadership team. An example of their collaboration is the current task and finish group that is co-chaired by Dr Tariq and Mr Ronan Carroll to deliver on the recommendations of the 9 aggregated Urology SAI's (54. *20211011 Q8.78 TOR Trust Task and Finish Group into Urology SAI Recommendations located in S21 53 of 2022 Attachments*).

Head of Service

79. The Head of Service is directly line managed by the Assistant Director and much of their work plan is dealt with internally within the urology team. As per above where issues of concern are not easily resolved these are escalated with a similar response pathway.

80. The interface with Acute Director and Clinical Director and Head of Service for Urology is minimal as these post holders align directly with the AD of ATICS and SEC (line management model) and AMD/DMD who escalate any issues or concerns to me as Acute Director and focus on delivering best outcomes with respect to performance, finance and governance. There are some collective and shared responsibilities between the AD and DMD and similarly for the HOS and CD. These includes issues such as Staffing and Staff Management, Adverse and Serious Adverse Incident Management, Litigation and Claims Management, Coronial Matters, Complaints, Patient Safety, Medications Management, Research and Development, Risk Management / Mitigation and Reduction, Learning from Experience, Quality Improvement, Education, Training and Continuing Professional Development, Ensuring Delivery of Effective Evidence-Based Care, Patient and Carer Experience and Involvement.

Executive Social Worker and Executive Nurse/ Allied Health Professional Lead

81. Where issues are raised with regard to other multidisciplinary team colleagues including Nursing, Social Workers, Physiotherapists, Occupational Therapists, Radiographers and Speech Language Therapists, the professional pathways across the operational and executive officers are operationalised similar to the Medical Director pathway.

82. With regard to the capability and nursing quality issues highlighted previously at Question 7 in Ward 3 South, the Executive Nurse (Heather Trouton) and her team worked with operational staff to improve the workforce (skewing of new posts to this ward, focus on increased training and allocation of International Nurses) and work to increase compliance with expected standards (55. *20190902 Q8.82 Email from Executive Director for Nursing located in S21 53 of 2022 Attachments*). A "Nurses in Difficulty" group has now been developed similar to the medical Doctors and Dentists Oversight group (56. *20220401 Q8.82 NiD Terms of Reference located in S21 53 of 2022 Attachments*).

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Clinical and Social Care Governance Coordinator

83. As Acute Services Director, I supervise the work plan of the Clinical and Social Care Governance Coordinator who leads a team across complaints, Serious Adverse Incidents, Incident Management, Standards and Guidelines, Risk Management and Medical Devices Governance. In addition, the post holder works across all collective operational and clinical teams to address the governance agenda within each service. This includes screening for concerns that meets the threshold of SAI's, establishing panels for SAI reviews, supporting report writing, escalating issues of concern to the Acute Clinical Governance monthly meetings (ACG) and approval of SAI reports prior to submission to the Health Board. During my tenure urology came to the ACG in:

- June 2019 – Patient 91 & Patient 16 (57. *20190607 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- September 2019 - Patient 16 re-presentation (58. *20190913 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- October 2019 - Patient 91 re-presentation (59. *20191011 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- January 2020 – Patient 92 new and Patient 16 re-presented (60. *20200117 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- February 2020 – Patient 92 re-presented, 6 new reports - Patient 12, Patient 15, Patient 14, Patient 13, Patient 11, 5 aggregated and 1 collective representing the 5 (61. *20200214 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- March 2020 – Patient 92 re-presented (62. *20200314 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- October 2020 – Patient 92 and the recommendations contained within the 1 collective SAI (relating to the 5 urology SAI's presented in February 2020) (63. *20201009 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- November 2020 – Patient 107 new and Patient 92 re-presented (64. *20201113 Clinical Gov Notes located in S21 53 of 2022 Attachments*);
- April 2021 – the 9 new Urology SAI's were presented in form of Recommendations only (29. *20210409 Clinical Gov Notes located in S21 53 of 2022 Attachments*)

84. The CSCG Coordinator is responsible for the operational coordination and completion of SAI's. The Director is responsible for approval of completed report content and recommendations. These would then be submitted in draft to the HSCB/SPPG and the service user/family for review and feedback. Following completion of feedback, a final report is submitted to the HSCB/SPPG and the service user/family.

85. The operational team assigned to each recommendation is accountable to progress the action. The Governance Team is responsible for oversight of recommendation completion. Both operational and Governance staff should escalate to Director any issues regarding an inability to achieve full compliance with a recommendation.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

86. The CSCG Coordinator would draft reports and communications for the operational teams/ Director. This would be shared with the operational team/ Director for oversight and approval. This would include the submission of an Early Alert to escalate areas of possible risk/media interest to the Department of Health. The CSCG Coordinator would draft the content included within the early alert, this would be escalated to the AD for the Division and then Director for approval. Following approval, the CSCG Coordinator would submit the Early Alert through the Corporate Governance Office.

Urology services/Urology unit – staffing

Q9. 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.

87. In March 2009, I was the Assistant Director of Promoting Wellbeing with the Older People and Primary Care Directorate in the Southern Trust with a focus on health improvement, community development, personal and public involvement (PPI) and building health and wellbeing as a core business deliverable across Southern Trust Directorates and Divisions. With regard to urology service, this was included in both PPI and wellbeing plans for Surgery Elective Care/Urology.

88. From April 2009, a new statutory duty of public involvement and consultation was placed on all Health and Social Care organisations, the Southern Trust committed to ensuring that everyone who needs to and wishes to be involved in the planning, development and evaluation of its services is facilitated to do so. As we plan and develop services, we can only make improvements by involving people who have experience of using these services, either as a service user, carer or member of the public.

89. In the Changing for the Better Public Consultation Document December 2008 to March 2009, the Trust signalled the wish to publicly consult on its 5-year Strategic Plan and the number of proposed service changes were detailed including urology services.

90. Following the Review of Adult Urology Services in Northern Ireland (65. *20090923 Regional Review of Adult Urology Services NI located in S21 53 of 2022 Attachments*), members of my promoting well-being team were assigned

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

to supporting Trust Directorates to consult on service changes. The Executive Summary of PPI Baseline Report November 2009 highlights that a return on the urology service was received from Surgery and Elective Care Division demonstrating that involvement with service users had taken place (66. *20091101 Q9.90 SHSCT - PPI Baseline Executive Summary Report located in S21 53 of 2022 Attachments*).

91. This was the only insight that I had into the establishment of the urology unit in the Southern Area. I had no more detailed knowledge of the service plan.

Q10. What, if any, performance indicators were used within the urology unit at its inception?

92. I was not actively involved with the urology unit at its inception, however, I was appointed to my first Director post (Director of Older People and Primary Care) in September 2017 and as such would have been in receipt of summary performance reports that were presented to Trust Board in November 2017 containing 31- and 62-day pathway performance indicators (67.-70. *20171122 Q10.92 OGIPerformanceReport, A1-A4 located in S21 53 of 2022 Attachments*). This performance report at that meeting highlighted – "*patients continue to be in excess of the 62-day pathway target, associated with demand in excess of capacity with the majority of breaches of the pathway related to urology and upper and lower gastro-intestinal (GI) specialties*". In September 2017, 18 patients breached the 62-day, with the majority within Urology 44% (8 out of 18)". The action with regard to pathway deviation was "*exploration of patterns in demand and capacity by tumour site including urology which was cited as one of the specialties where demand continues to be the greatest".*

93. At Trust Board in November 2017, further mention was made with regard to the 62-day pathway delays – "*The Trust is ring fencing urology capacity for biopsy and surgical work to meet the demand of those in the current cancer pathway. * The Trust has highlighted delays in PET scanning and access to specific urological surgical services, provided outside Northern Ireland, and Regional work is ongoing to secure additional capacity for these essential services. * Robust cancer tracking and monitoring in place*". (67.-70.*20171122 Q10.92 OGIPerformanceReport, A1-A4 located in S21 53 of 2022 Attachments*)

94. I have no other knowledge of performance indicators used within the urology unit from its inception.

Q11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

95. In April 2008, as Assistant Director for Promoting Wellbeing, I do not recall nor have I any documentary evidence of receiving the IEAP Protocol. I was not

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

responsible at that time for Acute Services and therefore would not have disseminated it to urology consultants.

96. During my tenure in Acute Services, I received the draft revised version of Integrated Elective Access Protocol on 2 June 2020 from Mrs Aldrina Magwood, Director of Performance and Reform which I circulated by my secretary, Emma Stinson, to my Assistant Directors seeking their views or any challenges regarding this document which we were invited to feedback to the Health and Social Care Board (HSCB) as the team had been involved in influencing the new version of the protocol. (71.-73.*20200602 Q11.96 Email re Draft Integrated Elective Access Protocol, A1-A2 located in S21 53 of 2022 Attachments*)

97. On 15 June 2020, Mr Ronan Carroll, shared the comments to the revised IEAP from his Heads of Service and Operations Support Lead. On 1 July 2020, comments were also provided by Anita Carroll, Assistant Director of Functional Support Services (with lead responsibility for the booking centres) and the Operational Support Leads, Lisa McAreavey, Sharon Glenny and Jane Scott (74. *20200615 Q11.97 OSL Comments re Draft IEAP located in S21 53 of 2022 Attachments*). The comments provided were shared with Performance and Reform team for consideration and escalation to HSCB.

98. Whilst the revised IEAP was circulated by me to the Assistant Directors and discussed with the Heads of Service and Operational Support Leads (OSL) and shared specifically with OSL's as they would be required to ensure compliance, it is an administrative protocol and therefore would not have been directly circulated by me to consultants. In my opinion, Consultants are aware of the Department of Health targets set out in IEAP, i.e., 31- and 62-day target pathways, however, they may not appreciate that the source document is the IEAP.

Q12. 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 that protocol or any subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

99. Prior to becoming Director of Acute Services, I had no insight into how the IEAP impacted on the management, oversight and governance of urology services. I had no knowledge if or how the time limits for urology services were monitored against the requirements of the 2008 protocol, nor any knowledge of any action taken.

100. From September 2017, I was a member of Senior Management Team and Trust Board and at Performance Committee reference would be made to targets contained within the IEAP as detailed in question 11. The process of escalation, oversight and governance was operationally managed within the

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Directorate teams. If compliance with the targets of the Protocol was a concern this would have been escalated within the reports to the Committee for information and discussion regarding actions. The Performance Committee seeks to be assured that targets are delivered as expected within Protocols and Guidelines and where there are issues that they are appropriately dealt with at operational level and progress subsequently reported back to Committee. I have no recall of any specific reference during the period September 2017 – June 2019 to urology services in this regard.

101. When the Integrated Elective Access Protocol (IEAP) was implemented in 2008, it was a Regional guidance document developed to encompass the scheduling/booking processes of patients on the elective care pathway outlining the guiding principles for the management of patients, in particular for out-patients, surgery, diagnostics and cancer pathways. This protocol was actively implemented, monitored and reported on as part of the performance agenda, and for active management of the processes embedded in Acute Head of Service and Operational Support Lead work plans and the booking centres management processes. I have reviewed the 2008 version of the IEAP (75. *20080430 Q.12.101 Integrated Elective Access Protocol Revised located in S21 53 of 2022 Attachments*) which outlines the Ministerial targets as stated below:

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

102. The Departmental waiting time targets outlined in the IEAP (2008 and 2020) are actively used by the Acute Senior Management Team to assess performance, in particular the Trust Performance team, Acute Heads of Service and Acute Operational Support Leads, as well as the Head of Admin Services who is responsible for the Referral & Booking Centre in conjunction with HSCB/SPPG. These staff are particularly operational and therefore fully involved in scheduling patients, partial booking, escalating capacity gaps, appropriateness of virtual clinics and smooth patient pathways across waiting lists, in line with approved procedures in managing elective referrals to first definitive treatment or discharge. This includes the clinical and chronological management of patients to be treated on the basis of clinical urgency, with urgent patients seen and treated first, patients with the same clinical need will be treated in chronological order on grounds of fairness and to minimise waiting times for all patients.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

103. When I came into post as Director of Acute Services, it was apparent that the urology service, like many other specialties within Acute Services, were unable to meet the specific targets outlined in the IEAP due to capacity and demand issues, as well as workforce issues. On 13 September 2019, Lynn Lappin, Head of Service in the Corporate Performance Team circulated the Corporate Performance Scorecard (overall summary of corporate position against a range of performance indicators) to SMT colleagues highlighting the key risks including 62-day cancer pathway, and length of times patients were waiting beyond their clinically indicated timescale for review and repeat procedure (76. *20190913 Q12.103 A1 CorporateCPDScorecard located in S21 53 of 2022 Attachments*). SMT discussion related to the need to assure that available capacity was directed to Red Flag and Urgent patients and also the need for focus and actions to manage and stratify any emergent risks in caseloads/ reviews for patients waiting to be seen beyond clinically indicated timescales (77. *20190913 Q12.103 A2 PerformanceScorecardCoversheet located in S21 53 of 2022 Attachments*). On the same date, Lesley Leeman, Assistant Director of Performance and Reform (Corporate Team), emailed Assistant Directors in Acute and copied myself regarding the July 2019 position that 99 patients had waited more than 62-days to commence their first treatment, with the majority of breaches occurring within urology (78. *20190913 Q12.103 A3 Email re SMT – Monthly Performance Report located in S21 53 of 2022 Attachments*).

104. With specific reference to urology services, the data including Red Flag cancellations, underutilisation of WLI funding, underperformance of Independent Sector contracts, services that are not meeting estimated activity, waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets was shared on a monthly basis at the Acute Performance SMT Meetings, with Assistant Directors and corporate performance colleagues in attendance. Waiting times were reviewed and actions were taken where possible to address. These included approving 'in-house' additionality for urology services (Consultants incentivised to do additional clinical activity), funded via non-recurrent "waiting list monies" from the HSCB for outpatient activity, inpatients and or day case activity. In addition, the Trust engaged with the Independent Sector (IS) to undertake agreed volumes of clinical activity, when additional non-recurrent waiting list monies from the HSCB was agreed (79. *20220627 Q12.104 A1 NonRecurrentFunding_CoverSheet located in S21 53 of 2022 Attachments*). The data, trends and issues were shared with the urology teams and HOS by Mr Carroll, AD and with the Acute Cancer Performance Meetings by Mr Conway, AD. I as Director shared these with corporate Performance SMT Meetings and they were discussed at the Regional Performance & Issues Meeting and the Regional Cancer Performance HSCB/SPPG meeting (all informed by the underpinning principles of IEAP).

105. With respect to the impact of the targets on the management of urology services, the referrals to the service for out-patient consultation are in excess of the current commissioned capacity as demonstrated in the table below:

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	Total outpatient referrals	Average monthly outpatients referrals	Commissioned outpatient activity per month	Variance of capacity gap
2016/17	5121	427	299	-128
2017/18	5965	497	299	-198
2018/19	6427	536	299	-237
2019/20	6136	511	299	-212
2020/21	4484	374	299	-75
2021/22	4824	402	299	-103
Average	5492.8	458	299	-159

(Sourced from Business Objects)

106. This has led to the numbers of patients on the waiting list and the waiting times growing as demonstrated in the table below:

OUT-PATIENT WAITING LIST – UROLOGY
Target 9 weeks

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

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

Date	Total	>13-Weeks	>52-Weeks	Longest Wait (Weeks)
@ 31/1/2022	**2086**	**1737**	**1263**	**399**
@ 31/3/2021	2063	1728	1407	361
@ 31/3/2020	1700	1437	934	309
@ 31/3/2019	1737	1421	807	269

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@ 31/3/2018	1757	1362	692	217
@ 31/3/2017	1495	890	343	165
@ 31/3/2016	970	567	301	120

(Sourced from Commissioning Plan Direction (CPD) Score Care month end position).

107. The increase in demand and the ongoing workforce challenges has also impacted on the urology service being able to deliver on the 31- and 62-day cancer targets, as demonstrated below:

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

(Sourced from Information Team)

108. This highlights that the urology service was unable to achieve the required 62-day cancer standard of 95%. This is attributable to the demand for red flag referrals being greater that the capacity within the service to enable patients to have their first definitive treatment by day 62.

109. I raised at the HSCB/Trust Cancer Performance meeting on 7 May 2021 the context of the recent 9 SAI's which were relevant to the Urology Services Independent Inquiry. I indicated that a number of recommendations will require Commissioner funding to address the gaps identified, including additional audit and tracking post 62-day pathway.

110. In relation to time limits not being met, there are a number of actions that have been taken:

- The in-patient/day case planned backlogs, which include Urology, have been on the Divisional Surgery and Elective Care risk register from October 2016, and the access waiting times for outpatients and inpatient/day cases have been on the Divisional risk register from April 2019
- The 62-day Cancer performance is on the Directorate risk register from 3rd September 2012 due to cancer pathway capacity issues in Urology and other tumour sites.
- The ongoing increase in demand pressures within the urology service has been raised with the Commissioners and a business case / Investment

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Proposal Template (IPT) for a seventh consultant urologist was developed in October 2020 with the aim to reduce the gap between capacity and demand and the time patients wait to see a consultant urologist.

- Independent sector contracts have been established and continue for new out-patient urology referrals with ongoing care and treatment where possible.
- Ongoing Regional capacity initiative through Regional Priority Oversight Group (RPOG). The purpose of the group is to equalise the waiting time for clinically urgent patients. It involves Mr McNaboe, as our DMD for Surgery and Elective Care and Ms Wendy Clayton participating in regional discussions, weekly or fortnightly, to agree the available capacity across all Trusts in Northern Ireland and the priority patients who should be allocated the next available priority slot in one of the hospitals. This process commenced in June 2021 as part of the Ministerial Recovery Plan for Cancer Services to maximise existing opportunities for surgical intervention for priority patients (classified under the Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic – Federation of Surgical Specialties Association (FSSA)) as COVID-19 had impacted on the availability of access to surgery.

Q13. 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, if any, with this plan?

111. As Assistant Director Promoting Wellbeing, my Personal and Public Involvement team officers supported the consultation into the Review of Adult Urology Services to ascertain the staff, individuals, and members of the public views on the impact of this change. In general, the Review of Adult Urology Services recommended Urology Services in Northern Ireland should be reconfigured into a three-team model to achieve long term stability and viability, with Team South as one of the Three Networks (65. *20090923 Regional Review of Adult Urology Services NI located in S21 53 of 2022 Attachments*).

112. Team South was envisaged to include the Lower third of Western Trust (Fermanagh) integrating into the Southern Catchment Area. The range of services to be delivered included acute elective and non-elective inpatients, day surgery and outpatients across Craigavon Area Hospital, Daisy Hill Hospital, South Tyrone Hospital and community outpatient centres.

113. I had no further involvement over and above facilitating the operational team to consult staff, service user groups and community.

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

114. As Assistant Director for Promoting Wellbeing at the time of its publication and implementation, I had no involvement in its implementation, review, and assessment of its effectiveness.

III. What was your role, if any, in that process?

115. My role in the Review of Urology Services was limited to overseeing the Personal and Public Involvement Team to support the consultation to ascertain staff, individuals, and members of the public views on the impact of this change. This consultation was included in the Reviewing our Hospital Services section of *Changing for the Better (Public* Consultation) (December 2008), to Trust Board.

IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

116. As stated above, I was not aware of the detailed rationale that informed the aims of the plan, at the time when I was involved in the oversight of the consultation.

117. When I assumed the post of Acute Director in June 2019, I was aware fairly soon thereafter that there were capacity issues and workforce challenges within the urology service which ultimately resulted in extensive waiting lists, patient waiting times and backlogs. If the aim of the service reconfiguration was to address capacity demand issues, in my opinion it was not fully effective in achieving this. However, it may well be that in the earlier stages impact of the new service model was positive and subsequently demand outstripped planned capacity for Team South. As I was not actively involved with its implementation, I would not be able to comment in an informed way.

Q14. As far as you are aware, 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.

118. As I had no involvement in the implementation of the Team South Plan until I assumed the post of Director in 2019, I would not have been fully au fait

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with the full extent of issues raised regarding the Implementation Plan and the extent to which these were reflected in Trust governance documents, minutes and/or Risk Register.

119. The Trust Delivery Plan (TDP) in 2017 – 2018 reported that waits over 52 weeks in March 2017 across 9 specialties including Urology continued to fall below baseline targets due to increased demand, insufficient capacity, and lack of recurrent investment in capacity gaps. The Delivery Plan in 2017 – 2018 also recognised that it was unlikely for the Trust to achieve its objective of meeting the target of 75% of patient not waiting longer than 9 weeks for diagnostic test due to inability to increase capacity even with additional resources due to competing urology input demands.

120. The Trust Delivery Plan also noted that patients referred to 5 specialty areas including Urology continued to wait longer than 52 weeks for inpatient/ day case treatment. This was despite the offer from the Department of Health of additional resources, as the Trust would be unable to source increased capacity required to reduce the number of patients waiting over 52 weeks, particularly in Urology where complexity of case mix affected the ability to utilise the Independent Sector.

121. From when I assumed post as Director of Acute Services, breaches in waiting times, waiting lists, and cancer pathway targets relating to Urology were regularly highlighted in performance and governance meetings including risk registers. (Detailed in Q12 including actions taken).

122. The responsibility for ensuring that risk was identified, defined, mitigations put in place and other control mechanisms were detailed in the Risk Register, sits with the affected Division – Assistant Director, Mr Ronan Carroll (SEC), Mr Barry Conway (Cancer Clinical Services), Divisional Medical Director, Mr Mark Haynes now Mr Edward McNaboe (SEC), Dr Shahid Tariq (Cancer Clinical Services) Head of Service, Mrs Martina Corrigan now Ms Wendy Clayton (SEC), Mrs Fiona Reddick [redacted] covered by Ms Clair Quinn (Cancer Clinical Services) and Clinical Director, Mr Edward McNaboe previously now vacant post (SEC), Dr David McCaul previously now vacant post (Cancer Clinical Services). If the risk is contained in one Division, the risk sits on the Divisional Risk Register. If the risk crosses more than 1 Division in the Directorate, it sits on the Directorate Risk Register. If the risk affects Directorates across the Trust, it sits on the Corporate Risk Register for example access to services which can relate to a range of service areas. The responsibility for including the risk at the Corporate Risk Register sits with the Directors of the Senior Management Team.

123. The risks currently included are within the Directorate, SEC and Corporate Risk Registers (5. *20220512 Q7.35 Summary Corporate Risk Register to Governance Committee located in S21 53 of 2022 Attachments)*.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- Directorate - Insufficient capacity and resources to manage patients waiting for a review appointment in Acute Services (15 October 2016) (80. *20220301 Acute Services Directorate Risk Register located in S21 53 of 2022 Attachments*)
- Surgery and Elective Care - backlog in inpatients and day cases who required to be reviewed for procedures presenting adverse clinical risks (15 October 2016), increased Access times for outpatients associated with capacity gaps and emergent demand (12 April 2019), Access time in accessing services for inpatients and day cases due to capacity gap and emergent demand (12 April 2019) (81. *20190607 Surgery and Elective Care Risk Register located in S21 53 of 2022 Attachments*)
- Cancer and Clinical Services - serious concerns following June 2015 Cancer Peer Review for specialties including urology highlighting serious concerns may result in risk to patients who are on the cancer pathway (1 September 2015), 62-day cancer performance, Trust failing to meet the performance standard due to the increase in red flag referrals, capacity issues, inability to downgrade and regional issues was noted (3 September 2012) (82. *20190607 Clinical and Cancer Services Risk Register located in S21 53 of 2022 Attachments*)

Q15. 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?

124. As I was not involved in the implementation plan of Team South, I cannot comment as to whether the issues noted were satisfactorily resolved. However, , the ongoing challenge with achieving compliance with the agreed indicators would suggest that there was not a significant impact from the new service model brought about by the Review of Adult Urology Service.

Q16. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

Adequate Staffing

125. It is evident from the frequent recruitment drives for substantive and locum Consultant Urologist posts that there were ongoing issues with achieving a full staffing complement. During my tenure the post for **Consultant** Urologist has been advertised 5 times since October 2020 as evidenced in table below. On two occasions 2 applicants were interviewed but none were appointed.

NO. OF TIMES ADVERTISED	DATE ADVERTISED	NORMAL ADVERTISING	APPLICATIONS RECEIVED	ENHANCED ADVERTISING

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Temporary Consultant Urologist	24/11/2016		No Applicants	
Consultant Urologist	10/01/2017		No Applicants	
Consultant Urologist	02/10/2018		Mr. Matthew Tyson Started post 25/02/2019	
Consultant Urologist	March 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	
Consultant Urologist	May 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
Consultant Urologist	October 2021	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	2 (interviewed & not appointable)	
Consultant Urologist	February 2022	Social Media Platforms Jobs.hscni.net BMJ website BMJ Journal	0	➢ BMJ website – Top Job
Consultant Urologist	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

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

(Sourced from Medical Human Resources Team)

126. The failure to recruit Consultant Urologists necessitated planning for the recruitment of locum Consultant Urologists until such a time that a suitable candidate is appointed. The below table illustrates the timeline and replacement reasons in respect of Locums from January 2017.

First Name of Doctor filling booking	Surname of Doctor filling booking	Start Date	Expected End Date	Reason for Locum
Thomas	**Jacob**	03/01/2017	04/01/2019	Replaced Mr Suresh
Gyorgy	**Solt**	15/07/2019	13/09/2019	Replaced Mr Suresh
Tamas	**Fel**	01/07/2020	04/09/2020	Mr Tyson on sabbatical
Shawgi	**Razig Omer**	21/09/2020	30/06/2021	Backfill AOB
Saifeldin	**Elamin**	19/07/2021	02/08/2021	Backlog clearance clinics only
Shawgi	**Omer**	16/08/2021	30/10/2021	Backfill AOB
Nasir	**Khan**	02/11/2020	Still in post	Backfill Con 7

(Sourced from Medical Human Resources Team)

127. Since September 2020, 4 locum Consultant posts have been recruited, 1 of whom has remained in post, Mr Nasir Khan. In addition, to support the Urology Service the current Junior Doctors include:

- 2x Permanent Specialty Doctors - Dr Laura McAuley and Dr Saba Hasinain;

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- 3x Registrars (1 vacant) – Dr Conor McCann and Dr Kishan Tailor;
- 3 x Clinical Fellows - Dr Susie Cull, Dr Fiona Griffin and Dr Juventine Asingei;
- 0.5x Physician Associate posts were recruited across Acute Services to reduce the workload for junior doctors on the wards. Urology secured 0.5 WTE (18.75 hours).

128. There are currently 3.5 Consultant Urologists namely Mr Haynes (part time) and Mr Glackin, Mr O'Donoghue and Mr Tyson (full time) and In addition, Mr Khan as a Locum Consultant Urologist, leaving a gap of 3.5 Whole Time Equivalent (WTE) staff. There is an ongoing enhanced recruitment to attract from a Global pool via a range of professional websites, recruitment journals marketing creatively as "premium job"/ "promoted job" to attract interested applicants, target emails using intelligence of anyone in the system were sent to potential recruits as well as CV database searches employed. From the recent recruitment exercise that closed on 10 May 2022, two applicants have been shortlisted for interview which hopefully will help us to increase capacity if appointed. The Trust is happy to recruit Consultant Urologists on a temporary basis if they are working towards being added to the specialist register which can take up to 2 years (this is a requirement for permanent Consultants).

129. The gap in Consultant Urologists translates into a more vulnerable service profile with an increased number of 'on-call and Urologist of the Week (UOW)' shifts requiring to be covered. The increase in UOW is currently 1:7 weeks. With the Consultant vacancies the shifts have been picked up by the current consultants which in turn has decreased clinical activity for that week and also risks greater stress and risk of burn-out of current staff.

130. With respect to nurse staffing, the ward allocated to urology is 3 South which is a surgical 36 bedded ward of which 18 are available for ENT and Urology Emergency patients (Please note during the COVID-19 pandemic the demand for medical beds resulted for prolonged periods in the full 36 beds being dedicated to acute medical patients, not surgical). From when I commenced as Director of Acute Services on 10 June 2019, there have been significant Band 5 registered nurse vacancies across all of Acute Services, with growing reliance on Bank and Agency posts to maintain safe staffing levels. Vacant shifts can still be a feature on rotas and all efforts are made on a daily basis to secure bank or agency staff and asking core staff to take on additional hours or overtime. In the event shifts remain uncovered actions are taken that include – cover from other wards that have higher level of staffing or reducing beds that can accept new admissions until the situation improves. The impact of lack of continuity of staff within the workforce is reflected at times in the key nursing quality indicators – pressure sores, falls, National Early Warning Scores, compliance with Infection, Prevention Control measures, Datix incidents, Serious Adverse Incidents, complaints, and compliments.

131. From a total of 31 registered funded Band 5 nursing staff for 3 South, there are 12.15 WTE permanently in post, 7.74 bank staff, leaving a deficit of

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11.11 WTE (35%) (10. *20190904 Q7.43 3 South Trust Risk Assessment located in S21 53 of 2022 Attachments)*. The oversight of the nursing workforce and the quality indicators sits with the Lead Nurse (Mrs Paula McKay), the Ward Manager (Mrs Laura White) and the Head of Service, Ms Wendy Clayton and Assistant Director, Mr Ronan Carroll who monitor this monthly. They take any available appropriate action to stabilise including recruitment, Nurse Bank liaison and redeployment. Additional Health Care Assistants are requested to bolster the registrant team and additional training and support is offered. The deficit in registered nurses and healthcare assistants is a regional issue, not specific to Southern Trust alone. There have been ongoing recruitment drives for several years and international nursing recruitment is being further progressed.

132. The senior nursing post of Clinical Nurse Specialists (CNS – title often used interchangeably as Clinical Nurse Specialists or Cancer Nurse specialists as some focus solely on cancer patients) supports complex patients on their cancer journey in the ward environment and in the outpatient clinics. There are currently 5 in post and their brief includes specialist nursing input, breaking bad news, follow up support and endoscopy (scoping/ camera sessions). Two of those posts commenced in August 2020, during my tenure to meet the increasing demand for services, supported by HSCB Commissioner *(11. 20191001 IPT - Expansion of Urology Services - Additional Clinical Nurse Specialists located in S21 53 of 2022 Attachments)*.

133. In summary, I would be of the opinion that the urology service/ unit was not appropriately staffed despite ongoing efforts to reduce staffing deficits. Where substantive post holders are not recruited at a sufficient level, alternative options of agency Nursing and locum agency Doctors are a much more expensive option, but in the absence of core staff, a reliance on flexible temporary staff has to form part of the workforce solution. Many core staff, both Registered Nurses and Doctors have left the Trust, attracted by the more lucrative financial rewards in the private sector agencies, highlighting the impact of ongoing dissatisfaction with Health & Social care pay scales for staff. It is my view that there was no financial barrier to attracting appropriate staffing levels but rather there has been an issue with availability of skilled, adequately trained applicants who were attracted to work in the Southern Trust or an ability to retain some staff in the Trust.

Resourcing

134. There have been ongoing discussions regarding funding with the Health & Social Care Board (now known as Strategic Planning Partnership Group - SPPG) resulting in the offer of additional resources. For example, the Health & Social Care Board agreed £200k non-recurrent funding in 2020/21. However, the Trust was unable to source increased capacity to reduce the number of patients waiting. The complexity of urology patients can affect the ability to utilise the Independent Sector at a sufficient level highlighting that finance is not always the panacea.

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135. A summary of the financial picture relating to Consultants, Middle Grade Doctors (Registrars and Specialist level Doctors), Clinical Nurse Specialist, nurse staffing, operational leads and expenditure against funding available is in the various finance reports produced by Corporate Management Accountants aligned to Acute Services. (83.-85. *20220622 Q16.135 3 South Finance Report 2019-20 A1-A3, 86.-88. 20220622 Q16.135 Urology Finance Report 2019-20 A1-A3, 89. 20220622 Q16.135 Nursing Pay Spend Analysis 3 South 2019-2022 located in S21 53 of 2022 Attachments*)

136. The risk of patient safety due to medical workforce shortages and vacancies in some specialties was added to the Corporate Risk register in July 2015, before my tenure (5. *20220512 Q7.35 Summary Corporate Risk Register to Governance Committee located in S21 53 of 2022 Attachments)*. This risk was mitigated by "current controls" noted in the Register which included ongoing monitoring of vacancy positions, improving requirement strategies, plan to fill gaps through locum agency, collaboration with other Trusts and Independent sector to increase capacity, international recruitment, use of alternative practitioners including specialist nursing, Physician Associates included in the workplace and escalating pressures to the HSCB and the DOH. The risk was reassessed in July 2018 regarding consistent provision of high-quality nursing care due to a shortage of registered nurses. "Current controls" implemented included escalation processes within Directorates to address staffing gaps, use of bank and agency support to stabilise staffing levels, international recruitment, open adverts for posts/ recruitment fairs, engaging Universities to attract Undergraduates, and supporting new employees with preceptorship and induction and optional rotation schemes and working with the Department of Health to increase the supply of registered nurses. Many of these controls were monitored operationally by Assistant Directors, linking with corporate nursing and HR teams.

137. Following concerns raised on 11 June 2020 regarding Mr O'Brien's patients, there was a requirement to focus on increased patient reviews to ascertain if there were patient safety issues that needed identified. The 18-month period from January 2019 to June 2020 was the starting point agreed, as likely to contain the higher risk patients who would require earlier review/follow up (logic being the patients from earlier years may have already been seen by Mr O'Brien, potentially entered the service through other Consultants or as emergency admissions). As patient reviews commenced, we collated an Investment Proposal Template (IPT) to secure additional resource for Consultants, Independent Sector contracts, clinical auditors and extended tracking outside the commissioned 31- and 62-day cancer pathway model (as follow up post-62-days on cancer pathway had been identified as a gap) (90. *20210329 Q16.137 IPT - Staffing Support Requirement for SAI Inquiry – Urology located in S21 53 of 2022 Attachments*).

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

138. Over the past 1-2 years, we had permission from the Health and Social Care Board to veer the funding from the 7th urologist post (91. *20201001 Q16.138 IPT - Expansion of Urology Services - 7th Urology Consultant located in S21 53 of 2022 Attachments*) we could not recruit to other elements of the service including additional clinics, extended multidisciplinary attendances at multidisciplinary meetings including pathology, radiology, oncology and a Band 5 post to be Administrative Officer to support the MDT chairs (90. *20210329 Q16.137 IPT - Staffing Support Requirement for SAI Inquiry – Urology)*. This was an attempt to address the shortcomings of the regionally commissioned resource for comprehensive participation and decision-making at the cancer related MDT's.

139. Macmillan (Cancer Support Charity) also entered into agreements with the Trust on improving cancer care, recovery service improvement. Mary Haughey, Cancer Services Improvement Lead, previously funded by Macmillan and subsequently by HSCB/SPPG, has supported the Trust to roll out baseline assessments using the National Clinical Assessment Service (NCAS) audit tool as part of the service improvement approach of achieving compliance with the 9 SAI report recommendations (11 recommendations in total).

140. Also, the Trust has secured funding in May 2022 for the new Lithotripsy/ Stone Treatment Centre (£500,000). 92. *20220401 Q16.140 IPT - Stone Treatment Centre 2021-22 located in S21 53 of 2022 Attachments*

141. Currently scoping is under way with Planning Colleagues and Urology team to consider the options of additional or improved space outside of the two acute hospitals, which may be an option for relocation of some urology services.

142. During my tenure equipment resource concerns were highlighted within Surgical Services which included equipment within the Urology Services. Questions 17 portrays the timeframe and mechanisms followed to address the equipment resource concerns with Urology Services. 93. *20220622 Q16.142 Theatres Equipment Capital Budget Allocation (Urology) - 2020-21 located in S21 53 of 2022 Attachments*

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

143. I have been aware of the staffing problems within the urology unit since I commenced post as Director of Acute Services as evidenced in my response to question 16. The lack of capacity in the medical workforce has been an ongoing problem before and since my tenure with a dedicated focus on retaining current staff and attracting new recruits.

144. In an email exchange on 12 June 2019, two days after I commenced post, from Mr Mark Haynes, Associate Medical Director to the Medical Director,

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Dr Maria O'Kane (shared with me by Mr Carroll), Mr Haynes had summarised his concerns as (94.*20190612 Q17.144* Patient 10 *Email re Elective Capacity located in S21 53 of 2022 Attachments*):

"In short, no we are not working at elective capacity or at maximum efficiency. Simply because we do not have the resource to do so…..

….Regarding efficiency in what we deliver, one aspect that is eternally frustrated is equipment investment. Within Acute services and from my perspective SEC/ATICS we have multiple items requiring investment sitting on a long list (attached). In total there are 54 items of equipment, totalling approximately £2.6 million…

….As you know, bed capacity is a major issue. In order for secondary care to deliver elective care at maximum capacity and maximum efficiency we need to fix the unscheduled care issues. Fundamentally this means an increase in bed capacity. No trust can manage elective care while bed occupancy runs in the high 80's to 90+%.....

…A first step in moving towards this is a corporate recognition that the primary issue affecting the trust is a lack of capacity for unscheduled care.

…Regarding increasing demand for trust services, I believe the underlying issue comes down to how services are commissioned and delivered within primary / secondary care…"

145. Consequently, I arranged a 1:1 supervision with Mr Ronan Carroll, Assistant Director for the following week to allow me to fully understand the scale of the problem and the range of actions ongoing and required to be implemented.

146. On 17 June 2019, I carried out my first 1:1 discussion with Mr Ronan Carroll, Assistant Director, where he highlighted a number of vacant posts (1.5 vacant urologist consultant post out of 6 funded posts) and the added load on the core consultants resulting in the need for locum cover. He also highlighted that 3 South ward (surgical ENT/urology) was operating with 80% agency/ non-core staff and four beds had been closed as a patients' safety measure (two of these beds reopened in November 2019 which indicates the scale of the nurse staffing problem and the benefit of taking action until the situation improves). He also noted the range of ongoing re-banding Agenda for Change submissions including ward staff and nurse Endoscopists in Urology. A range of ongoing processes to increase capacity, address vacancies, allocate available medical time to priority patient in outpatients, inpatient, theatre lists, and also holding a risk register on the equipment concerns with a range of control measures to increase patient safety (95. *20190617 Q17.146 ADs 1-1 meetings proforma- Ronan Carroll located in S21 53 of 2022 Attachments*).

147. On 8 July 2019, in a follow up 1:1 discussion with Mr Carroll, he informed me that the risk to promoting safe and high-quality care in 3 South remained

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unchanged and was still actively monitored. He also fed back concerns from the Associate Medical Director, Mr Mark Haynes, that the service was not keen to reduce surgical beds as they required them to meet the needs of their patients including urology patients. At that time the competing demands from unscheduled admissions via the Emergency Department resulted in high levels of medical outliers (patients who are placed in other wards including surgical wards because there are not sufficient medical beds available). In the same supervision session, Mr Carroll, highlighted concerns regarding equipment predominantly for surgery - £2.8 million of equipment was required, a risk assessment had been completed detailing the equipment age, need for replacement and consequence of failure (96. *20190612 ATICS Medical Equipment priorities 2019-20 located in S21 53 of 2022 Attachments*). I agreed to follow up with Aldrina Magwood, Director of Performance and Reform, who held responsibility for the Capital Allocation Group (CAG). I successfully negotiated increased equipment from the Capital Allocation, However, the budget for the whole organisation would not have permitted all required equipment to be replaced and this remained on our equipment risk priority list for ongoing oversight and monitoring (97. *20190718 Q17.147 ADs 1-1 meetings proforma- Ronan Carroll located in S21 53 of 2022 Attachments*).

148. Mr Carroll also highlighted the impact of changes in pensions which would negatively affect surgical waiting times. He advised that some surgeons were needing to reduce the hours that they would work to reduce the financial impact of the pension changes (98. *20190617 Q17.148 Pension Changes - Risk to Surgical Waiting Times located in S21 53 of 2022 Attachments*). I agreed to discuss the potential of consultants reducing their working hours and its impact on the service and ultimately on the patients with Dr Maria O'Kane, Medical Director, as there was already reduced capacity within the system. I was involved in several conversations regarding impact of pensions with Dr O'Kane, with the consultants, the British Medical Association and the Local Negotiating Committee. The output of this was escalation as this is a problem on a regional/ national scale and out with the gift of the Trust to resolve.

149. On 7 August 2019, Mr Carroll's follow up 1:1 discussion focused on a number of concerns including completing a priority equipment list for £500,000 which was being made available and he was also reviewing the risk assessment scoring/ rationale and measures. Pension news at that stage was slightly more positive, which it was hoped would increase interest from consultants to take up additional clinics. He confirmed that workforce issues remained problematic and that he was working with Human Resources to secure agency staff. The endoscopy nurse's post had been re-banded and re-advertised, also the 7th urology consultant had been approved and two clinical nurse specialists. Discussion about 3 South ENT/Urology ward also took place which was an ongoing concern. 3 further Band 6 post holders had left leaving 2 in post. Recruitment was under way and Heather Trouton, Executive Nurse, was working with the Directorate to address concerns (99. *20190807 Q17.149 ADs 1-1 meetings proforma- Ronan Carroll located in S21 53 of 2022 Attachments*).

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

150. On 3 September 2019, I completed Mr Carroll's personal development review form where he recognised that he had worked to create a strong management team to enable the work plan to be achieved and acknowledged the numerous challenges in the delivery of services with a solution-based approach to overcome them. In the work plan he included 6 actions for Urology. His action plan included – to stabilise 3 South, to expand the urology service to Daisy Hill Hospital, to increase the Stone Treatment delivery sessions, to increase a further 1 Cancer Nurse Specialist and increase by 1 non-Cancer clinical nurse specialist, and to work with the region on Regional Surgical and Assessment Centres for Urology. This action plan was monitored in subsequent 1:1 sessions with an annual performance review (100. *20190903 Q17.150 Personal Development Review Ronan Carroll located in S21 53 of 2022 Attachments*).

151. On an email from Ronan Carroll on 16 September 2019, he confirmed that a new Clinical Education Practitioner (funded at risk and approved by the Chief Executive) was to be implemented across surgery and would be dedicating time to ward 3 south initially. Mrs Ruth Law was appointed to this post (101.-103. *20190916 Q17.151 Email re Confirmation of Clinical Education Practitioner post, A1-A2 located in S21 53 of 2022 Attachments*).

152. On 13 June 2021, the follow up annual performance review was completed (delay due COVID-19 pandemic demands) and it was noted that the 2019/2020 workplan had not been significantly progressed, hence, was subsequently carried forward in 2021/2022 workplan. In that annual review, I commented on the challenging intervening year, trying to balance COVID-19 pandemic demands and continuing with as much core business as possible. The pandemic action plans required resources to be redeployed from across all Divisions which resulted, in standing down a range of services. Ronan continued in parallel to ensure the delivery of emergency and urgent services, both unscheduled and elective, for prioritised surgical and cancer patients (104. *20210613 Q17.152 Personal Development Review Ronan Carroll located in S21 53 of 2022 Attachments*).

153. Mr Carroll raised in an email to me on 21 August 2019 a complimentary poem written by a service user and on the same date he shared an email trail from Louise Currie (who was acting ward manager 3 South) to Sarah Ward (then Lead Nurse in Surgery) and to Mr Carroll, whereby she mentioned concerns that had been raised at a meeting earlier that day which highlighted major staffing issues and the lack of Senior cover and the expectation therefore that staff from the other surgical wards at band 6 level would take charge of the 3 South for the next four days. I shared the plan with Heather Trouton, Executive Director for Nursing, Midwifery and Allied Health Professionals, with regard to assurances re nursing practices and patient safety.

154. On 5 September 2019, Mr Carroll further updated me on the position in 3 South and included the Risk Assessment due to staffing deficits which showed a deficit of 15.98 staff nurses, the bed complement had been reduced

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to compensate for this deficit, from 36 to 32 beds (ENT and Urology of which 19 were urology beds). There had been an open advert for additional band 5s to work specifically in 3 South, but no applicants for the post. The Core Trust Nurse to Agency ratio was 60% agency staff and 40% Trust staff (daytime) with 50-50% split for night duty which he highlighted was affecting the ability for patient's needs to be fully met (10. *20190904 Q7.43 3 South Trust Risk Assessment located in S21 53 of 2022 Attachments)*.

155. There was from a nursing perspective a capability issue which was reviewed and supported from a Human Resource and Executive Nurse perspective. This is related to the 3 South ENT/Urology ward, and also had an impact on the stabilisation of the core workforce with some staff requesting to work in other areas or indeed leaving the Trust. On 11 September 2019, I received a related email from Mrs Helen Walker, (Assistant Director Human Resources) who was supporting the management and nursing team, to advise that the [redacted] and shared an appropriate managerial action plan to address the workforce challenges (105.-107. *20190911 Q17.155 Email re Managerial Action Plan 3 South, A1-A2 located in S21 53 of 2022 Attachments*). These escalations highlighted the ongoing difficulty with recruiting and retaining staff, high level of agency nurse dependence, capability issues and safety indicators of specific concern within the ward.

Personal Information redacted by the USI

156. In addition, the high levels of non-core staff (bank and agency) have had an impact on the ward requiring a greater attention to the nursing quality indicators to improve standards in the ward. This has resulted in a higher level of assurance from the corporate Executive Nursing Team regarding quality care.

157. Over several years, and definitely pre COVID-19 pandemic, there was reduced capacity for surgery in Southern Trust, as a result of reduced theatre nursing workforce, access to theatres at the required level and workforce recruitment and retention challenges both medical and nursing. Since March 2020, ward 3 South became predominantly a medical ward. This resulted in the surgical ward staff being less content as their preferred career pathway was to support surgical patients. This also had the impact of losing staff to other wards, areas of the Trust or other Trusts (108.-109. *20191118 Q17.157 email, A1 Briefing Paper CAH Theatre Nursing Challenges located in S21 53 of 2022 Attachments*).

Email,

158. I set up Urology team meetings with a purpose of keeping the team informed of the evolving issues within urology services in 2020 which was welcomed especially following the Health Minister announcing to the Assembly of his intent to set up a statutory public inquiry under the Inquiries Act 2005 into the Urology Service in the Southern Health and Social Care Trust. At a meeting with the urology team towards the end of November 2020 (date not specified),

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Kate O'Neill said that Thorndale Unit has highly skilled doctors supported by 5 clinical nurse specialists who have 120 years of clinical experience between them. She also highlighted that Thorndale was a good unit with a team that works well together (110. *20220324 Urology Team Meeting Notes located in S21 53 of 2022 Attachments*).

159. On 12 February 2021, Kate O'Neill, Urology Clinical Nurse Specialist, sent an email to request a meeting as I had at previous meetings with the Urology team highlighted my open-door policy. At that meeting on 17 February 2021, Kate informed me that she and some of her colleagues were unhappy with the Agenda for Change banding, at they had increased their scope of practice, predominantly relating to increased endoscopy procedures which had been previously carried out predominantly by medical colleagues. One of the clinical nurse specialists who submitted a job evaluation was successful in achieving a higher band. I comment on this as she requested to meet me in my office to discuss the situation. When I met her, she talked about the urology service, how much she enjoyed her post but felt she needed to be valued at a higher level. I advised Ronan Carroll, Assistant Director, that I had met with Kate and had listened to her concerns and looked forward to the outcome of Agenda for Change Evaluation (AFC team external to the Directorate). I received an email from Kate on 16 March 2021 to say she had positive feedback from AFC yesterday with a second colleague also being positively evaluated. The impact of this is staff feeling that they are paid fairly for their level of expertise and as she stated would allow her to concentrate on further progression and developments within the unit. I was very happy with the acknowledgement the two clinical nurse specialists got for their increased scope of practice. 13. *20210322 Q7.45 A3 CNS AFC Discussion located in S21 53 of 2022 Attachments*

160. On 14 October 2021, in a 1:1 discussion with Mr Carroll, he raised capacity concerns with backlogs and additionality related to the lookback exercise in an already reduced capacity service. 40% of Priority 2 (category for urgent and cancer patients who need seen within 1 month) were sitting in the urology service. It has been raised at both Health and Social Care Board and Department of Health requiring additional Commissioner support. With regard to governance, I recorded that the focus on urology had highlighted the need for additional capacity to ensure robust governance was embedded. 1 Band 5 Governance post was requested for each Division in Acute services and I agreed to discuss this with the Chief Executive and the Senior Management Team. The governance posts were approved and are currently in recruitment. As an interim measure, I allocated some capacity from the two Quality Improvement Officers (1 day per week per Assistant Director) from within the Directorate to prioritise areas for action and support Assistant Directors and their teams to implement leaning and action plans set out in SAI reports (111. *20211014 Q17.160 ADs 1-1 meetings proforma- Ronan Carroll located in S21 53 of 2022 Attachments*).

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

161. I cannot recall any further staffing issues being raised with me from urology services.

Q18. 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?

162. Yes, there were periods of time when posts within the unit remained vacant for a period of time.

163. There have been ongoing issues with vacant Consultant Urologist posts (as detailed in question 16). Out of 6 funded Urologists (7th post only funded in 2021 but recruitment not successful), the most ever in post was 4.5 Whole Time Equivalent (WTE) substantively, during my tenure. Mr Tyson was on sabbatical 2020 – late 2021, Mr O'Brien retired in July 2020 and Mr Young retired in May 2022, leaving 3.5 WTE Consultant Urologists. There is 1 locum in post which equates now to 4.5 WTE Consultants in total in urology out of 7 funded posts. The workforce challenges and impact on access to services is detailed in the Corporate Risk Register (5. *20220512 Q7.35 Summary Corporate Risk Register to Governance Committee located in S21 53 of 2022 Attachments)*.

164. This has an automatic knock-on effect on waiting lists and waiting times and paralleled with an increase in demand, has impacted on the urology service being able to deliver on the 31- and 62-day cancer targets. It has also caused delays in accessing assessment, diagnosis and treatment with the ultimate consequence on patient outcomes. This invariably affects staff morale as there is an inability to meet patient need at the level required, resulting in patient harm.

165. When I commenced post in June 2019, there were only 3 Clinical Nurse Specialists (CNS). In 2019, Macmillan funded a further post. In 2020, through funding from HSCB a further two were recruited *(11. 20191001 IPT - Expansion of Urology Services - Additional Clinical Nurse Specialists located in S21 53 of 2022 Attachments)*. The impact of now having 5 x CNS has allowed them to undertake some of the work previously done by medical staff, e.g., cystoscopy (endoscope into the urinary bladder). This allows patients suspected of having cancer to have their diagnostic tests more timely. Also in line with the cancer standards and the previously discussed "Fail Safe", this allows patients to be allocated a CNS as their 'key worker'. This has had a positive impact on the recognition of the specialist nursing role and function within the department, has freed up consultant time to be repurposed to other clinical areas. It also potentially enabled the key worker role to be focused towards patients, although some learning from the recent SAI's (9 completed in 2021) is that this was not as standardised and comprehensive as expected, varying across Consultants. The 5 CNSs and their dates of appointment are as follows:

- Jenny McMahon 04.07.2005

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- Kate O'Neill 04.07.2005
- Leanne McCourt 01.03.2019
- Patricia Thompson 03.08.2020
- Jason Young 31.08.2020

166. Nursing challenges in ward 3 South, with at times as low as 20% substantive post holders in post, impacted on the whole nursing team in terms of morale, retention, high agency usage and quality assurance. COVID also aggravated this position further as some staff left due to diminished surgical services and indeed frustration with the COVID pandemic.

167. These challenges were managed across medicine and nursing by recurrent recruitment processes for appropriate levels of substantive staff in an attempt to attract quality staff. This is detailed extensively in response to Question 16. Locum posts were also appointed where available, to increase patient safety by having higher staffing levels as part of the plan to bridge the gaps. There were also ongoing efforts to offer support, build morale and increase both capability and capacity to meet the increasing gap between capacity and demand. New approaches were introduced including "buddying" arrangements across wards to stabilise and support and positively skewing new recruits and international staff to 3 South. The impact of this has been felt in terms of a now stabilised team and nursing Quality Assurance Indicators having improved and new targeted quality improvement projects embedded and ongoing.

Q19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

168. Depleted staffing levels is directly correlated with an inability to provide services. Professional staff (medicine and nursing) work to job plans, maximum clinic numbers and nurse to bed ratios. This is to enable professional standards to be maintained. In addition, new staff and higher levels of locum/agency staff often require greater support and supervision, which impacts on volumes of patients able to be seen or cared for appropriately.

169. The data regarding increasing referrals, longer waiting lists and waiting times is detailed in Question 12. The impact is for the most part on patients who cannot access services in a timely way, may come to harm, some of whom we are not fully aware of their changing health status. Not to provide services at the desired level to meet need has a negative impact on team morale, as the majority of staff coming in to the health service are committed to providing the best service to patients in need.

170. The impact specific to urology provision was most acutely felt with reduced theatre nurses resulting in reduced theatre access, meaning less surgery available to people in need. Less Consultants and less nursing availability resulted in a shrinking surgical bed footprint. This was further aggravated since March 2020 with increased demand from medical patients

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

during COVID-19 pandemic surges. The imbalance of commissioned surgical versus medical beds is difficult to reverse.

Management

171. As a result of the above workforce challenges, (on 5 September 2019, the position in 3 South staffing deficits showed a deficit of 15.98 staff nurses), the bed complement had been reduced to compensate from 36 to 32 beds, of which 19 of those beds normally were dedicated to ENT and urology. The Core Trust Nurse to Agency ratio was 60% agency staff and 40% Trust staff (daytime) with 50-50% split for night duty which was affecting the ability for patient's needs to be fully met. *10. 20190904 Q7.43 3 South Trust Risk Assessment located in S21 53 of 2022 Attachments*

172. The reduced surgical footprint in acute services and in parallel reduced access to theatres due to theatre nursing gaps and increased unscheduled pressures with medical patients outlying in surgical beds, resulted in reduced patient access and longer waiting times. This caused some nursing staff to leave the service or move to other areas. The impact of this was a dedicated focus on supporting and trying to retain staff. If staff advised regarding their intent to leave the service, an interview is held to try and encourage them to stay and rebuild the team. It also led to creative recruitment processes and approaches including Health Fairs and careers work with schools to encourage the Health Service staff of the future to uptake training.

173. This created the need for greater management innovation and solution finding in terms of attracting people to apply to SHSCT, creativity in providing safe nursing rotas and stretching the Consultant Urologists to cover as much of the demand and need as possible within safe working practices. This included increased "Waiting List Initiatives", incentivising core staff to do additional in-house clinical activities to meet unmet need. Part of the role of management is to nurture the teams to remain resilient and sustain their service delivery.

174. It also resulted in developing relationships with the Independent Sector to increase the capacity they had towards SHSCT population. This has included contracting with providers such as Orthoderm to see oncology patients, 352 to support the patient reviews (face to face and desk top) and scoping the potential for increased support from Republic of Ireland. All of this absorbs management time and whilst well intentioned and necessary, detracts from service improvements and quality initiatives which would otherwise be progressed. *(112.-117. 20201016 Q19.174 Urology SAI Patient Review IS Contract, A1-A6 located in S21 53 of 2022 Attachments)*

Governance

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

175. Ensuring safe, effective, quality care is a core objective in SHSCT and good clinical governance ensures this quality is maintained to a high standard. There are seven key pillars of clinical governance including Clinical Effectiveness, Education & Training, Risk Management, Audit, Personal & Public Involvement, Information and Staff Management.

176. With regard to urology services, the staffing problems resulted in reduced capacity which inevitably led to complaints regarding waiting times. Risk management approaches were embedded including recording risks and taking action to address them as highlighted earlier. Processes were embedded to oversee any actions that were outside policy or normal procedures/guidance.

177. Due to a lack of staffing resources, there was limited capacity to complete functions outside operational care delivery. This would include implementing some governance processes such as timely implementation or sign off of governance action plans. Alternatively, some functions contained within job plans proceeded including screening of SAI's, Mortality and Morbidity meetings and Multidisciplinary Discussion regarding patient treatment pathways. As described earlier, additional Governance Officer support was made available, one day per week, per division until the additional four Band 5 Governance Officers are appointed (one per division).

178. Where there is reduced staffing levels there is a correlation with increased risk of harm to service users and staff. Therefore, as ward 3 South had low core nursing staff, high bank and agency usage and shifts when inadequate number of staff were available, attention to governance was reduced at ward level while priority was placed on delivering care. This is reflected in performance/governance concerns which include poorer nursing quality indicators (NQIs), including increased pressure ulcers and falls, increase in complaints, clinical incidents, increase in patient length of stay and decrease in staff training compliance. As a result of this, the governance function was supported at local level by the Acute Lead Nurse prioritising her time into 3 South over her other clinical areas for the implementation of safe effective care by building staff capacity, training and role modelling. This was all with an end purpose of building into the ward core team a sustainable quality and governance ethos for improved patient care, with the desired effect.

Q20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

179. There were several changes of staffing posts, duties and responsibilities during my tenure. Urology Consultants and role of Locum Consultants, Specialist & Associate Specialist (SAS) Doctors and Physician Associates all were a moving feast, as an attempt was made to stabilise the workforce challenges. The workforce challenges and impact on access to services and risk of patient harm is detailed in both Corporate and Divisional Risk Registers.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

180. There were ongoing issues with achieving a full staffing complement of substantive and locum Consultant Urologists. The posts of Consultant Urologists have been advertised 5 times since October 2020. On two occasions 2 applicants were interviewed but none were appointed.

181. Out of 6 funded Urologists during my tenure, with a 7th post funded in 2021 (but recruitment not successful), the most ever in post was 4.5 Whole Time Equivalent (WTE) substantively, during my tenure. Mr Tyson was on sabbatical 2020 – late 2021, Mr O'Brien retired in July 2020 and Mr Young retired in May 2022. There are currently 3.5 Consultant Urologists namely Mr Haynes (part time) and Mr Glackin, Mr O'Donoghue and Mr Tyson (full time) in addition to Mr Khan as a Locum Consultant Urologist, leaving a gap of 3.5 Whole Time Equivalent (WTE) staff. From the recent recruitment exercise that closed on 10 May 2022, two applicants have been shortlisted for interview which hopefully will help us to increase capacity if appointed.

182. The gap in Consultant Urologists translates into a more vulnerable service profile with an increased number of 'on-call and Urologist of the Week (UOW)' shifts requiring to be covered. The increase in UOW is currently 1:7 weeks. With the Consultant vacancies the shifts have been picked up by the current consultants which in turn have decreased clinical activity for that week and also risks greater stress and risk of burn-out of current staff.

183. Since September 2020, 4 locum Consultant posts have been recruited 1 of whom has remained in post, Mr Nasir Khan. In addition, to support the Urology Service the current Junior Doctors include:

- 2x Permanent Specialty Doctors - Dr Laura McAuley and Dr Saba Hasinain
- 3x Registrars (1 vacant) – Dr Conor McCann and Dr Kishan Tailor
- 3 x Clinical Fellows - Dr Susie Cull, Dr Fiona Griffin and Dr Juventine Asingei
- 0.5x Physician Associate posts were recruited across Acute Services to reduce the workload for junior doctors on the wards. Urology secured 0.5 WTE (18.75 hours).

184. With respect to nurse staffing, the ward allocated to urology is 3 South. From when I commenced as Director of Acute Services on 10 June 2019, there have been significant Band 5 registered nurse vacancies across all of Acute Services, with growing reliance on Bank and Agency posts to maintain safe staffing levels. Vacant shifts can still be a feature on rotas and all efforts are made on a daily basis to secure bank or agency staff and asking core staff to take on additional hours or overtime. In the event shifts remain uncovered actions are taken that include – cover from other wards that have higher level of staffing or reducing beds that can accept new admissions until the situation improves. The impact of lack of continuity of staff within the workforce is reflected at times in the key nursing quality indicators.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

185. At date of writing this, from a total of 31 registered funded Band 5 nursing staff for 3 South, there are 12.15 WTE permanently in post, 7.74 bank staff, leaving a deficit of 11.11 WTE (35%). The oversight of the nursing workforce and the quality indicators sits with the Lead Nurse (Mrs Paula McKay), the Ward Manager (Mrs Laura White), the Head of Service, Ms Wendy Clayton and Assistant Director, Mr Ronan Carroll who monitor this monthly. They take any available, appropriate action to stabilise the team including recruitment, redeployment, training and support, Nurse Bank liaison and additional Health Care Assistants to bolster the registrant team.

186. The senior nursing post of Clinical Nurse Specialists support complex patients on their cancer journey in the ward environment and in the outpatient clinics. In 2020, the Clinical Nurse Specialist posts were increased within Urology Services by two positions; Patricia Thompson (appointed 03/08/2022) and Jason Young (appointed 31/08/2020), with commissioner support to meet growing demand. There are currently 5 in post.

187. The Head of Service, Martina Corrigan, left her substantive position to take a promotion as Assistant Director within the Public Inquiry Team. This Head of Service vacancy was filled in an acting basis by Wendy Clayton in October 2020.

188. Mr Mark Haynes was the Divisional Medical Director for Surgical and Elective care throughout my tenure. His role changed to focus on Urology Services Improvement in November 2021 and another post as DMD for Surgery and Elective Care was created and has been filled by Mr Edward McNaboe since November 2021. Mr Edward McNaboe was previously the Clinical Director for Urology and ENT Surgery and the CD post that he originally held is currently vacant.

189. A new Clinical Assurance lead post was created to focus specifically on the demand associated with the Look Back Review into Mr O'Brien's patients and on increased service improvement. Mrs Sarah Ward commenced in November 2021 to lead on this and deliver on improvement related to the recent urology SAI's x 9 (April 2021). Margaret O'Hagan commenced in April 2022 as Independent Advisor to Urology for the Trust and works across the Senior Managers, Public Inquiry Team and operational staff. 90. *20210329 Q16.137 IPT - Staffing Support Requirement for SAI Inquiry – Urology located in S21 53 of 2022 Attachments*

190. There has been a modified structure of Medical Governance posts to strengthen the professional governance aspects of clinical practice. Specifically additional programmed activity added to Divisional Medical Directors job plans was agreed. Additional Clinical Directors were also appointed and a Deputy Medical Director with responsibility for appraisal and revalidation was formalised.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Q21. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

191. When I commenced my role as Acute Services Director, Dr Tracey Boyce, Director of Pharmacy, line managed the Acute Clinical and Social Care Governance Coordinator (Patricia Kingsnorth). This arrangement had been implemented under the previous two Acute Services Director, Mrs Deborah Burns and Mrs Esther Gishkori.

192. At this time, I held weekly meetings with Dr Tracey Boyce to review the governance standings across the Acute Directorate. As Director I reverted to directly overseeing governance in line with my job description and took over direct management of the CSCG Coordinator role. This took effect from September/October 2019 with Patricia Kingsnorth and subsequently Chris Wamsley on his appointment on 4 July 2021. Previously Dr Boyce had reported to the accountable Director. This change facilitated a direct line of assurance in relation to governance processes across the Directorate from the CSCG Coordinator directly to the Director.

193. As part of Dr Tracey Boyce's governance oversight role prior to my commencement in post, she chaired Acute Clinical Governance meetings within the Directorate. On my appointment to Acute Services Tracey maintained this role for approximately 2 months until I inducted myself to the new Directorate role. I subsequently assumed lead governance role and function and chaired all governance meetings within the Directorate. The rational for this change was to ensure I have full oversight and assurances of all processes within the Acute Directorate.

194. As evolving concerns regarding Mr O'Brien came to attention, it was necessary to establish focused urology oversight meetings, working collaboratively with the Medical Director Dr O'Kane, Mrs Toal and Mrs Hynds (Human Resources) and Mr Haynes as the Divisional Medical Director. The purpose of this group was to fully identify the concerns, risk assess the potential patient safety issues and prioritise a patient safety plan and prevent any further patient risk. In addition, it considered the mechanisms to advise Mr O'Brien of the concerns, mobilise the oversight of his Clinical Director at that stage, Mr McNaboe, and to offer support to Mr O'Brien.

195. This group also instigated the Review of Administrative processes which was a recommendation of the 28 September 2018 MHPS Case Determination Report by Dr Ahmed Khan. The Review of Administrative Process enables closer scrutiny of agreed administrative indicators with escalation to operational line management whereby action can be taken in respect of non-compliance.

196. In addition, I established a weekly/fortnightly Trust Urology Review Group which sought to scope the concerns identified, ensure patients had been stratified into appropriate cohorts, agree the patient reviews in terms of priority and methodology and offer patient assessment to ensure correct pathways

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

were in place. The membership of this group included Dr O'Kane, Dr Gormley (Deputy Medical Director), Mr Haynes, Mr Carroll, Mrs Corrigan, Mrs Ward once she commenced in November 2021 and Wendy Clayton since her appointment as Head of Service in October 2020. 118. *20211206 TOR Internal Lookback Review Group located in S21 53 of 2022 Attachments*

197. Where individual patient cases met the threshold for Level 3 Serious Adverse Incidents, Patricia Kingsnorth CSCG was a facilitative support to the external panel and I continued to supervise and guide Patricia, without insight to the SAI's under review (119. *20201016 L3 SAI Review 2 A located in S21 53 of 2022 Attachments*). Therefore, I had no influence over the external panel. When the external SAI's for the 9 Urology cases were drawing to a close, I met towards the end of the review process to discuss with Mr Dermott Hughes (SAI Chair) the draft recommendations and the implications for the Trust and more specifically for the patients and families involved.

198. I oversaw the setting up of the Service Improvement Task and Finish Group which was established to ensure implementation of the 11 recommendations included in the 9 urology SAI's (April 2021). This was chaired by Mr Carroll and Dr Tariq (DMD Cancer & Clinical Services). As this was applicable to all teams and specialities, it outreached across all multi-disciplinary teams and MDT's and MDT chairs to adopt early learning from urology and embed better governance processes across services. 120. *20211011 Q8.78 TOR Trust Task and Finish Group into Urology SAI Recommendations,* 121. *20220422 Q21.198 Task and Finish Group into Urology SAI Recommendations - Action Log*

199. My role also required the commissioning of additional capacity to instigate some new governance approaches and processes. Examples of this include commissioning new experts from across the UK to increase out capacity to review patients' journeys, commissioning additional Independent Sector support for patient reviews and the implementation of the Trust Urology Structured Clinical Record Review (SCRR) process. The SCRR process has replaced the standard SAI review process for cases identified via the Urology lookback that met the set criteria that is in place for a SAI review. This process is as an alternative process which was guided by and agreed with DOH. 122.-123. *20210426 Structured Clinical Rec Rev, A1-A2 located in S21 53 of 2022 Attachments*

200. In addition, a series of meetings were established with HSCB to update on progress regarding the Urology concerns and Look Back Review (118. *20211206 TOR Internal Lookback Review Group located in S21 53 of 2022 Attachments*) and in preparation for our attendance at the DOH Urology Accountability Group (UAG) (124. *20201023 Ltr re UAG A located in S21 53 of 2022 Attachments*), whereby the Trust was held to account for our operational and governance processes and the range of patient focused approaches improvements. Dr O'Kane also updated on the professional / governance issues.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

201. The Chief Executive and Trust Board were kept appraised with a focus on assurances regarding improving patient safety.

Q22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

202. Anita Carroll, AD for Functional Services manages the Urology Consultant administrative staff and Katherine Robinson is Head of Service for Administration. Each consultant is allocated 0.5 (18 ¾ hours) whole time equivalent (WTE) secretarial support per week.

203. In addition, to the Urology Consultant clerical staff there is an Administrative Ward Support Band 3 x 1.0 whole time equipment (WTE) (37.5 hours per week) supporting the Thorndale Unit. This post is currently vacant since 21st March 2022 with a planned new start commencing on 16 May 2022.

204. 0.5 (18 ¾ hours) WTE Administrative Officer was recruited to support the last two CNS Urology Nurse Specialists appointed, on 9th August 2020.

205. I would not necessarily be aware of concerns in relation to the adequacy of support staff availability, it would be best answered by Wendy Clayton, HOS, Ronan Carroll, AD or Katherine Robinson, HOS (Administration). However, my general oversight of all teams and disciplines is that they feel under resourced with administrative and secretarial support. The secretarial teams have responsibility for scheduling elective patients, typing of all medical clinical sessions and dealing with all consultant queries.

206. The new backlog report format was commenced in 2016 to quantify workload between secretarial and audio typist staff and allows movement of work where necessary. The Secretaries complete this monthly information template, quantifying the level of work awaiting to be done either by their Consultant or themselves. This information is circulated to consultant staff, Heads of Service and Assistant Directors (not to Clinical Directors or Divisional Medical Directors). Following a meeting on 24 January 2020, Simon Gibson, Assistant Director (Medical Director's Office) provided an update by email, regarding a meeting he chaired with colleagues including Mr Carroll, Mrs Anita Carroll and Mr Haynes. At this meeting discussion took place that the information contained within the monthly template was not deemed to be accurate and as such was not regarded as a useful mechanism. This meeting was in preparation for the planned Urology Oversight meeting.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

207. Mrs Carroll added the typing backlog for medical secretaries to her Divisional Risk Register on 19 November 2018 and on 9 December 2019, a further addition was included regarding a potential for patients not to be followed up on time or lost on the system, due to inadequate secretarial support. Outstanding typing and filing were highlighted In the April 2022 review backlog report within surgery, which is a likely indicator of inadequate resource.

208. For the ward-based service, additional demands on the ward clerk are often mentioned anecdotally regarding busy phone lines, communication with relatives and managing planned visiting during restrictions as a result of covid.

Q23. 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?

209. Whilst there is secretarial support aligned to particular Consultants (0.5 WTE), it is the expectation that administration staff work collaboratively, for example, to equalise workload or cover if a colleague is off on sickness absence. This is the same across all of our teams, including urology.

210. The administrative workload is measured monthly via the amount of backlog in the Surgery Elective Care backlog report, which is then shared by the HOS (Urology) Wendy Clayton with all Consultant Urologists, highlighting dictation or typing delays requiring action. Consultants are normally aware if there are backlogs and have a plan to address. This is monitored again the subsequent month in the SEC backlog report.

Q24. Were concerns from 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.

211. There were no concerns raised with me by administrative support staff, nor was I aware of any concerns they may have had.

212. The Consultant secretarial staff are aligned to Functional Support Services Division and any issues. I would expect that any issues of concern would be escalated to me via Mrs Anita Carroll, Assistant Director for Functional Support Services. As far as I can recall, no urology administrative support staff raised any issue with me.

213. After Mr O'Brien had retired, there was an ongoing scoping of the issues that had been triggered before he retired. Mrs Martina Corrigan (HOS Urology at the time) found evidence of records in Mr O'Brien's office which had results not signed off by Mr O'Brien before he left. I heard from Mrs Carroll that his secretary Noeleen Elliot whom Mrs Carroll had spoken to, Personal Information redacted by the USI [redacted] was a bit upset. I decided to contact her and reassure her regarding the process. I rang her by appointment (I can no longer recall the exact date but this was confirmed to me by Mrs Anita Carroll) and talked to her candidly as I knew she would have been aware of media coverage and I anticipated she

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

may be concerned. She had moved to the Breast service and commented that the workload there was easier than in Urology.

Q25. 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.

214. Mr Ronan Carroll is the AD for ATICS and SEC and has overall responsibility for Surgical Services in which Urology is a sub-speciality. Mr Carroll reported/answered to me, was supervised by me and escalated any concerns and we developed plans to address concerns.

215. The day-to-day running of the Urology Service is provided by the Head of Service (previously Martina Corrigan, now Wendy Clayton) in collaboration with the Clinical Director (previously Mr McNaboe, currently vacant). These two staff members directly link with the AMD/DMD for Surgical and Elective Care (Mr Haynes, now Mr McNaboe) and the AD (Ronan Carroll) as the collective leadership team for Urology Services. The AMD/DMD role reports to me as Acute Director operationally but professionally is accountable to the Medical Director.

216. The delivery of day-to-day Nursing support for urology Services is provided by their Lead Nurse (previously Sarah Ward, now Paula McKay). The Lead Nurse works in collaboration with the senior nurses and Clinical Nurse Specialists form a collaborative multi-disciplinary approach to the delivery of Urology Nursing across the Urology Service. If nursing concerns are identified and need escalated within Urology Services the Head of Service for Nursing within Surgery (Brigeen Kelly) is notified, and the Nursing Governance Team is engaged if necessary.

Q26. What, if any role did you have in staff performance reviews?

217. The Trust is committed to the individual performance review process as an important component of the Trust Governance process, contributing towards organisational and service development and individual opportunities for staff to develop their potential. Individual Performance Reviews are completed annually between the individual staff member and the line Manager and a Personal Development Plan is produced and jointly agreed.

218. As Director of Acute Services, I host meetings with each person who reports to me. This includes individual Assistant Directors as part of a review of their individual performance and the Acute Clinical Social Care Governance Coordinator who I directly line manage. I complete the Individual Performance Review template, populating it with a review of the previous year, with a plan for the following year and checking compliance with corporate mandatory training requirements. The opportunity is afforded to the staff member to identify training and development needs and requirements and once agreed these form

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

part of the individual plan for that year. A copy of the agreed Individual Performance Review and personal development plan is kept on file and a copy sent to Human Resources Department in line with corporate expectation.

Urology and Cancer Services

219. As the line manager of Mr Ronan Carroll, Assistant Director with responsibility for Urology, I have completed two individual performance reviews during my tenure thus far, which were completed on 3 September 2019 and 13 June 2021 (100. *20190903 Q17.150 and 104. 20210613 Q17.152 Personal Development Review Ronan Carroll located in S21 53 of 2022 Attachments*). In the first of these performance reviews he included his work plan across his five areas of responsibility including the urology service and 3 South. In his work plan for urology and 3 South, he referenced stabilising 3 South, expanding urology services to Daisy Hill including additional theatres and nurse led and consultant clinics, increasing Stone Treatments, increasing clinical nurse specialists and working with the Regional Surgical and Assessment Centre for Urology. It is my responsibility to reflect on the work plan in terms of deliverables and barriers on subsequent 1:1 supervisions throughout the year. At these 1:1 supervisions, the Assistant Director raises issues for discussion related to his work plan, concerns for escalation, problems that require Director level support for decisions, escalation to Trust Senior Management Team and Trust Board as appropriate or for further discussion at regional meetings. These 1:1 sessions give me the opportunity to mentor, guide and check in personal health and wellbeing of the Mr Carroll.

220. I also complete the individual performance review and personal development plan of Mr Barry Conway, Assistant Director for Cancer and Clinical Services and Integrated Maternity and Women's Health until October 2021. In his performance review on 4 December 2019 and 5 May 2021, Mr Conway advised that he had commenced Assistant Director for Integrated Maternity and Women's Health in February 2018 and Cancer Clinical Services in June 2018. He noted that the span of services within his portfolio was large, typically split with 50% radiology, 20% Integrated Maternity and Women's Health, 10% Cancer Services, 10% Laboratories and 10% Acute Allied Health Professionals. He believed consideration should be given to making a standalone Assistant Director for Integrated Maternity and Women's Health portfolio as it had been previously to create space for him to focus on his other areas (126. *20210505 Personal Development Review Barry Conway located in S21 53 of 2022 Attachments*). I agreed in principle with the need to split the portfolio, at that stage the Trust was restructuring and there was a plan for Integrated Maternity and Women's Health to potentially transfer under the Executive Director for Nursing and Midwifery portfolio, in effect the structure conversations were not progressed as planned throughout the COVID-19 pandemic, and by Summer 2021, I had decided to progress the separation of the two portfolios due to the high level of risk in those services. In summer 2021, I recruited a standalone Assistant Director for Integrated Maternity & Women's Health who commenced in October 2021 (Caroline Keown). As an interim measure to mitigate the risk in those services, Wendy Clarke, Head of

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Midwifery, assumed Acting Assistant Director of Integrated Maternity & Women's Health from May 2021 to October 2021.

221. In addition, to his concerns about the risks in the services within his portfolio, his objective for the next year included finalising a 10 year equipment replacement programme for Radiology, completing a demand and capacity exercise for Radiology, reviewing Daisy Hill Hospital laboratory staffing arrangements, implementing the Regional Pathology Transformation programme in Laboratories, embedding the new Cancer Strategic Forum in the Trust, establishing its role in setting the future direction for the delivery of Cancer Services and working with the Head of Service for Cancer Services to support and improve performance against the 62-day pathway for Cancer (127. *20191204 Personal Development Review Barry Conway located in S21 53 of 2022 Attachments*). Taking cognisance of Mr Conway's objectives particularly supporting and improving performance against the 62-day pathways, I ensure that focus is given to the 62-day performance target both in internal performance meetings agreeing where possible mitigating actions to increase performance and escalating to HSCB Cancer Performance Group the need for additional capacity for unmet need and resource for urology.

222. In the subsequent individual performance review on 5 May 2021, Mr Conway included in his objectives for 2021/2022 that he would support the implementation of the recommendations from the Urology SAI Review (Dermot Hughes). This would include implementation of enhanced support to Cancer MDT's and enhanced tracking for some tumour sites starting with urology. A new role of Multidisciplinary Meeting (MDT) Administrator was to be considered as a priority to support and improve data sharing with the MDT chairs and enhanced support for audit of patient pathways. He also included the requirement to work to implement the Cancer Rebuild Plan across the multidisciplinary team to address the backlog of Cancer cases which built up during the COVID-19 pandemic. This would include supporting tumour sites to meet 31- and 62-day targets (126. *20210505 Personal Development Review Barry Conway located in S21 53 of 2022 Attachments*). These were monitored at subsequent 1:1 meetings and I also represented the Directorate at the Northern Ireland Cancer Network Steering Group to influence the Cancer strategy and Action Plan for implementation. In these regional meetings, I took the opportunity to highlight service concerns regarding workforce, capacity and potential harm to patients which were all included in the Directorate and Corporate Risk Register. I also attended the Trust/HSCB Cancer performance meetings and escalated the access issues to both performance and governance committees and Trust Board.

Q27. 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.

223. My role as Director of Acute Services was subject to annual performance review and appraisal by the Chief Executive. I would have prepared the Trust

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

individual performance review (IPR) template in advance of our planned meeting and we would have discussed the objectives, planned actions and measures if appropriate. These were signed off by both the Chief Executive and myself and updated in a progress column and revisited to assess deliverables/ outcomes at the end of the year. This then would have formed the basis for the subsequent IPR for the following year. 128. *20200323 Melanie McClements Individual Performance Review 20-21, 129. 20210325 Melanie McClements Individual Performance Review 21-22 located in S21 53 of 2022 Attachments*

224. For the year 2020/2021 (128. *20200323 Melanie McClements Individual Performance Review 20-21 located in S21 53 of 2022 Attachments)*, my key objectives specific to this notice included ensuring maximum patient safety and best outcomes for care delivery for patients during the pandemic and to address the urology concerns first escalated by Mr Haynes on 11 June 2020 with a focus on patient safety and quality care (34. *20200611 Pts to be added to UBL located in S21 53 of 2022 Attachments*). Throughout the year, I implemented and noted progress regarding escalation and an early alert was completed (*Early alerts are a process of escalating issues to Trust Board, SPPG and Department of Health regarding issues which may be of regional media interest or where patients might have come to harm*). 130. *20200731 Q27.224 A1 DoH Early Alert AOB located in S21 53 of 2022 Attachments*

225. Weekly/fortnightly urology review Trust meetings, HSCB meetings and DOH urology accountability meetings took place and an investment plan developed to improve services. 2113 reviews of patients under Mr Aidan O'Brien's care are recorded as having been carried out, relating to patient care over the January 2019 to June 2020 period. A work plan to meet evolving requirements of patient and staff was implemented, governance arrangements were evolving and partially implemented and this was on the agenda of the Acute Clinical Governance meeting as part of sharing the learning with the expectation of embedding that learning with each Division in the Directorate and areas of responsibility.

226. In year 2021/2022, the subsequent IPR focused on developing the actions from the previous year including carrying out a range of patient reviews, embedding governance arrangements and monitoring the implementation of the Urology SAI recommendations working with Cancer and Clinical Services (129.*20210325 Melanie McClements Individual Performance Review 21-22 located in S21 53 of 2022 Attachments)*. This was shared with the Acute Clinical Governance members. Any additional learning from SAI's and Structured Clinical Record Reviews was also cascaded to the clinical teams.

227. In addition, to the annual IPR and performance review, I also have regular supervisions with the Chief Executive to discuss my ability to deliver on the core requirements of the Acute Directorate post, taking the opportunity to escalate positive outcomes and to discuss issues that require further support or alternative approaches.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

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.

Divisional Medical Directors of Surgery and Elective Care and Cancer & Clinical Services

228. As described earlier, I met the AMDs of both respective services on a 1 to 2 monthly basis to discuss any issues that they wished to inform me about and which they needed some direction or support with. These discussions included issues such as workforce challenges, capacity and demand imbalance, the impact of pressures in unscheduled care outside of surgical and cancer services which impacted on beds available for the same level of surgical services previously.

229. During the COVID-19 surges, many staff were redeployed to medical wards, respiratory wards and intensive care to cope with the patient demands. This resulted in less capacity to deliver theatre sessions to meet the needs of surgical, cancer and urology patients. This would have been understood by the AMDs as to why this was the case, however, as patient advocates, we had regular discussions regarding the need to reinstate their services at the previous level.

230. Following the concerns that were raised by Mr Haynes regarding Mr O'Brien's patients prior to his retirement, we would have also taken the opportunity to discuss any issues regarding ability to meet the level of patient reviews required within a depleted urology team. However, the majority of these discussions took place in the urology oversight, urology review group and assurance groups, referenced above.

231. My discussions with Dr Tariq at 1:1 meetings every 1-2 months (DMD, Cancer & Clinical Services) with specific regard to urology, centred on his Chair role on the Service Improvement Task and Finish group and the need for investment to realise the goal of implementing the best practice approach espoused within the recommendations. He also helpfully scoped evidence of best practice to inform the improvement plan.

Clinical Directors

232. Clinical Directors align directly with the AD and the Head of Service so I don't hold individual meetings with them, however, all AMDs/DMDs and CD's are members of the Acute Clinical Governance Meetings monthly. As mentioned above, these meetings are focused on the responsibility that each has across the governance agenda, highlighting the data, trends, levels of

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

incidents, serious adverse incidents and bringing completed reviews for approval and progressing to implementation of SAI action plans. Any current governance issues of concern are raised and would have included information on the public inquiry, once announced, the focus of this being the relevance to how we provide services. Part of this would have addressed the need to review the role of the MDT's and complete baseline audits across the Tumour specific MDT's to ensure fully informed decisions are taken and implemented for patients presented as part of their clinical pathway. 121. *20220422 Q21.198 Task and Finish Group into Urology SAI Recommendations - Action Log located in S21 53 of 2022 Attachments*

233. I was aware that Dr O'Kane in her email of 30 October 2019 (131. *20191030 AOB Notes located in S21 53 of 2022 Attachments*) had advised she would follow up with Mr McNaboe re concerns regarding Mr O'Brien's reported breaches in monitored actions. I did not directly discuss this with Mr McNaboe but I was aware from Mrs Corrigan that they were having difficulty organising the meeting.

234. Mr McNaboe has since become Divisional Medical Director and I have commenced 1:1 discussions with him. There has been no conversation regarding Mr O'Brien as he is aware Mr Haynes is focusing on this within his DMD/AMD Service Improvement Urology role.

Assistant Directors of Surgery and Elective Care and Cancer & Clinical Services

235. As cited in my previous responses, I offered supervision on a 1:1 basis to both Mr Carroll, AD SEC (Urology in his portfolio) and Mr Conway, as AD Cancer Clinical Services linked here because of the interface with urology and cancer services. These meetings took place 1-2 monthly, referred to the objectives set for the year in their individual performance reviews and allowed for discussion on progress against their work plans and an opportunity to explore any issues of concern. Invariably, these related to workforce challenges, impact of COVID on staff redeployment and the impact of the unscheduled care pressures on their ability to deliver appropriate levels of surgery, outpatients and theatre lists to meet their service targets including cancer pathway targets.

236. It also was an opportunity to highlight gaps including issues such as need for additional equipment and capital investment in their respective Divisions as highlighted earlier. Concerns of a clinical governance nature relating to patient care pathways were discussed with specific reference to the ongoing challenges of identifying, creating capacity and implementing targeted clinical time to review patients identified under the care of Mr O'Brien using the look back review process. This also required escalation to HSCB/SPPG, and Department of Health to share the issues, findings and additional capacity required. Monthly, a summary report was sent to the HSCB/SPPG and the Department of health to summarise the work plan that had taken place over the previous month.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

237. In addition, to the four Directorate themed meetings of Human Resources, Finance, Performance, and Governance, during the COVID-19 pandemic, I initiated a daily huddle at one stage around midday and as the surges have increased and decreased, we changed the frequency of the huddles, currently twice a week. These are touch base meetings for Director and Assistant Directors (represented by Heads of Service if AD not available) to escalate any areas of concern, patient safety or public interest such as overcrowded EDs, lack of available acute inpatient beds for patients, need to cancel planned outpatients or theatre lists and impact of staff sickness on ability to deliver planned services.

238. Mr Carrol was also a member on the Trust Urology Review Meetings.

Head of Service

239. As the Head of Service is supervised by the Assistant Director, my role with Heads of Service is more adhoc either from casual interfaces in the corridor, to requests to meet me with issues of concern or whilst covering for Assistant Directors on any given day. Specific to this notice, I would have had email exchanges and conversations with Mrs Martina Corrigan regarding the patient reviews and also assisted with the report writing for the SPPG and Urology Accountability Group (UAG) in the Department of Health. Mrs Corrigan and I would also have agreed the development of the investment template (IPT) for funding from commissioner.

240. Since Ms Clayton has taken up post as Head of Urology Services, I regularly meet her in the Admin floor and when I go to her office regarding a service issue. She is supporting the capacity plan to meet the higher capacity needed for the patient reviews and is also supporting the new Clinical Assurance Lead (noted below). I have regular conversations regarding capacity and workforce challenges.

Other urology Staff Members

241. Prior to June 2020, my engagement with urology staff was limited to meeting the DMD's, Assistant Directors, HOS and CNS in both urology and cancer and clinical services.

242. Once the patient concerns had been identified by Mr Mark Haynes on 11 June 2020 relating to the clinical practice of Mr O'Brien (34. *20200611 Pts to be added to UBL located in S21 53 of 2022 Attachments*), patients who were under his care and needed reviewed were seen predominantly by Mr Haynes or via a contract with Orthoderm, in the Independent Sector (115. *20201016 Uro Review Contract A4 located in S21 53 of 2022 Attachments*). The decision to engage an independent sector provider was due to the need to expedite the review of oncology patients and also due to the lack of available capacity within the Southern Trust. Professor Sethia, a subject matter expert in Urology from the UK also completed virtual patient reviews. I was not actively involved in directly communicating with clinical staff at this point as my focus was to engage

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

with Mr Haynes and Mr Carroll for them to communicate agreed actions as appropriate with relevant team members.

243. However, from September 2020, I met with the Urology Clinical Team (Trust Urology Review Meeting) with Dr O'Kane, initially on a weekly basis for an hour to discuss the operational plan to deal with concerns raised regarding the patient reviews and the desktop review of results across histology, radiology and cytology from January 2019 – June 2020. From my notes, there were 2113 patients identified at that stage whose care required further scrutiny. Discussion also focused on the helpline plan for patients who had concerns with the care that they had received and follow up call backs to the patients were planned. There was a subject expert who had been engaged to assist the patient reviews.

244. On 8 December 2020, I had a meeting with the Urology Clinical Team after the Ministerial Statement on 24 November 2020 regarding the establishment of a Statutory Public Inquiry, under the Inquiries Act 2005. I learned at that meeting that there were no Senior House Officers within Urology and an incomplete registrar tier. They are not commissioned posts so therefore Trust funded SHOs and registrars are needed. The Trust had gone out to recruit Registrars with no success. The option that the team suggested going forward was to recruit for a two-year period and allow rotation across surgical specialties to prevent using Locums and to stabilise middle tier rota.

245. The Clinical Nurse Specialists (CNS) who attended the meeting commented that they were going to need advice from the Trust going forward and that their previous and current practice was stretched. One Clinical Nurse Specialist referred to recent minutes from the weekly Trust urology review meeting highlighting terms in it that she was not familiar with, for example, Structured Clinical Record Reviews (SCRR's). The CNS highlighted that a team meeting was needed for better collaboration between medical and nursing team. It was also suggested that there should be a team meeting with the wider group which included porters and domestics and the potential for psychological support for the team.

246. On 19 October 2021, I had a meeting with the Urology Clinical Team, with Dr O'Kane I believe, to update regarding the commencement of the public inquiry and was advised of the availability of Trust legal counsel. We were awaiting further detail on the public inquiry. The 9 recent urology SAI's had been sent to the USI panel. They were advised regarding the expectation of Section 21 notices which would be a formal process to individuals across the teams. I also gave them an update on the patient reviews and communications to families that was under consideration. I also discussed access to independent sector for additional capacity.

247. I advised that Sarah Ward had been appointed to the Clinical Assurance Lead post and I advised that Dr Shahid Tariq and Mr Carroll were co-chairing the task and finish group to address the recommendations and implement the learning from the recent 9 urology SAI's. The urology clinicians reiterated the

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

need for appropriate governance and administrative support throughout this period.

248. Following the announcement of the ministerial intent to proceed to a statutory public inquiry, I commenced regular team meetings with urology staff across AMD, AD, Head of Service, consultants, clinical nurse specialists and on occasion admin and clerical staff. These regular team meetings were also attended by the Medical Director. The purpose of this meeting was to be open and transparent with our communication, informing the team of any plans and listening to their concerns and offering reassurance and support as we worked through the next stage of the inquiry collaboratively.

249. When Sarah Ward, previous Lead Nurse for surgery and Elective Care (including Urology), took up her post of Clinical Assurance Lead for Urology (equivalent to Head of Service Lead) in November 2021, she would have often approached me for advice or guidance on steps she was taking to support the appointment of patient reviews as part of the Lookback review of urology patients. She would have also escalated issues such as the ever-changing patient numbers, as new patients were identified, some patient details had been entered twice on the system, which were then counted as two separate patients. This required quality assuring the list. Some coding errors were identified that had to be addressed to ensure all patients were captured who required review.

250. I believes this covers the detail regarding the engagement I had with all staff within the unit.

Q29. 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.

251. On a 1-2 monthly basis I meet with the Assistant Director for 1:1 meeting and also had 1-2 monthly meetings with the Divisional Medical Directors, Mr Haynes and more recently Mr McNaboe. The Urology Clinical Director/ DMD and AD attended the Acute Clinical Governance monthly meeting.

252. The first Urology Oversight meeting commenced on 8th October 2019 (post breach in sept 19) (131. *20191030 AOB Notes located in S21 53 of 2022 Attachments*) with the subsequent one on 12 February 2020 (46. *20200212 Oversight Meeting re AOB located in S21 53 of 2022 Attachments*) in relation to progressing, in particular, the MHPS Case Determination Recommendations. These Urology Oversight meetings are a forum that is called on when further concerns arise. It is attended by Medical Director, DMD (Mr Haynes), Director of Acute Services, and Director of Human Resource and Organisational Development/ Deputy Director Employee Relations and Engagement.

253. I commenced formal meetings with the urology staff on 3 September 2020 following a scoping exercise that was initiated as a result of the June 2020

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

concerns raised by Mr Haynes, regarding 10 cases of concern. The average duration of meetings was 60 minutes and the discussion revolved around planning the stratification of the cohorts of patients under Mr O'Brien that required review. These included (*20201022 Volumes*):

- Review of stent removals Jan 2019 - June 2020 - 160 patients;
- Review of elective activity Jan 2019 - June 2020 - 352 patients;
- Review of pathology results Jan 2019 August 2020 - 168 patients;
- Review of Radiology requests Jan 2019 - August 2020 - 1028 patients episodes;
- Review of MDM episodes Jan 2019 - July 2020 - 271 patients;
- Oncology Review Backlog – 236 patients Orthoderm Independent Sector contract.
  (Note: numbers changed as a single patient may have had several episodes for example surgery and pathology results/radiology requests)

254. These meetings then took place weekly, progressing to fortnightly and I chaired those meetings. These meetings subsequently became the Look Back Steering Group (in line with Look Back Review Guidance - December 2021).

255. I also commenced engagement meetings with the operational and clinical urology team to keep them appraised of concerns and ongoing issues which required their engagement to participate in patient reviews of previous Mr O'Brien patients. Following ministerial announcement in November 2020 of the Urology Public Inquiry, the added information when available was added to the agenda in this regard. Mr Shane Devlin and Dr O'Kane attended alongside consultants, clinical nurse specialists, Locum staff, AD, Head of Service and the Acute Director. The focus of these meetings was also one of support and the frequency of them was monthly initially and then held when the clinical team feel that they would benefit from a further meeting.

256. On a fortnightly /monthly basis I communicated progress regarding the Urology patient reviews as a result of the patient safety concerns, in meetings to HSCB and in the Department of Health's Urology Accountability Group. The latter is the Department's mechanism to hold the Trust to account for actions taken and is attended by myself, Chief Executive and Medical Director. There are reduced in frequency to 1-2 monthly.

257. Details of weekly, monthly and daily scheduled meetings with any urology staff are not formally minuted (133. *Notes of Meetings February 2020 – September 2021 located in S21 53 of 2022 Attachments*). The minutes of the weekly and fortnightly Urology Oversight Meeting (with Mr Carroll, Mr Haynes, Mrs Corrigan and latterly Ms Clayton) are in Appendix Question 29.257.

Q30. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

258. I believe that all of the Urology meetings were of a formal nature as noted above. The concerns had been raised either in 1:1's or by email and such were the concerns, this led to formal meetings being established and minuted.

259. On the admin floor in Craigavon Area Hospital, where the operational Assistant Director and Head of Service for urology are based, I would have informal interactions but with little substance otherwise it would be directed to the regular formal meetings.

260. I agreed following an email on 12 February 2021, to meet Kate O'Neill, Clinical Nurse Specialist, on 17th February 2021 regarding her re-banding issue. I met her as requested and advised Mr Carroll, that the meeting had taken place. I got an email from Ms O'Neill a couple of months after the meeting to advise she has successfully been re-banded. 13. *20210322 Q7.45 A3 CNS AFC Discussion located in S21 53 of 2022 Attachments*

261. Following identification of records in Mr O'Brien's office by Mrs Corrigan, with results and reports that remained unsigned, Mrs Anita Carroll investigated this further and spoke directly to Mrs Noeleen Elliot, medical secretary to Mr Aidan O'Brien. Mrs Carroll advised me that Mrs Elliot was a bit upset following the retirement of Mr O'Brien and I agreed to contact her and assure her of our support as the public inquiry had been announced. I cannot recall nor have I recorded the date of this phone call.

262. There have been no further informal meetings between myself and the urology staff and management apart from those cited above.

Q31. 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.

263. On 17th June 2019, Mr Carroll at his first 1:1 made me aware of ongoing issues within Urology services. At no point was I concerned regarding "working Well Together" issues but rather that the issues related to workforce capacity issues, access for patients to urology services and impact of unscheduled pressures on urology services. I would have experienced the operational and urology team to be a team who were focused on maximising opportunities for better patient outcomes, fighting for their bed stock to be returned to surgical staff, increased access to theatres and additional staff. The working relationships I observed were always positive. 95. *20190617 ADs 1-1 meetings proforma- Ronan Carroll located in S21 53 of 2022 Attachments*

264. The first time I became aware of the ongoing monitored Action Plan (Post MHPS) regarding Mr O'Brien was on 27th August 2019, following an email communication from Dr O'Kane, which I was copied into (51.-53. *20190827 Q8.77 GMC Referral - AOB, A1-A2).* This email was with regard to her referral of Mr O'Brien to the GMC in April 2019. This referral was prompted as Dr O'Kane was newly appointed into the Medical Director role and had become aware of the MHPS Case Determination report and the subsequent grievance

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

which had been lodged by Mr O'Brien. The GMC had responded requesting further information. I can recall enquiring what the concerns were from Mr Carroll Assistant Director. He described Mr O'Brien as being held in very high esteem by his patients and that clinically he was reported to be good. The term "Rolls Royce" was used as a metaphor for the type of service he offered. He also referenced the concern regarding timeliness of administrative processes which were under review, but that there had been no issues since commencement of monitoring against the 4 areas identified in the agreed Action Plan (until September2019) (136. *20191008 AOB Oversight A1 located in S21 53 of 2022 Attachments*).

265. Once the concerns were raised on 11 June 2020 regarding the 10 patient delays identified on one day (34. *20200611 Pts to be added to UBL located in S21 53 of 2022 Attachments*), I worked more closely with Mr Haynes, Mr Carroll and Dr O'Kane and with operational colleagues including Mrs Corrigan and subsequently Ms Clayton. There was a healthy respect across all staff and good relationships were apparent.

266. When the concerns were officially shared with the clinical team in September 2020 (Mr Haynes may well have advised of service issues to his consultants in advance of that), there appeared to be a sense of loyalty and respect for Mr O'Brien. I say that as no one raised any concerns regarding the services he offered. The concern appeared to be more on the fact that such high demand levels outstripped the team's ability to deliver and as such left them all feeling vulnerable.

267. At any subsequent meetings, the healthy team relationships were displayed including the consultants referencing the esteem the nursing colleagues were held in and indeed the appreciation for the support of, in particular the Heads of Service Mrs Corrigan and Ms Clayton.

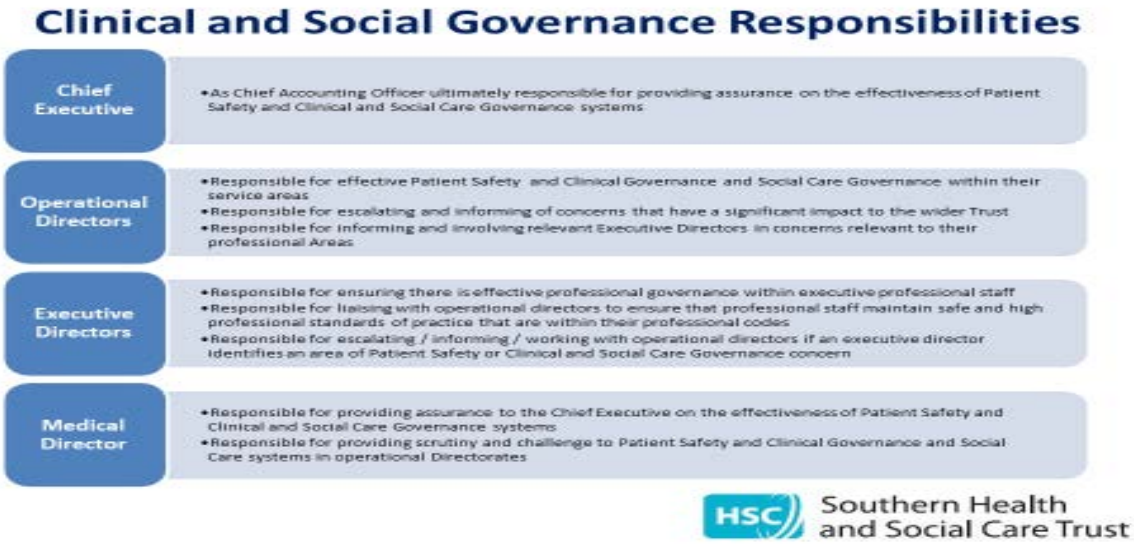
Governance – generally

Q32. What was your role in relation to the Directors of Human Resources and Organisational Development, the Assistant Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in the urology unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

268. 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 will flourish (Department of Health (UK), 2021). The roles for each are portrayed below both at corporate level and individual responsibility level. The governance systems are designed to assure and challenge the care delivered, to ensure patient safety and quality of care.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Urology Services Inquiry



269. The Medical Director is the Trust corporate lead for Clinical and Social Care Governance and also is the Responsible Officer for all Doctors to ensure professional standards are upheld, including one to one Appraisal, Revalidation, training, local regional and national benchmarking, peer review, mortality and morbidity oversight, dealing with professional concerns and working within the General Medical Council code of practice. In terms of governance, I work alongside the Medical Director, attending a range of governance fora including Doctors and Dentists oversight meetings, accountability meetings with DOH and Trust Board/Governance committee.

270. The Director of Human Resources and Organisational Development and Deputy Director for Employee Relations & Engagement, Siobhan Hynds support operational Directors when there are issues that require their expertise and oversight. With specific regard to Urology, in my tenure, this related to working with Mrs Toal (Director HR) and Mrs Hynds (Deputy Director) on the Urology Oversight meetings in October 2020 and then from February 2021. Both colleagues were aware of the previous issues regarding the MHPS Investigation and Case Determination and the grievance that had been lodged by Mr O'Brien subsequent to that. I liaised with Mrs Toal specifically with regard to the concerns raised in June 2020, Mr O'Brien's planned retirement and later request to rescind his retirement notice as there was no Trust commitment to reinstate him on a part-time basis.

271. As Director of Acute Services since June 2019, I was a member of Senior Management Team (since September 2017 as Director of Older People & Primary Care), alongside the Director of Human Resources and Organisational Development (Mrs Vivienne Toal) the Medical Director (Dr Maria O'Kane), the Executive Director for Nursing, Midwifery & Allied Health Professionals (Mrs Heather Trouton), all line managed by the Chief Executives (Francis Rice, Stephen McNally and Shane Devlin).

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

272. When issues of concern relating to sub-optimal practice and potential patient risk arose within Acute Services, HR and Medical Directors and on occasion the Executive Nursing Director worked collaboratively with me to discuss and agree appropriate actions and escalating to the Chief Executive.

273. With respect to governance specifically, I operationally line manage the DMD and the Assistant Directors of my divisions. I expect these staff to escalate any governance concerns, operational or professional. I also line manage the Acute CSCG Coordinator who I hold to account for monitoring, implementing action plans and learning from incidents, complaints and SAI's.

274. The urology oversight meeting called by Dr O'Kane for 8 October 2019 was in response to the escalated concerns re breaches of actions agreed during the MHPS Case Investigation (131. *20191030 AOB Notes located in S21 53 of 2022 Attachments)*. Collaborative working necessitated participation from HROD, Mrs Siobhan Hynds (Deputy Director HROD), Dr Ahmed Khan (Case Determination Manager and the Acting Medical Director), Dr O'Kane Medical Director, DMD Mr Mark Haynes and myself, as my operational team needed to be sighted on the issues and actions agreed. This group met again in February 2020 to discuss progressing the recommendations in the MHPS Case Determination, which I agreed my team could support Dr Mary Donnelly and Dr Rose McCullagh in their review of Administrative processes (46. *20200212 Oversight Meeting re AOB located in S21 53 of 2022 Attachments)*.

275. Following the 11 June 2020 concerns escalated by Mr Haynes (34. *20200611 Pts to be added to UBL located in S21 53 of 2022 Attachments)*, I chaired the Trust Urology review meeting referenced above, weekly for a significant time, now fortnightly. This group included Mr Carroll, AD, Mrs Corrigan, HOS, Dr O'Kane Medical Director and her Deputy Medical Director Dr Gormley. This group evolved into a more formal Urology Lookback Review, in line with guidance published in 16 July 2021 by the Department of Health. 118. *20211206 TOR Internal Lookback Review Group located in S21 53 of 2022 Attachments*

Assistant Directors

276. In my role as Director of Acute Services, I am responsible to ensure that the urology service within the Southern Area is delivered in line with Commissioner Intent with respect to workforce, performance, governance and finance. To deliver on these, I line manage Mr Ronan Carroll, Assistant Director (AD) for Surgery and Elective Care (SEC) and Anaesthetics, Theatre and Intensive Care (ATICS), who has direct operational and governance responsibility for the urology service. As line manager to Mr Carroll, I offer supervision, and opportunity to discuss options, situations and make decisions when he escalates areas of concerns where all operationally appropriate approaches have already been taken. If necessary, I also escalate situations and issues of concern within Mr Carroll's Division to agree a way forward with the Chief Executive, Senior Management and Trust Board.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

277. Mr Carroll works collectively with the Divisional Medical Director, Clinical Director and Head of Service for Urology, to plan, implement and oversee service delivery, addressing ongoing challenges in terms of demand outstripping capacity, lack of workforce capacity or daily operational issues to be addressed. The Heads of Service for urology (Mrs Martina Corrigan, latterly Ms Wendy Clayton) are line managed by Mr Carroll directly. However, when some of the governance actions required escalation, for example when Mrs Corrigan identified non-compliance with the agreed Return-to-Work MHPS Administrative Action Plan in September 2019 (136. *20191008 AOB Oversight A1 located in S21 53 of 2022 Attachments*), she would have joined the appropriate meeting alongside Mr Carroll. This included attending the Trust Urology review meeting.

Associate Medical Directors /Divisional Medical Directors

278. The Divisional Medical Director of Surgery and Elective Care (DMD) is accountable to the Medical Director to provide assurance around the completion of duties, outcomes and actions. He/she is also responsible to /reports to me as the Acute Services Director. The DMD has responsibility within the aligned Division for the delivery and assurance surrounding all aspects of professional and Clinical and Social Care Governance. In partnership with the Assistant Director, Clinical Directors and Heads of Service, the DMD is also responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

279. From commencement of my post as Acute Director, I met with the DMD, (formerly Mr Mark Haynes, Consultant Urologist, and now Mr Edward McNaboe, ENT Consultant) every 1-2 months to discuss issues and escalate any concerns from a medical perspective. With respect to urology services, the discussion between myself and Mr Haynes and now Mr McNaboe focused on the lack of capacity in urology services and inability to recruit Consultant Urologists, despite repeated recruitment efforts to fill gaps. The specific governance concerns escalated regarding Mr O'Brien and the urology service were addressed in the meetings that were set up specifically for that purpose (noted earlier in this response). Mr Haynes remains a DMD in Urology with a focus on service improvement, with a lead role in ensuring the division maintains high-quality, safe and effective services and works alongside Mr McNaboe (DMD).

Clinical Directors

280. The DMDs are also supported by the Clinical Directors (CD) who sit at Divisional Management Teams and Directorate Senior Management Team. The CD reports to the DMD and has a lead role in ensuring their Division maintains high-quality, safe and effective services and contributes to the Division's strategic direction. They hold delegated responsibility on behalf of the DMD within their areas Division for the delivery and assurance surrounding all

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

aspects of Professional and Clinical and Social Care Governance. Mr Carroll liaises directly with the Clinical director of Urology (Mr McNaboe until November 2021, now vacant)

281. The Clinical Directors and DMD's (all specialities and divisions) attend the monthly Acute Clinical Governance meetings with Assistant Directors from across Acute Services, where all governance related issues are itemised on the agenda.

Consultant and other Clinicians in urology Unit

282. The direct interface with the clinical teams is with the Assistant Director Mr Carroll and through the operational and clinical Senior Team working in a collective leadership style. Since the specific concerns with regard to urology arose, we set up a regular touch-point meeting mainly focused on communication, highlighting that the focus was on the broader governing of our services, rather than on individual clinicians.

Clinical & Social Care Governance coordinator for Acute Services

283. The role of the Clinical and Social Care Governance Coordinator is to work across the multidisciplinary senior teams in Acute Services to identify risks, develop and host Risk Registers, oversee compliments and complaints, patient and family interfaces and responses, to have oversight of all incidents reported and screening of serious cases of concerns against Serious Adverse Incident threshold. Progressing SAI investigations/reviews and report writing with feedback to patients, families and HSCB/SPPG and deliver learning and action plans for implementation of recommendations.

284. When I took up the post of Director, I assumed line management of the Clinical and Social Care Governance Coordinator. Dr Tracey Boyce, Director of Pharmacy, who was also part of the Acute Management Team (until 31 January 2022) covered the Clinical and Social Care Governance Coordinator post for approximately four years In addition, to her substantive role as Director of Pharmacy. Subsequently, Trudy Reid became Clinical and Social Care Governance Coordinator, then Patricia Kingsnorth and since July 2021, Mr Chris Wamsley.

285. A review of Clinical & Social Care Governance structures has been underway since 2019 to realign and strengthen structures for improved assurance. 137. *20190513 Terms of Reference Clinical and Social Care Governance Review, 138. 20190801 Draft Report Clinical and Social Care Governance Review, 139. 20190925 Clinical and Social Care Governance Review Response*

286. Urology services are also interlinked with Cancer and Clinical Services Division. Consequently, I offer the same supervision and oversight

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

arrangements to Mr Barry Conway, Assistant Director, Cancer and Clinical Services and Dr Shahid Tariq, Divisional Medical Director, Cancer and Clinical Services.

Explain all lines of management and accountability for matters of patient risk and safety and governance

287. The governance of urology service is undertaken on a daily basis by the operational teams who escalate any issues of concern with regard to patient safety or staff for discussion and agreed actions.

288. I chair the Acute Governance monthly meetings with Assistant Directors and the Clinical and Social Care Governance Coordinator (CSCG) Mr Chris Wamsley, which allows for issues to be specifically discussed. Data reports and trend analysis are provided for this meeting by the Clinical Social Care Governance Coordinator and Senior Clinical Audit Facilitators (Mr Raymond Haffey and Mr Colum Robinson) including clinical audits, annual audit plans, recorded volumes and severity of incidents (Datix is the electronic system used to report and host investigations and status of all incidents until closure), Serious Adverse Incidents (SAI's), ongoing SAI reviews and application of learning, research, audits, best practice standards and guidelines.

289. In addition, I chair a fortnightly Standards & guidelines meeting with the Assistant Directors, Quality & Safety Manager for Standards & Guidelines (Mr Chris Warr, previously Mrs Caroline Beattie and Mrs Joanne Bell), Governance Pharmacist (Jillian Redpath) and CSCG Coordinator.

290. On a monthly basis, I chair the Acute Clinical Governance meeting with the Assistant Directors, the Clinical Social Care Governance Coordinator, Divisional Medical Directors and Clinical Directors from all specialities across Acute Services including urology. This forum allows all governance issues, data and trends on complaints, Datix Incident reports detail to be shared, best practice to be highlighted, SAI reports to be discussed, debated and approved and Action Plans for learning agreed.

291. Any governance issues of concern are escalated to these meetings for discussion and action across members. Any further escalations are reported by me to Medical Director, SMT, Governance Committee and Trust Board as appropriate. For example, once the serious governance concerns regarding the practice of Mr O'Brien were identified, I implemented and chaired a weekly meeting with the Medical Director, Dr Maria O'Kane, Deputy Medical Director, Dr Damian Gormley, DMD, Mr Mark Haynes, AD, Mr Ronan Carroll, and HOS for Urology, Mrs Martina Corrigan, to further scope the issues.

292. In addition, The Trust is held to account on operational and governance issues relating to patient reviews and urology services by both the HSCB/SPPG and Department of Health through the Urology Accountability Group (UAG) (124. *20201023 Ltr re UAG A)*.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Q33. 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?
Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

293. The day-to-day governance responsibility sits with the collective leadership team composed of the Assistant Director (Mr R Carroll) and Divisional Medical Director (Mr M Haynes) and more recently Mr E McNaboe has joined as DMD alongside Mr Haynes. They work with the Clinical Directors (previously Mr McNaboe, now a vacant post) and the Head of Service Martina Corrigan until October 2020 and since then, Wendy Clayton to support the governance agenda across the team.

294. Similar to the 4 themed areas I have highlighted in my role; Workforce, Governance, Performance and Finance, these are mirrored in the operational/clinical governance team meetings and reflected in appropriate agenda items. For the most part the team deal with operational and clinical governance issues, escalating to me any concerns that they cannot resolve. Mr Carroll had the opportunity to discuss concerns or issues of a governance nature individually with me, at planned 1:1 or by requesting a meeting with me. Likewise, the DMD has the responsibility to escalate any governance concerns separately, with or through the Assistant Director, with discussion and agreed actions afforded as a result. In addition, an informal opportunity exists on a daily basis for phone calls or discussions in relation to daily issues or issues which the AD's require support with.

295. Some of the leadership dimensions of my role are "Evaluating Effectiveness" "Drive for Results" and "Holding to account" which allows challenge where further assurances are necessary. I chair a monthly Acute Governance meeting for all Assistant Directors, Director of Pharmacy and CSCG Coordinator. This presents the opportunity to share data across the range of governance issues, allowing data trends to be highlighted, actioned and agreements made regarding further governance actions required across teams. Any changes or areas of concern are fed into these meetings and followed up at subsequent meetings regarding progress and outcome.

296. I also chair the Monthly Acute Clinical Governance Meeting with the Assistant Directors, the Clinical Social Care Governance Coordinator, Divisional Medical Directors and Clinical Directors from all specialities across Acute Services including urology. This forum allows all governance issues, data and trends on complaints, Datix Incident reports detail to be shared (Datix is the electronic system used to report and host investigation and status of all incidents until closure), best practice to be highlighted and SAI reports to be discussed, debated and approved and action plans for learning agreed. Any governance issues of concern are escalated to this meeting for discussion and action across members. Any further escalations necessary are reported by me

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

to Medical Director, SMT, Governance Committee and Trust Board as appropriate.

297. I get assurances across these range of meetings and verbal assurances from each of the staff members as appropriate. Comparisons and benchmarks internally and regionally are available for a range of domains across the data sets including trends upwards and downwards, complaints, compliments, incidents and SAI review outcomes to help inform actions.

298. The Acute Clinical & Social Care Governance Coordinator, Chris Wamsley works closely with the team to guide and support across the brief of the governance agenda including dealing with complaints, incident reporting, screening cases of concern to identify if the threshold of Serious Adverse Incident (SAI) has been met, overseeing SAI investigations/reviews and report completion, liaison with families and Health and Social Care Board to submit approved reports and oversee implementation of related action plan to address recommendations.

299. The CSCG Coordinator is responsible to me as Acute Director for supporting the processes surrounding defined Clinical & Social Care governance activity within the directorate. He also is accountable to the Assistant Director CSCG (Medical Directors Office) and to the Medical Director for ensuring that CSCG processes are delivered in a consistent, equal and transparent manner across all services. All of these are mechanisms to oversee and gain assurance that the governance arrangements are appropriate and effective and allowing opportunity to challenge and redress any areas of concern.

Q34. 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?

300. The Institute of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Therefore, my response to this question embraces patient experiences, access to services, waiting times, quality of care delivered, patients safety domains, quality improvement initiatives, learning and consideration against local, regional and national benchmarks. This requires many approaches built into the operational and clinical work plans, supported right across the Trust by bespoke teams including “Patient Experience” “Nursing Quality Assurance” and performance teams, critically supporting and evaluating the Directorate’s performance and taking corrective action to maximise performance against specific objectives and goals for Improvement.

301. Quality and performance are inextricably linked. My quality oversight of the urology service is focused firstly on 1:1 meetings and supervision of staff, affording an opportunity to escalate any issues or concerns with regard to service areas. This allows for discussions with regard to the ability of the service

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

to deliver against required performance levels as set out by the Commissioner. In these discussions, there is a recognition that the performance of the service is constrained by the available workforce.

302. There is a daily focus on quality related to performance levels as informed by referrals in, triage, trends in cancer pathways, clinic volumes, "do not attend" rates, waiting lists and waiting times. This is monitored through the Operational Support Lead's for each cancer speciality/division and liaison with the Head of Service and Assistant Director. This data is discussed in a range of multi-disciplinary meetings chaired by the Assistant Director of SEC/ATICS Mr Carroll and/or Barry Conway AD CCS, throughout the month including Speciality Tumour Site and Cancer Pathways meetings with medical colleagues in attendance.

303. With regard to compliance with performance targets, I chair the Acute Performance Meeting with Assistant Directors and the Assistant Director/Head of Service from Performance and Reform Corporate team. This forum analyses and discusses compliance against a range of targets, actions for implementation are agreed as appropriate and service activity levels against planned clinics and theatre lists are monitored. It also considers the performance of the Independent Sector providers with whom we contract. It does not consider individual Clinicians' performance, rather a composite picture of all specialities including the urology service.

304. Performance targets from SEC and ATICS that are escalated to me as Director of Acute Services include Red Flag cancellations and the reasons for the same, underutilisation of WLI funding, underperformance of Independent Sector contracts and services that are not meeting estimated activity as projected in the Rebuild plans. For Cancer Services, waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets are also escalated. 140. *20220516 31- and 62-Day Cancer Performance for Urology Tumour Site located in S21 53 of 2022 Attachments,*

305. There is also a Corporate Performance Committee which is a subcommittee of the Trust Board. I am required to attend by invite when specific issues relating to the Acute Directorate are under scrutiny. The corporate suite of performance data is shared and discussed within that Committee with escalation to Trust Board as required.

306. As Director I am a member of the regional interface meetings with Health and Social Care Board (HSCB now known as Strategic Planning and Partnership Group, SPPG) with Assistant Directors, Heads of Service and Operational Support Leads. These meetings consider waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets, among other issues. 140. *20220516 31- and 62-Day*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Cancer Performance for Urology Tumour Site, 141. 20210520 Performance Committee Cancer Presentation located in S21 53 of 2022 Attachments

307. The link with quality and governance is also fundamental. The issues discussed in the Governance meeting includes identification of risk, development of controls and mitigating actions for inclusion in the risk register, monitoring complaints, compliments, serious adverse incidents and all incidents recorded.

308. Where actions are agreed to improve assurances in relation to quality, performance and governance, these are monitored in line with intended impact at subsequent meetings. Despite workforce challenges, capacity issues, delays in access to services and treatment times in urology services, resulting in unacceptable waiting times and backlogs with risk of harm to patients, I was assured that all necessary steps to increase capacity and improve quality were being taken across a committed team.

309. The response to patient complaints often detailed the context which the team were operating within, which undoubtedly was a factor behind many complaints. There have been two specific issues regarding quality of services that required focused attention during my tenure to date. The first was the staffing issues in Ward 3 south (urology), detailed earlier, regarding workforce and capability challenges which required achieving assurances at a higher level on nursing quality (10. *20190904 Q7.43 3 South Trust Risk Assessment located in S21 53 of 2022 Attachments)*. The second related to the clinical concerns raised on scrutinising the issues regarding Mr O'Brien, following the June 2020 escalation of concern by Mr Haynes (34. *20200611 Pts to be added to UBL located in S21 53 of 2022 Attachments*). I had no other concerns regarding quality of care in urology services

Q35. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

310. Performance metrics in urology include patient experience, access to services, waiting times, quality of care delivered, patients safety domains, quality improvement initiatives and comparisons against local, regional and national benchmarks. These are built into the operational and clinical work plans, supported right across the Trust by bespoke teams including corporate teams dedicated to performance & reform, "Patient Experience" "Nursing Quality Assurance" and performance indicators.

311. Overseeing performance is one of the 4 key aspects in my acute operational plan with themed meetings on Performance, Governance, Human Resources and Finance. There is a daily focus on performance levels as informed by referrals in, triage, trends in cancer pathways, clinic volumes, "do not attend" rates, red flag cancellations, waiting lists and waiting times. This is monitored through the Operational Support Lead for each cancer speciality/division (OSL) and liaison with the Head of Service and Assistant Directors (21. *20220509 Q7.50 Acute Performance Report - Performance*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Committee located in S21 53 of 2022 Attachments). This data is discussed in a range of multi-disciplinary meetings chaired by the Assistant Director of SEC/ATICS Mr Carroll and/or Barry Conway AD CCS throughout the month, including Speciality Tumour Site and Cancer Pathways meetings with medical colleagues in attendance. Specific to cancer services, waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets are also escalated to me. 140. *20220516 31- and 62-Day Cancer Performance for Urology Tumour Site located in S21 53 of 2022 Attachments*

312. As Director I oversee the various strands. I chair the Acute Performance monthly meeting which is my mechanism to monitor the performance agenda by bringing together the Assistant Directors, OSL's and corporate officers, to critically support and evaluate the Directorate's performance, compliance with targets and agreeing remedial action to maximise performance. This includes service activity levels against planned clinics, theatre activity and performance of the Independent Sector providers with whom we contract. The minutes of the meetings and agreed actions are discussed in the follow up meetings and matters arising raised. Assistant Directors are responsible for holding their teams to account to deliver and improve the performance metrics. This meeting does not consider individual Clinicians' performance, rather a composite picture of all specialities including the urology service.

313. There is also a Corporate Performance Committee which is a subcommittee of the Trust Board. I am required to attend by invite to offer assurances when specific issues relating to the Acute Directorate are under scrutiny. The corporate suite of performance data is shared and discussed within that Committee with escalation to SMT and Trust Board as appropriate, regarding concerns and actions taken or required.

314. The Integrated Elective Access Protocol (IEAP) is a regional guidance document developed to encompass the scheduling/booking processes of patients on the elective care pathway. It outlines the guiding principles for the management of patients, in particular for out-patients, surgery, diagnostics and cancer pathways. This protocol is actively implemented, monitored and reported on as part of the performance agenda and for active management of the processes embedded in Acute Head of Service and Operational Support Lead work plans and the booking centres management processes. In the 2008 version of the IEAP the Ministerial targets were outlined as stated below:

- Outpatients 9 weeks from receipt of first referral appointment;
- elective inpatient/day cases 13 weeks from date a patient is added to the waiting list;
- Cancer targets;
- 14-day – 100% for the 2-week wait breast symptomatic outpatient appointment;
- 31-day – 98% from date decision to treat to first definitive treatment;

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- 62-day – 95% date of receipt of referral to first definitive treatment;
- Diagnostic 9 week wait from receipt of referral.

315. The refreshed 2020 version of the IEAP (74. *20200615 Q11.97 OSL Comments re Draft IEAP located in S21 53 of 2022 Attachments)* is used by the Acute Senior Management Team to assess performance and quality of services the Trust offers. The Head of Administrative Services who is responsible for the Referral & Booking Centre also actively applies the targets. These operational staff are fully involved in scheduling patients, partial booking, escalating capacity gaps, appropriateness of virtual clinics and smoothing patient pathways across waiting lists, in line with approved procedures in managing elective referrals to first definitive treatment or discharge. This includes the clinical and chronological management of patients to be treated on the basis of clinical urgency, with urgent patients seen and treated first. Patients with the same clinical need will be treated in chronological order on grounds of fairness and to minimise waiting times for all patients.

316. When I came into post as Director of Acute Services, it was apparent that the urology service, like many other specialties within Acute Services, were unable to meet the specific targets outlined in the IEAP due to capacity and demand issues, as well as workforce issues. With specific reference to urology services, waiting times were reviewed and actions taken where possible to address. These included approving 'in-house' additionality for urology services (Consultants incentivised to do additional clinical activity), funded via non recurrent "waiting list monies" from the HSCB for outpatient activity, inpatients and or day case activity. In addition, the Trust engaged with the Independent Sector (IS) to undertake agreed volumes of clinical activity, when additional non recurrent waiting list monies from the HSCB was agreed.

317. The data, trends and issues were shared with the urology teams and HOS by Mr Carroll, AD and with the Acute Cancer Performance Meetings by Mr Conway, AD. I as Director shared these with corporate Performance SMT Meetings and they were discussed at the Regional Performance & Issues Meeting and the Regional Cancer Performance HSCB/SPPG meeting (all informed by the underpinning principles of IEAP).

318. With respect to the impact of the targets on the management of quality urology services, the referrals to the service for out-patient consultation are in excess of the current commissioned capacity which has led to increased numbers of patients on the waiting list and lengthening waiting times. In addition, the waiting lists have been growing year on year, as evidenced in an earlier response, for in-patient and those in need of day surgery. The combination of increased demand and workforce challenges results in an inability to deliver against performance targets. The urology service is unable to achieve the required 62-day cancer standard of 95%. This is attributable to the demand for red flag referrals being greater that the capacity within the service to enable patients have their first definitive treatment by day 62. In

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

relation to time limits not being met, there are a number of actions that have been taken as a result:

- The in-patient/day case planned backlogs, which include Urology, have been on the Divisional Surgery and Elective Care risk register from October 2016, and the access waiting times for outpatients and inpatient/day cases have been on the Divisional risk register from April 2019 (82. *20190607 Clinical and Cancer Services Risk Register, 81. 20190607 Surgery and Elective Care Risk Register located in S21 53 of 2022 Attachments*);
- The Cancer performance is on the Directorate risk register due to cancer pathway capacity issues in Urology and other tumour sites. *(80. 20220301 Acute Services Directorate Risk Register located in S21 53 of 2022 Attachments*);
- The ongoing increase in demand pressures within the urology service has been raised with the Commissioners and a business case / Investment Proposal Template (IPT) for a seventh consultant urologist was developed in October 2020 with the aim to reduce the gap between capacity and demand and the time patients wait to see a consultant urologist (91. *20201001 Q16.138 A1 IPT - Expansion of Urology Services - 7th Urology Consultant located in S21 53 of 2022 Attachments*);
- Independent sector contracts have been established and continue for new out-patient urology referrals with ongoing care and treatment where possible;
- Ongoing Regional capacity initiative through Regional Priority Group (RPOG) - the purpose of the group is to equalise the waiting time for clinically urgent patients across Trusts. 142. *20211004 RPOG Meeting Notes located in S21 53 of 2022 Attachments*

Q36.1 How did you assure yourself regarding patient risk and safety in urology services in general?

319. In general, assurance requires me to be confident in both individual clinicians and the team's ability to deliver on reducing risk and keeping patients safe. I was assured that all operational approaches within urology services (as detailed in question 35) were being maximised to address the performance in the service, despite the many challenges regarding demand, capacity, workforce and risk of patient harms with delays in accessing assessment and treatment.

320. With specific reference to patient risk and safety in urology services, my first challenge came in October 2019. Mrs Corrigan (Head of Service) had escalated concerns to Dr Ahmed Khan and Siobhan Hynds in September 2019, subsequently notified to me by Dr O'Kane on 4 October 2019 (136. *20191008 AOB Oversight A1 located in S21 53 of 2022 Attachments*). There were reported breaches with two of the four elements relating to administrative processes in the Action Plan agreed following the MHPS formal investigation, regarding triage of referrals, contemporaneous note keeping, storage of

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

medical records, and private practice. I was informed by Mrs Corrigan that this was the first breach detected by her following ongoing monitoring for a 2-year period. Ongoing monitoring was agreed as part of the assurance going forward and this continued with no other non-compliance noted in this regard until Mr O'Brien retired in July 2020.

321. For the year 2020/2021, my key objectives in my Individual Performance Review, agreed with the Chief Executive (Mr Shane Devlin), included ensuring maximum patient safety and best outcomes for care delivery for patients during the pandemic which had taken hold in our community. It also included addressing the urology concerns first escalated on 11 June 2020, with a focus on patient safety and quality care (128. *20200323 Melanie McClements Individual Performance Review 20-21 located in S21 53 of 2022 Attachments*). An early alert was completed and submitted (*Early alerts are a process of escalating to Trust Board, SPPG and Department of Health, issues which may be of regional media interest or where patients might have come to harm*).

322. Throughout the year, I implemented a work plan and monitored progress on the patient safety and risk issues that were raised. This included weekly/fortnightly Trust Urology review meetings, HSCB meetings and DOH Urology accountability meetings. At each of these meetings a live picture of the various patient cohorts was shared, describing those identified, stratified and prioritised for review in line with potential for risk and harm aligned with available capacity to review the patients. The urology clinical team, in particular Mr Haynes was actively involved in working with the operational team to identify clinical risk, offer patient reviews, face to face or desk top and ensuring patients were on the correct treatment plan or if required, transferred to an alternative pathway. A series of questions were devised, based on learning from BHSCT and HSCB to standardise the patient assessment and review. Whilst 4 questions was the minimum dataset required for patient safety assessment, 10 questions were used by Mr Haynes and Professor Sethia (Subject Matter Expert commissioned form England), facilitating a more comprehensive, historical review of care and treatment to those patients.

323. I oversaw the operational team devising and implementing patient reviews for patients who had been under the care of Mr Aidan O'Brien for the January 2019 to June 2020 period. A work plan to meet evolving requirements for patient and staff was implemented, governance arrangements were embedded including risk identification, adding same to risk register with mitigating actions, Serious Adverse Incident screening and investigations were completed. Early learning from SAI's was shared with the clinical teams and the Acute Clinical Governance meeting. As part of sharing the learning came the expectation of embedding that learning within each Division in the Directorate by the operational and clinical team.

324. A Task and finish group was established focused on implementing the overarching recommendation of the 9 Urology SAI's completed by the external panel chaired by Dr Dermot Hughes (2021) (120. *20211011 TOR Trust Task and Finish Group into Urology SAI Recommendations located in S21 53 of 2022*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Attachments). All of this was part of the plan to ensure learning, reduce risk and improve patient safety.

325. Acknowledging further investment was required to address the recommendations of the SAI's, such as the need for additional support for Multi-Disciplinary Meetings (MDT's), additional speciality input to MDT and greater benchmarking with national standards, I coproduced an investment plan developed to submit to HSCB/DOH to enable improvement of services (90. *20210329 Q16.137 IPT - Staffing Support Requirement for SAI Inquiry – Urology located in S21 53 of 2022 Attachments*).

326. In year 2021/2022, the subsequent IPR focused on developing the actions from the previous year, including completing a further range of patient reviews, embedding governance arrangements and monitoring the implementation of the Urology SAI recommendations working with Cancer and Clinical Services. The Trust Urology Structured Clinical Record Review (SCRR) process has replaced the standard SAI review process for cases identified via the Urology lookback that meet the set criteria that is in place for a SAI review. This was agreed with the Department of Health to replace the Serious Adverse Incident process and involves an external clinician reviewing the patient pathway and treatment plan to ascertain if further patient review is required. 122.-123. *20210426 Structured Clinical Rec Rev A1-A2 located in S21 53 of 2022 Attachments*

327. The patient safety and risk elements escalated within the urology service and the related governance and learning have implication for systems and processes across acute services.

Q36.2 What systems were in place to assure you that appropriate standards were being met and maintained?

328. The systems to assure that standards are being met include Nursing Quality Indicators, IEAP protocol and monitoring against targets with agreed action as cited above and discussed at performance and governance directorate meetings in acute. Assurances and/or escalations from AD's is an important mechanism to assure that appropriate standards are being met and maintained.

329. In addition, there is an expectation in line professional and regulatory standards, that each registered clinician regardless of discipline is up to date with evidenced-based practice and applies all relevant guidelines to their specialty area. On a monthly basis, I chair the Standards and Guidelines group which considers all new guidance and agrees change leads and a process to implement the new standard or guideline. A process of compliance is embedded to monitor practice, audits and implementation of learning. This is subsequently reported to the HSCB and Trust Board.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

330. Each MDT chair completes an annual business report with support from Mrs Mary Haughey, Cancer Services Improvement Lead. This was the opportunity to highlight gaps in the service model. Some of these were shared with Mr Barry Conway but not all. The total picture would have been helpful. Some feedback included the need for additional clinical audit support to assess compliance against guidelines. Whilst this was not in place at the required level due to funding constraints, a Clinical Audit and Information Officer is now in the process of being recruited. As an interim measure, the recently appointed MDT Chair Business Support Officer, Angela Mulgrew, carries out sample checks post urology MDT to validate actions agreed and taken at MDT meetings. 143. *20201105 Q36.2.330 Urology MDT Annual Report 2019 located in S21 53 of 2022 Attachments*

331. In addition, a new process for the past 6 months has been in place cross referencing cancer diagnoses through cellular pathology and discussion at Cancer MDT. This means that there is now an expectation that all reported cancer diagnosis should be brought to the MDT meeting and if not, the cases are highlighted and brought to the attention of the MDT chair to ensure these are escalated for discussion.

332. Following the specific concerns with regard to Mr O'Brien, Dr O'Kane conducted discussions with the GMC employer liaison service and the case was discussed with NHS Resolutions who recommended restrictions of clinical practice. These restrictions were put in place by the Trust preventing Mr O'Brien from undertaking clinical work within the Trust and denying him access to patient information. The Trust also requested that he voluntarily undertook to refrain from seeing any private patients at his home or any other setting and asked him to confirm the same in writing. A preliminary discussion was also undertaken with the Royal College of Surgeons Invited Review Service regarding Mr O'Brien's practice and the potential scope and scale of any further lookback exercise which may be required.

333. The Trust Urology Patient Review Group which I chaired, assessed the findings of the initial lookback exercise from August 2020 and explored the potential need for a further lookback exercise in the context of the concerns emerging. The Review Group looked at the timeframe from 1 January 2019 until 30 June 2020 and during this time there were a total of 2,327 patients identified as being under his care. The Review Group identified the most vulnerable group of urology patients within this cohort and concentrated on these patients initially. The areas of concern related to:

- elective and emergency activity;
- radiology, pathology and cytology results;
- patients whose cases were considered in Multidisciplinary Team Meetings;
- oncology;
- The prescribing of a drug, outside of established NICE guidance in the management of prostate cancer.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

334. An action log was kept of all issues to ensure we remained focused on all issues, patient cohorts, priority, areas of risk and communication issues (144. *20220523 Action Plan Internal Lookback Review Group located in S21 53 of 2022 Attachments*).

335. 9 cases were identified that met the threshold for a Serious Adverse Incident review and patients and / or their families were contacted to inform them and the reviews were completed. The Royal College of Surgeons were asked to carry out an independent review of a sample of the clinical cases included in the initial lookback exercise to determine whether a further, more extensive, lookback or patient recall by the Trust was required. Currently this is being extended from the original 18 months to a 5-year lookback.

336. A Urology Information Phone Line was established to encourage anyone concerned to come forward, to extend a further opportunity to assure regarding patient safety. The Trust also implemented a patient support package to include counselling and psychological support, alongside provision of family liaison and related support services, in line with best practice and evidence-based quality care.

Q37. How could issues of concern relating to urology services be brought to your attention? What systems or processes were in place for dealing with concerns raised?

337. There are a range of ways that issues of concern relating to urology services could be brought to my attention. Firstly, I have an open-door policy for any staff member to arrange to meet me or to call into my office opportunistically if I am available. I would ensure active listening on any issues raised and would endeavour to follow up depending on the issue and level of concern. I would implement any relevant policies such as Raising Concerns (previously known as Whistleblowing), if appropriate, and ensure learning or any actions necessary were embedded.

338. From a staffing perspective, I carry out 1:1 meetings with Mr Carroll and Mr Conway from the Cancer Clinical Services interface perspective. This affords them the opportunity to escalate any issues and work with me to agree the best way to approach going forward. This method has been successful for both Assistant Directors who raise concerns in particular with regard to access, capacity, workforce challenges and impact on service users. An example of this is the creation of a second Assistant Director, dedicated to Integrated Maternity & Women's Health, previously covered by Mr Conway. Reducing his AD responsibilities has created capacity for him to dedicate increased time to the cancer and clinical service teams. The service improvement work focused on improving the MDT model (post April 2021x 9 SAI's) was facilitated by Mr Conway having greater availability to oversee, develop and support the teams. The impact of this is already being felt in terms of improved quorate attendances and compliance with outcomes agreed post MDT.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

339. In line with the four themed approaches to Human Resources, Performance, Governance and Finance, I chair monthly meetings which addresses issues both from planned agenda perspective and allowing the opportunity for discussion on issues and also for any other business to be opened to all members. This is a successful method for an interactive discussion on concerns.

340. The Acute Clinical Governance (ACG) Meeting has a wider membership across Assistant Directors, Divisional Medical Directors, and Clinical Directors which also creates the opportunity for discussion and the raising of any other concerns. The range of MDT's where professional colleagues discuss patients' conditions and appropriate treatment pathways affords the opportunity to challenge and raise concerns regarding suggested alternative viewpoints. This process relies heavily on the accuracy of the information presented, attendance from a range of professional groups willing to offer their perspectives and on timely application of agreed patient pathways. In addition, the range of roles to support patients on their journey needs to be fully maximised including specifically the Clinical Nurse Specialists (CNS). This post is designed to offer an additional support to patients and is a failsafe mechanism to ensure good communication and follow up.

341. Monthly, I chair a meeting with Trade Union Colleagues (Joint Operational Forum) which allows each Assistant Director to update on service issues, staffing related issues and any proposed changes to services. The trade union colleagues also take the opportunity to escalate any concerns they have on behalf of their members who are indeed our staff. An example of this specific to urology was the opportunity to advise of the Public Inquiry and to offer assurances to them that we were in direct communication with our teams and were working together to implement recommendations and service improvement approaches going forward.

342. Corporately in my Director role, if issues relating to urology services have been brought to my attention, I would further escalate these to the Medical Director, Chief Executive, Performance Committee, Governance Committee, SMT and/or Trust Board as appropriate. I have evidenced during my tenure, appropriate escalation of issues and assurances regarding processes to improve patient safety. An example of this is the significant patient reviews which have been instigated following the June 2020 concerns relating to Mr O'Brien. Keeping SMT and Trust Board appraised of the patient issues, the themes identified including some patients needing to be moved to evidence-based treatment pathways, the capacity issues and the mechanisms employed to enable higher levels of reviews to be completed and offering assurances of our focus on patients and their families. 146. *20201116 TB Paper A located in S21 53 of 2022 Attachments*

343. Email communication has also become a mechanism for highlighting concerns. In my opinion, this has been the most likely way that issues have been escalated with regard to urology, for example, this was the mechanism

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

chosen by Mrs Martina Corrigan in September 2019 to notify Dr Ahmed Khan (Case Manager) of the breach in agreed actions by Mr O'Brien regarding administrative processes. (I had this email forwarded to me on 4 October 2019 by Dr O'Kane) (136. *20191008 AOB Oversight A1 located in S21 53 of 2022 Attachments)*. It was also the mechanism Mr Haynes used in June 2020 (34. *20200611 Pts to be added to UBL located in S21 53 of 2022 Attachments*) to highlight the anomaly with the block entry of patients onto urgent waiting lists. There's also the potential for staff to opportunistically have a conversation in the corridor, but in my experience this method has not been used when there are serious issues of concern. If it was, I would ask for a more formal meeting or written communication.

344. Finally, the formal meetings that were set up specific to urology including the weekly Trust urology review meeting, urology oversight meeting and laterally the Lookback Review meetings would be main vehicle to escalate any ongoing concerns identified specific to urology services.

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?

345. From a service user and carer perspective, I regularly get calls into my office or via the Chief Executive office requiring me to call back or to delegate follow up to Assistant Directors or Heads of Service. I do not recall ever receiving urology concerns through this route.

346. The formal and informal complaints process has been used to express dissatisfaction with some element of urology service, normally related to delays in accessing treatment. If a phone call or an inquiry is made regarding service issues, I would respond directly in anticipation of being able to resolve the issue at source. If that is not possible, I would advise on our formal complaints process and ensure the complaints team (sits within the Governance Structures) forwards the appropriate details to the complainant and supports the complaint response and embedding of learning to prevent recurrence where possible.

347. Family meetings or meetings with individual patients are planned when they wish to share the details of their experience or concerns with our staff members, in such cases, we would extend an invite to members of the clinical and operational teams to fully, openly and transparently discuss the issues. Often this enables resolution, ultimately, where patients or their families remained dissatisfied with our complaint response, they can proceed to the Northern Ireland Ombudsman to seek resolution with their support.

348. The Trust has progressed the Care Opinion web-based service which gives service users and families the opportunity to comment on their experiences in our care both positive and negative. Where there is a specific concern, the staff can respond and advise of any service change they would

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

make as a result. Monthly reports are disseminated from the website for Director Oversight.

349. One of the recent developments within the Trust, specific to urology, has been the implementation of the Family Liaison Service (30. *20201020 SAI offer of support located in S21 53 of 2022 Attachments)*. Officers were appointed and dedicated to the patients and families of the urology SAI's (the 9 external SAI's supported by Dr Dermott Hughes). This has proved very beneficial to patients and their families and the mix of home visits, phone contacts, and letters has enabled a range of other issues and expressions to be made for example whilst the family were aware of the Serious Adverse Incident, they had broader concerns regarding their experience across community and primary care. Whilst these were not directly relevant to the Trust, some context could be shared and the offer of communicating the concerns further with, for or by the families themselves. One of the successes of this approach has been two service users joining the Service Improvement Task and Finish to influence better communication with patients and families and ultimately, influencing a better service going forward as this demonstrate the Trust commitment to be a learning organisation.

350. Patient Client Council (PCC) is a regional organisation who offers support to members of the public and either directs them towards the Trust or advocates on their behalf to the Trust where they have concerns regarding services. I do not recall any issues specific to urology being raised via this route. In addition, the elected representatives often raise inquiries or concerns on behalf of their constituents or indeed can ask an Assembly Question which comes to the Trust for a response.

351. Two other approaches available that often are linked to dissatisfaction with services are Freedom of Information Requests and Subject Access Request. Both of these are seeking access to information regarding the subject matter or personal access to for example Health Records. Finally, where service users, patients and families feel the Trust and the services therein have done them a disservice they can proceed to litigation.

What is your view of the efficacy of those systems?

352. My personal opinion is there is no one size that fits all. It is important to have a range of options and entry points, to encourage dissatisfaction or poor experiences to be communicated and appropriate action taken by the Trust. Alternatively, where positive experiences are shared, these are cascaded to the relevant teams to celebrate good work and act as a morale booster for the individuals involved.

353. Regarding efficacy, my experience leads me to favour personal phone calls, meetings or feedback with a non-defensive response and an apology and explanation as to perhaps the circumstances on a given day. I say this because this often leaves families happy having had the opportunity for open, honest discussion and whilst it does not do away with the original concern, they feel

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

satisfied that the Trust has listened and is happy to learn and apply the learning to prevent recurrence. This informal process for dealing with concerns is effective for patients, service users, families and staff.

354. Specific to urology, the opportunity for the external panel chair to meet patients and families to advise of the process, to update on a regular basis regarding progress, to be transparent regarding any learning or findings, and to share draft recommendations, in my opinion, allowed the 9 families to trust the process being used and to feel fully engaged in the learning process. I was given this feedback verbally from CSCG Coordinator at that time (Mrs Patricia Kingsnorth). The positive off spin of this is evidenced by the two service users/ family members wishing to be part of the service improvement work. In addition, the support offered by the Family Liaison Officer added a further personal approach and safe place to share ongoing concerns and emotions. This was reported very positively by the families affected.

355. When I came to Acute Services in June 2019, I assumed chair of the Acute Clinical Governance Forum, which has Clinical Directors, Divisional Medical Directors, Assistant Directors and the Clinical Social Care Governance Coordinator in attendance. At this Forum, one of the key agenda items is dedicated to sharing the draft Serious Adverse Incident reports for approval. It is my observation that this was a very healthy mechanism to challenge colleagues regarding the appropriateness of recommendations, the need for amendments, all in the spirit of learning and improving patient safety and better patient outcomes going forward.

356. With regard to formal processes, i.e., Raising Concerns and Formal Complaints, they both have a place when they are the preferred route for raising the issue into the system. The Raising Concerns Policy provides a process for staff who wish to choose anonymity, as not all staff wish to be named as the person raising the concern. Some of the complaint responses can become very protracted if the complainants are not content with their response and may ask for the issue to be reconsidered and if still not happy still seek ombudsman support. Whilst this adheres to due process, as Director of Acute Services it disappoints me that the concern cannot be resolved to the satisfaction of the individual.

357. With specific reference to urology services, there had been staff concerns raised over a number of years prior to my tenure. If the methodologies for dealing with concerns were effective, there should have been an earlier resolution. It would appear that many issues never reached a satisfactory conclusion and perhaps, were not fully explored, monitored or delivered. I say this, probably being better informed now as a result of the ongoing Discovery relating to the public inquiry. For example, the role of the MDT was not adequately resourced to ensure appropriate discussion of patient cases, nor did it always have the correct mix of professionals in the room, nor the capacity to follow up actions outside the 62-day pathway. Patients who were put on to specific patient pathways or required timely diagnostics and follow up were not afforded appropriate monitoring. It is important to note that this forum was not

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

adequately resourced for end-to-end patient care as demonstrated in the recommendations from the 9 SAI's. We now know, there has been significant harm as a result and are now applying improved audits, support for MDT chairs and oversight. In addition, the role of the Clinical Nurse Specialist is now fully embedded in the range of patient interfaces including outpatients and inpatient care.

Q38. Did those systems or processes change over time? If so, how, by whom and why?

358. Many of the systems and processes are standardised and informed by regulatory standards and guidelines including incident reporting, Serious Adverse Incidents, the screening thresholds and investigative processes. The range of mechanisms mentioned earlier, including complaints and MDT and MDT processes, whilst relatively standardised have evolved in response to new methodologies, technology, and improved ways of working or service improvement approaches.

359. The evolution of the approaches to many meetings has been brought about by the learning from complaints or Serious Adverse Incidents, particularly those that impacted on patients and families and the provision of services going forward. Earlier engagement, hearing the story of the patient or family, face to face meetings and personal apologies or approaches are welcomed by many.

360. I had previously been Director in Older People and Primary Care (Community Services) and whilst the same corporate systems and processes apply, their application in Acute Services is slightly different due to patient complexity of acute patients. For example, the role of the MDT does not exist in Community Services, but these meetings if running effectively, play an important role in influencing best outcomes for patients.

361. When I joined Acute Services, I assumed the chair of many oversight groups including performance, governance and specialty meetings including urology. My style of chairing, I believe, encouraged a more open and engaged conversations whereby I stimulated thoughts, raised queries and challenged professional colleagues. The professional-to-professional challenge across the medical fraternity is inspiring where they are both open to and receptive of peer challenge in the interest of patients, resulting in a dynamic model of raising, responding to and addressing concerns.

362. Additional wrap-around mechanisms including the added value from Care Opinion, the establishment of Family Liaison Officers to support patients and their families, and the inclusion of service users in developing service improvements all have contributed to improving systems and processes for dealing with concerns. The learning from the Hyponatraemia related Deaths Inquiry (2018) placed an emphasis on the duty of candour. The work streams related to this within the Trust are ongoing and the need to focus on value-based care and communication, including, honesty, openness, and candour

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

have been driven especially from the Medical Director's office (Dr Maria O'Kane). I believe this is now being manifested at a higher level with some of the developments noted above and with managers and clinical staff being more comfortable with apologising when services have not met the required standard or expectation.

363. The impact of Personal and Public Involvement (PPI) legislation and the Trust PPI work plans has further supported the inclusion of patients and service users in shaping, designing, implementing and evaluating services and approaches in collaboration with Trust staff. This is more the norm, than previously, and indicates the Organisation's commitment to learning and evolving how we work and how we engage.

Q39. How did you ensure that you were appraised of any concerns generally within the unit?

364. My expectation as Director of Acute Services is that any concerns that are not easily resolved should be notified to me and an appropriate process agreed to address those concerns. Some of these will relate to operational issues, some staff concerns and other patients or family concerns or complaints. All of this is based on the appropriate style of listening to, engaging with, and acting on concerns raised. The value base espoused within Health & Social Care of openness, honesty, compassion, clinical excellence and working together is one I have tried to embed across the teams in acute services.

365. I am an approachable and responsive Director who values relationships within and across the team, and accepts whatever concerns that are raised on face value with a commitment to listen, address and resolve. Sometimes concerns can be raised confidentially or of an open nature. Appreciating what the expectation is at the outset for example anonymity is an important factor. All of these qualities work towards a trusting relationship underpinned by integrity and a desire to do the right thing. The Open-door policy I referred to earlier, regularly resulted in staff members calling in to discuss something that was of concern to them.

366. The 1:1 meetings with Assistant Directors and Divisional Medical Directors presented the opportunity to raise any concerns. The range of meetings and fora also presented a further opportunity for me to be appraised of any concerns. I sought frequent updates on previous concerns raised and I also was happy to probe and stimulate discussion on sensitive issues or where more information was required.

367. Specific to urology, after the initial escalation of concerns from Mrs Corrigan in September 2019 to Dr Ahmed Khan, regarding breaches in the agreed action areas of Mr O'Brien's administrative processes, Dr O'Kane forwarded the email to me on 4 October 2019 with an invite to a first oversight urology meeting. This was planned to ensure there was a mechanism to discuss, scope, investigate and progress any concerns using a patient centred approach, to ensure patient safety. These meetings presented the opportunity

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

for me to be appraised of any further concerns identified which were then shared with the urology operational meeting (noted below) as appropriate.

368. The Trust urology meetings flowed from this oversight meeting and were an operational and clinical forum which planned the informed approach to reducing patient risks associated with delays in accessing services, establishing the mechanism for types of patient reviews, timely follow up on agreed actions and compliance with standards and guidelines. This was embedded in the work plan for the patient reviews to ensure patients were on the appropriate pathway.

369. The specific interface urology meetings set up with the clinical and operational teams, also had the Medical Director in attendance and occasionally the Chief Executive joined. This meeting offered another opportunity for me to be appraised of any concerns by the urology staff members. This often related to the need for information and communication with regard to the urology services issues that had been raised, the Public Inquiry expectation, and the potential for lack of capacity and workforce challenges to be conflated with a public perception of inferior service delivery.

370. On a daily basis, there are meetings that take place thrice daily concentrating on the flow of patients through the hospital from ED to discharge. The ward based multidisciplinary team members are welcomed to this alongside the management and patient flow team. This is an open forum to escalate issues and as I regularly attend this meeting, for me to be appraised of any concerns on a variety of issues. These typically related to social issues, family issues, lack of available placements and concern re patient safety if staffing levels were not adequate. In addition, I held huddles at one stage daily and now twice weekly for Assistant Directors to touch base and share any issues of concern and appraise me personally of anything they wished to escalate. I cannot recall a urology service issue specifically being raised in either of these two fora, possibly due to the alternative urology focused meetings being in place.

Q40. How did you ensure that governance systems, including clinical governance, within the unit were adequate?

371. The clinical governance systems that are in place in the management of the urology service in the Southern Area include a focus on effective education and training, audit, personal and public involvement, staff management, clinical effectiveness, information and risk management. Adequate clinical governance is hard to define and relies on the triangulation of data from clinicians, managers, patients and service users and cross reference with the governance indicators such as high volume of complaints, adverse incidents or dissatisfied staff. Despite the arbitrariness of the triangulation process, the Trust, in particular, the Directorate make use of governance benchmarks, regional and national, to identify patient safety, mortality, morbidity and national clinical audits.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

372. When I commenced in Acute Services in June 2019, Mrs Patricia Kingsnorth was the Governance Coordinator and Dr Tracey Boyce was supervising the Clinical and Social Care Governance work plan for approximately 4 years. As Director of Pharmacy, she felt that she did not have the capacity to sustain this function. I fully empathised with her position and following a short period of induction, I assumed responsibility for Clinical and Social Care Governance in Acute Services and line management of Mrs Kingsnorth. I soon became aware that there were capacity issues within the team, and some posts were unfunded within the team. Over the past three years, I have invested in additional posts to support the high volume of complex governance issues across Acute Services including high levels of complaints, incidents and serious adverse incidents, oversight of standards and guidelines implementation and a range patient interface issues.

373. Specific to urology, the oversight of governance systems including clinical governance sat within the collective leadership team including Mr Carroll, Assistant Director, Mr Mark Haynes, Divisional Medical Director and more recently, Mr Edward McNaboe as an Additional Divisional Medical Director in Surgery and Elective Care including urology. The expectation as an operational team is that they will oversee and develop governance arrangements appropriately in line with their job descriptions, cascading down and across the operational and clinical teams.

374. The 1:1 supervisions with both the Assistant Director and Divisional Medical Director offered me an opportunity to discuss any issues of concern. The Clinical and Social Care Governance Coordinator was involved in all Divisions supporting the range of governance issues including incident management, screening cases of concern that met the threshold for Serious Adverse Incidents, working with the operational team to progress SAI reviews and reports to families and the identification of risk and supporting appropriate inclusion within the Divisional and Directorate Risk Registers. The 1:1 supervision that I also held with the Governance Coordinator presented a further opportunity to discuss governance issues.

375. The monthly Acute Governance meetings present data with regard to the range of governance and clinical governance domains allowing trends to be monitored or outlying positions to be highlighted in line with Trust, regional and national benchmarks. Any deviation from these benchmarks is subject to further scrutiny and evaluation. This is exemplified when the escalation of the breach with the administrative action plan was identified, in September 2019, by the establishment of the oversight group with Director of Human Resources, Medical Director and Acute Management Team.

376. Furthermore, when the subsequent concerns were escalated in June 2020, further governance arrangements were put in place including the Trust Urology review group, the purpose of which is to identify the risk across the range of Mr O'Brien's patient cohorts and put in place patient review mechanisms to assure that appropriate treatment pathways are in place.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Weekly communications were established to HSCB and ultimately to the Urology Accountability Group at Department of Health.

377. This is evidence that once clinical governance risk was identified, appropriate approaches were instigated and embedded in line with governance frameworks.

Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

378. I had no concerns that governance issues were not being identified, addressed or escalated. There was a thorough process which included incident reporting, identifying concerns, screening concerns for review against SAI criteria, active engagement with families, progressing complaint responses. I also got evidence on two occasions of effective monitoring against expected levels of compliance and oversight of practice anomalies, both relating to Mr O'Brien.

379. The delay in progressing SAI's from 2016 to 2020 (5 x 2016 cases reviewed by Mr J Johnston) I believe prevented earlier pick-up of issues regarding the care given by Mr O'Brien to patients. I became aware of this delay on 10 September 2019, when the Clinical & Social Care Governance Coordinator (Patricia Kingsnorth) brought to my attention for the first time that there were five 2016 Serious Adverse Incident reviews, relating to urology which had not yet been completed by the external panel. These were subsequent to an Index case Patient 10 (2016). All were patients of Mr O'Brien.

380. I also feel if there had been greater transparency and openness regarding previous issues before my tenure, there could have been a greater identification and action with regard to concerns. I also feel the 28 records found in Mr O'Brien's office once he retired and the range of results and reports requiring his approval could and should have been escalated by his secretary. He retired in July 2020, Covid-19 hit in March 2020, with many staff working from home. I am unsure if this was a causative factor but the organisation should have contingency arrangements to prevent such eventualities.

381. Mr Carroll has indicated to me on a couple of occasions that one of the things that kept him awake at night was the lack of capacity to fully focus on governance issues within his Division. An example of this was the inability to progress action plans and implementation of recommendations following Serious Adverse Incidents or to deal with the volume of incidents that required active management and the complex complaints that required attention. There was a review of Clinical and Social Care Governance corporately in September 2019 which looked at the system within the Trust and the potential to realign structures and increase resource available for the clinical and social care governance function. It was my hope that this would present the opportunity for additional support into the operational Directorate teams.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

382. Whilst the proposals of the 2019 Review were presented to SMT in September 2020, they were not fully accepted and required further work with regard to the corporate vs operational implementation of same. In November 2021, a further presentation to SMT agreed to establish a Clinical and Social Care Governance working Group to strengthen assurance mechanisms and to realign the resources into a corporate team to facilitate standardisation and equalisation of processes and workloads, with delivery arms within each operational Directorate. 137. *20190513 Terms of Reference Clinical and Social Care Governance Review, 138. 20190801 Draft Report Clinical and Social Care Governance Review, 139. 20190925 Clinical and Social Care Governance Review Response located in S21 53 of 2022 Attachments*

383. In the interim, I was conscious of the request for additional governance support within each Division, and in the absence of adequate commissioned governance posts, I realigned some support from the recently established Quality Improvement team in Acute Services, to support the Assistant Directors and Heads of Service to address some of the backlogs in incidents and action plans. This was in place from summer 2021 and by May 2022 I had secured investment for 4 Divisional Governance Officers, 1 for each Division which as I write are in recruitment.

384. Acknowledging that there had been escalated concerns to me about the lack of capacity to fully address governance, I was concerned that there was potential risk of inadequate identification of governance concerns and thus, the potential for lack of appropriate action to address and escalate same. That was my driver, for allocating interim resource and remaining focused on this unmet need until I had secured the resource to progress to recruit the governance posts. It was my expectation that the 4 pillars of operational management, namely, performance, governance, human resources and finance all had equal priority and therefore the operational team were aware of the need to afford dedicated time for identification and prioritisation of governance issues.

Q41. 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.

385. Concerns raised by the Clinical and Management Teams were discussed with the Clinical and Social Care Governance Coordinator, risk assessed and control mechanisms/mitigations were included in the Divisional and Directorate Risk Register as appropriate. For example, since September 2012 an inability to meet the performance standard for 62-day cancer performance was entered into the Acute Directorate Risk Register, this remains on the register and is updated regularly. In October 2021, it was recorded, that all tumour site pathways continue to have capacity problems affected by the ongoing pandemic, referral levels for the majority of tumour sites have continued to increase and are now back to pre-Covid-19 levels or higher. Most are affected by limited access to Surgery and the Trust participates in regional equalisation meetings to review priority patients and decisions regarding allocation of theatre sessions across the region. Fortnightly cancer checkpoint

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

meetings involving MDT leads and Senior Management are in place for clinical teams have opportunities to escalate areas of concern and potential solutions. Fortnightly cancer reset meetings with HSCB continue. 82. *20190607 Clinical and Cancer Services Risk Register located in S21 53 of 2022 Attachments*

386. On the Acute Services Directorate Risk Register from 16 April 2010 was the insufficient capacity and resources to manage patients waiting for a review appointment with a range of actions to address including virtual clinics, clinical validation, additional clinics and by the 24 June 2019 each Division had performance risks on their risk register. 80. *20220301 Acute Services Directorate Risk Register located in S21 53 of 2022 Attachments*

387. On 15 October 2016 there was a delay recorded on the Surgery and Elective Care Divisional Risk Register for planned inpatients and day cases with regard to backlogs with potential harm to patients as a result. On 12 April 2019, increased access times for outpatients were added associated with capacity gaps and emergent demand. On the same day, access times for inpatients/ day cases was added due to deteriorating access times, associated with capacity gaps and emergent demands. Both noted urology as one of the specialties of concern. 81. *20190607 Surgery and Elective Care Risk Register located in S21 53 of 2022 Attachments*

388. On 1 September 2015, a risk was added on serious concerns following the June 2015 Cancer Peer Review against the peer review standards. By 22 January 2018, it was noted that this was no longer of serious concern as there were new action plans in place for each MDT. 81. *20190607 Clinical and Cancer Services Risk Register located in S21 53 of 2022 Attachments*

389. The Corporate Risk Register updated in May 2022 identified the risk of medical workforce shortages, nursing shortages, high usage of agency and locum staff, delay in accessing planned services including outpatients and elective procedures and the oversight of red flag referrals with reference also to the delay in accessing services and the delay in cancer pathways. It also identified in May 2022 the capacity risks in urology and the Trust potentially being unable to undertake the lookback into service users under the care of Mr O'Brien in a timely way, and the Trust being unable to implement all aspects of the Urology SAI action plan in a timely and complete way, and risk of reputational damage to Trust brought about by the SAI's. 5. *20220512 Q7.35 Summary Corporate Risk Register to Governance Committee located in S21 53 of 2022 Attachments*

390. The ongoing patient reviews identified 9 urology patients who met the threshold for an external Serious Adverse Incident Review, once completed, these reports were shared with the Trust Board and Governance Committee. The 11 overarching recommendations were highlighted to Trust Board with a summary update of the Service Improvement Approaches to assure Trust Board of the appropriateness of the current service approaches, reviewed patient treatment pathways and ongoing process of identifying issues and patients of concern for further assessment. These recommendations were also

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

shared with Acute Clinical Governance members as the Governance issues had resonance across all Divisions and specialties and all recommendations required to be addressed across tumour specialties. The learning from these has informed a Service improvement group and the majority of the recommendations are implemented with the remaining 3 well underway, with involvement from families of those who came to harm.

Q42. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

391. As Director of Acute Services, I am not fully aware of the various systems that were in place for collecting patient data in the urology unit. The Northern Ireland Electronic Care Record (NIECR) is used to detail the care episodes and transfers of patients across Acute and Community. I am unsure of any further detail on this. Other systems that are used to collect patient data include E-triage (a mechanism for referrals from GP to Secondary care Consultants for appropriate assessment and addition to waiting lists), digital dictation for inpatients and outpatients which enables Consultants to dictate patient episodes, for secretaries to type and upload onto NIECR.

392. In addition, hard copies of patient records are completed and collated by all Clinical Staff (medical, nursing AHP) from admission to discharge and in the outpatient clinics. Individual records are returned to Health Records and if removed, are tracked to the individual clinician so that they can be retrieved for further recording of patient episodes. Where records are not able to be retrieved, there is a follow up mechanism across Health Records, Consultant secretaries and clinical teams to locate same.

393. Any incidents that take place are recorded on the Datix system and this enables investigation and reporting on themes, trends and outcomes. The Datix system is used on a daily basis by operational teams and is overseen by the Clinical and Social Care Governance Coordinator. Any concerns are escalated to me on a weekly basis by the CSCG Coordinator.

394. The Nursing Quality Indicators are collected on the wards in a rolling audit programme across a range of domains including Nursing Early Warning Score, Falls, Pressure Ulcers, Fluid Balance Charts and Nursing documentation. NQIs contain analysis of volume, intensity and trends. The data is hosted on the Trust SharePoint database and the teams are supported by the Corporate Nursing Team with quarterly reporting to Governance Committee and Trust Board.

395. Cancer referrals are captured on Cancer Patient Pathway System (CaPPS). This is a regional system which is used by clinicians and operational support leads and is monitored by Operational Support Leads to track MDT actions across the 31- and 62-day pathway.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

396. The Operational Support Leads collate information with regard to Integrated Elective Access Protocol detailing compliance with targets from referral, triage, assessment or cancer pathways access and treatment targets. This included individual patient level data so that patients can be matched for follow up.

397. I do not have any greater knowledge on the use of these systems or their potential to identify concerns over and above the concerns relating to individual patients for individual clinical review.

Q43. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

398. Overall, the data efficacy of the systems that capture patient data depends on timeliness of clinicians reading results, dictating letters and following up patient episodes. This will result in the patient data being accurately recorded on NIECR. The system is not sophisticated enough to alert if clinicians are not dictating in a timely way and this places a reliance on the secretary to disclose that in the backlog report. This is dependent on accuracy, openness and transparency by the secretarial staff.

399. E-triage was a development to replace paper-based referrals from 2016 and works effectively with no changes since then.

400. Patient Administration System (PAS) and its case note tracking functionality has not really changed. I am aware that there have been occasions when records have not been traceable. I am aware there was a previous issue with records being retained in Mr O'Brien's home and had to be collected. The 4 key actions relating to Mr O'Brien's administrative practices which were subject to review by Mrs Corrigan, monitored the compliance against these. The two breaches referenced earlier, regarding non-compliance in September 2019 did not include patient record issues.

401. Mr O'Brien was reported to me by Mrs Corrigan in and around the time of his retirement, not to have used his office during the COVID-19 period (from March 2020). Following the escalation by Mr Haynes of the 10 cases of concern on 11 June 2020, Mrs Corrigan was asked as an action from the Urology Oversight Meeting to liaise with his secretary, Mrs Noeleen Elliot to identify if there were any further issues. At that time, Mrs Corrigan informed me she was disappointed to discover that there were 28 patient records in Mr O'Brien's office and a series of patient results were with his secretary as they required reviewing and sign off with regard to diagnostics and decisions regarding subsequent patient treatment pathways.

402. Reports can be run on case note tracking so that we are fully aware where records are. One of the impacts of COVID was that staff including secretaries were displaced from their offices to reduce risk and footfall in the building. This may have impacted on why these 28 notes were not flagged with HOS. In addition, 28 records may be appropriately with the Consultant for action

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

and variables such as how long they have been there need considered. The escalation processes to raise concern regarding this appear to have failed which was affected by the pandemic and the fact that operational staff were not allowed to access ward areas. This reinforces some concern with the Backlog Report which was reported by teams to be subjective and inaccurate. The Review of Administrative Process completed in May 2021 aimed to address the risk with regard to patient data. The quality indicators and escalation processes that were agreed for implementation enable Heads of Service to monitor compliance.

403. The Southern Trust is still paper-based for medical and nursing notes whilst the South Eastern Trust is piloting electronic records. Paper based records are large and cumbersome and create issues with regard to legibility, storage and access. Digitisation of records is eagerly awaited.

404. The Datix system is reasonably easy to use and the discipline is embedded across the teams to identify incidents and to record them to allow effective investigation and learning. The issue relates to the volume of incidents that are reported which can make management, investigation and closure of incidents difficult to deliver. This is especially an issue as many of the incidents are coded as minor but still need investigation.

405. Nursing Quality Indicators are based on regionally agreed metrics. The evidence of effectiveness can be best portrayed in the 3 South ward whereby quality issues were identified, monitoring put in place with regular audits, training and support resulting in improved quality patient care.

406. The CaPPS and IEAP and related data collection are both invaluable and used daily by Operational Support Leads/ Operational and Clinical teams to monitor patient pathways and help inform service planning of outpatient clinics and theatre lists.

Q44. 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.

407. I have no direct role for setting performance objectives for consultant medical staff or specialty teams. This responsibility sits with the relevant Assistant Director, Divisional Medical Director, Clinical Director and Head of Service. They form part of the job planning process and are overseen by the Medical Director's office.

408. There is an expectation on my part that performance objectives for consultant medical staff and specialty teams will be linked to a range of targets including the IEAP. To make this happen, service level meetings take place within the operational team to consider targets that the team are required to meet and cross reference these to ensure the job plans facilitate the service

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

delivery plan. Whilst the operational team actively plan for and oversee the delivery of this expectation, the individual consultants or medical staff may not appreciate that these targets emanate from regulatory documents such as IEAP.

409. The product of the performance objectives and targets set for and by the medical and specialty teams with the Assistant Director and Head of Service, results in data sharing, trend analysis, agreeing actions and escalations as described in question 12 and 32 and these are shared at the Acute Performance and Acute Clinical Governance meetings with active engagement by Divisional Medical Directors, Clinical Directors and Assistant Directors.

410. The time dedicated within job plans for Clinical Directors and Divisional Medical Directors has been reconsidered over the 2021/2022 year. This has led to a readjustment of the job description and an increased time allocated to the Clinical Directors and Divisional Medical Directors as agreed with the Medical Director. This increased time allows capacity for a greater focus on performance, governance and operational planning in line with the job description.

411. I believe there is greater opportunity to focus on performance objectives as the current approach is very focused on operationalising the delivery of outpatients, inpatients and theatre capacity without full regard for the performance element within that. For example, maximising the numbers of patients who can safely attend outpatients or volumes of patients who can access theatre. Qualitative measures could also be considered at a higher-level including correlation with post-operative complications, readmission rates and impact of delays in diagnostic and treatment pathways.

Q45. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

Job Planning

412. Job planning is a contractual responsibility of both consultant and operational managers. Job Planning is completed by the Divisional Medical Director and Assistant Director with assistance from the Head of Service and Clinical Director as appropriate. It is a joint responsibility to ensure job plans reflect work undertaken. Despite job plans being time based, they are in effect professional contracts and they won't always reflect and record absolutely everything that a consultant does but should be a reasonable reflection of commitment since there will always be an element of time shifting and moving activities around.

413. I have no direct involvement in the job planning process, however, the data has been shared with me and with Senior Management Team/ Trust Board regarding the status of completed annual job plans and the improvement targets to increase the volume of signed off job plans across the operational Directorate team and Medical Director's office. I am aware that there was not

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

full compliance with the sign off of completed job plans for reasons such as lack of agreement that the Programmed Activity (PA – unit of measurement within the job plans. 10PAs = full time) is reflective of the work role and responsibility. This can cause operational difficulty when planning services without full job planning alignment. With regard to Urology specifically, job plan status update as of December 2021 showed only 1 job plan remaining to be signed off from a consultant, Mr Matthew Tyson, who recently returned from sabbatical.

414. For the most part, it is my view that the job planning process works well. However, it can be a protracted process and difficult to get meetings for approval and sign off in the midst of busy operational and clinical roles. For example, I got an email from Mr Haynes on 7 September 2019, regarding a need to review his job plan which had been agreed in October 2018 but further changes to that had not been signed off. The protracted nature of the discussions resulted in the sign off of Mr Haynes job plan not being completed until 12 February 2021. The delay in approving the sign off was complicated by the need to quantify and verify the additional activity and the method of reimbursement to accurately reflect his time worked.

Appraisal

415. The appraisal process is the professional responsibility of the Medical Director and is delegated across the Senior Medical team under the Deputy Medical Director for Appraisal and Revalidation, Dr Damian Scullion. This is a process between the Doctor and the Medical professional manager. I have no role in this process, however, as a Director in the Trust, I can confirm that the percentage of annual appraisals is reported to Trust Board.

416. A revised policy on the appraisal process was developed in line with professional and clinical governance frameworks since the introduction of medical revalidation. There is now a much stronger focus in the appraisal process as it is a requirement of medical revalidation. Appraisal also helps inform the Continuous Professional Development (CPD) requirements and plans for the individual medical staff member and is linked to the job plans.

Q46. 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.

Personnel

417. Governance concerns which have the potential to impact patient care and safety can be raised in a variety of ways. Normally, a communication by email is sent detailing concerns to the line manager or to the professional

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

executive lead as appropriate. Sometimes the email exchanges are preceded by a phone call or face to face discussion to highlight the content of the email.

418. Anyone in the organisation can raise a governance concern through escalation structures, to direct line managers. Each governance concern that impacts on patient care and safety will be escalated and communicated to those operationally responsible for that area, so appropriate mitigations can be implemented. The level of escalation will depend on the level of risk and how the risk is communicated and managed within the operational structure.

419. An example of this is the breach Mrs Corrigan escalated in September 2019 to Dr Ahmed Khan with regard to compliance with Return-to-Work Action Plan on Administrative Process. This was further escalated to Dr Maria O'Kane, Medical Director and copied to Mrs Siobhan Hynds, Deputy Director of Employee Relations & Engagement and to Simon Gibson, Assistant Director (Medical Director Office) as there had been a previous Maintaining High Professional Standard (MHPS) Formal Investigation. The information about the breach was subsequently shared 0n 4 October 2019 with Mr Haynes, Divisional Medical Director and myself as Director of Acute Services and an oversight meeting was set up.

Process and Procedures

420. Complaints can be escalated in an informal or formal way from conversations between patients, service users and/or families and staff through to requested meetings or written formal complaints. The informal resolution is a preferred option as it expedites the opportunity to listen intently and address the concerns as soon as possible with the application of appropriate learning. Where this is not possible or where individuals chose to go directly to a written approach, there is an official Trust complaints process with responses expected within 20 days. Lack of satisfaction with complaint responses on occasion can lead to a reopening of the complaint and where that does not bring about closure, the Trust signposts to the Northern Ireland Public Services Ombudsman.

421. In addition, incidents of concern are recorded on the Datix Incident Management System and are screened and investigated by the Operational/Clinical Management Team. Any learning from this is applied and specific governance issues addressed. Potential Serious Adverse Incidents (SAI) are identified within this process by reviewing major and catastrophic incidents, this results in the Clinical and Social Care Governance Coordinator working with the operational and clinical team to screen, ascertain if the incident meets the threshold of SAI. This system will have been part of the identification of the series of urology SAI's over the past 6 years.

422. Another process/ procedure relevant to urology services relates to the role of the Divisional Medical Director carrying out his governance and oversight role. Mr Haynes on 11 June 2020, observed an anomaly of 10 patients having been added to the urgent waiting list in one day. This is an unusual number

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

which made Mr Haynes curious and as a result he interrogated the details of the patients on the system. He discovered that there appeared to be significant delays with some of the patients who should have had earlier access to diagnostics or treatment. This resulted in Mr Haynes working closely with the Head of Service to scope the detail and an oversight meeting with Medical Director's office and myself as Acute Director was called leading to the early alert and the early development of patient reviews.

423. Clinical Negligence litigation claims can be raised by individuals who feel their experience or treatment was below the expected standard. This is a process that is supported legally within the Trust, with input from clinical and operational teams regarding case discovery, response and management.

424. The monitoring of governance concerns that impact patient care and safety takes place in a range of ways including inclusion in the agenda between the Clinical Social Care Governance Coordinator and Acute Director on our weekly meetings. Monitoring level of complaints, incidents, SAI's, litigation claims our actions aligned to those and any specific issues for further discussion are addressed. This includes monitoring timelines against compliance with key performance indicators specific to governance targets. In addition, oversight meetings are called in response to escalated concerns that require either information across or input from Medical Director, Director Human Resource and Organisational Development and operational and clinical management teams.

Q47. Did you feel supported in your role by general management and medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

425. In my role as Director of Acute Services, I agreed to redeploy to cover Personal Information redacted by the USI and was conscious from the outset that I would have the support of my Director and Trust Board colleagues. The weekly Senior Management Team (SMT) meetings focusing on business of the organisation also allows the opportunity to escalate issues of concern and to elicit support for any challenges.

426. From when I assumed the post of Acute Services Director, I began developing relationships across the acute teams including the urology staff and listened to the service issues. Within the first week I was in communication with both Mr Carroll and Mr Haynes regarding issues of concern in Surgery and Elective Care that they wanted my support with. My response and solutions to improve service delivery were well received and I believe on an ongoing basis, I felt supported by them and they felt supported by me, evidenced by the ongoing discussions and escalations.

427. For example, when I was made aware of the lapses in clinical practice of Mr O'Brien, I worked with Dr O'Kane, Mrs Vivienne Toal, Mrs Heather Trouton, Mr Shane Devlin and members of their teams to address the governance concerns, support nursing and medical colleagues, plan for a

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

balance between reviewing the patients who had potentially come to harm against new priority patients who needed to be seen by securing additional capacity and financial support to enable me to do so. I also took the opportunity to present governance and performance concerns at Performance and Governance Committees and Trust Board for information and for assurance regarding the ongoing processes. In addition, Dr O'Kane, Mr Devlin, and I represented the Trust at the accountability mechanisms to HSCB/ SPPG and Department of Health. I got 1:1 support from Dr O'Kane and Mr Devlin which I offered in return to my Assistant Directors and Divisional Medical Directors.

428. The Urology Oversight Meetings which are attended by Mrs Toal (and her Assistant Director, Siobhan Hynds), Dr O'Kane, Mr Carroll, Mr Haynes, Mrs Corrigan and myself are focused on patient safety and securing best health outcomes. These Oversight Meetings maximised the best of each of our skills and expertise to deliver on that commitment to patients.

429. On occasion, the planned 1:1 meetings with Divisional Medical Directors were displaced due to competing diary commitments but were never due to a lack of willingness to engage or support. Opportunistic drop-ins to my office or phone calls to have a chat about specific issues or broader concerns, demonstrates to me that the relationships were positive and supportive. Action as a result of some of the issues raised in 1:1 discussions is another measure of feeling supported. For example, progressing urology medical and nursing workforce recruitment, targeting available capacity to priority patients, implementation of agreed actions and recommendations post the 9 SAI's (April 2021) and the specific focus on service improvement further demonstrates the commitment and support in collective working.

Concerns regarding the urology unit

Q48. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with: 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 urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (vii) above but with whom you interacted on matters falling within the Inquiry's Terms of Reference.

(i) The Chief Executive – the Inquiry understand the post holder to have been Shane Devlin

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

430. Shane Devlin was Chief Executive when I commenced the Acute Services Director post in June 2019 until February 2022. Since then, Dr Maria O'Kane has been in post as Chief Executive.

431. As Director of Acute Services, I escalated issues of concern to the Chief Executive in a timely way, for example, when issues were raised regarding patient care and safety in urology which related to the clinical and administrative practice of Mr O'Brien. I also offered assurances of the collaborative approaches underway across operational and professional governance leads (Dr O'Kane, Medical Director, and Mrs Vivienne Toal, Director of Human Resources and Organisational Development due to previous and ongoing proceedings and investigations into the practice of Mr O'Brien).

432. These interactions took place by phone, normally, to escalate concerns or in 1:1 discussions. Presentation of updates to Senior Management Team or Trust Board were the formal mechanisms employed.

433. The change in post holder of Chief Executive has not affected the style of liaison or escalation.

(ii) the Medical Director(s) - the Inquiry understand this to have been Maria O'Kane;

434. Dr Maria O'Kane has been the Medical Director since I commenced my tenure in Acute Services until February 2022. Since then, she has had interim support from both Dr Damian Gormley and Dr Aisling Diamond. However, Dr O'Kane has retained a commitment to support some of the work from a Medical Director perspective until the post is formally appointed (currently in recruitment).

435. Dr O'Kane offers access in and out of hours when there are any areas of concern, I need support with. This could either be through written or oral communications. She was actively involved in the escalation of concerns to me when she had been made aware through professional lines (escalated concerns from Mr Haynes in June 2020) and earlier breach (escalation from Mrs Corrigan). She has been a member of the Urology focused oversight meetings and the operational weekly Urology meeting focused on patient reviews and operational plans to address service concerns within governance and performance frameworks.

436. Following conversations between Mr Haynes and Dr O'Kane regarding any additional concerns as a result of patient reviews or particular patient groups that needed to be prioritised for reviews, Dr O'Kane would have ensured I was fully informed in a timely way to facilitate operational service delivery plans.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

437. The approach across the Medical Director's office and Acute Services was one of willingness to learn and improve our services. A key underpinning principle of this was ensuring the voice of service users and families influenced how we deliver urology services going forward. This required many conversations regarding implementing the Family Liaison Service, embedding psychology support for staff and patients/families, embedding evidenced based practice and securing additional resource to implement additional safeguards including clinical audit, MDT chair support, follow up of decisions made at MDT and service improvement actions and evidence of change.

438. As we both attended the SPPG (previously HSCB) and UAG (Urology Accountability Group) we would have actively liaised in preparing the update reports for same.

439. We would also have discussions about the impact of the urology concerns and public inquiry on our staff's health and well-being, complicated by the demand capacity gap, workforce challenges and their desire to deliver quality, safe patient services.

(iii) the Assistant Directors - Heather Trouton, Ronan Carroll and Barry Conway

440. Heather Trouton was operationally involved with the urology unit as Assistant Director until 2016 which was before my tenure in Acute Services. However, as Executive Director for Nursing, Midwifery and AHP, she was a member of SMT and Trust Board and therefore received any reports or escalations presented to them. In her Executive role, I also involved her with the Clinical Nurse Specialist staff in the urology unit as they were anxious regarding their professional reputation, due to urology services being under scrutiny and they were unsure of its implication going forward. She met with the specialist nursing team separately to address these issues and she also attended one of the operational/clinical urology team meetings which Dr O'Kane and I regularly held to offer support. Mrs Trouton also supported 3 south when the nursing quality assurance indicators were not at the expected standard.

441. Mr Carroll was Assistant Director for Surgery and Elective Care from the commencement of my tenure in June 2019. As soon as concerns would have been raised to me, I would have advised Mr Carroll either in person, as he works on the same office block as me (two days per week), by email or by phone of these concerns. I actively involved Ronan, from a governance and performance perspective, in all operational issues. With the escalation of governance concerns relating to Mr O'Brien, Mr Carroll implemented the operational action plans to address the issues – including working with his team colleagues to prioritise capacity for additional patient reviews, to engage additional contracts with Independent Sector providers to increase capacity to meet patient demand, and to participate in the operational patient review

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

meetings, HSCB meetings, co-chairing the Task and Finish Group which is focused on service improvement as a result of the April 2021 SAI reviews.

442. In addition, Wendy Clayton was appointed to replace Martina Corrigan and Sarah Ward as Clinical Assurance Lead to support the urology look back review and implementation of service improvement action plans. Occasionally, Mr Carroll escalated any concerns to me outside the working groups that we participated on together. For example, when information, written in error, had been sent to patients and where patients had not been identified at first due to coding errors when interrogating the electronic systems. As a member of the Acute Senior Management Team, he also participated in my Directorate Performance and Governance meetings and at the Acute Clinical Governance monthly meeting. He would have been actively involved in the discussions with regard to the urology SAI's and the recommendations required to be addressed. He also worked with the Cancer Clinical Services Assistant Director, Barry Conway and Dr Shahid Tariq, Divisional Medical Director Cancer Services, to cascade the learning applicable to all tumour sites and MDT processes.

443. Mr Barry Conway, as Assistant Director for Cancer and Clinical Services, whilst sitting outside the urology team, is inextricably linked due to the cancer pathways and the range of processes including data analysis and sharing with regard to waiting lists, waiting times and access to service target compliance. Multidisciplinary involvement from pathology, oncology, palliative care and radiology all of which fall within his remit and their participation in MDT meetings, service improvement approaches. As a member of the Acute Senior Management Team, he also participated in my Directorate Performance and Governance meetings and at the Acute Clinical Governance monthly meeting and was exposed to governance concerns in urology particularly those that relate to cancer services, implementing the SAI recommendations (presented in April 2021) which he supported from baseline audit positions to service improvement approaches.

(iv) the Associate Medical Directors - the Inquiry understand this to have been Mark Haynes and Damian Scullion;

444. Mr Mark Haynes was Associate Medical Director (now Divisional Medical Director) of Surgery and Elective Care including Urology from the beginning of my tenure at Acute Services. My point of contact was through 1:1 meetings (1-2 monthly) and also he was a member of the Acute Clinical Governance monthly meeting referenced earlier. Within a few days of my being Director of Acute Services, Mr Haynes had begun to escalate his concerns as referenced in question 7. It was indeed Mr Haynes who escalated concerns to me as he became aware of them and or who actively worked on operational urology groups to address those concerns including Trust urology review weekly meetings, oversight meetings and on interface meetings with the clinical team to update regarding the urology concerns. He played a key role in patient's assessments for the patients of Mr O'Brien who needed urgent review, he liaised across the operational team of Assistant Director and Head of Service

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

to plan services, to update inpatient outcomes and to influence appropriate service development and additional capacity within the Trust, across Trusts and the independent sector.

445. He met families and patients who had been affected and offered them personal discussions on their cases, therefore, he was very actively involved with myself and my operational team and across to the Medical Director. Following the SAI recommendations, it was agreed to dedicate his DMD time to focus on the urology lookback and service improvement related to same.

446. From November 2021, Mr Edward McNaboe, who had been Clinical Director of ENT and Urology (ENT consultant) was appointed to the post of co-Divisional Medical Director for Surgery and Elective Care. Whilst I offer 1:1 support to Mr McNaboe, Mr Haynes remained my first point of contact as he was fully aware of the details of the previous and ongoing governance concerns within urology. In his previous role as Clinical Director, Mr McNaboe would have been the line manager to Mr O'Brien and following a meeting on 8 October 2019 (relating to the escalated breaches by Mrs Corrigan), Dr Maria O'Kane agreed to ask Mr McNaboe to discuss the concerns with Mr O'Brien to make him aware that this had been raised with his previous MHPS case manager, Dr Ahmed Khan.

447. Dr Damian Scullion was Associate Medical Director/ Divisional Medical Director for Anaesthetics when I commenced post as Director of Acute Services, therefore, my 1:1 meetings with him were not focused on urology. He was a member of the Acute Clinical Governance meetings and therefore provided with the information on the urology concerns and the SAI recommendations. I can recall that Dr Scullion told me at one stage that he had been Mr O'Brien's appraiser. Recently, Dr Scullion was appointed as Deputy Medical Director for Appraisal and Revalidation.

(v) the Clinical Directors - the Inquiry understand this may have been Colin Weir/Ted McNaboe

448. Mr Colin Weir was Clinical Director of General Surgery when I commenced in Acute Services and therefore, I had no direct interface with him with regard to urology services.

449. Mr Edward McNaboe, was Clinical Director for ENT and Urology when I commenced post and would have been actively engaged with the Operational Assistant Director and Head of Service in operational planning, performance and governance issues, both professional and clinical social care. As referenced in my response above, Dr Maria O'Kane agreed to ask Mr McNaboe on 8 October 2019 to discuss the concerns with Mr O'Brien to make him aware that this has been raised with his previous MHPS case manager, Dr Ahmed Khan.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

450. Mr McNaboe has now been appointed to the post of Divisional Medical Director for Surgery and Elective Care (CD post remains vacant) and at 1:1 meetings he will escalate any areas of concern, However, the bulk of the discussions with regard to urology are between myself and Mr Haynes and Mr Carroll.

(vi) the Head of Service, namely Martina Corrigan, and now Wendy Clayton

451. Martina Corrigan was Head Service for ENT and Urology until October 2020 when Wendy Clayton took up the post. Martina Corrigan has moved to the post of Assistant Director for Public Inquiry. Both have been/are line managed by Mr Ronan Carroll so I have no direct 1:1 planned meetings with them.

452. Mrs Corrigan operationally was responsible for the day-to-day planning and operation of urology, ENT and outpatient services. She was the named person who took responsibility for monitoring the action plan agreed with Mr O'Brien following his MHPS formal investigation. In addition, once further concerns were raised by Mr Haynes in June 2020, she was an active member of the team working with Mr Haynes to plan rotas and clinics to increase capacity for additional patient reviews as a result of the escalated concerns and the need to ensure patient safety. She was instrumental in implementing databases of patient cohorts, stratifying and prioritising patient groups for review, and communicating across the operational and clinical team, participating on the urology Trust meetings and attending HSCB regional urology meetings.

453. Since Wendy Clayton took up the post of Head of Service, she has assumed many of these roles. The one differentiating factor is now that Sarah Ward is in post as Clinical Assurance Lead, Sarah has taken responsibility for the patient recall/ lookback and the oversight of the Service Improvement Task and Finish (post 9 SAI's).

(vii) The consultant urologists in post.

454. Since my tenure as Director of Acute Services, the team of Consultant Urologists has been Mr Mark Haynes, Mr John O'Donoghue, Mr Michael Young (now retired May 2022), Mr Anthony Glackin, Mr Matthew Tyson and Mr Aiden O'Brien (retired July 2020). They are line managed professionally by Mr McNaboe as the previous Clinical Director and now as the Divisional Medical Director alongside Mr Haynes. The Assistant Director and Head of Service operationally line manage and oversee the operational work plan of the above consultant urologists. I have no direct 1:1 meetings with the consultants, however, since the advent of urology concerns and the announcement of the public inquiry, I have had several meetings to offer support, reassurance and information to the consultants.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

(viii) Clinical and Social Care Governance Coordinators

455. When I commenced in Acute Services in June 2019, the Clinical and Social Care Governance Coordinator (coordinator) was Patricia Kingsnorth until July 2021, with a short period [redacted] covered by Connie Connolly (October 2019 – February 2020). Currently, Chris Wamsley is in post as coordinator since July 2021.

456. I offer weekly supervision to the coordinator to discuss all elements of clinical and social care governance embracing all elements and issues for consideration, discussion or escalation. The coordinator supports the operational teams to progress the operational aspects including incident recording and management, screening for serious adverse incidents, carrying out Serious Adverse Incident reviews, report writing and interface discussions with patients, service users, families and HSCB/SPPG.

457. With regard to urology services, the Coordinator has an active role to play in supporting the external panel chaired by Mr Dermott Hughes with the 9 SAI's. The follow up recommendations, action plans and embedded learning is the responsibility of both the coordinator and the clinical/operational team. On 1:1 meetings with both Assistant Director and the Coordinator, I get updated on progress and the opportunity to escalate any concerns. The Coordinator also attends the Acute Governance meetings monthly and the Acute Clinical Governance meeting which the DMDs and CDs attend with the operational team.

Q49. During your tenure, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

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

458. On 27 August 2019, I first became aware of issues regarding Mr O'Brien. It followed a communication from the GMC Triage Team seeking further information from Dr O'Kane following Dr O'Kane's referral of Mr O'Brien to them on 3 April 2019. 10 points were raised by the GMC seeking a response in advance of 6 September 2019. Dr O'Kane forwarded the email to Mr Simon Gibson, Assistant Director Medical Director's Office, Siobhan Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs Vivienne Toal, Director of Human Resources and Organisational Development. On 10 September 2019, I was further copied in to an email reminder for the requested information to the same email recipient as above.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

459. One of the main problems that was brought to my attention related to the numbers of concerns that resulted in SAI's, into patients under the care of Mr O'Brien. Patricia Kingsnorth, Acute Clinical and Social Care Governance Coordinator, sent an email on 9 September 2019 to the members of the Acute Clinical Governance Group, including myself as chair. In it she stated that a draft SAI report on Patient 16 was to be re-presented at the planned meeting on 13 September 2019. Mr Haynes and Mr Carroll agreed to present that report at that meeting. It had first been presented on 7 June 2019, prior to my commencement in Acute Services. At the meeting, there were discussions about the recommendations which needed further consideration by the SAI panel, and it was now ready for further consideration. On 10 September 2019, Mrs Patricia Kingsnorth brought to my attention, for the first time, that there were five 2016 Serious Adverse Incident reviews, relating to urology which had not yet been completed by the external panel. These were subsequent to an Index case Patient 10 (2016), all were Mr O'Brien's patients.

460. Patricia Kingsnorth liaised with Trudy Reid, previous Acute Clinical Social Care Governance Coordinator, who had been in post before Patricia and at the time when the external Serious Adverse Incidents relating to urology patients had been commissioned. Mr Julian Johnson (previously BHSCT) was the Chair of the external panel for the 5 aggregated reviews – all of whom had been patients of Mr Aidan O'Brien, Consultant Urologist. There was liaison with Mr Johnson which I recall was undertaken by Trudy Reid to enable the completed reports to be received by the Trust. These were on the agenda for approval at subsequent ACG meetings.

461. The sequence of the urology presentations at ACG was as follows:

- June 2019 – Patient 120 & Patient 16; (prior to my tenure which commenced on 10 June 2019)
- September 2019 - Patient 16 re-presentation;
- October 2019 - Patient 120 re-presentation;
- January 2020 – Patient 103 new and Patient 16 re-presented;
- February 2020 – Patient 103 re-presented, 6 new reports - Patient 12, Patient 15, Patient 14, Patient 13, Patient 11, 5 individual and 1 collective representing the 5;
- March 2020 – Patient 103 re-presented;
- October 2020 – Patient 103 and the recommendations contained within the 1 collective SAI (relating to the 5 urology SAI's presented in February 2020)
- November 2020 – Patient 107 new and Patient 103 re-presented.
- April 2021 – the 9 new Urology SAI's were presented in form of Recommendations only

462. Following the 11 June 2020 concerns raised by Mr Haynes, some of the patient's reviews resulted in the need for further investigation including the 9

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

SAI's (presented in April 2021) and at time of writing now 71 patients that have been screened as meeting the threshold for the alternative process to Urology SAI's, the Structured Clinical Judgement Review. This reinforces the appropriateness of the concerns that had been raised.

463. The general governance concerns raised with me from June 2019 related to workforce challenges, capability issues, nursing staff vacancies, inability to deliver quality nursing care at an expected standard, consultant urologist vacancies, delay in accessing services for assessment or treatment and non-compliance with the key performance indicators outlined in the IEAP. These are outlined earlier in this submission.

464. Mr Carroll raised in an email to me on 21 August 2019 highlighting ongoing staffing issues and the lack of senior cover for 3 South ward (urology). I shared the concerns and plan with Heather Trouton, Executive Director for Nursing, Midwifery and Allied Health Professionals, with regard to assurances in relation to nursing practices and patient safety. On 5 September 2019, Mr Carroll further updated me on the position in 3 South and included the Risk Assessment due to staffing deficits which showed a deficit of 15.98 staff nurses, the bed complement had been reduced to compensate for this deficit, from 36 to 32 beds (ENT and Urology of which 19 were urology beds). There had been an open advert for additional band 5s to work specifically in 3 South, but no applicants for the post. The Core Trust Nurse to Agency ratio was 60% agency staff and 40% Trust staff (daytime) with 50-50% split for night duty which he highlighted was affecting the ability for patient's needs to be fully met.

465. On 11 September 2019, I received a related email from Mrs Helen Walker, (Assistant Director Human Resources) who was supporting the management and nursing team, to advise that the [redacted] and shared an appropriate managerial action plan to address the workforce challenges. These escalations highlighted the ongoing difficulty with recruiting and retaining staff, high level of agency nurse dependence, capability issues and safety indicators of specific concern within the ward.

Personal Information redacted by the USI

466. On 16 September 2019 when the breaches in Mr O'Brien's administrative agreed Return-to-Work action plan were escalated, these were sent from Mrs Corrigan to Dr Ahmed Khan, Case Manager and copied to Siobhan Hynds, Deputy Director Employee Relations and Engagement. A follow-up included Mr Gibson, and subsequently Dr Khan informed Dr O'Kane on 18 September 2019. By 30 September 2019, Mr Haynes was copied in and I was informed by Dr O'Kane about the breaches on 4 October 2019 as a meeting had been called to respond to the concerns. This was the first that I was aware that there was some ongoing monitoring with regard to Mr O'Brien, following issues identified in 2015/16 with non-compliance with Trust Policies and Procedures in relation to triaging of referrals, contemporaneous note

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

keeping, storage of medical records and private practice. Mrs Martina Corrigan, HOS, was monitoring his administrative processes. An oversight meeting took place on 8th October 2019 chaired by Dr O'Kane with Dr Ahmed Khan, Mrs Siobhan Hynds, and Mr Mark Haynes to consider the concerns raised and the previous MHPS case determination report.

467. On 7 February 2020, Mrs Hynds, emailed myself, Dr O'Kane, Mrs Toal, Mr Gibson, Mr Carroll, Mrs Corrigan and Dr Khan highlighting that there were a range of matters which needed to be discussed and progressed in respect of Mr O'Brien's case and requested a meeting. She highlighted we had correspondence from the GMC which needed a response. Mr Gibson replied on 10 February 2020, that Trudy Reid and Stephen Wallace were coordinating a response to RQIA (who had been provided with the Case Manager report by Dr O'Kane) in relation to a number of issues including Mr O'Brien. He referred to an email from Mr Wallace, where he noted that RQIA were seeking information on any plans to undertake a review of administrative processes within the Trust or rationale underpinning a decision not to proceed with review if this was the case. Mr Simon Gibson (Assistant Director) clarified in an email on the same day that the draft Trust response to RQIA referenced the backlog report as evidence of assurance, even though it was noted to have had significant weaknesses within it, at a meeting that he chaired on 24 January 2020 where the backlog report was discussed.

468. On the 10 February 2020, Mrs Trudy Reid, Interim Assistant Director, Clinical and Social Care Governance (Medical Director's Office), responded with some comments and suggestions regarding previous processes and potential review going forward. On the same day, Mrs Hynds responded that she felt the recommendation regarding an independent review of relevant administrative processes was being read somewhat out of its full context as it was a line at the end of a range of conclusions and needs read in conjunction with the conclusions.

469. This recommendation followed the Case Manager's Determination following the MHPS Investigation which was completed by Dr Khan. As Dr Khan had moved to the post of Acting Medical Director, the case determination was sent to Mr Shane Devlin, Chief Executive. The process was stalled In November 2018 soon after the determination report had been issued (28 September 2018) as Mr O'Brien raised a grievance about the investigation. Mrs Hynds noted that a substantial Subject Access Request on the investigation had been submitted by Mr O'Brien causing a delay and noted it was now about to be progressed. She wished all of this to be discussed at the planned oversight meeting and of note she asked Dr Khan in the email to provide clarity on what he was seeking as an outcome of the said recommendation mentioned in the determination report.

470. I responded to this email trail on 10 February 2020 to say;
"*Dear All, I would prefer to discuss this in person where clear roles and remits need identified. There was a lot of background information that I am not fully aware of.*"

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

471. Mr Carroll responded on 11 February 2020 to say how frustrating he found this. The Aidan O'Brien process was controlled by Headquarters/Governance (MDO). He stated that the outcome and recommendations of the MHPS Case Determination Report were not shared with operational AD's, yet the recommendation affected all Acute Services. He stated that there were ongoing emails from the Medical Director's office with regard to Acute Services processes and signed it "*Disconnect.com*".

472. I responded to Mr Carroll, to confirm that I had requested an urgent meeting the previous evening to agree roles and remits and clarity on who is owning this. I then stated:
"*Unfortunately as operational managers we can't disconnect.com but we need to address the governance arrangements and our commitment to monitoring etc. as previously detailed. Talk later*." I then forwarded Mr Carroll's email to me to Mrs Toal and Mrs Hynds (Human Resources) to state:
"*A lot of strength of feeling, we need to resolve and get clarity urgently*".

473. On 12 February 2020, I attended the Oversight Meeting which Mrs Hynds had requested to get clarity as stated above. Actions agreed at that meeting:–

- Dr O'Kane agreed to have a meeting/ conversation with Mr McNaboe, Clinical Director, regarding him having a meeting with Mr O'Brien regularly and seeking assurances through that supervisory process that Mr O'Brien was working in accordance with the triage process, was not holding notes at home and was undertaking all digital dictation immediately following each individual contact with the patient (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was discussed and agreed with Mr McNaboe);
- Dr O'Kane to speak with Mr McNaboe and Mr Haynes to ensure an agreed job plan was in place for Mr O'Brien as a matter of priority or to escalate to the next stage of the job planning process (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was discussed and agreed with Mr McNaboe and Mr Haynes);
- Dr O'Kane to seek assurance from Dr Damian Scullion to ensure Mr O'Brien was completing annual appraisals (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that Dr Scullion had assured her of this);
- Dr O'Kane to draft a response to the GMC and RQIA in respect of their recent correspondences to the Trust seeking additional information about the case (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was being completed by Mr Gibson for 27 February 2020. She also noted the recent update shared with the GMC ELA who had requested the SAI's and Dr O'Kane stated that this will need agreement. The Case Manager report had been shared with RQIA;
- Mrs Hynds to draft the Terms of Reference for the Independent Review of the SAI recommendations and the MHPS Review Recommendations and send the TOR to the Oversight Group for agreement;

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- Mrs McClements to share SAI reports and recommendations with Mrs Hynds for drafting of the Terms of Reference
- Dr O'Kane to speak to Dr Rose McCullagh (GP/ Associate Medical Director in Primary Care SHSCT) to undertake the independent review (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, she was awaiting Terms of Reference from Mrs Hynds);
- Dr O'Kane to update Mr Shane Devlin, Chief Executive (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was done);
- Mrs Toal to progress Mr O'Brien's grievance process.

474. On the 13 February 2020, I forwarded an update regarding the status of the MHPS admin review recommendation to Dr O'Kane, Mrs Toal and Mr Gibson as it had been requested by RQIA. The response detailed the progress against the MHPS recommendation regarding administrative processes, it clearly stated that the Trust had not undertaken an independent review of the relevant Administration Processes within the Acute Directorate, however, it stated the range of processes that were in place. It referenced the monitoring of administrative/clinical aspects of the patient's journey producing the "Backlog Report" which is shared to the Divisions on a monthly basis. It also referenced with regard to electronic referrals that the process of e-triage had been embedded within urology from 2017. It referenced issues with GP practices not on e-triage and the system to deal with paper referrals as a result and standard operating procedures in place for admin staff to process internal referrals. It referenced a plan to introduce robust electronic processes for internal referrals by September 2020 and referenced the IEAP, regional guidance regarding the process which should be used when triaging letters.

475. In June 2020, in advance of Mr O'Brien retiring I was made aware by Mr Mark Haynes, DMD Surgery and Elective Care and Dr Maria O'Kane, Medical Director, that an anomaly had been noted which involved Mr O'Brien adding 10 patients, all on the same day, to the waiting lists for urgent admission. Some of these appeared to have been waiting months without being added to the lists. An oversight group was set up to look into this anomaly further, which concluded that patients had appeared to have been delayed in proceeding to diagnostics or treatment following assessment by Mr O'Brien.

476. As a result of these serious governance concerns regarding the practice of Mr O'Brien, I chaired a weekly meeting with the Medical Director, Dr Maria O'Kane, Deputy Medical Director, Dr Damian Gormley, DMD, Mr Mark Haynes, AD, Mr Ronan Carroll, and HOS for Urology, Mrs Martina Corrigan, to further scope the issues. This led to a refinement of the administrative and clerical escalation processes which had been agreed to address earlier issues regarding timely triage, case note tracking and follow up referrals/ diagnostics and acting on diagnostic results in a timely way. At these meetings, Mr Haynes agreed to review the patients as some concerns were raised.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

477. A retrospective 18-month patient review was commenced across elective and emergency patients as this was clinically seen as potentially the highest priority patient group. Consequently, 9 Serious Adverse Incidents were identified to go forward to SAI investigation. Dr Dermott Hughes, previous Medical Director Western Health and Social Care Trust, was appointed to chair the External Panel.

478. The 9 SAI reviews and 1 overarching report were presented to ACG in April 2021. An action plan was developed and a task and finish group was established to deliver on the 11 recommendations of the external panel and to progress service improvement initiatives across cancer specialties and multidisciplinary team meetings. This included the need to address more effective MDT's and evidencing outcomes. This also involved Commissioner discussions on the application of this learning to other Trusts in the region and also with NICaN regarding support and sharing of learning.

479. Family liaison was provided throughout the period from identification of the issues of concern to feedback of the outcomes of the reviews. Some family liaison support is still ongoing currently, and two families are engaged with the Trust on embedding service improvement and learning.

480. There were also direct interface meetings with the urology team to support them regarding sharing the learning and eventually with regard to the Public Inquiry approach.

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.

481. As detailed in section i of this question, the mitigation I took with regard to the SAI's was to ensure the CSCG Coordinator Mrs Kingsnorth liaised with the former CSCG Coordinator Mrs Reid, to discuss the 5 SAI's that were with Dr Julian Johnston as panel Chair to complete. The request was for him to expedite a timely conclusion, to allow closure for the individuals and families and for learning to be applied. For the subsequent SAI's (the 9 completed by Dr Hughes), these were closely monitored to ensure compliance with an expected timeline.

482. Following the June 2020 escalated concerns, the main focus was on scoping the validity of the concerns and implementing patient reviews to ensure patient safety, by ensuring appropriate treatment pathways were in place. Where further investigation was required, this was expedited.

483. The mitigation referenced in earlier questions with regard to workforce capacity issues and the resultant impact on delays in accessing assessment, treatment and care resulted in extensive recruitment and retention approaches,

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

close monitoring of waiting lists and times and management of priority patients, prioritising services to those most in need.

484. After the Oversight meetings on 8 October 2019 and subsequently 12 February 2020, Dr O'Kane had taken responsibility for the majority of the actions agreed by at the Oversight meeting to mitigate against the issues of concerns raised against Mr O'Brien. My main responsibility related to oversight of the monitoring arrangements by Mrs Corrigan and mobilising administrative support within Acute Services to support the Review that Dr McCullagh and Dr Donnelly had agreed to complete.

485. By 31 July 2020, Mr Stephen Wallace, Assistant Director Systems Assurance (Medical Directors Office), circulated Terms of Reference for the Review of Administration Processes as per MHPS Recommendation which Dr Khan had reviewed. Dr Rose McCullagh and Dr Mary Donnelly (Divisional Medical Directors - Primary Care) had agreed to conduct this work and commence it the following week. The purpose of the review was to review the Trust administrative processes for management of patients referred into the service. Mrs Carroll and her team subsequently collaborated with Mrs Corrigan and liaised with Belfast Trust to develop these administrative processes, culminating in a final admin review and recommendations by May 2021. These described the issue across the four domains within the MHPS Case Determination Recommendations and related Return-to-Work Action Plan, specifically, triage, undictated clinics, hospital notes and private patients. It clearly detailed in an action plan template the issue and description of same, the gaps that led to the problem, the policies and processes in place, the ongoing risks, action required, the owner/responsible and timescale.

486. As described in Question 49 Section i, the Task and Finish Service Improvement Group focused on MDT, embedded a significant piece of work including assessing the baseline picture of all the Cancer specialty MDT's, agreeing the action required to improve against the NCAT guidance and I secured investment for additional posts to support more effective working of the MDT.

487. All of the above steps were taken in an attempt to reduce potential impact on patient care and safety.

488. These concerns were all reflected in the risk registers and in May 2022 the corporate risk register was updated with regard to the risks associated with the Public Inquiry and the Lookback Review and associated patient impact.

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

489. In my view, the concerns relating to performance including access times, delays in patient cancer pathways across 31 and 62-days, as addressed in question 35, has an impact on the patient journey and the potential of harm as

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

a result. The detail included earlier describes the steps taken to mitigate against non-compliance with targets and ensuring that HSCB were fully aware at our Trust HSCB Performance meetings to agree actions as appropriate across commissioner and the Trust.

490. Specific to Urology, the volumes on the waiting lists and the waiting times increased year on year across outpatients, inpatients, day cases and the red flag performance deteriorated from 54.8% on 1 April 2019 to 27.4% on 1 April 2022 in the Southern Area. A series of mitigations were put in place to address this including entering the backlog risk onto the Divisional Risk Register (since October 2016) and further adding access waiting times from April 2019. The 62-day performance has been on the Risk Register since 3 September 2012. The ongoing increasing demand within urology was raised with the commissioner, a business case for the 7th consultant urologist was developed in October 2020 and subsequently approved to help reduce the gap between capacity and demand and improve access times. As no appointment has yet been possible, as agreed with HSCB, the Trust has got approval to veer the resource towards the Stone Treatment Centre to address increased demand for that service. In addition, independent sector contracts were established for outpatient urology referrals with ongoing care and treatment where possible. Mr McNaboe, Divisional Medical Director and Mrs Wendy Clayton, Head of Service, represent the Trust on the Regional Priority Oversight Group (RPOG), the purpose of which is to equalise waiting times for clinically urgent patients to agree the available capacity across all Trusts and priority patients are then allocated the next priority slot across the Trust. This process commenced in June 2021 as part of the Ministerial Recovery Plan for Cancer Services. I appraised Senior Management Team and Trust Board regarding the performance of urology services.

491. When workforce is compromised, the impact will be on patients in terms of timely access to treatment and care, longer waiting times for diagnostics and elective surgery and ongoing review within clinically indicated timescales, all potentially causing patient harm. The steps to build the team, recruit and retain all disciplines, adding in new roles as described earlier, including Specialty and Associate Specialist (SAS) Doctors and Clinical Fellows were part of this mitigation to reduce patient risk. In addition, the appointment of two Clinical Nurse Specialists in August 2020 allowed some capacity to be veered to reducing impact on patients.

492. Once an individual is identified as causing concern, in this case Mr O'Brien, a series of steps were taken including:

- the monitoring of actions agreed under MHPS;
- dealing with breaches in his compliance with these;
- Conducting several Serious Adverse Incident Reviews, implementing recommendations and learning as a result;
- Instigating service improvement approaches;
- And appreciating the potential risk from the June 2020 "10 patient concerns", this resulted in a review of significant numbers of his patients. This led to the identification of further harm, necessitating patients to be

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

transferred to the correct treatment pathway and mobilising resources to increase capacity to meet the volume of patient reviews for those previously under Mr O'Brien's care, whilst prioritising other urgent and emergency patients who were under other Consultants and deserved the same priority for treatment.

493. With regard to the MDT, if a patient case is not discussed at an MDT, or if the clinical breadth of representation is not in attendance to influence the decisions and challenge others' thinking, or if the agreed actions are not followed up, embedded, or audited to offer assurances that decisions have been implemented, all of these have the potential to impact patient care and safety. The learning from the 9 SAI's (April 2021) identified the need for strengthening the MDT and the processes aligned to same as a result of the Task and Finish Service Improvement Project, many of the proposed actions to improve MDT working are now embedded and continue to be progressed.

iv. If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

494. There is a daily focus on performance levels as informed by referrals in, triage, trends in cancer pathways, clinic volumes, "do not attend" rates, waiting lists and waiting times. This is monitored through the Operational Support Lead for each cancer speciality/division and liaison with the Head of Service and Assistant Director. This data is discussed in a range of multi-disciplinary meetings chaired by the Assistant Director of SEC/ATICS Mr Carroll and/or Barry Conway AD CCS, throughout the month including Speciality Tumour Site and Cancer Pathways meetings with medical colleagues in attendance.

495. With regard to compliance with performance targets, I chair the Acute Performance Meeting with Assistant Directors and the Assistant Director/Head of Service from Performance and Reform Corporate team. This forum analyses and discusses compliance with a range of targets, agrees actions for implementation as appropriate and oversees service activity levels against planned clinics, theatre lists etc. It also considers the performance of the Independent Sector providers with whom we contract.

496. Performance targets from SEC and ATICS that were escalated to me as Director of Acute Services include Red Flag cancellations on the day, underutilisation of WLI funding, underperformance of Independent Sector contracts and services that are not meeting estimated activity that were part of the Rebuild plans. For Cancer Services, waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets are also escalated to me.

497. There is also a Corporate Performance Committee which is a subcommittee of the Trust Board. I am required to attend by invite when specific issues relating to the Acute Directorate are under scrutiny. The corporate suite

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

of performance data is shared and discussed within that Committee with escalation to Trust Board as required.

498. As Director I am a member of the regional interface meetings with Health and Social Care Board (HSCB now known as Strategic Planning and Partnership Group, SPPG) with Assistant Directors, Heads of Service and Operational Support Leads. These meetings consider waiting list volumes, time of longest waits, specific tumour site analysis and compliance with 14-, 31-, and 62-day cancer targets.

499. The first agreement that I was aware of since my tenure was the Action Plan that was implemented during the 2017/2018 MHPS Investigation and Determination Report. This was agreed with Mr O'Brien during that period and was monitored weekly by Mrs Corrigan, then Head of Service in Urology. She completed this by reviewing the backlog reports, cross referencing Patient Administrative System (PAS), Northern Ireland Electronic Care Record (NIECR) patient data and E-Triage and whilst non-compliance was picked up in September 2019, Mr O'Brien did not agree monitoring should have still been in place post the MHPS formal investigation. This frustrated the Return-to-Work monitoring process and attempts to meet him to discuss.

500. Following the MHPS Determination report, the lodging of the grievance by Mr O'Brien and the subsequent appeal, resulted in an inability to act until the outcome of these were known. We now know this resulted in further patient harm.

501. Following the significant SAI's , "Index case" in 2016, 5 subsequent 2016 SAI's reported in 2020, the 9 SAI's in April 2021, an implementation plan to address recommendations required a Service Improvement Task & Finish group to be established. The focus of this was to ensure learning was applied across all cancer services and specialities and required the engagement of DMD's, CD's AD's, HOS and operational teams with service users to address deficits in systems and processes including MDT quorate meetings, ensuring the inclusion of a range of clinical opinions, better decision-making and following up actions and patient outcomes. This also has escalated to Commissioners the importance of appropriately resourcing cancer services and specialities including urology.

502. In addition, a better system of administrative and clerical escalation processes has been agreed to address issues regarding timely triage, case note tracking and following up referrals and diagnostics and acting on diagnostic results in a timely way. All of these are designed to prevent patients coming to harm in our care.

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

503. As per response in Question 49 Section iv, I was assured through the 1:1 meetings with Assistant Directors and Divisional Medical Directors, in the

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Acute Performance Meeting and in liaison with the Corporate Performance and Reform Team who prompted concerns with targets and work with me to address them with the team. I escalated the performance issues to the Corporate Performance Committee/ Trust Board and HSCB, offering assurances that systems and processes were in place to maximise performance within available capacity. The systems and agreements are working as evidenced in the attention to every single solution that can be mobilised to ensure prioritisation and creating capacity for maximum patient reviews. The addition of further urology consultants is the real solution to this going forward.

504. Individuals from across the teams were aligned to the various roles and remits regarding monitoring compliance, service improvement, MDT support and outcomes focus. I was updated through the 1:1 meetings with AD's regarding progress and impact to date, showing positive impact. This was also recorded and discussed with HSCB and DOH at Urology accountability meetings.

505. I assured myself that the tool being used to assess the baseline picture of the MDT's was evidence-based and we agreed the NCAT tool as the best mechanism. I got regular updates from Mr Barry Conway, Mr Ronan Carroll and Dr Shahid Tariq regarding the progress being made, the issues that required to be addressed, including additional capacity to support the MDT's and the positive feedback from the teams. The ownership of the MDT service improvement model was clearly expressed. The tools and processes being implemented in the MDT's was shared at NICaN both by me and by the AD and HOS in Cancer & Clinical Services. The investment in support for MDT working as detailed earlier has been very gratefully received by teams and will have benefit for patients.

506. Escalation processes are now embedded across all specialities to identify and escalate up through line management for appropriate action. This can include addressing the issue with the clinician involved and reallocating workload if pressures are impacting on patients such as triage delays or capacity to assess.

vi. If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

507. Assurances are inbuilt to the line management and 1:1 meetings that I have with Mr Ronan Carrol (AD) and Mr Conway (AD). I tested these by reviewing the baseline audits of the MDT's and some of the action plan progress updates to follow the improvement pathway.

508. I offered support and guidance to Mrs Ward when she was appointed in November 2021, with responsibility for the Look Back Review and Service Improvement. This allowed me the opportunity to discuss issues, scope options and solutions, for example regarding the involvement of the independent sector

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

in patient reviews. Part of that assurance for example was by inviting independent sector colleagues to the Trust to test their application of the Structured Clinical Review Process to assure us that they were both competent and confident in completing same. The Deputy Medical Director (Dr Gormley) oversaw this process and fed back on their suitability.

509. Mr Haynes is actively involved in patient reviews and participates in the fortnightly urology meetings (clinical capacity allowing) escalating issues of concern and also assuring of the impact of reviews and outcomes and that treatment issues have been picked up and addressed. I have chaired that group since its inception, recently handing over the Chair in June 2022 (in preparation for retirement) and whilst I trust Mr Haynes' clinical opinions and judgement, Dr O'Kane and Dr Gormley being present, offers professional challenge and scrutiny which strengthens assurances offered.

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

510. With regard to performance, in the context of demand outstripping capacity, the best option available to management, related to oversight of our systems, to ensure that the highest priority patients accessed services at the earliest possible opportunity, within available capacity. It has not resulted in reduced waiting lists or times and many of the performance targets have not been met but I am assured by the Urology team and offered my assurances to Trust Board that every possible mechanism currently is in place to improve performance.

511. I believe we are currently tracking patients in a comprehensive manner, mobilising resources and identifying patient harm and putting in place actions to address same. This is focused on the patients who have been under Mr O'Brien's care.

512. The broader governance issues have been supplemented by additional capacity within Clinical Directors and Divisional Medical Directors to support professional governance across operational teams. In addition, Deputy Medical Directors for Medical Education (Dr Aisling Diamond) and for Revalidation and Appraisal (Dr Damian Scullion) are increasing a focus on innovative education approaches including simulation techniques, job planning approval and sign off and revalidation compliance. I can see the impact of these approaches to date evidencing greater scrutiny and oversight. In addition, the Doctors and Dentists oversight allows discussion on professional issues and action to be agreed to ensure patient safety. Mr O'Brien concerns have been presented at this during my tenure, allowing effective communication and awareness of relevant issues to be highlighted for attention as appropriate.

513. Attendance at quorate MDT's, the impact of support for the Chair and the ability to sample decisions and actions post MDT, is receiving positive feedback in terms of impact, compliance and better patient outcomes. This is shared by Mr Conway as AD Cancer & Clinical Services. Motivated, engaged

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

staff who now understand why this is not just about urology services is another palpable sign of success.

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

514. Success has been measured by:

- Daily monitoring by the OSL and Head of Service using for example agreed indicators under IEAP and other performance metrics described in question 12;
- Completion of baseline audits across cancer specialities with KPI's regarding characteristics of good MDT working;
- Agreed action plans to improve, subject to future audit;
- Attendance levels;
- Quorate MDT's;
- Sampled post MDT outcomes re actions agreed showing compliance with agreement;
- Volumes of patients reviewed in urology and moved to more appropriate treatment pathways in line with best evidence;
- Additional clinical capacity and core staff dedicating clinics to Mr O'Brien's patients evidencing a committed workforce, keen to be part of ensuring patient safety;
- Administrative delays being picked up, escalated and resolved;
- Service user involvement to shape and influence the future of urology services.

50. 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 –

515. The 6 main areas I will refer to here are:

- workforce challenges;
- delays with progressing SAI's;
- compliance with MHPS agreed actions;
- progressing the Review of Administrative processes;
- the concerns raised in June 2020 by the 10 patients escalated in one day, raising alarm;
- Performance.

(a) properly identified,

516. I believe all of the above have been properly identified and the responses throughout this notice detail the rational for my thinking including workforce data and strategies to address. In addition, the identification of delays with Dr J Johnston' 5 SAI's which had been protracted over more than two years, was

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

brought to a conclusion but caused unnecessary patient and family concern and harm.

517. Clear non-compliance with the 2 areas within the MHPS action plan were detailed with numbers and issues. Mr O'Brien did not agree that this monitoring was relevant outside the investigation period. I believe his grievance being lodged, in effect resulted in the extending of the monitoring period as no outcome had been reached.

518. As the MHPS reports had not been shared or communicated with me until 27 August 2019 and with the Assistant Director until 8 October 2019, the admin review had not been progressed as the operational teams were unaware of the recommendation which was included in the Case Determination Report that was finalised on 28 September 2018. Once this was shared and focused on, this was delivered on 10 May 2021.

519. The evidence since the June 2020 concerns has not only identified that there were legitimate concerns, but increasingly the numbers and types of concerns and patients who have been identified and come to harm has been clearly detailed and appropriate action taken to address.

520. Performance issues were clearly identified on a daily basis as described earlier in this response and shared with the relevant performance meetings.

(b) their extent and impact assessed,

521. With regard to workforce the attempts to deal with the challenges is described in Question 16 in terms of the extent and the impact of reduced capacity on patients accessing treatment and care in a timely way.

522. The MHPS formal investigation, the related case determination and the grievance lodged by Mr O'Brien all had the impact of enabling the agreed actions to be progressed and ultimately improving patient safety as a result. The administrative delays identified within the MHPS recommended a review to embed better systems and processes going forward. This has been progressed.

523. There has been a rigorous thorough process to scope the extent and impact of the identified concerns. The total of 2113 patients who have been identified, reviewed and either assured of their care or moved to an appropriate treatment plan in line with best practice and guidelines is clear to be seen in activity logs and patient outcomes to date. In addition, the SAI's have clearly evidenced harm and made recommendations. For some patients and families, that is too little too late.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

524. As discussed earlier in this question, the extent of the performance concerns and their impact on patient safety was clearly considered on a daily, weekly and monthly basis, to minimise impact on patient care and treatment within available resources.

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

525. From a workforce performance and need to review and embed more robust administrative processes, I believe all of these considered the patient as the main focus of why we needed to monitor, action and improve our approaches.

526. The application of best practice, thorough patient reviews (face to face and desktop), the inclusion of Subject Matter Experts to assess patients objectively and the numbers of SAI's identified and investigated, evidences proper consideration of potential risks to patients and the need to progress these range of measures.

527. Following the 9 SAI's (April 2021), 77 patients were then identified from the patient reviews who were considered to meet the SAI threshold. The Structured Clinical Record Review Process had been agreed with the Department of Health as the best way forward for the urology patients, due to this being an evidenced based tool that focuses on learning in a more expedient way. 53 of those 77 patients were screened in by the clinical team and a further 18 have since met the threshold for SCRR. The patients who had been on Bicalutamide (drug levels outside of guidance and those who had delayed referrals, diagnostics and/or report reading to inform next treatment steps, all have been considered in-house, by the independent sector and/or by UK subject matter experts. This is evidence thus far of having fully considered patient risks and our efforts to provide safe, effective, high-quality services.

General Concerns

528. The general governance concerns raised with me from June 2019 related to workforce challenges, capability issues, nursing staff vacancies, inability to deliver quality nursing care at expected standard, consultant urologist vacancies, delay in accessing services for assessment or treatment and non-compliance with the key performance indicators outlined in the IEAP.

529. I am of the view that these were properly identified as they were supported by appropriate data regarding staff in post, vacancies, audit outcomes, data provided in relation to IEAP targets, complaints, incidents and Serious Adverse Incidents which confirmed the governance issues within urology services.

530. Many of these governance concerns were recorded on risk registers and are being actively progressed. Others such as Nursing Quality Indicators were

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

recorded in reports from the Executive Nursing team and formed the basis of the action plan with the operational team including recruitment, training, capacity building, retention strategies and quality nursing care bundles and approaches (Nursing Early Waning Scores, Pressure Ulcers and Falls Prevention and Management).

531. From a medical perspective, ongoing recruitment of consultants and locum doctors and implementation of new posts including clinical fellows and physician associates were all in response to the risk of reduced medical capacity to deliver the service and the implementation of new posts to stabilise the team.

532. The potential risks to patients were clearly identified in the risk registers at Directorate and Corporate level including 62-day cancer performance, impact of appropriate and nurse staffing levels on the ability to provide safe, high-quality care, and access to inpatient, outpatient, day cases, and treatments outside clinically indicated timescales.

Deficiencies in Practice

533. The two main issues that were escalated to me of a more serious nature during my tenure as Acute Services Director were the breaches already cited regarding the MHPS Return-to-Work Action Plan escalated by Mrs Corrigan (September 2019) and the escalation from My Haynes in June 2020 prior to Mr O'Brien's retirement.

534. With regard to the MHPS agreed Action Plan, the breaches were clearly identified on 16 September 2019 that Mr O'Brien had 26 paper referrals outstanding and on e-triage 19 routine and 8 urgent referrals. This was in breach of the 1st Concern that was to be addressed within the action plan and monitoring arrangements – *that Mr O'Brien when urologist of the week (once every 6 weeks) must action and triage all referrals for which he is responsible. This will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters, it must be ensured that the Secretary will record receipt of these on PAS (Patient Administration System) and then all letters must be triaged. All referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends. Red flag referrals must be completed daily.*

535. The second concern related to the action on digital dictation which was not complied with. On 16 September 2019, Mrs Corrigan noted –

"Clinics held in Thorndale Unit (Craigavon Area Hospital)
CAAOBTDUR 20 August 2019 had 12 booked to clinic, 11 attendances and 1 CND (cancelled on the day) but no letters at all.
CAOBUO 23 August 2019 had 10 attendances and only 1 letter on NIECR

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

CAOBUO 30 August 2019 12 booked to clinic, 1 CND, 1 DNA (did not attend) and 0 letters on NIECR
CAOBUO 3 September 2019 8 booked to clinic, no letters on NIECR"

536. The escalation from Mrs Corrigan confirmed that the concern regarding the two issues above were a clear breach and properly identified on Trust systems. The remaining two actions being monitored were complied with namely; no notes were stored off premises nor in Mr O'Brien's office (confirmed on the basis that there had been no issues raised regarding missing charts that Mr O'Brien had) and no more of Mr O'Brien's patients that had been seen privately as an outpatient had been listed in the Trust.

537. The impact of these is the potential of the referred patients not having been triaged or prioritised by the consultant, therefore delaying access to appropriate treatment pathways and potential risk of harm. With regard to contemporaneous dictation following clinic attendances at the Thorndale Unit, some letters not having been dictated will have delayed communication, and therefore access to information by GP or other clinicians on Northern Ireland Electronic Care Record (NIECR). There is also the potential of delay in the referral for follow-up diagnostics or treatment plans as the output of the clinic assessment is not available.

538. The learning from the Serious Adverse Incidents (April 2021) regarding Mr O'Brien's patients has shown delays in accessing triage, assessment, diagnostics and appropriate treatment pathways caused significant harm to patients.

539. The second serious concern that was escalated to me, Dr O'Kane, Mr Carroll and Mrs Corrigan on 11 June 2020, was the incident relating to patients identified by Mr Haynes that Mr O'Brien had requested to be added to the urgent bookable list which should have been added to the waiting list anytime between 18 July 2019 and 4 June 2020. This was as a result of an email from Mr O'Brien on 7 June 2020 to Linda Neville and Jacqueline McIlveen (temporary Secretarial cover) adding the 10 patients who required urgent admission and he had advised Mr Glackin of same on 4 June 2020. Mr Haynes had already arranged to admit 1 of those patients to Kingsbridge Private Hospital.

540. This is a serious concern as the standard procedure is that a patient is added to the PAS waiting list at the time of listing and not a time of offering a date for surgery. The concern expressed by Mr Haynes was that there could be other patients who were not administratively on the waiting list but should be with a risk that patients could be lost to our care. Out of the 10 patients that were reviewed by Mr Haynes, 3 were classified as having malignant disease and 1 with potentially malignant disease.

541. A response from Dr O'Kane on 11 June 2020 highlighted how concerning this finding was and the need for an urgent meeting to be planned to assure ourselves that these patients were safe, identified others that had been delayed and referencing the spirit of openness regarding conversations

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

with patients that might be made to make them aware. She also was concerned that this appeared to be a continuation of the behaviours that led to the Serious Adverse Incidents previously.

Q51. 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. (Q65 will ask about any support provided to Mr O'Brien).

542. In the earlier days of my tenure as Acute Services Director, the support for the team focused on building capacity, recruiting medical and nursing staff (substantive preferably and locum/ agency if necessary), stabilising the teams focusing on quality care and involving the professional Executives, Medical Director and Executive Nurse, in operational plans that required professional support and oversight, reducing bed complement to improve the nurse to patient bed ratio and reducing patient safety risks.

543. Once the more serious concerns noted above were communicated to the urology team, the need for additional patient reviews on an already stretched team, with vacant posts and significant backlogs, waiting lists and waiting times, increased anxiety levels. As a result of the announcement of a Public Inquiry into urology services, regular meetings were set up to check in with the team, offer 1:1 or peer support if they felt that would be helpful, and access to psychological support internally within the Trust or via INSPIRE was offered (independent contract available for staff health and wellbeing). The Director of Human Resources was kept appraised of the concern among urology staff as the psychology services and wrap around support sits within her brief.

544. Regular team meetings were offered at the pace and level that the team requested, monthly in the first instance and then scheduled whenever a communication needed to be shared. This offer was one of support with the spirit of one team working on resolving the issues together, staying united and strong and focused on patient safety. Having the Medical Director, Chief Executive and Executive Nurse in attendance was an opportunity to discuss any concerns among the team.

545. The consultants were concerned regarding the displacement of their priority patients by the need to review Mr O'Brien's patients as identified. As their concerns related to lack of capacity, subject matter experts were sourced from British Association of Urology Specialists (BAUS) to offset some of the demand of the patient reviews. In addition, an independent sector contract was agreed for approximately 236 oncology patients to be reviewed as a matter of priority. These approaches were an attempt to retain some capacity for their priority patients.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

546. Additional clinics were also put in place, offering core consultants additional payments to work beyond their normal job plan by way of appreciating their extra commitment to resolving the patient safety issues.

Q52. Was the urology department offered any support for quality improvement initiatives during your tenure?

547. The Quality Improvement Division of the Trust provides a range of support into directorates including QI capacity building, workshops, QI clinics, supporting awards and recognition and project facilitation and support. I do not have information on individuals who accessed quality improvement support formally, however, I am aware the urology team are focused on quality services and new models of working. This is demonstrated by their ongoing escalation of service priorities and service challenges as they seek support for continuous quality improvement. This has resulted in securing the resource for the 7th urology consultant (appreciating the available recruitment market challenges). In addition, an Investment template was completed to secure £500,000 for a Regional Stone Treatment Centre which has been approved and is in the process of going live.

548. Some additional workforce investments have included the two additional Clinical Nurse Specialists from commencement of my tenure, and the re-banding based on increased scope of practice for higher professional inputs of urology clinical nurse specialists aligned to urology. Following the implementation of the lookback review, a Clinical Assurance Lead (Mrs Ward) post was appointed predominantly to lead on the urology patient lookback reviews to ensure the safety and quality of care is monitored and improved. Finally, the additional governance capacity (Band 5 governance officers), as previously referenced, will impact on improving quality of services by ensuring there is dedicated resource focused on the validation, implementation and monitoring of agreed actions and learning from incidents, complaints, and SAI's is embedded.

549. Over the past 18 months, a series of service/quality improvement approaches have taken place including Macmillan investing in the Service Improvement Lead post (Mary Haughey) and the Trust investing in the Clinical Educator post for surgical areas including 3 South ENT/Urology ward.

550. The 9 SAI's presented at ACG in April 2021 highlighted the recommendations with regard to improving service delivery and governance. This resulted in literature reviews and evidence of best practice and the adoption of the National Cancer Action Team (NCAT) audit tool which facilitated baseline audits across all tumour sites. New standards of MDT working and compliance with the NCAT Characteristics of an Effective Multidisciplinary Team have been applied and additional administrative support secured for the MDT chairs.

551. With regard to this, a Task and Finish Service Improvement project was implemented in May 2021 that works across urology, surgery and all cancer

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

MDT's. This has resulted in the 11 recommendations of the Serious Adverse Incidents being almost fully implemented (8 completed and 3 well under way and nearing completion). This has actively involved two family members who had experienced the serious adverse incident process following care under Mr O'Brien.

552. I as Director of Acute Services sit at the NICaN project steering group and the Assistant Directors of both Surgery and Elective Care Services and Cancer and Clinical Services worked closely with NICaN officers to deliver on the Regional Cancer Strategy and best practice care.

Mr. O'Brien

Q53. 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)?

553. As Director of Acute Services, I operationally manage all acute staff. As there are approximately 5200 staff, the line management structures to do this are broken down by individual teams, Departments and Divisions. There is an Assistant Director in charge of each Division and a Head of Service, Lead Nurse(s) and levels of staff from Band 8 – Band 2. In addition, the Medical Leaders of Divisional Medical Director and Clinical Director, support the Assistant Director of each Division. Operationally, a consultant would be managed within the operational team and would be clinically and professionally responsible to the Clinical Director, Divisional Medical Director and ultimately to the Medical Director.

554. With specific regard to Mr Aidan O'Brien, as a core member of the urology team, he would have been operationally managed within the urology team through the Head of Service, Mrs Martina Corrigan, who reported to Mr Carroll, as Assistant Director. Mr McNaboe as Clinical Director for ENT and Urology would have been his operational and clinical line manager, ultimately, escalating to Divisional Medical Director, Mr Mark Haynes. Within that collective leadership model across operational and medical staff, it is the responsibility of the Assistant Director and Divisional Medical Director to escalate concerns of any nature regarding consultants with me.

555. I never met, spoke with or had email conversations with Mr O'Brien. I once was alongside him in a lift and when he left the lift, I asked who he was, and was told that he was Mr O'Brien.

Q54. 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.

556. I had no direct involvement with the job planning process. With regard to Mr O'Brien his job plan was completed by the Clinical Director with the Head of

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Service and subsequently signed off by the Assistant Director and Divisional Medical Director. It is a joint responsibility between Assistant Director and Divisional Medical Director to ensure job plans reflect work to be undertaken.

Q55. 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?

557. On 27 August 2019, I first became aware of issues regarding Mr O'Brien. It followed a communication from the GMC Triage Team seeking further information from Dr O'Kane following Dr O'Kane's referral of Mr O'Brien to them on 3 April 2019. 10 points were raised by the GMC seeking a response in advance of 6 September 2019. Dr O'Kane forwarded the email to Mr Simon Gibson, Assistant Director Medical Director's Office, Siobhan Hynds, Deputy Director Human Resources, and Mark Haynes, Divisional Medical Director. I was copied into the email alongside Mrs Vivienne Toal, Director of Human Resources and Organisational Development. On 10 September 2019, I was further copied in to an email reminder for the requested information to the same email recipient as above.

558. On 16 September 2019, an email exchange commenced following two breaches to the post MHPS formal investigation Action Plan. This was from Mrs Corrigan to Dr Ahmed Khan and Mrs Hynds. By 4 October 2019, this email exchange was shared with me by Dr O'Kane who requested an Oversight meeting for 8 October 2019 to prepare the Trust response to the GMC with the attached email trail of the escalated breaches. In preparation for the meeting planned for 8 October 2019, Dr O'Kane forwarded the MHPS Return-to-Work Action Plan for Mr O'Brien which I forwarded on to Mr Carroll following the Oversight meeting taking place. This was the first time either of us had seen the MHPS Return-to-Work Action Plan.

559. Following the Oversight meeting of 8 October 2019, Dr O'Kane shared draft notes of the meeting including discussion on the escalation of concerns with regards the action areas of the agreed MHPS Return-to-Work Action Plan including timely triage processes, undertaking digital dictation immediately following each contact and not holding notes at home.

560. Dr O'Kane noted that Mr O'Brien's secretary had not engaged with the monitoring of the action plan, which required Mrs Corrigan to go on the electronic care record (NIECR) to check if notes have been uploaded. It was also noted that an incident report (1R-1) had been submitted on 3 October 2019 regarding a delay with a cancer patient. This gentleman, Patient 112, had been discussed at MDT on 27 June 2019, and the outcome was Mr O'Brien was going to organise a renal biopsy. On 24 July 2019, Mr Haynes emailed Mr O'Brien and his secretary, Noeleen Elliot, to advise that a further referral had come in about this gentleman's renal lesion which Mr Haynes was triaging. He asked Mr O'Brien in the email *"had you the biopsy in hand?"* On 4 October

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

2019, Mr Haynes again emailed Mr O'Brien and his secretary Mrs Elliot to advise that this gentleman's case was discussed again at MDT on 3 October 2019 regarding clarity re investigations. The gentleman had not yet had a biopsy and there was no outpatient letter on NIECR from his outpatient appointment with Mr O'Brien on 16 October 2019. Mr Haynes asked if the biopsy was on hand and could Mr Haynes help by organising whilst he was in Belfast City Hospital. Mr O'Brien responded on 4 October 2019 that we would update the MDT the following week.

561. It was agreed at the Oversight meeting that Dr O'Kane would ask Mr McNaboe to discuss the concern with Mr O'Brien and to make him aware that this had been raised with the MHPS Case Manager, Dr Ahmed Khan. Dr O'Kane also agreed to consider the escalation including potential option to exclude and also to consider progressing the full system review noted in the 28 September 2018 MHPS Review. This later point references the final conclusion/recommendation in the MHPS Case Manager Determination Report dated 28 September 2018 authored by Dr Ahmed Khan, which states:

"The Report highlights issues regarding systemic failures by managers at all levels both clinical and operational within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in the practice of Mr O'Brien. No one formally assessed the extent of the issues or properly identified the potential risks to patients. Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there were wider issues of concern to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien. In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."

562. I became aware from having received documents in preparation for 8 October 2019 Oversight meeting that the MHPS formal investigation had taken place in September 2018. The MHPS Case Manager Determination Report (Dr Ahmed Khan 28 September 2018) under section 4 Investigation findings stated that –

"It was found that Mr O'Brien did not undertake non red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged and Mr O'Brien had accepted this fact. The same section of the report also highlighted that Mr O'Brien returned 307 sets of patient notes in January 2017. In addition, it was found that there were 66 undictated clinics by Mr O'Brien during the period of 2015 and 2016. Finally, it was found that Mr O'Brien scheduled 9 of his private patients sooner and outside clinical priority in 2015 and 2016".

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Having read this, I can advise that I was then aware that issues relating to Mr O'Brien were in existence from 2015.

563. There were additional patient safety concerns escalated by Mr Haynes on 11 June 2020 leading to significant patients reviews resulting in 9 SAI's and to date 71 structured clinical judgment reviews.

Q56. 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.

Initial Oversight Meeting

564. The Oversight meeting which was arranged by Dr O'Kane on 8 October 2019 was in preparation for an update to GMC, following the 3 April 2019 referral of Mr O'Brien by Dr O'Kane. The discussions at this meeting are detailed in my response to question 55.

565. On the same day I had a face-to-face discussion with Mr Carroll to advise that the Oversight meeting had taken place and agreed to send him on the documents discussed at the meeting.

5 Urology SAI Reports – Meeting

566. I met with Dr O'Kane on 31 October 2019 to talk about the 5 urology SAI reports under external SAI review by Dr Julian Johnson. The reports had been received by the Trust as one aggregated report for the Clinical and Social Care Coordinator, Patricia Kingsnorth, to disaggregate. I stressed that this needed to be done by the original author, Dr Johnson, as the findings and learnings needed to be rewritten and this was best done by the author.

567. During the meeting, I emailed Mrs Connie Connolly (covering Personal Information redacted leave for Patricia Kingsnorth) and Dr Tracey Boyce who had been overseeing the governance coordinator for the previous 4 years until I came in to post, to check if the disaggregation of the report had started and if they were in agreement that we should ask Dr Johnson to do this. Mrs Connolly replied that the disaggregating element was due to be done following Mr O'Brien's check for factual accuracy. The Coordinator had planned to then segregate the cases and send back to Mr Haynes and Mr O'Brien to validation.

568. It is noteworthy that the Royal College of Nursing had planned strike action from December 2019 to March 2020 and much of November 2019 was dedicated to planning services in preparation for strike action, which delayed the follow up meetings.

Oversight Meetings

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

569. I have referenced earlier the Doctors and Dentist Oversight Meeting which *supports 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, 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 any 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.*

570. At the Oversight Meeting on 8 October 2019 following the MHPS breaches, the follow up meeting was on 12 February 2020. Prior to the establishment of the monthly Doctors and Dentist Oversight meetings in May 2019, the mechanism used was specific meetings with regard to individual professional concerns and concerns about Mr O'Brien were discussed at those meetings (I have no knowledge of the detail of these meetings as these were held before my tenure). The 12 February 2020 meeting has already been detailed in question 49 with Dr O'Kane taking responsibility for most of the action agreed.

571. Following 12 February 2020 meeting, concerns regarding the clinical practice of Mr O'Brien were now discussed at Oversight Meetings on the dates below with summary notes:

- May 2020 – MHPS Investigation completed and grievance process invoked, GMC referral had been made in April 2019, Retirement planned for June 30th 2020, some request by Mr O'Brien to return to the Trust part time;
- June 2020 – no further update;
- July/ August 2020 – Mr O'Brien retired July 2020. GMC referral completed and Early Alert to DoH completed regarding concerns. Grievance Hearing held on 31 July 2020 and 7 August 2020 (I have no knowledge of the detail as I was not involved);
- September/ October 2020 – noted Stage 1 Grievance decision expected by 9 October 2020.
- January 2021 – Stage 1 Grievance decision has been communicated and appeal lodged;
- February 2021 – Mr O'Brien advised on 4 March 2021 re FOI request (historic issue which I have no detail of)

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

- April 2021 – Data protection letter issued as per DLS advice to Mr O'Brien with regard to issue above (9 April 2021), Terms of Reference for Grievance Review agreed at Urology Oversight and to proceed to arrange Panel to take forward;
- June 2021 – Noted that a separate Oversight is in operation (chaired by Mrs Siobhan Hynds), Grievance Panel to complete within 8 weeks;
- July 2021 – Grievance report in final stages of completion;
- November 2021 – no discussion as separate oversight was in operation;

Directorate of Legal Services Meeting

572. I attended a zoom meeting on 16/6/20 seeking legal opinion on the concerns raised by Mr Haynes on 11 June 2020, regarding patients under the care of Mr O'Brien. Dr O'Kane, Mr Haynes, Mr Carroll, Mrs Vivienne Toal and myself met with Mrs June Turkington to seek guidance on appropriately addressing the issues under concern.

573. I attended a further meeting on 23/6/20 with Mrs Vivienne Toal and Dr Maria O'Kane regarding a letter received from Mr O'Brien, regarding his termination of notice on 26th March 2020. He was unhappy with the Trust not agreeing to his subsequent Return-to-Work on a part time basis. The Trust maintained its position on not agreeing for Mr O'Brien to return to work on a part-time basis.

Acute Clinical Governance Forum

574. At the Acute Clinical Governance Forum, on 9 occasions from June 2019, patients who had been under the care of Mr O'Brien and had Serious Adverse Incident investigations carried out, were presented or re-presented at those meetings. The discussions related to the care of the patient and the recommendations to be progressed. The Forum did not discuss Mr O'Brien although the clinicians would have been aware he was consultant involved

External SAI Panel Chair Meetings with CSCG Coordinator

575. Dr Dermot Hughes was the External Panel Chair of the 9 SAI's which were concluded and presented to the ACG for approval in April 2021. Mrs Patricia Kingsnorth, Clinical and Social Care Governance Coordinator at that time, facilitated the external panel. I was asked to attend two meetings with Dr Hughes and Mrs Kingsnorth, firstly to discuss the planned SAI process for the 9 patients with the expectation of 1 aggregated report (23 October 2020) and secondly, to discuss the draft recommendations on 19 February 2021.

576. My hand written notes of the meeting have already been included in the Discovery to date. In summary, at the first meeting Dr Hughes highlighted concerns around Bicalutamide prescription and the requirement for discussion at MDT by clinicians if prescribing outside guidelines. It was highlighted that Mr O'Brien was the Southern Trust representative on the NICaN Group (Chair of the NICaN Urology Clinical Reference Group). The MDT role and function was

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

discussed at that meeting and the need to have appropriate representation from specialties and potential for tracking decisions that had been agreed at the MDT. He noted that standard attendance at Urology MDT was 66% and that Mr O'Brien attended 68% of them. He observed that the average number of cases presented was about 30 per MDT which limited opportunity to discuss in a 60-90 minute meeting. The need to explore failsafe approaches was to be considered.

577. On the follow up meeting, on 19 February 2021, when the draft report was ready, Dr Hughes advised of his concerns which would be included in the recommendations such as the need for working within NICE guidance, following up MDT recommendations which would require additional resource, issues regarding onward referral for curative intent and palliative care, the exclusion of CNS's, adherence with the penile pathway regionally, the potential of the Laboratory running weekly tumour site reports to cross reference with MDT actions and need for assurance audits on related data to increase confidence in the process. He also referenced the need for operational escalation when staff are concerned about suboptimal care.

Urology Team Meetings

578. Following the concerns raised by Mr Haynes on 11 June 2020, a series of meetings ensued namely on 11 August 2020 and 25 August 2020, including Dr O'Kane, Mr Haynes, Mrs Martina Corrigan, Mrs Siobhan Hynds, Mr Stephen Wallace, Mr Ronan Carroll, Mrs Vivienne Toal and myself, to discuss the concerns raised and to agree a plan to address the patient related issues.

579. In addition, to the meeting referenced above under *Oversight Meetings,* weekly meetings commenced on 15 September 2020 including participation from Dr O'Kane, Dr Damian Gormley (Deputy Medical Director), Mr Haynes, Mrs Corrigan, Mr Carroll, Mrs Hynds, Mrs Toal, Mr Wallace and myself. Not all members attended every meeting. These meetings predominantly focused on agreeing the patient safety issues, stratifying the cohorts and operationally planning the patient reviews. These continued weekly moving to fortnightly and more recently formalised into the Lookback Review Steering Group on 20 December 2021.

580. A few meetings for the clinical staff involving all consultants, clinical nurse specialists, locums, Head of Service, Assistant Director, Dr O'Kane, occasionally the Chief Executive in attendance and myself were set up to offer support to the team. For example, when the Public Inquiry had been announced, staff anxiety had been raised, also they were a good vehicle to update the team on occasions regarding clinical demands, establishing independent sector services and on SAI recommendations that required implementation.

57. 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

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

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.

581. As a direct result of these concerns, I took many actions on an individual basis, and worked with others to agree a collective plan for patients to be reviewed following the concerns raised, to assure the Trust that no patients had come to any harm or where they had, that appropriate actions were instigated to address these. These actions include:

- attending a number of meetings (details of which are described above) to understand fully the background information and the concerns;
- On understanding the delay with the 5 SAI's which Dr Julian Johnston had been charged with completing, I initiated a series of conversations across Mrs Kingsnorth and Mrs Trudy Reid to enable Mrs Reid to request a timely conclusion of the reports from Dr Johnston which were presented to ACG in February 2020;
- I engaged clinically with Mr Haynes, and urology colleagues including Mr Carroll, Mrs Corrigan and Ms Clayton with Dr O'Kane and Dr Gormley present to ensure a fully informed clinical decision on the way forward was agreed;
- I worked with Mr Wallace and Dr O'Kane to agree subject matter experts in liaison with the British Association of Urology Specialists (BAUS) to increase the capacity for patient reviews following the concerns;
- I commissioned the services of those experts recommended by BAUS to deliver patient services including performing Structured Clinical Record Reviews (SCRR);
- I oversaw operational planning of identified priority patients for face-to-face review;
- I ensured communication was sent to all patients who had been under the care of Mr O'Brien from January 2019 – June 2020 (the first priority cohorts agreed within these dates), advising them they were included in the review of those patients who had been under the care of Mr O'Brien, updating them on their specific issues or reassuring them if there were no concerns identified with their care;
- I oversaw the establishment of the patient information line (still in operation) and in the initial months a GP line for primary care to escalate issues to the Trust
- As chair of the weekly Urology Review Meeting, I listened to feedback from the clinics held and agreed with the group the respective governance actions that were required including, incident reporting, screening for and carrying out SAI's for those who met the threshold, involved patients and families at whatever level worked for them;
- I commissioned Dr Dermot Hughes to do an investigation into the 9 identified SAI's and to progress this in a timely way to secure early learning. I met Dr Hughes on two occasions pre and post his review to

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

plan the process and to understand the early learning towards the end of his review, prior to submission as a final report;

- I chaired the monthly Acute Clinical Governance Forum where the SAI's were discussed, challenged and approved for submission to HSCB;
- I communicated weekly/ fortnightly and moving to monthly with HSCB and the Urology Accountability Group with Department of Health which Mr Devlin, Chief Executive and Dr O'Kane also attended. We secured agreement to employ the SCRR process as the alternative to SAI due to the increasing volumes and the potential to expedite the learning with an evidence-based process. This approach is now firmly embedded;
- I supported the team to increase capacity by establishing contracts with the Independent Sector including Orthoderm and 3fivetwo to offer patient reviews and related care;
- I oversaw the establishment of the Task and Finish Service Improvement Group that was tasked with addressing the 11 recommendations from the 9 SAI's, with all the cancer specialties as there was learning over and above the urology service;
- I updated Senior Management Team, Governance Committee and Trust Board on Patient Safety Concerns and assurances of the range of mechanisms established to address these;
- I participated in the Doctors and Dentist Oversight Meetings which enabled the professional issues to be discussed and concluded;
- I supported the clinical and operational teams as the impact of the concerns having been raised and the commencement of the Public Inquiry caused some anxiety and we established within the Trust support mechanisms including 1:1 psychology support, peer support and Executive Director support from Dr O'Kane and Mrs Trouton.

Q58. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

582. In my view, the concerns that had been raised regarding delays in triage, lack of contemporaneous note keeping and delays in referrals or escalation to waiting lists would have had the potential to negatively impact on patients, causing significant harm to their care and safety.

i. what risk assessment did you undertake, and

583. I did not personally undertake a risk assessment about the concerns relating to Mr O'Brien regarding triaging of referrals, contemporaneous note keeping, storage of medical records and private practice. The concerns which related to his individual clinical practice had been raised before I commenced my tenure and were monitored weekly by Mrs Corrigan as Head of Service.

584. It is the responsibility of the Clinical Director to oversee clinical and professional practice. It would not have been considered appropriate to include individual clinician concerns regarding administrative and clinical practices on

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

the Divisional Risk Register, as it focuses on service risks which have the potential to cause risk or harm to patients. The mechanism for risk assessment and management of professional issues is the Doctors and Dentists Oversight Meeting, underpinned by the MHPS framework, which deals with individual clinical and professional concerns as opposed to the service approach of the risk register.

585. Following the October 2019 Oversight Meeting which I attended, chaired by Dr O'Kane, a series of actions ensued to refocus on the actions contained in the Case Determination report including the Review of Administrative Processes, broader than urology services. As a result of the need to renew focus on the expected review of systems and processes, Dr O'Kane agreed to consider the way forward. In the meantime, the monitoring of Mr O'Brien's four key action areas continued by Mrs Corrigan.

586. I discussed the detail of the meeting with Mr Carroll following the meeting and forwarded on the papers including the MHPS Case Determination Report which had been shared with me previously on 27 August 2019, for the first time, as it was a highly confidential report which is shared in the first instance with the Medical Director by the Case Manager. This will have been the first time that Mr Carroll would have been provided with it, as far as I know.

587. The Oversight meeting actions included that:

- Dr O'Kane would ask Mr McNaboe to discuss the recent concerns with Mr O'Brien and to make him aware that this had been raised with the MHPS Case Manager, Dr Ahmed Khan.
- Dr O'Kane had also agreed at that meeting to consider the escalation including potential option to exclude.
- She also agreed also to consider progressing the full system review noted in the 28 September 2018 MHPS Review.

588. It is noteworthy that the Royal College of Nursing had planned strike action from December 2019 to March 2020 and much of November 2019 was dedicated to planning services in preparation for strike action, which delayed the follow up meetings.

589. On 24 January 2020, Simon Gibson, Assistant Director (Medical Director's Office) emailed Dr O'Kane, Mr Carroll, Mr Haynes, Mrs Corrigan, Mrs Hynds, Mr McNaboe, Dr Khan, Mrs Anita Carroll, Mrs Toal and myself. In the email he provided an update regarding the meeting he chaired on 24 January 2020. The purpose of the meeting was in response to an email to Mr Gibson on 17 November 2019 from Dr O'Kane to describe in detail

- the management plan around the Backlog Report,
- to discuss the expectation re compliance (with standards re dictation),
- And the escalation.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

590. This was all to assist a meeting with Mr O'Brien to discuss his deviation from the Action Plan. Present at the meeting that Simon chaired were Mr Carroll, Mrs Corrigan, Mr Haynes and Dr Khan.

Backlog Report

591. The meeting highlighted that the Backlog Report was shared with consultants, Heads of Service and Assistant Directors but not with Clinical Directors or the Divisional Medical Director. It was felt that as the data was never independently verified, there may have been inaccuracies so wasn't viewed as robust. The Backlog was never raised in the patient safety meetings in urology and was not regularly discussed at urology specialty meeting.

Expectation re Compliance with Standards re Dictation

592. No one present at the meeting was aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard and there was no awareness of any standards set externally by Royal Colleges or other organisations. Therefore, when this data was considered, there was no agreed standard to use as a gauge against reported performance

Escalation

593. As there was some cynicism in relation to the validity of the data combined with a lack of standards against which to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report.

594. Those who attended the meeting acknowledged the challenge that this presented. The agreed Actions were for a group of staff to –

- Agree and describe why the information is being collated
- Separate in to two areas indicators for which clinicians are responsible and those for which admin staff are responsible
- Agree a consistent process for collation of the information on the method to independently verify it
- Provide a Trust wide standard of performance in relation to this performance indicators which all clinical staff should be expected to adhere to
- Agree the process for escalation when monthly information indicates a deviation from the Trust wide standard of performance

595. On 7 February 2020, Mrs Hynds, emailed myself, Dr O'Kane, Mrs Toal, Mr Gibson, Mr Carroll, Mrs Corrigan and Dr Khan highlighting that there were a range of matters which needed to be discussed and progressed in respect of

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Mr O'Brien's case and requested a meeting. She highlighted we had correspondence from GMC which needed a response.

596. Mr Gibson replied on 10 February 2020, that Trudy Reid and Stephen Wallace were coordinating a response to RQIA (who had been shared the case manager report from Dr O'Kane) in relation to a number of issues including Mr O'Brien. He referred to an email from Mr Wallace, where he noted that RQIA were seeking information on any plans to undertake a review of administrative processes within the Trust or rationale underpinning a decision not to proceed with review if this was the case. Simon Gibson clarified in an email on the same day that the draft Trust response to RQIA uses the backlog report as evidence of assurance even though it was noted to have had significant weaknesses within it as indicated in the recent meeting highlighted above.

597. Mrs Hynds responded that she felt the recommendation regarding an independent review of relevant administrative processes was being read somewhat out of its full context as it was a line at the end of a range of conclusions and needed to be read in conjunction with the conclusions.

598. This recommendation followed the Case Manager's Determination following the MHPS Investigation which was completed by Dr Khan. As Dr Khan had moved to the post of Acting Medical Director, the case determination was sent to Mr Shane Devlin, Chief Executive. The process was stalled in November 2018 soon after the determination report had been issued (28 September 2018) as Mr O'Brien raised a grievance about the investigation. Mrs Hynds noted that a substantial Subject Access Request on the investigation had been submitted by Mr O'Brien causing a delay and noted it was now about to be progressed. She wished all of this to be discussed at the planned oversight meeting and of note she asked Dr Khan in the email to provide clarity on what he was seeking as an outcome of the said recommendation mentioned in the determination report.

599. I responded to this email trail on 10 February to say;
"*Dear All, I would prefer to discuss this in person where clear roles and remits need identified. There was a lot of background information that I am not fully aware of*."

600. Mr Carroll responded on 11 February to say how frustrating he found this. The Aidan O'Brien process was controlled by Headquarters/Governance (MDO). He stated outcome and recommendations of the MHPS Case Determination Report were not shared with operational Ads, yet the recommendation affected all Acute Services. He stated that there were ongoing emails from the Medical Director's office with regard to Acute Services processes and signed it "*Disconnect.com*".

601. I responded to Mr Carroll, to confirm that I had requested an urgent meeting the previous evening to agree roles and remits and clarity on who is owning this. I then stated, "*Unfortunately as operational managers we can't disconnect.com but we need to address the governance arrangements and our*

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

commitment to monitoring etc. as previously detailed. Talk later." I then forwarded Mr Carroll's email to me to Mrs Toal and Mrs Hynds (Human Resources) to state:
"*A lot of strength of feeling, we need to resolve and get clarity urgently*".

602. On 12 February 2020, I attended the Oversight Meeting which Mrs Hynds had requested to get clarity as stated above. Actions agreed at that meeting –

- Dr O'Kane agreed to have a meeting/ conversation with Mr McNaboe, Clinical Director, regarding him having a meeting with Mr O'Brien regularly and seeking assurances through that supervisory process that Mr O'Brien was working in accordance with the triage process, was not holding notes at home and was undertaking all digital dictation immediately following each individual contact with the patient (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was discussed and agreed with Mr McNaboe)
- Dr O'Kane to speak with Mr McNaboe and Mr Haynes to ensure an agreed job plan was in place for Mr O'Brien as a matter of priority or to escalate to the next stage of the job planning process (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was discussed and agreed with Mr McNaboe and Mr Haynes)
- Dr O'Kane to seek assurance from Dr Damian Scullion to ensure Mr O'Brien was completing annual appraisals (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that Dr Scullion had assured her of this)
- Dr O'Kane to draft a response to GMC and RQIA in respect of their recent correspondence to the Trust seeking additional information about the case (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was being completed by Mr Gibson for 27 February 2020. She also noted that she had shared an update with GMC ELA who had requested SAI's. She stated that this will need agreement and confirmed that the Case Manager Determination Report had been shared with RQIA.
- Mrs Hynds to draft the Terms of Reference for the Independent Review of the SAI recommendations and the MHPS Review Recommendations and send the TOR to the Oversight Group for agreement
- Mrs McClements to share SAI reports and recommendations with Mrs Hynds for drafting of the Terms of Reference
- Dr O'Kane to speak to Dr Rose McCullagh (GP/ Associate Medical Director in Primary Care SHSCT) to undertake the independent review (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, she was awaiting Terms of Reference from Mrs Hynds)
- Dr O'Kane to update Mr Shane Devlin, Chief Executive (Confirmed on 24 February 2020 by Dr O'Kane to me and Mr Haynes, that this was done)
- Mrs Toal to progress Mr O'Brien's grievance process

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

603. On the 13 February 2020, I forwarded a confidential response (which was shared to me from Patricia Kingsnorth on 4 February 2020) to Dr O'Kane, Mrs Toal and Mr Gibson for Dr O'Kane to forward on to RQIA. The response detailed the progress against the MHPS recommendation regarding administrative processes, it clearly stated that the Trust had not undertaken an independent review of the relevant Administration Processes within the Acute Directorate, however, it stated the range of processes that were in place. It referenced the monitoring of administrative/ clinical aspects of the patient's journey producing the "Backlog Report" which is shared to the Divisions on a monthly basis. It also referenced with regard to electronic referrals that the process of e-triage has been embedded within urology with a built-in failsafe on this system to prevent referrals not being triaged. It referenced issues with GP practices not on e-triage and the system to deal with paper referrals as a result and standard operating procedures in place for admin staff to process internal referrals. It referenced a plan to introduce robust electronic processes for internal referrals by September 2020 and referenced the IEAP, regional guidance regarding the process which should be used when triaging letters.

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.

604. There are range of governance mechanisms that were put in place to identify, screen and progress incidents and serious adverse incidents. Completed reports were brought to Acute Clinical Governance monthly, recommendations and action plans put in place to embed learning. An important part of learning is to feedback to individuals and families and evidence to them that the Trust is committed to safe quality service. As Director of Acute Services, I ensured all Urology SAI's relating to patients of Mr O'Brien were brought to a conclusion and approved for submission to HSCB, by the Acute Clinical Group members.

605. Following the 9 SAI's reported in April 2021, I oversaw the establishment and progress against the 11 common recommendations, 8 of which are now fully implemented and 3 well underway (Service Improvement Task and Finish Group). The learning is already being applied to more robust MDT processes. I have secured investment to build additional roles into the MDT processes including admin support for the MDT chair and baseline assessments, action plans and audits of progress and outcomes post MDT decisions. The patient reviews were based around four questions regarding safe diagnosis and appropriateness of current treatment plan. There was a 10-question tool which added the historical treatment and care that had been in place In addition, to the current assessment. Originally, the 10 questions were used by Mr Haynes and Prof Sethia (Subject Matter expert in Urology from UK), however, as some SCCRs have been identified with the application of the 10 questions, these are now being applied retrospectively to patient reviews that took place using the 4-question approach only (since May 2022). This standardises the approach

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

for all patients with a view of their current and historic assessment, diagnosis, treatment and care plan.

606. Ongoing processes were embedded with competent, skilled urology clinicians across the Trust and the Independent Sector to build capacity for patient reviews, both face to face and desktop. This process enabled patients to be assessed and confirmation that the diagnosis and treatment was appropriate and where issues of concern were picked up, converting to an alternative patient treatment pathway and/or implementing governance processes including SAI's and structured clinical record reviews. An established formal lookback exercise has now commenced, extending the previous 18 – month review timeline (January 2019 – June 2020) to priority patients over the last 5-years.

607. I established and chaired Trust Urology Review meetings, weekly then fortnightly, with attendance from Medical Director's Office, operational teams and clinical urology staff. An action log was held to help inform the stratification of patients and prioritisation for review within available capacity. I also was a member on the Trust Urology Oversight, meeting chaired by Dr O'Kane, which considered the professional governance concerns including GMC referral, implementation of the MHPS recommendations and clinically informing the patient reviews for operational planning of clinics.

608. After the Oversight meeting on 12 February 2020, Dr O'Kane had taken responsibility for the majority of the actions agreed at the meeting, raised against Mr O'Brien. My main responsibility to mitigate against these concerns related to oversight of the monitoring arrangements by Mrs Corrigan and mobilising administrative support within Acute Services to support the Review that Dr McCullagh and Dr Donnelly had agreed to complete.

609. By 31 July 2020, Mr Stephen Wallace, Assistant Director Systems Assurance (Medical Directors Office), circulated Terms of Reference for the Review of Administration Processes as per MHPS Recommendation which Dr Khan had reviewed. Dr Rose McCullagh and Dr Mary Donnelly (Divisional Medical Directors - Primary Care) had agreed to conduct this work and commence it the following week. The purpose of the review, was to review the Trust urology administrative processes for management of patients referred to the service.

610. The document outlines processes regarding receipt of referrals and triage of referrals received to the urology service from all sources (this applies to all referrals not only urology). It referenced the effectiveness of monitoring and escalation of the administrative processes including by whom and how often the information is reviewed. The document also sought to identify any potential gaps where processes could be strengthened. Recommendations and Actions were included for all three areas.

611. Subsequent to this, it was agreed that it would be worthwhile working with another Trust to compare systems and processes. Further work was

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

progressed with Belfast Health and Social Care Trust culminating in a final admin review and processes by May 2021. The process described the issue across the four domains within the MHPS Case Determination Recommendations and related Return-to-Work Action Plan, specifically, triage, undictated clinics, hospital notes and private patients. It clearly detailed the issue and description of same, the gaps that led to the problem, the policies and processes in place, the ongoing risks, action required, the owner/responsible and timescale.

612. All of the above steps were taken in an attempt to reduce potential impact on patient care and safety.

Q59. 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.

613. I was not directly involved with Mr O'Brien. He retired 13 months after I commenced post.

614. Prior to his retirement, the monitoring of the Return-to-Work Action Plan on Administrative Process continued by Mrs Corrigan. I have seen a letter sent from Mr O'Brien to Mrs Corrigan following the identification of the breaches to the agreed actions in September 2019, when a meeting had been requested by Mr McNaboe and Mrs Corrigan with Mr O'Brien following the aforementioned oversight meeting which Dr O'Kane chaired. In the letter, he clearly expressed that monitoring was no longer appropriate as it was defined in the Terms of Reference of the Investigation to be in place for the period of the Investigation.

615. The subsequent concerns in June 2020 once identified, were close to Mr O'Brien's retirement which was planned for July 2020. Mr Haynes commenced scoping the patients' concerns and Mr O'Brien through a letter from the Directorate of Legal Services was advised of the concerns by Dr O'Kane.

616. There was no agreed way forward in relation to concerns raised at this point as Mr O'Brien had retired and the Trust was directed that any communication after his retirement be coursed through his legal team.

Q60. 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?

617. During my tenure, the only metrics which were measurable were the 4 Action areas in the agreed Return-to-Work Action plan. I believe these were effective as the 2 breaches in September 2019 were identified by Mrs Martina Corrigan with due escalation to Dr Ahmed Khan and onward to the Medical Director and subsequently myself. These measures remained unchanged throughout the period of monitoring.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

618. With regard agreeing an appropriate and robust administrative process as a result of the recommendation in the MHPS case determination report, the four areas identified for monitoring were triage, undictated clinics, hospital notes and private patients. The review process which was concluded in May 2021 described the policies and processes in place, the risks identified and the action required to address those risks. All of those metrics were embedded to prevent further issues arising.

619. Following the concerns regarding potential patient safety, a series of questions were devised, based on learning from BHSCT and HSCB to standardise the patient assessment and review. Whilst 4 questions was the minimum dataset required for patient safety assessment and these were used by Trust consultants and independent sector colleagues to assess the patients with regard to current condition and appropriateness of their treatment pathway, the 10 questions were used by Mr Haynes and Professor Sethia (Subject Matter Expert commissioned form England), facilitating a more comprehensive, historical review of care and treatment to those patients. As a result, it has come to light the enquiry using the 10 questions has highlighted historical issues that have now progressed to SCRR. The 10 questions are now considered a more appropriate assessment tool and there are current plans to ensure all patients' assessments are reviewed using this tool.

Q61. 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?

620. From my participation in the initial Oversight Meeting 8 October 2019 and the eventual refocus on the MHPS recommendation to implement an administrative review across Acute Services, my Assistant Director, Anita Carroll (Functional Support Services), worked with Dr Mary Donnelly and Dr Rose McCullagh (both AMDs in Primary Care and practicing GP's) and Mrs Martina Corrigan to review the current processes being used. As an action of the Oversight Meetings, it was agreed to work with BHSCT to ascertain any learning they had with regard to effective administrative processes. This collaborative piece of work allowed the May 2021 new administrative processes to be fully evidence-based and underpinned by best practice. Following their implementation, the monthly reporting and escalation processes are communicated to the Head of Service who addresses any non-compliance and monitors performance month-on-month.

621. The 4 areas that were monitored by Mrs Corrigan as agreed with Mr O'Brien and Dr Khan during the Case Investigation period picked up two areas of non-compliance in September 2019. I was aware there had been weekly monitoring in place by Mrs Corrigan and this identification assured me that the monitoring mechanism was robust.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

622. Following the June 2020 escalation of concerns by Mr Haynes regarding Mr O'Brien's patients, a scoping exercise and patient reviews were established to assess patients and identify issues of concern. All of the clinicians who carried out these assessments were using the standardised questions for the assessment process, with consideration of best practice guidance, to gain assurance that the diagnosis was safe and the treatment pathway appropriate. Where issues were identified, treatment pathways in line with NICE Guidance and other appropriate standards guidelines used within urology services were implemented. An example of this is where the patients who were on doses of Bicalutamide outside clinical guidelines, with no clinical indication for deviation, were transferred to the appropriate clinical dose in line with best practice guidance. Pharmacy colleagues also supported the clinicians, specifically with regard to the Bicalutamide medication governance issue.

623. As many of the clinicians were sourced through BAUS, there was ongoing clinical discussions across Professor Sethia (UK Subject Matter Expert in Urology), Mr Haynes, Mrs Corrigan and the clinical team. This allowed cross reference of clinical expertise and the application of appropriate standards and guidelines to assure that the patients were in receipt of safe quality care. This was communicated at the weekly urology review meeting.

Q62. 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?

624. The agreements and systems which were put in place did operate to remedy the concerns. They allowed patient concerns which had resulted from delayed triage, assessment, treatment and care pathways and sub optimal care to be identified. 9 SAI investigations as a result, evidenced significant learning from the patient reviews.

625. As described in question 61, the collaboration across independent sector, Trust urology staff, BAUS subject matter experts and the external Urology SAI panels chaired by Dr Johnston and Dr Hughes, presented a series of recommendations to prevent further recurrence of issues raised and service improvement approaches that positively have and will continue to impact across cancer specialties including urology.

626. Finally, the implementation of the 10-question assessment tool and the SCRR have been further advancements which enhanced the assessment process for patients. These allow clinicians to follow up identified concerns that require further clinical investigation and to implement recommendation as a result.

Q63. 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

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

whom? If nothing was done, who was the person responsible for doing something?

627. Mr O'Brien did not raise any concerns directly with me, however, I have since seen an email attachment containing issues for concern for discussion at a departmental meeting on 24 September 2018. His main issue of concern related to the practice of urologist of the week, triage of referrals, waiting times for a first outpatient consultation, waiting time for elective admission for surgery and the various relationships and influences between all of these.

628. He did express that he had struggled how best to have these issues discussed as he appreciated, they would be contentious with a range of individual perspectives. His overall hope was to agree standards of practice with Senior Trust Management and to get written clarification of expected practices. There were no other clinical concerns raised with regard to the Urologist of the Week model from other consultants that I am aware of. I saw this communication for the first at the 8 October 2019 Oversight Meeting.

629. The 5 SAI aggregated report (SAI Personal Information redacted by the USI completed by Dr Julian Johnston, was shared with Mr O'Brien. On 11 December 2019 his feedback 148. *20191227 SAI* Personal Information redacted by the USI *A1 located in S21 53 of 2022 Attachments* was received. In summary, Mr O'Brien stated that he had reviewed all retained documentation and believed that the singular and significant flaw of the review had been to investigate the failure to triage urgent and routine referrals, in isolation of other pressures and clinical priorities, which he believed were more important. His issues raised related to the Urologist of the Week model, triage and waiting times, factual inaccuracies and a particular issue was raised with recommendations 10, 11 and 12. Mr O'Brien stated that whilst he agreed that triage was indeed a serious issue, he felt he should not be expected to agree that triage of referrals has number one ranking, in the overall scheme of things, as reported in the SAI. He stated that there were many other demands during Urologist of the Week commitments including ward rounds and carrying our emergency/ urgent operations

630. In conclusion, he agreed with the recommendations in the report with a number of caveats which required amendments in his view and clear agreed written policy from the Trust regarding triage. Finally, he stated that a recommendation should be included concerning the establishment of systems enabling clinicians and particularly clinical departments to deal with difficult or dysfunctional management.

631. This feedback was shared with Dr Johnston and in an email on 27 January 2020, he stated that following reflection and consideration of the points raised, he did not consider that any changes to the report or recommendations were required. He stated that he assumed that unless he heard back from the Trust, that the review panel agreed with his approach. Dr O'Kane, following feedback from Mr Haynes and Mrs Reid on 17 February 2020 that they had no issues with Dr Johnston's decision, agreed that the report should proceed for approval to the ACG on the 14 February 2020. Dr O'Kane agreed to be in

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

attendance at that ACG meeting which I chaired. SAI Personal Information redacted by was duly approved and submitted to HSCB. The recommendations for implementation were taken forward within the operational and clinical teams.

632. The other communication that I am aware of where Mr O'Brien raised concerns was with regard to the monitoring of the 4 action areas referred to within the MHPS Return-to-Work Action Plan. On 7 November 2019, Mr O'Brien wrote to Mrs Corrigan following a request to meet with Mr McNaboe and Mrs Corrigan with regard to the deviations from the Return-to-Work Plan. He stated that the action plan was due to conclude following the formal investigation process under MHPS. As the case determination report was submitted on 28 September 2018, Mr O'Brien quoted the recommendation "*that a further (action plan) should be put in place with the Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by both parties…must address any issues with regard to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme*". He stated the Trust failed to implement this recommendation and therefore the breach issues that had arisen could not be considered deviations from a Return-to-Work plan which had expired in September 2018.

633. As Mr O'Brien had lodged a grievance following the MHPS case determination report, in principle, the investigation into his clinical and administrative practices, technically, had not concluded. This was the rationale for the Trust continuing the monitoring until his retirement.

634. Following the retirement of Mr O'Brien, Directorate of Legal Services advised that Mr O'Brien's solicitors had indicated that all further communication should be directed to Tughans. I have had no further concerns raised since then.

Q64. 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?

635. I did not raise any concerns about the conduct or performance of Mr O'Brien.

636. I responded to concerns raised by Mrs Corrigan following the identification of breaches in September 2019 as described earlier via the Oversight process and the implementation of the Administrative Review.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

637. I also responded to the concerns raised by Mr Haynes directly to Dr O'Kane in the first instance. I was actively involved in the Oversight and Urology Review teams to implement patient safety plans in response to these concerns as described in my response to earlier questions.

638. I did not raise any concerns about the conduct/performance of Mr O'Brien as the mechanism I have as the Acute Services Director is to work with the DMD and AD who as part of the clinical/ operational team have the opportunity to identify concerns. Following escalations of any concerns to me, it is my duty to put in place effective mechanisms to address the concerns and assure Senior Management Team and Trust Board that concerns raised are being appropriately considered, in the interest of patient safety and reducing harm.

639. As stated earlier, I never met Mr O'Brien in the 13 months that I was the Acute Director, before his retirement.

Q65. 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.

640. I was not in direct contact with Mr O'Brien to offer support. The normal approach to offer such support is via line management.

641. I am aware that Mr Mark Haynes sent a letter to Mr O'Brien, by email on 11 July 2020, following the concerns that had been raised from Mr O'Brien's 7 June 2020 email. Mr Haynes advised in the letter that the concerns identified would be managed in line with the '*Maintaining High Professional Standards in the Modern HPSS*' Framework (MHPS) and indicated that as we were at the initial enquiry stage of the process, he offered Mr O'Brien the opportunity to make any initial representations on the concerns outlined.

642. He also advised that Dr O'Kane had been in contact with NHS Resolution (formerly National Clinical Assessment service (NCAS)) to seek advice on the management of Mr O'Brien's case, as a normal part of any MHPS process. He advised Mr O'Brien that he could contact them directly to discuss his case confidentially with an advisor. In that communication, he advised of restrictions with immediate effect. Mr Haynes also advised that given Mr O'Brien's existing referral to the GMC, in respect of the outstanding MHPS case, the Medical Director had informed the GMC's Employment Liaison Officer, regarding the most recent concerns.

643. He ended the letter by stating that he fully acknowledged that this would undoubtedly be a difficult time for Mr O'Brien and highlighted the services of the Trust's Occupational Health Department and the staff counselling service, CareCall as being available for Mr O'Brien. He shared the contact number of both Occupational Health and CareCall.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

644. The Human Resource team had been involved with Mr O'Brien throughout the MHPS and Grievance procedures and I am aware that support services are routinely offered and communicated as part of the staff member's pathway of support.

645. In addition, as a result of the Covid-19 pandemic (from March 2020), additional psychology support services were regularly communicated by global email and in the Trust electronic Newsletters, so that all staff were aware that they could access confidential support services for whatever personal or professional reason.

Q66. 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 raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

646. The ongoing issues within Urology, with regard to demand outstripping capacity, were of concern to the staff within both the clinical and operational teams over many years. The volumes on the waiting lists and the waiting times increased year on year across outpatients, inpatients, day cases and the red flag performance deteriorated from 54.8% on 1 April 2019 to 27.4% on 1 April 2022 in Southern Area. A series of mitigations were put in place to address this including:

- 62-day performance has been on the Risk Register since 3 September 2012;
- the risk of patient safety due to medical workforce shortages and vacancies was added to the Corporate Risk register in July 2015;
- the risk due to the backlogs was added onto the Divisional Risk Register in October 2016;
- Access waiting times were added to the Divisional Risk Register in April 2019.

647. I included urology performance and governance issues in both Acute Governance meetings and the Acute Clinical Governance forum, as described in earlier questions, with discussion and approval of all SAI's including those specific to urology and Mr O'Brien. The Service Improvement Task & Finish work plan to address the recommendation of the 9 urology SAI's (April 2021) has been progressed with engagement across divisions and is reported through governance structures. As Director of Acute Services, I escalate issues of concern to the Chief Executive, SMT and Trust Board in a timely way, including evidence of actions underway and assurances to the performance and Governance Committees.

648. When issues were raised regarding patient care and safety in urology which related to the clinical and administrative practice of Mr O'Brien, I offered assurances regarding the collaborative approaches that were underway across operational and corporate governance leads (Dr O'Kane, Medical Director, and

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Mrs Vivienne Toal, Director of Human Resources and Organisational Development). I shared progress reports detailing the risks, concerns and actions of the Urology focused oversight meetings and operational meetings focused on patient reviews and plans to address service concerns within governance and performance frameworks.

649. With specific reference to the concerns raised on 11 June 2020, regarding Mr O'Brien's patients, there was a requirement to focus on increased patient reviews to ascertain if there were patient safety issues that needed identified. The 18-month period from January 2019 to June 2020 was the starting point agreed, as likely to contain the higher risk patients who would require earlier review/follow up (logic being the patients from earlier years may have already been seen by Mr O'Brien, potentially entered the service through other Consultants or as emergency admissions).

650. As patient reviews commenced, we collated an Investment Proposal Template (IPT) to secure additional resource for Consultants, Independent Sector contracts, clinical auditors and extended tracking outside the commissioned 31- and 62-day cancer pathway model (as follow up post-62-days on cancer pathway had been identified as a gap).

651. The Corporate Risk Register was updated in May 2022, identifying the risk of medical workforce shortages, nursing shortages, high usage of agency and locum staff, delay in accessing planned services including outpatients and elective procedures and the oversight of red flag referrals. Reference was made to the delay in accessing services and the delay in cancer pathways. The May 2022 update also identified the capacity risks in urology and the Trust potentially being unable to undertake the Lookback into service users under the care of Mr O'Brien in a timely way. It also included the Trust being unable to implement all aspects of the Urology SAI action plan in a timely and complete way. It also includes risk of reputational damage to Trust brought about by the SAI's.

Learning

Q67. 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.

652. I was not initially aware that In addition, to Mr O'Brien's sub optimal administrative processes, which delayed the management of referrals and treatment of patients, that there were also clinical issues. These came to light following the 11 June 2020 escalations by Mr Haynes, of the 10 patients of Mr O'Brien's, requested by Mr O'Brien to be added to the Urgent Bookable list on the same day.

653. One of the themes identified to date is with regard to compliance with standards and guidelines for the prescription of medication (Bicalutamide in this

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

instance). The usual mechanism following identification of medicine governance concern within the Trust, is to record an incident on Datix, escalate serious issues to me through the Director of Pharmacy and include the issues in the quarterly Medicine Report to Governance Committee. However, with regard to this specific medication, Bicalutamide is prescribed by General Practice on the advice of the urology consultant and therefore, the clinical team or the Pharmacy Department in the Trust would not have been aware of the anomalies. If a GP receives a dosage of medication for prescription from a Urologist, they may be guided by the Urologist's clinical expertise and not query what appears to be an unusual dose. This highlights the necessity for effective auditing of systems and processes used by individual clinicians across primary and secondary care interfaces.

654. I was aware of governance concerns regarding the urology service from early June 2019 as described in earlier responses, including the aggregation of several SAI's that were related to Mr O'Brien's patients. As I have progressed within the Acute Director post, I have become more aware of things I didn't fully appreciate including:

- Dr Neta Chada and Mrs Siobhan Hynds did the MHPS Investigation into Mr O'Brien with governance and patient safety at the core;
- Mr O'Brien had been previously excluded from work;
- Dr Ahmed Khan's Case Determination report was based on the MHPS Investigation;
- The Determination report had been shared with the CEO and was paused due to the grievance being lodged by Mr O'Brien;
- One of the recommendations in the MHPS Case Determination report was for a system wide review in Acute, broader than urology;
- There appears to have been enough concern in 2016 to merit close monitoring and further scrutiny to proceed;
- I didn't know when I commenced my tenure in June 2019 that Mr O'Brien had been referred to GMC in April 2019;
- I didn't know from the outset how many SAI's were 4 years old and not completed, how many had been significantly linked to Mr O'Brien and pro-rata appeared at a higher level than other urology Consultants.

655. At the heart of all of these concerns were ongoing governance and patient safety concerns and they should have been triangulated and acted upon. It is important when new in post to receive an effective induction and to ensure the post holder is appraised of ongoing issues to allow for effective monitoring and oversight. I was in post for 13 months before Mr O'Brien retired.

656. There were two significant issues in that time which were picked up. The first regarding non-compliance with the Return-to-Work Administrative Action Plan and on 11 June 2020, the concerns leading to the significant patient reviews. The resultant large volume of patient reviews has highlighted issues that could have been prevented. This has led to SAI's, the need for patient

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

assessment and corrected treatment pathways and SCRR's. These have caused patient harm and human trauma for the patients and families involved.

657. Since the 9 SAI's have been completed (April 2021), it has evidenced that the MDT process needed to be augmented. All MDT's followed the same process in line with commissioner investment with no inbuilt tracking after 31 and 62 cancer pathway target. There was no capacity for MDT decisions and outcomes to be audited to check compliance with agreed actions. Additional investment has now been secured and the improvement work has commenced across all cancer specialities. There is a need for sharing of SHSCT experience to date to be applied for regional learning.

Q68. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

658. Urology services are provided by a team that is committed, expert and patient focused through and through. Firstly, my thought is that a lot went right within urology services. This journey has started out with one individual who had been reported as clinically good and held in good esteem by many patients but who had been found wanting with regard to administrative processes. Those processes had patients at the end, who had been referred in and/or referred for investigations or treatments and they were exposed to unnecessary delays because of the inaction or lack of timely action by Mr O'Brien with significant patient safety risk. There had been a level of concern regarding Mr O'Brien from 2015 onwards. When I commenced my tenure in June 2019, I was not aware of these historical issues and from August 2019, there were the series of escalations and concerns regarding Mr O'Brien's practice.

659. I believe from April 2019 (before my tenure commenced) that there were many steps taken to address concerns that had been around for too long. For example, referral to GMC and since I commenced post, completion of the administrative review which had been recommended by the MHPS Case Determination Report, review of patients prioritised as being potentially at risk of significant harm, which, as additional concerns were uncovered across a range of issues, extended into a full lookback review.

660. The first thing that went wrong was failure to effectively act across a range of people over a number of years. It would appear to me now although I was not involved in the service at that time, that operational managers, Medical Directors, Acute Directors and Chief Executives were aware of ongoing issues and never quite managed to deal with them effectively.

661. The second thing was that Mr O'Brien was allowed to drag out many processes including his lengthy subject access requests, grievance process and his delayed feedback on SAI's relating to his patients. The tolerance to these protracted approaches was too high. Time was lost in lengthy processes that should have been expedited in the interest of patients and families. For example, the series of case investigations, MHPS determination report, grievance, and appeal took almost 4 years to conclude.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

662. As I have reflected, I appreciate that this is actually not about a single practitioner but about a system that has the potential to allow sub-optimal practice to go unnoticed or clinicians not be held to account. This is probably similar across all Trusts. This leads me to think of our operational and medical structures and the link to the broader governance and to clinical and social care governance systems. We need to get to a better place that clinicians including doctors are held to account in a collaborative way rather than within professional lines, which has the potential to operate in silos. I feel that the MHPS escalated through the Medical/ Chief Executive lines with no communication to the Director or Assistant Director at that time, even though actions contained within it were expected to be operationally progressed, was a missed opportunity. Whilst this is in line with due process and respects the confidentiality within that process, there is a requirement to connect our services professionally and operationally at a higher level.

663. A main mechanism that needs to be absolutely water tight is the MDT whereby individual patient cases are presented in a quorate, representative forum where the range of skilled clinicians discuss the cases, agree the actions and have a follow up mechanism to ensure that all actions are delivered. Since the 9 SAI (April 2021) recommendations, considerable efforts have gone in to addressing the recommendation in this regard. This required additional investment in MDT chair support, tracking of actions post meetings, and each tumour specialty taking responsibility for improvement approaches and evidencing same. This approach needs to be rolled out to other areas across administrative processes so that results, reports and referrals are actioned in a timely way and escalated if there are concerns. The review of administrative processes has resulted in a systematic way to prevent these untimely delays and due escalation to address.

664. In addition, a peer reviewed model was not in place to use the clinical expertise available within the MDT's to review their working model. This has now been embedded across all tumour specialties to ensure evidence-based guidance from the National Cancer Action Team is used to assess the practices within the MDT and learning applied to facilitate more effective multidisciplinary team working.

Q69. 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?

665. From a governance perspective, it has to be considered that if the actions of one person are not at the required standard, then there is the potential for other clinicians also to be acting in a similar way. The focus therefore has to be on improving governance systems and processes, including effective clinical audit, that aim to reduce risks of patient harm, improve patient safety and learn from and apply that learning across the system.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

666. Since the receipt of the 9 SAI's and the requirement to embed improved governance systems and processes, the Trust has evidenced greater attention being paid to effective approaches and service level improvement audits that have highlighted areas for attention and improvement work to be embedded. An example of this is the implementation of the National Cancer Action Team (NCAT) baseline audit across all tumour specialties which promotes self-assessment against MDT characteristics and is an evidenced based tool to address membership, leadership, team working, culture, infrastructure for meetings, scheduling, coordination of services post MDT meeting, patient centred clinical decision-making, governance issues including organisational support, data collection, analysis and audit of outcomes, and clinical governance domains. The implementation of NCAT baseline audits has recently been shared across the region, as a direct impact of the Southern Trust experience.

667. With specific reference to concerns regarding Mr O'Brien's practice, the focus of concern up until June 2020 was mainly of an administrative nature. The potential impact of this for significant patient harm due to lack of timely action or inaction by Mr O'Brien, appears not to have been fully considered. In addition, to the detail offered in the previous question, I would suggest that a deficit in one area of practice should provoke curiosity and require sampling of other areas of practice, to gain assurance that the identified concern is singular in nature. In addition, the learning since June 2020 has evidenced deficits in Mr O'Brien's assessment, decision-making and compliance with clinical guidelines. In conjunction with his lack of recording and updating systems in a contemporaneous way and implementing inappropriate treatment pathways, this has resulted in significant patient harm and individual and family distress.

668. There was potential to focus on clinical practice at an earlier stage without compromising due process and confidentiality. I would suggest if there were ongoing issues, mainly regarding administrative processes, we should have lifted that stone to discover what other deficits there potentially were in Mr O'Brien's practice and what patients under his care may have suffered as a consequence. Where there appears to be no clear evidence of harm or wrongdoing, clinical audits would have proved or disproved this. Going forward additional individual clinical audits by peers and/or independent subject matter experts would provide a more objective evaluation that would be in the best interest of patients. I also believe the positive accolades he received from both colleagues and patients and their families was a distraction that allayed the concerns.

669. As this situation with Mr O'Brien evolved over a period of years, the system appears to have accommodated and accepted this as, *that's just how Mr O'Brien works*. It is unacceptable to have recurrent concerns and issues raised without due attention to a comprehensive review of practice. The learning therefore has to focus on increased inquisitiveness and scoping of early signs of sub optimal practice, even with clinicians who have long standing years of professional experience and clinical expertise.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

670. The issue of evolving technology and the transition from a paper-based to a system-based record keeping has been difficult for many in health and social care who have worked across the technological era. Greater building of skill and competence and support services to meet the needs of less technically proficient staff members needs to be considered.

671. Overall, there is a duty to act, to identify irregularities, to triangulate data, to build clinical skill and competence where required, to address any requirements and monitor the impact of same. All of this would have the patient at the centre and work towards professional and clinical excellence.

Q70. 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.

672. I believe there was a failure to engage fully with the problems within urology services. I believe the main factor in this is that the issue appeared to relate to a single clinician who was perceived to be clinically good at his job and was described by many patients in a positive way. I also believe because Mr O'Brien was a senior urology consultant, some may not have been comfortable to challenge his practice. It may also be possible that his practices were perceived as reasonable. For example, taking notes home, to complete due to the lack of capacity in the system to do same at work and staffing challenges in the unit, this may have been viewed as an acceptable work around. Similarly, having capacity to do contemporaneous dictation at end of each clinic may have been considered onerous, requiring this to be completed at a later date. Of note in this regard, the practices of Mr O'Brien were out with that of his colleagues and peers who were not reported in the Backlog Reports to have similar level of issues.

673. Historical issues regarding Mr O'Brien's private patients reportedly accessing services earlier than clinically indicated timescales, compared to non-private patients, would appear to have been resolved as no further breaches were picked up and the metrics detailed in the Administrative Review 2021 have been embedded. This may have led staff to believe progress had been made.

674. As stated earlier, it is my view that Medical Directors, Acute Directors, Human Resource Directors, Chief Executives, regional peers and operational managers did not engage in an early enough or brave enough way to escalate and/or fully discuss and scope concerns over a prolonged period of time. They failed to fully investigate the depth of other potential concerns rather than just investigating the face value concerns that arose.

675. The series of MHPS Investigation and Case Determination reports, the ensuing Grievance and the Grievance appeal lodged by Mr O'Brien and the protracted nature of these processes prevented the Trust from arriving at an

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

earlier decision regarding Mr O'Brien's practice. (The latter focused on a Review of Stage 1 Grievance Panel Decision as Mr O'Brien had indicated to that he would not be engaging. Dr Ronan O'Hare, Consultant WHSCT and Ms Therese McKernan, Associate, HSC Leadership Centre, Belfast were the panel members in April – October 2021)

676. When the administrative issues had been raised, an in-depth review of patient impact, due to lack of timely action, would have been a preferable process and potentially circumvented some of the issues we have since been faced with. If an in-depth patient review had been done in 2016, actions could have been taken to prevent the significant harm that has been identified over the past two years, since the June 2020 escalated concerns. The 10 cases being loaded on the system on one day provoked Mr Haynes to look into each and he identified significant delays in some patients having been added, ultimately delaying treatment. Had this not happened, perhaps we would not have understood the patient harm at the same level. I think it is fair to add that in 2016, the staff involved may not have had their antennae raised to scope further. I also believe that at that time Mr O'Brien was viewed as a sound clinician and this, in my opinion, may have coloured judgements and decisions.

Q71. 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?

677. Hindsight is a wonderful thing. Mr O'Brien commanded great respect. However, there were issues that came to light that needed more intense investigation. During my tenure, when the September 2019 escalations were raised by Mrs Corrigan, an Oversight meeting was arranged on 8 October 2019 to discuss the concerns. Acknowledging that the Royal College of Nursing strike was about to take place sporadically over the next few months, this may have delayed any opportunity to progress the agreed actions at an earlier stage. These actions as detailed in the minutes sent out by Dr O'Kane on 30 October 2019 detailed the need to consider operational and professional sanctions including exclusion and progressing the in-depth administrative review across Acute Services which had been recommended in the September 2018 MHPS Case Determination Report.

678. I shared the MHPS report for the first time with Mr Carroll after the meeting on 8 October 2019. I was aware that we were awaiting Dr O'Kane's deliberation on the way forward, however, I should have proactively engaged with her to agree to proceed, as I was now aware that the administrative review recommendation for Acute Services had not been implemented. I also regret that I didn't follow up with Mr Carroll regarding his need to act as Assistant Director, having now had access to and insight into the MHPS Case Determination Report and Recommendations.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

679. It is my opinion that the Oversight Group members (including myself) focused on Mr O'Brien rather than a whole systems consideration regarding governance, systems and processes. Since the 9 SAI's and the establishment of the Task and Finish Service Improvement work plan, there has been broader application of the improvement methodologies and learning across teams and departments. On reflection this could have been done at an earlier stage. Each of the members of the Urology Oversight group has a responsibility in line with their roles and remits, to implement effective governance processes. Therefore, as Medical Director, Divisional Medical Director, Human Resource Director/ Deputy Director, Acute Services Director and MHPS Case Manager there was a missed opportunity to review governance systems and processes and to embed better patient care and reduce patient risk at an earlier stage.

680. From August/ September 2016, a Doctors and Dentist Oversight Group had been established for the Medical Director, Divisional Medical Director, Human Resource Director/ Medical Director's Office HR staff and respective operational Director, to discuss issues of concern regarding doctors and agree appropriate actions at operational and professional level. The purpose of the Medical and Dental Oversight Group 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, 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 any 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.

681. As concerns regarding Mr O'Brien preceded this group, the individual oversight meeting was the established vehicle to explore the concerns regarding his practice. He was included in the agenda from 2016 but the majority of the discussion took place in the dedicated oversight meetings. I believe this Medical and Dental Oversight Group offers great potential to discuss professional issues and the cross-fertilisation of DMD, Medical Director, Human Resource and Operational Director ideas, stimulates challenge and learning in how to embed equitable, professional governance safeguards, ultimately to prevent patient harm.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

682. The role of the Clinical Nurse Specialist is to act as a failsafe during patient reviews, being there to support patients when they receive bad news about their condition offering support and follow up care. Their role was not fully embedded in all patient reviews, particularly with Mr O'Brien's clinics. This was a concern raised by the CNS's at urology clinical team meetings which I attended with Dr O'Kane and on occasion Mr Shane Devlin. If these concerns had been raised at an earlier stage some of the issues that we are now facing could have been prevented.

683. The role of the Operational Support Leads (OSL) across the region is very much focused on the 31- and 62-day cancer pathway. The ability therefore to track patient outcomes outside the 62-day pathway was not feasible. Since the 9 SAI recommendations (April 2021), the service improvement plan has required additional investment to resource administrative support for the MDT Chair and dedicated clinical audit and information officer. The impact of this has been felt so far and there are additional posts in recruitment. Whilst it is the Southern Trust implementing this added value resource, it is the responsibility of the Commissioner to fund this going forward in all five Trusts across Northern Ireland to ensure the learning in Southern Area is implemented across the region.

684. Overall, the opportunity to mobilise referrals to GMC and RQIA could have taken place before 2019 when Dr O'Kane used this mechanism after she commenced as Medical Director. The initial focus was on managing and mitigating the risk associated with the clinical and administrative practice of Mr O'Brien, as such the processes that were used to manage these concerns were limited to the regulatory guidelines in the management of individual clinicians. The extension of the learning towards a system wide governance approach highlights that there was an opportunity to consider the concerns across a broader governance framework. Had Mr O'Brien's sub optimal practice been scrutinised using the broader governance framework, the Directorate could have reviewed its current systems across teams and specialties which could have minimised patient risk and harm at an earlier stage. This would have been the responsibility of the Medical Director, Acute Services Director, Assistant Directors (operational and clinical and social care governance), Divisional Medical Directors and Clinical Directors in conjunction with Director and Deputy Directors of Human Resources.

Q72. 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?

685. The Trust governance arrangements were designed in line with regulatory and legislative frameworks. The Review of Clinical and Social Care Governance by Mrs June Champion in 2019, although not fully accepted, clearly indicated that there was greater potential to strengthen existing arrangements by way of additional capacity, equalising resource, standardising systems and processes and aligning the governance structures under 1

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corporate team aligned to the Medical Director's office. From November 2021, following a further iteration to SMT, progress has been made to deliver against the recommendations of the 2019 review.

686. From a personal perspective, I do not believe the clinical and social care governance team within Acute, the operational and clinical teams within Acute nor by default were the patients and families who access our services well served by these governance arrangements. I say this specifically relating to the complexity of the processes, the volume of governance issues within a large Acute workforce, the numbers of incidents, Serious Adverse Incidents, complaints and negligence claims within a service focused on caring for and treating complex patients.

687. During my tenure, the acute data was regularly reported through Governance Committee and to Trust Board evidencing trends in activity and the seriousness of complaints or incidents recorded. As a result of this, I had conversations with the Chief Executive at 1:1 meetings and secured additional resource to support governance and quality improvement approaches. An example of this is the secondment of Joanne Bell for a year to support governance, alignment of the quality improvement officers 1 day per week to assist each division for one year, and the current recruitment of one Band 5 governance officer per Assistant Director. This is In addition, to posts recruited specifically to deal with the Public Inquiry and Urology Lookback demands.

688. I was content with the mechanisms employed to share, discuss and agree a range of issues with the Acute Governance meetings and the Acute Clinical Governance meetings which also included Divisional Medical Directors and Clinical Directors. Learning from governance activities including serious adverse incidents and patient complaints was applied, However, I do believe that increased staff dedicated to governance would have affected our ability to embed learning at an earlier and higher level.

689. Overall, for the majority, these systems work. However, as we have learned there needs to be a tighter approach to scrutinising concerns, triangulating data and clinically auditing all patient data and outcomes to ensure any issues or individuals are appropriately identified and addressed to improve safe, quality, effective services.

73. 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?

690. The focus of the Public Inquiry's Terms of Reference includes reviewing the Southern Trust handling of relevant complaints and concerns prior to May 2020 and its participation in processes to maintain standards of professional practice. It also seeks to evaluate the corporate and clinical governance procedures within the Trust which led to the Trust conducting a lookback review of urology patients under Mr Aidan O'Brien.

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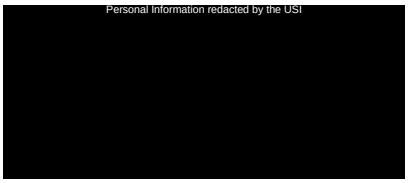
691. The roles of commissioning teams in HSCB/ SPPG are inextricably linked to the Trust role and function particularly with regard to resourcing the Trust to fulfil its obligations to quality, safe care and well governed systems and processes. In scrutinising the Trust, I feel the Inquiry needs to consider the commissioning intent of the HSCB/ SPPG. The volume of administrative support has been an issue across the Trust as has the equity position which has resulted in teams feeling they need additional resource to improve their service approaches. The need for redressing the resource allocations to Southern Trust as a provider organisation could ultimately result in improved patient services and higher professional satisfaction.

692. I believe I have covered the remainder of my information throughout my answers and welcome the opportunity to have been involved in the last 3 years with Acute Services.

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

Statement of Truth

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

Signed: 

Date: _____08/07/2022_____

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Section 21 Notice Number 53 of 2022

Witness Statement: Melanie McClements

Index

Attachment	Document Name
1	20070801 Q5.20 JD - AD - Promoting Wellbeing
2	20120901 Q5.23 JD - AD - Older People Services
3	20170901 Q5.26 JD - Director - Older People and Primary Care
4	20190610 Q5.33 JD - Director - Acute Services
5	20220512 Q7.35 Summary Corporate Risk Register to Governance Committee
6	20190704 Q7.38 A1
7	20200127 Q7.38 A2
8	20200529 Q7.38 A3
9	20201220 Q7.38 A4
10	20190904 Q7.43 3 South Trust Risk Assessment
11	20191001 IPT - Expansion of Urology Services - Additional Clinical Nurse Specialists
12	20220606 Q7.45 A2 Volume and Funding Allocation – Urology
13	20210322 Q7.45 A3 CNS AFC Discussion
14	20220215 Q7.46 Agenda and Notes HR-Planning-Finance Meeting
15	20190718 Q7.47 A
16	20191016 Q7.47 A2
17	20200302 Q7.47 A3
18	20210215 Q7.47 1-1 Meeting - Ronan Carroll
19	20220426 Q7.48 Acute Performance Scorecard
20	20220322 Q7.49 A1 Acute SMT Performance Meeting Action Notes
21	20220509 Q7.50 Acute Performance Report - Performance Committee
22	20211122 Q7.51 HSCB-Southern Trust Directors Meeting
23	20211222 Q7.52 A1 NICaN Workplan 2021_22
24	20210630 Q7.52 A2 Minutes/ Action Notes NICaN Board
25-26	20221204 Q7.53 Acute Financial Position A1-A2
27	20220412 Q7.54 Acute HR-Planning-Finance Meeting Minutes
28	20210105 Acute Gov Notes
29	20210409 Clinical Gov Notes
30	20201020 SAI offer of support
31	20210831 Q7.61 A1 Memo - Family Liaison Service
32	20210831 Q7.61 A2 Liaison Service Referral Pathway
33	20201124 Mins Incident Gp A
34-43	20200611 Patients to be added to UBL, A1-A9
44	20211206 Q8.69 TOR Internal Lookback Review Group
45	20220624 Q8.70 A1 MedicalDentalOversight TOR
46	20200212 Q8.70 A2 O&G Minutes – Case AOB
47-50	20191004 Q8.75 Escalation of Breaches AOB, A1-A3
51-53	20190827 Q8.77 GMC Referral - AOB, A1-A2
54	20211011 Q8.78 TOR Trust Task and Finish Group into Urology SAI Recommendations
55	20190902 Q8.82 Email from Executive Director for Nursing

56	20220401 Q8.82 NiD Terms of Reference
57	20190607 Clinical Gov Notes
58	20190913 Clinical Gov Notes
59	20191011 Clinical Gov Notes
60	20200117 Clinical Gov Notes
61	20200214 Clinical Gov Notes
62	20200314 Clinical Gov Notes
63	20201009 Clinical Gov Notes
64	20201113 Clinical Gov Notes
65	20090923 Regional Review of Adult Urology Services NI
66	20091101 Q9.90 SHSCT - PPI Baseline Executive Summary Report
67-70	20171122 Q10.92 OGIPerformanceReport, A1-A4
	20171122 Q10.92 OGIPerformanceReport, A1-A4
71-73	20200602 Q11.96 Email re Draft Integrated Elective Access Protocol, A1-A2
74	20200615 Q11.97 OSL Comments re Draft IEAP
75	20080430 Q.12.101 Integrated Elective Access Protocol Revised
76	20190913 Q12.103 A1 CorporateCPDScorecard
77	20190913 Q12.103 A2 PerformanceScorecardCoversheet
78	20190913 Q12.103 A3 Email re SMT – Monthly Performance Report
79	20220627 Q12.104 A1 NonRecurrentFunding_CoverSheet
80	20220301 Acute Services Directorate Risk Register
81	20190607 Surgery and Elective Care Risk Register
82	20190607 Clinical and Cancer Services Risk Register
83-85	20220622 Q16.135 3 South Finance Report 2019-20 A1-A3
86-88	20220622 Q16.135 Urology Finance Report 2019-20 A1-A3
89	20220622 Q16.135 Nursing Pay Spend Analysis 3 South 2019-2022
90	20210329 Q16.137 IPT - Staffing Support Requirement for SAI Inquiry – Urology
91	20201001 Q16.138 IPT - Expansion of Urology Services - 7th Urology Consultant
92	20220401 Q16.140 IPT - Stone Treatment Centre 2021-22
93	20220622 Q16.142 Theatres Equipment Capital Budget Allocation (Urology) - 2020-21
94	20190612 Q17.144 Patient 10 Email re Elective Capacity
95	20190617 Q17.146 ADs 1-1 meetings proforma- Ronan Carroll
96	20190612 ATICS Medical Equipment priorities 2019-20
97	20190718 Q17.147 ADs 1-1 meetings proforma- Ronan Carroll
98	20190617 Q17.148 Pension Changes - Risk to Surgical Waiting Times
99	20190807 Q17.149 ADs 1-1 meetings proforma- Ronan Carroll
100	20190903 Q17.150 Personal Development Review Ronan Carroll
101-103	20190916 Q17.151 Email re Confirmation of Clinical Education Practitioner post, A1-A2
104	20210613 Q17.152 Personal Development Review Ronan Carroll
105-107	20190911 Q17.155 Email re Managerial Action Plan 3 South, A1-A2
108-109	20191118 Q17.157 email, A1 Briefing Paper CAH Theatre Nursing Challenges
110	20220324 Urology Team Meeting Notes
111	20211014 Q17.160 ADs 1-1 meetings proforma- Ronan Carroll
112-117	20201016 Q19.174 Urology SAI Patient Review IS Contract, A1-A6
118	20211206 TOR Internal Lookback Review Group

119	20201016 L3 SAI Review 2 A
120	20211011 Q8.78 TOR Trust Task and Finish Group into Urology SAI Recommendations
121	20220422 Q21.198 Task and Finish Group into Urology SAI Recommendations - Action Log
122-123	20210426 Structured Clinical Rec Rev, A1-A2
124	20201023 Ltr re UAG A
126	20210505 Personal Development Review Barry Conway
127	20191204 Personal Development Review Barry Conway
128	20200323 Melanie McClements Individual Performance Review 20-21
129	20210325 Melanie McClements Individual Performance Review 21-22
130	20200731 Q27.224 A1 DoH Early Alert AOB
131	20191030 AOB Notes
133	Relevant to Acute Evidence After 10 December Melanie McClements Notes of Meetings February 2020 – September 2021
136	20191008 AOB Oversight A1
137	20190513 Terms of Reference Clinical and Social Care Governance Review
138	20190801 Draft Report Clinical and Social Care Governance Review
139	20190925 Clinical and Social Care Governance Review Response
140	20220516 31- and 62-Day Cancer Performance for Urology Tumour Site
141	20210520 Performance Committee Cancer Presentation
142	20211004 RPOG Meeting Notes
143	20201105 Q36.2.330 Urology MDT Annual Report 2019
144	20220523 Action Plan Internal Lookback Review Group
146	20201116 TB Paper A
148	20191227 SAI Personal Information redacted by the A1

88207019

Southern Health and Social Care Trust
Assistant Director for Promoting Wellbeing Band

Job Description

JOB SUMMARY

The jobholder will be responsible to the Director of Older People and Primary Care for the development and delivery of the Trust's Promoting Wellbeing Strategy embracing health improvement, health promotion and community development within the Southern Trust area. He/She will be provide strategic leadership for the development of health and wellbeing policy, strategy, service development and delivery across Trust Directorates and Divisions ensuring adherence to regional priorities, local need and clinical governance standards for health and wellbeing.

The post holder will lead the development and implementation of the Trust's Personal and Public Involvement (PPI) policy, strategy and action plan across Directorates and with stakeholder organisations. He/She will lead on the development of a range of consultation, involvement and engagement approaches with local community groups.

The post holder will have a lead role in representing the Trust at local, area and regional levels, ensuring effective working of cross-sectoral partnerships and synergy across the policies, strategies, funding direction and service development of external partners, agencies and community organisations in line with the objectives of the Trust's Corporate Plan.

He/She will provide clear leadership to all those involved in the Promotion of Wellbeing and PPI both within the Trust and across partners. They will be responsible for effective financial management efficient use of the PWB resource and the external commissioning of services to meet this agenda. He/she will have responsibility for management of the Promoting Wellbeing Specialist Division.

The jobholder will also support the Director of Older People and Primary Care with long term planning and service reform initiatives. As an Assistant Director, the jobholder will be a member of the Directorate's senior management team and will therefore contribute to policy development and the achievement of its overall objectives.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

KEY RESULT AREAS

Service Delivery

- provide strategic leadership for the Promotion of Wellbeing and Personal and Public Involvement for the Trust. 7
- Implement the methodologies to test Trust compliance with Patient / Client Experience Standards. 6
- lead the management and integration of health improvement, health promotion and community development agendas across the work of all Directorates and staff teams to support the Trust in meeting the targets set in Investing for Health, Priorities for Action, Commissioning Plans and other strategies. 7
- Lead the development of joint strategies and services across Trust Directorates and with key stakeholder organisations and partnerships to improve the delivery and provision of services to patients and carers..
- ensure full involvement, with the community and voluntary sectors and other statutory organisations to effectively implement Investing for Health and other Promoting Wellbeing strategic targets. 1
- Manage the provision of health improvement services to clients and patients to address local, area and regional priorities. 7
- lead the development of new information sources and medias to support Priorities for Action and Trust targets to support people with chronic diseases and enable self care. 7
- maximise the opportunities to secure grant aid and external sources of funding for both PWB and PPI both internally for the Trust and externally with other partners and provider organisations. 8
- Lead the development of research programmes and undertake specific research projects that seek to improve services for people across southern area. 11

Quality and Governance

- ensure that the needs of local communities and groups are at the core of how the Trust delivers its wellbeing and PPI services and are in accordance with DHSSPS *Quality Standards for Health and Social Care, Regional PPI Guidelines* and professional standards for wellbeing and other relevant requirements. 6
- ensure high standards of governance which are compliant with controls assurance standards, the assessment and management of risk and, the implementation of the DHSSPS's *Safety First* framework.
- ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales. 6
- ensure performance management arrangements are implemented.
- ensure the defining and monitoring of performance standards in contracts/service level agreements for Directorates and with independent service providers. 12
- ensure the management of complaints within the division complies with HPSS and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement. 12

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- lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division. 12

Service Planning and Development

- lead the development of innovation and change to underpin the modernisation of health improvement, health promotion and community development services 4
- lead the development and implementation of a strategic plan for the promotion of health and wellbeing in the Trust and in line with regional strategies and priorities. 4
- lead the development and implementation of the Trust's Strategic Action Plan and procedural guidelines for Personal and Public Involvement in line with DHSSPS Guidelines. 4
- shape the development of the Trust's Volunteering Policy and Carer's support approaches across all Directorates. 4
- work closely with Commissioners and stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms. 4
- act as a member of the Directorate's Senior Management Team and contribute to its policy development processes. 12
- represent the division and/or directorate in Trust and/or regional/international planning and service development as appropriate. 12

Financial and Resource Management

8

- responsible for the management and accountability of the PWB and PPI budget to include grant aid the commissioning and development of services and the effective use of external sources of funding.
- ensure the effective implementation of all Trust financial policies and procedures in the division .
- lead the development of cross Directorate and multi-agency applications for resource from regional, national and international funding bodies.
- participate in contract and service level negotiations with commissioners and other funding bodies.
- manage the budgets and resource allocations of multi-sectoral partnerships and joint working projects and programmes.
- ensure the effective management, use and maintenance of all physical assets in the division.

People Management

9

- provide clear leadership to Directorates, staff teams and staff within the division and ensure all services have a highly skilled, flexible and motivated workforce.
- manage the staff who deliver PWB and PPI services and programmes within the Trust and on behalf of other multi-agency partnerships and projects.

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- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the division and in joint projects and programmes support a culture of effective team working, continuous improvement and innovation.
- lead the development of the Trust's Workplace Health Strategy and initiatives to promote the health and wellbeing of all staff.
- ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the division.

Information Management

- ensure the effective implementation of all Trust information management policies and procedures in the division.
- ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.
- assess and analyse a wide range of information and data to inform the setting of priorities, strategies and service direction.
- provide specialist knowledge and expertise to Trust Board, Directors, staff teams and partner organizations to shape their approaches to PWB and PPI.
- lead the design and development of communication systems to inform and shape the development of Trust and partner priorities, strategies and programmes.
- lead the design and development of PWB library and health information materials and training to promote better understanding and service uptake across communities and stakeholders.

Corporate Responsibilities

- provide specialist advice and support to inform and shape the development of PWB and PPI policies and strategies within the Trust across its Directorates and their divisions to ensure achievement of Trust objectives, regional requirements and best practice.
- provide specialist advice and support to other organisations and partners to shape their contribution to the promotion of health and wellbeing across the southern area.
- establish and develop collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

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- adhere to the Trust's corporate planning, policy and decision making processes as a member of the directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
- lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

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

GENERAL RESPONSIBILITIES

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

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.

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- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

March 2007

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88207017

Southern Health and Social Care Trust
Assistant Director of Older People's Services
Band 8C

Job Description

JOB SUMMARY

The jobholder will be responsible to the Director of Older People and Primary Care for the delivery of high quality community based care to older people in the Southern Trust area. He/She will be responsible for the operational management of all services within the division which will include directly managed domiciliary/home care, residential and day care services. He/She will ensure the objectives of the Trust's Delivery Plan for older people are successfully implemented through effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Older People and Primary Care with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

- lead uni and multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality domiciliary, residential and day care to older people living in the Trust's area. This will include the delivery of domiciliary care to clients in other programmes of care.
- ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets for older people with a particular emphasis on those relating to the assessment and meeting of continuing care needs and the maximization of independent living and rehabilitation.
- work closely with other senior managers in the Trust to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay within a 24/7 context.

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- ensure clear pathways are developed and implemented for patients/clients referred to/from other divisions in the directorate.
- ensure active engagement with user groups and the voluntary and independent sectors in the design and delivery of services in order to inform service improvement.

Quality and Governance

- ensure that the needs of older people and their carers are at the core of how the division delivers its services and are in accordance with DHSSPS Quality Standards for Health and Social Care and other relevant requirements.
- ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's Safety First framework.
- ensure all residential and day care facilities for older people meet high standards of ambience and environmental cleanliness.
- liaise closely with senior professional/governance staff to ensure the division complies with the standards and codes of practice of the relevant professional bodies such as NMC, NISCC and HPC.
- ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.
- ensure performance management arrangements are implemented.
- ensure the defining and monitoring of performance standards in contracts/service level agreements with independent service providers.
- ensure the management of complaints within the division comply with HPSS and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.
- lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

Service Planning and Development

- promote innovation and change to underpin the modernisation of services to older people and their carers.
- assist the Director of Older People and Primary Care with the development of a strategic plan for the delivery of community based and domiciliary care to older people in line with regional strategies and priorities.
- work closely with commissioners and stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- liaise closely with senior planning staff on service and capital development initiatives.
- act as a member of the directorate's senior management team and contribute to its policy development processes.

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- represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

Financial and Resource Management

- responsible for the management of the division's budget and the meeting of all financial targets by each facility and team.
- ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.
- participate in contract and service level negotiations with commissioners.
- ensure the effective management, use and maintenance of all physical assets in the division.

People Management

- provide clear leadership to staff within the division and ensure all services have a highly skilled, flexible and motivated workforce.
- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.
- ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the division.

Information Management

- ensure the effective implementation of all Trust information management policies and procedures in the division.
- ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Corporate Responsibilities

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.
- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

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- adhere to the Trust's corporate planning, policy and decision making processes as a member of the directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

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

GENERAL RESPONSIBILITIES

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

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.

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- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

March 2007

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Description

JOB TITLE Director of Older People and Primary Care

LOCATION Trust Headquarters, Craigavon Area Hospital

ACCOUNTABLE TO Chief Executive

JOB SUMMARY

The post-holder will be a key member of the Trust's Senior Management Team and will be accountable to the Chief Executive for leading the delivery of safe, effective and high quality services within the portfolio of the Trust's Older People and Primary Care Directorate. S/he will play a key strategic role in leading and managing the transformation of services for older people and others in line with the principles and strategic direction for health and social care contained in *Health and Wellbeing 2026: Delivering Together.*

As a Director, the post-holder will be an effective and influential ambassador for the Trust. S/he will engage with external stakeholders to enhance local partnerships and new and innovative collaborative approaches to enable and support people living in the Trust's area to achieve their full health and wellbeing potential.

The post-holder will provide exemplary and visible leadership. S/he will be a member of the Trust's Senior Management Team and therefore will have both an individual and a corporate leadership responsibility to contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

KEY RESULT AREAS

SERVICE DELIVERY

1. Act as an ambassador representing the Trust on regional work streams, which will include influencing policy direction, contributing to and / or leading on strategic development, implementation, review and evaluation of transformation plans for older people and primary care services.

2. Lead the development and implementation of the Older People & Primary Care Directorate's strategic plan in line with Health and Wellbeing 2026 - Delivering Together and other key strategic reforms.

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3. Work collaboratively with regional colleagues to strengthen the achievement of scale and spread of evidenced based local service improvement models. Seize opportunities for Trust participation in the testing of prototypes / pilots that will enable innovation to inform further system wide learning.

4. Lead and be accountable for having effective arrangements in place in the Trust to enable as many older people as possible to be cared for safely in their own homes or return there as soon as possible following a hospital admission or care episode. This will include responsibility for the Trust's domiciliary care service across all programmes of care.

5. Ensure a close interface between Trust Directorates ensuring early intervention to promote an upstream approach to prevention, rehabilitation, optimum health and wellbeing for efficient patient flow and patient experience.

6. Shape and develop the implementation of evolving Primary Care models including Trust managed GP Services in line with Alternative Provider Medical Services (APMS) contractual arrangements.

7. Lead and be accountable for active engagement with primary care providers, GP Federations, commissioners, user groups and the voluntary and independent sectors in the design and delivery of services in order to inform service improvement.

8. Influence and work collaboratively with commissions and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

9. Lead and be accountable for the development and implementation of the Trust's Personal Public Involvement (PPI) and Promoting Health and Wellbeing Strategy, and maximize the co-production model in service development and delivery.

10. Lead and be accountable for the development and implementation of all Trust wide and corporate initiatives to support carers in line with the DOH strategy "Valuing Carers".

QUALITY, GOVERNANCE & PERFORMANCE

1. Ensure that the needs of older people and their carers are at the core of how the Directorate delivers its services and are in accordance with DOH Quality Standards for Health and Social Care and other relevant requirements. This will include driving up the quality of care, improving outcomes and enhancing the patient/client experience in line

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with the principles for change contained in Health and Wellbeing 2026: Delivering Together.

2. Lead and be accountable for ensuring excellent standards of governance in the Directorate to include compliance with all relevant professional requirements and standards, adult safeguarding policies and procedures, the assessment and management of risk and the implementation of all relevant learning and best practice.

3. Ensure ongoing, critical evaluation of the Directorate's performance, taking corrective action as required, to maximize performance against specific Objectives & Goals for Improvements (OGIs) and agreed trajectories for improvement.

4. Lead the defining and monitoring of performance standards in contracts/service level agreements with independent service providers and oversee arrangements through the cross directorate Independent Sector Governance Committee.

5. Ensure the management of complaints and SAIs within the Directorate comply with DOH, HSCB and Trust complaints procedures / SAI procedures and are underpinned by candour, transparency and a culture of continuous improvement.

SERVICE TRANSFORMATION & ORGANISATIONAL DEVELOPMENT

1. Deliver on a challenging agenda to realise "home as the hub of care" and transform Trust services for older people in line with the principles contained in Health and Wellbeing 2026: Delivering Together.

2. "Horizon scan and plan" and lead on the Directorate's response to strategic and cross cutting issues so as to ensure the Trust is best placed to meet future challenges and meet need.

3. Identify and drive the necessary changes to culture and practice within the Directorate to support the strategic and transformational agenda and ensure the focus for transformation is understood, accepted and delivered.

4. Lead the development and implementation of workforce modernisation initiatives including 'Power to the People' regional policy directions.

5. Build and lead successful partnerships and collaboration with other sectors, providers and local communities to deliver sustainable and new approaches to health and wellbeing and the delivery of care.

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LEADERSHIP AND PEOPLE MANAGEMENT

1. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.

2. Promote and maintain highly positive working relationships with trade union colleagues and ensure effective engagement with them in planning for and implementing service reforms and changes.

3. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust's area.

4. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.

5. Ensure the Directorate has a robust workforce strategy to enable all service changes and plans.

6. Ensure the effective management of staff health and safety and support in the Directorate.

7. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

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

9. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

10. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.

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

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FINANCIAL & RESOURCE MANAGEMENT

1. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.

2. Ensure the effective implementation of all Trust financial policies and procedures in the Directorate which will include ensuring the safe custody of residents' property and accounts and the use of endowments and gifts.

3. Lead Directorate procurement of services from the independent sector including domiciliary care and other independent sector services.

4. Lead and be accountable for the effective management, use and maintenance of all physical assets in the division.

CORPORATE & COLLECTIVE LEADERSHIP

1. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation of same.

2. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the four key components of the *HSC Collective Leadership Strategy.*

3. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.

4. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

5. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.

6. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.

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7. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.

8. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.

9. Participate in the Director on-call rota.

EMERGENCY PLANNING AND BUSINESS CONTINUITY

1. Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited

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exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the General Data Protection Regulations (GDPR). Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

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

8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

May 2018

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PERSONNEL SPECIFICATION

JOB TITLE Director of Older People & Primary Care

ESSENTIAL CRITERIA	
The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the selection / interview stage. You must therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted.	
Factor	**Criteria**
Eligibility	1. Be an employee of an organisation within Health & Social Care within Northern Ireland.[1]
Qualifications/ Experience	2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[2] subject. 3. A minimum of three years' experience in a senior management[3] role in a major complex organisation[4] AND clear significant[5] personal evidence of:- • managing major service improvement and transformation; • implementing financial control • high level leadership and people management skills; • effective governance and risk management; • building strategic relationships with external agencies / partners
Other	4. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[6]. In respect of this point the

[1] ***'Organisation within Health & Social Care NI'*** *is defined as any one of the following: HSC Trusts; Health & Social Care Board; Business Services Organisation; Public Health Agency; Patient Client Council; Regulation & Quality Improvement Authority; NI Practice & Education Council; NI Medical & Dental Training Agency; NI Guardian Ad Litem Agency; NI Blood Transfusion Service, and; NI Social Care Council.*

[2] ***'relevant subject'*** *will be interpreted to mean any business, administrative, corporate function or health related qualification.*

[3] ***'senior management'*** *is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation.*

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

[5] ***'significant'*** *is defined as contributing directly to Key Corporate Objectives of the organisation concerned.*

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	successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

Selection / Interview stage

Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the *NHS Leadership Academy Healthcare Leadership Model.* Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.

Notes to applicants:

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;*

2. *You must clearly demonstrate on your application form how you meet each of the required criteria – failure to do so will result in you not being shortlisted.*

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn.*

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trust's Smoke Free Policy

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

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Terms & Conditions of Service

Hours – Full-time. The set hours of work are 37.5 hours per week however the number and pattern of hours will reflect the demands of the post.

Remuneration – £72,712 - £96,949 per annum (Level 4 range).

Annual Leave and Statutory / Public holidays – the Trust offers excellent provision for annual leave and Public / Statutory Holidays. In addition to 10 statutory/public holidays, the annual leave allowance will be between 27 and 33 days.

HSC Pension Scheme / HPSS Superannuation Scheme

One of the leading pension schemes available, Trust staff are automatically enrolled in the Health & Social Care Pension Scheme upon taking up employment within the HSCNI. Further information may be obtained from the HSC Pension Service Website at **www.hscpensions.hscni.net**. Applicants who are already members of the HPSS Superannuation Scheme may continue with their current arrangements

Current contributions are as follows:

Employer contribution rate:	16.3%
Employee contribution rate:	13.5%

Human Resources Policies

The Trust offers a wide range of Human Resource Policies to underpin the value that is placed on its staff such as:

- A range of Work Life Balance/Flexible Working Policies;
- Special Leave;
- Child Care Voucher Scheme;
- Cycle to Work Scheme;
- Access to savings on Social and Leisure Activities;

The HSC Code of Conduct is available on request.

Committed to Equality of Opportunity

The Trust recognises and values the diversity of its workforce and the population it serves. The Trust is committed to a working environment free from intimidation of any kind. Through a systematic and objective recruitment & selection process the Trust is committed to ensuring that appointment decisions are taken solely on the basis of merit.

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Completing your Application Form

The application form is designed to ensure that applicants provide the necessary information to determine how they meet the essential criteria. We strongly encourage all applicants to complete their application online at www.HSCrecruit.com. For those who wish to complete an offline application, please note that in order to ensure Equality of Opportunity for all applicants:

- The space available on the application form is the same for all applicants and must not be altered;
- We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;
- Applicants must complete the application form in either typescript font size 12, or legible block capitals using black ink;
- Applicants must not reformat electronic application forms;
- Information in support of your application will not be accepted after the closing date and time for receipt of applications;
- Applications will not be examined by the selection panel until after the closing deadline;

Completing the Criminal Convictions / Offences Section

The application form requires you to confirm your understanding that the Trust's positions fall under the Rehabilitation of Offenders Exceptions (NI) Order 1979 as amended. Within the Health Service, criminal convictions are never regarded as spent and therefore if you are offered a post with the Trust you must tell us about all previous or pending convictions or offences (including motoring convictions), even if they happened a long time ago (other than protected convictions).

The Trust is committed to the equality of opportunity for all applicants, including those with criminal convictions. We will undertake to ensure an open, measured and recorded discussion on the subject of any offences or other matters that might be considered relevant for the position concerned e.g. the individual is applying for a driving job but has a conviction history of driving offences. This will be conducted following the selection process if this applies to the successful candidate. Whilst the disclosure of information will not automatically prevent an individual from obtaining employment, it is essential that all convictions (other than protected convictions) are disclosed to allow the Trust to adequately consider their relevance to the post in question. The Trust considers failure by applicants to declare complete and accurate information about convictions to be a serious breach of trust.

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Access NI Disclosure – the Trust operates in line with the Access NI Code of Practice. Further details can be obtained from www.accessni.gov.uk

It should be noted that some posts will fall within the definition of 'Regulated Activity'. Further information on Regulated Activity can be obtained on request. Any post falling within the definition of Regulated Activity will be subject to an Access NI Enhanced Disclosure check with Barred list check.

Completing the Medical History Section

The application form requires you to confirm your understanding that you must be in a fit state of health to render regular and reliable service in the post you are applying for. If successful, you will be asked to tell us about any periods of sickness you have had in the last 3 years, whether you have been in employment or not. Your sickness absence record will be verified through the reference checking process; therefore it is important that you give full and accurate information when requested.

Meeting the Criteria set out in the Personnel Specification

- Always refer to the Job Description and Personnel Specification when completing your application form.
- Clearly demonstrate on your application form how you meet the essential shortlisting criteria as detailed in the Personnel Specification. Failure to do so will result in you not being shortlisted for interview. Please remember that selection panels cannot make assumptions on whether or not you meet the essential shortlisting criteria.

Completing the Reference Section

We will want to seek references which cover the previous 3 years to the date of application in relation to your employment / training / education.

Completing Your Current / Previous Employment Details

- Ensure that full details are provided.
- Be specific about all the dates that you provide, in the format DD.MM.YYYY.
- Explain any gaps between periods of employment and include reasons for leaving each post.
- Provide a list of key duties that you have been responsible for in current post / previous posts.

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Disability requirements
We ask on the application form if you require any reasonable adjustments, due to disability, to enable you to attend the interview or undertake the duties of the post. Details of any disability are only used for this purpose and do not form any part of the selection process. If you require any reasonable adjustments to be made during the Recruitment Process please contact Lynn Magee, Resourcing Manager by email to Personal Information redacted by the USI or by phone to Personal Information redacted by the USI who will be happy to discuss your requirements

Completing the Personal Declaration
It is important to remember that when signing the personal declaration section or submitting your form via email you are stating that the information is true, complete and accurate, and confirming your understanding that giving wrong information or leaving information out could lead to the withdrawal of an offer of employment, or dismissal if you take up a post.

Data Protection
The information you provide the Trust will be processed in accordance with the Data Protection Act 2018.

Completing the Equal Opportunity Monitoring Form
Please note that this information is regarded as part of your application and you are strongly encouraged to complete this section. This information is treated in the strictest confidence and is for monitoring /statistical purposes only. Selection panels do not have any access to this information at any stage of the recruitment process.

Advising us if you are not available to attend for assessment / interview
If you have any planned holidays, it is useful to tell us about this by detailing it on your application form. However please note that the selection panel are under no obligation to take these into account when arranging assessment / interview dates.

Submitting your completed form
Forms must be received by the stated closing date and time, as **late applications will not be accepted**.

Please remember that the Trust's standard Application Form is the only acceptable method of application to the Trust.

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Closing Date for Receipt of Completed Applications

The closing date for receipt of completed applications is **Thursday 9th August 2018 at 12.00 noon**.

Applications can be submitted via www.HSCRecruit.com or in hard copy format to:

Mr Iain Gough
HR Resourcing Team
Hill Building
St Luke's Hospital site
Loughgall Road
Armagh
BT61 7NQ

Please note the Trust will not accept any late, incomplete or reformatted application forms received after the closing date and time.

Applicants using Royal Mail should note that 1st class mail does not guarantee next day delivery. It is the responsibility of the applicant to ensure that sufficient postage has been paid to return the form to the address above by the stated closing date and time. Existing Health & Social Care staff should not rely on the internal postal system.

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Selection Process

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and skills are relevant to this post and the extent to which they satisfy each criterion specified. This includes demonstrating how they meet the definitions of 'major complex organisation', and 'senior management' as defined within the Personnel Specification. **Please note this should be detailed under each appropriate criterion heading on your application form.** Only those applicants who clearly demonstrate on their application form how they meet the essential criteria, and if applied, the desirable criteria, will be shortlisted. Failure to demonstrate clearly how you meet each element of the essential / desirable criteria will result in you not being shortlisted for the further stages in the assessment process.

Candidates who are shortlisted following a review of their application form will then be invited to the further stages in the assessment process. The Trust reserves the right to incorporate additional shortlisting stages dependent on the number of applications received.

Throughout the assessment process applicants will need to demonstrate that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that applicants who meet the essential criteria will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the NHS Healthcare Leadership Model.

In accordance with best practice all appointments within the Trust are made under the 'merit principle' where the best person for any given post is selected in fair and open competition.

Candidates may be contacted by telephone following each stage of the assessment process to confirm onward arrangements. This method, if used, is to ensure those being invited to the next stage have as much time available for preparation as possible. Candidates are therefore asked to ensure that mobile telephone numbers are provided where possible and that in any event the contact telephone numbers stated provide for ease of contact. All such communication will be followed up in writing.

Please note that the Trust is under no obligation to take account of your planned holiday arrangements.

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Useful Links / Further Information

Further details on the HSCNI may be obtained from;

Southern Trust Website - http://www.southerntrust.hscni.net/ or you can follow us on Facebook or Twitter

Click here to view the Southern Trust's Facebook page.
Click here to view the Southern Trust's Twitter account.
Click here to view the Southern Trust's YouTube Channel.

Department of Health www.doh.gov.uk

Further Enquiries / Information

Applicants requiring any further information on the application process, shortlisting or interview arrangements should contact Lynn Magee, Resourcing Manager on [redacted] Personal Information redacted by or by email to [redacted] Personal Information redacted by the USI.

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Southern Health and Social Care Trust
Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Director of Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Chief Executive[1]
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Acute Services will be responsible through the Chief Executive for the development and delivery of safe**,** high quality emergency and elective hospital care within the Southern Trust. He/She will lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. He/She will provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, the postholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives.

KEY RESULT AREAS

SERVICE DELIVERY

1. Ensure the co-ordination of multidisciplinary teams to deliver safe, high quality and equitable emergency and elective hospital care to the Trust's population and lead the effective and efficient deployment of all resources to achieve all relevant targets. This will include delivering against Ministerial and commissioning standards and targets.

2. Responsible and accountable to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the successful delivery of agreed Patient Safety Programmes, and the reporting of appropriate safety and quality indicators to provide assurance to the Chief Executive and Trust Board.

[1] *This reference should also be taken to mean 'Deputy or Interim Chief Executive' where the Chief Executive post is substantively vacant*

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3. Work closely with other Directors to secure an integrated approach to managing demand on hospital services, reducing admissions where appropriate and minimizing length of stay in line with benchmarked best practice.

4. Actively promote the development of clinical and professional networks across the Trust.

5. Lead the strategic development and integration of specialty and sub-specialty services across the Trust's hospital network, ensuring implementation of an effective and efficient service configuration in line with Commissioner intent.

6. Work closely with other Directors to ensure efficient patient flows into, through and out of acute hospital care, including the effective management of discharge planning in liaison with community services.

QUALITY

7. Ensure that the needs of patients and their carers are at the core of the way the Trust delivers acute hospital care.

8. Ensure high standards of governance including the effective assessment and management of risk.

9. Ensure the Trust's acute care services comply with all professional regulatory and requisite standards and the discharge of statutory functions.

10. Ensure that robust performance management arrangements are developed and implemented within the directorate.

11. Lead innovation and change to underpin the modernisation of acute hospital care in the Trust.

12. Lead quality initiatives in the Directorate to improve the patient experience.

STRATEGIC PLANNING AND DEVELOPMENT

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13. Ensure the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies, Ministerial and HSCB priorities.

14. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

FINANCIAL AND RESOURCE MANAGEMENT

15. Responsible for the management of the Trust's acute services budget and ensure the meeting of all financial targets within the directorate.

16. Participate in contract and service level negotiations with commissioners.

17. Lead the development of capital investment strategies within acute services, ensuring these reflect and contribute to meeting targets set by the HSSA and the Trust's Corporate Plan.

PEOPLE MANAGEMENT

18. Provide clear and strategic leadership to staff within the directorate and ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality acute hospital care.

19. Ensure that staff working in Acute Hospital Care are trained and developed in line with professional standards as defined by the relevant Executive Director for that professional workforce and as agreed by the Senior Management Team.

20. Lead the development and implementation of workforce modernisation initiatives.

21. Ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation.

22. Ensure the full engagement of all professional staff working in acute services.

CORPORATE MANAGEMENT

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23. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

24. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

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

26. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

27. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

28. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

29. Maintain staff relationships and morale amongst staff.

30. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

31. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

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

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

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EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

34. Actively promote the development of an emergency management strategy with the Directorate to ensure a state of preparedness to respond to a range of internal and external emergency situations.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

37. Adhere at all times to all Trust policies/codes of conduct, including for example:

    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

38. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

39. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

40. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

43. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

44. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

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

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Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE Director of Acute Services

Ref No: 73215008

Notes to applicants:

1. ***We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;**

2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted****. Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn*

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

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

QUALIFICATIONS / EXPERIENCE

1) Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 5 years' experience in a senior management[2] role in a major complex organisation[3].

2) Have at least 3 years' experience of managing major change programmes addressing significant[4] organisational, managerial or service change demonstrated through personal involvement in;
    a. Risk management,
    b. Planning and implementation of the change,
    c. Evaluating the impact of the change in transforming services for the better

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3) Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[4] improvements demonstrated through personal involvement in;
    a. The associated strategy development,
    b. Implementation and;
    c. Sustainability of the objectives

4) Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders;
    a. To successfully implement a significant[4] change initiative,
    b. Building sustainable commitments in developing and maintaining networks through lasting working relationships,
    c. Where the contribution of others is encouraged.

5) Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation[3],demonstrating;

    a. how value for money has been secured,
    b. how efficiencies have been achieved.

6) Hold a full current driving license valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

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

KNOWLEDGE, TRAINING & SKILLS

7) Have an ability to provide effective leadership at a Strategic level to enable the ongoing development and improvement of services.

8) Demonstrate evidence of high level skills in;
    (a) effective planning and organisation
    (b) Governance and Risk Management
    (c) Financial Control
    (d) People Management

9) Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

10) Demonstrate effective communication skills to meet the needs of the post in full.

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1) Experience in the managing of a range of services within a health and / or social care setting.

The following further Clarification on the terms used in the Specification is provided

[1] 'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification

[2]'senior management' is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation

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

[4]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

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

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the NHS Leadership Model.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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

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Southern Health and Social Care Trust

Summary Corporate Risk Register

April 2022

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register is linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

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The overall risk score is based on the cummulative assessment of the likelihood and impact of each risk trigger as summarized in the Risk Assessment Matrix below:

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels					
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**	**Total**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**	**25**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**	**20**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**	**15**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**	**10**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**	**5**

Risks are scored for inherent risk, residual risk and target level of risk. Each is defined below.

Inherent Risk is the current risk which exists before any management controls are applied. This enables decisions to be made about resources and the level of priority given to managing a risk.

Residual Risk is determined as the level of risk that remains after existing controls have been actioned. The residual risk gives an indication of how effectively a risk is being managed by existing controls.

Target Level of Risk is the level of risk that management has set as its target level of risk.

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SUMMARY OF KEY DEVELOPMENTS

The Corporate Risk Register has been reviewed by SMT on 4 occasions since the last Governance Committee meeting, most recently on 28.4.2022.
This document provides a summary of the risks and details the key actions planned by the SMT to manage these risks and achieve progress against the Trust's corporate objectives.

The high level risks identified are underpinned and informed by risk triggers overseen at an operational level within Directorates and are captured in a supplementary document.

CHANGES TO THE REGISTER

New risks:-

Risk 1.1a Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to consultant psychiatry workforce shortages (agreed by SMT on 12.4.2022)

Risk No.1.5 Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families (agreed by SMT on 1.3.2022)

Risk No.1.6 Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level (agreed by SMT on 15.2.2022).

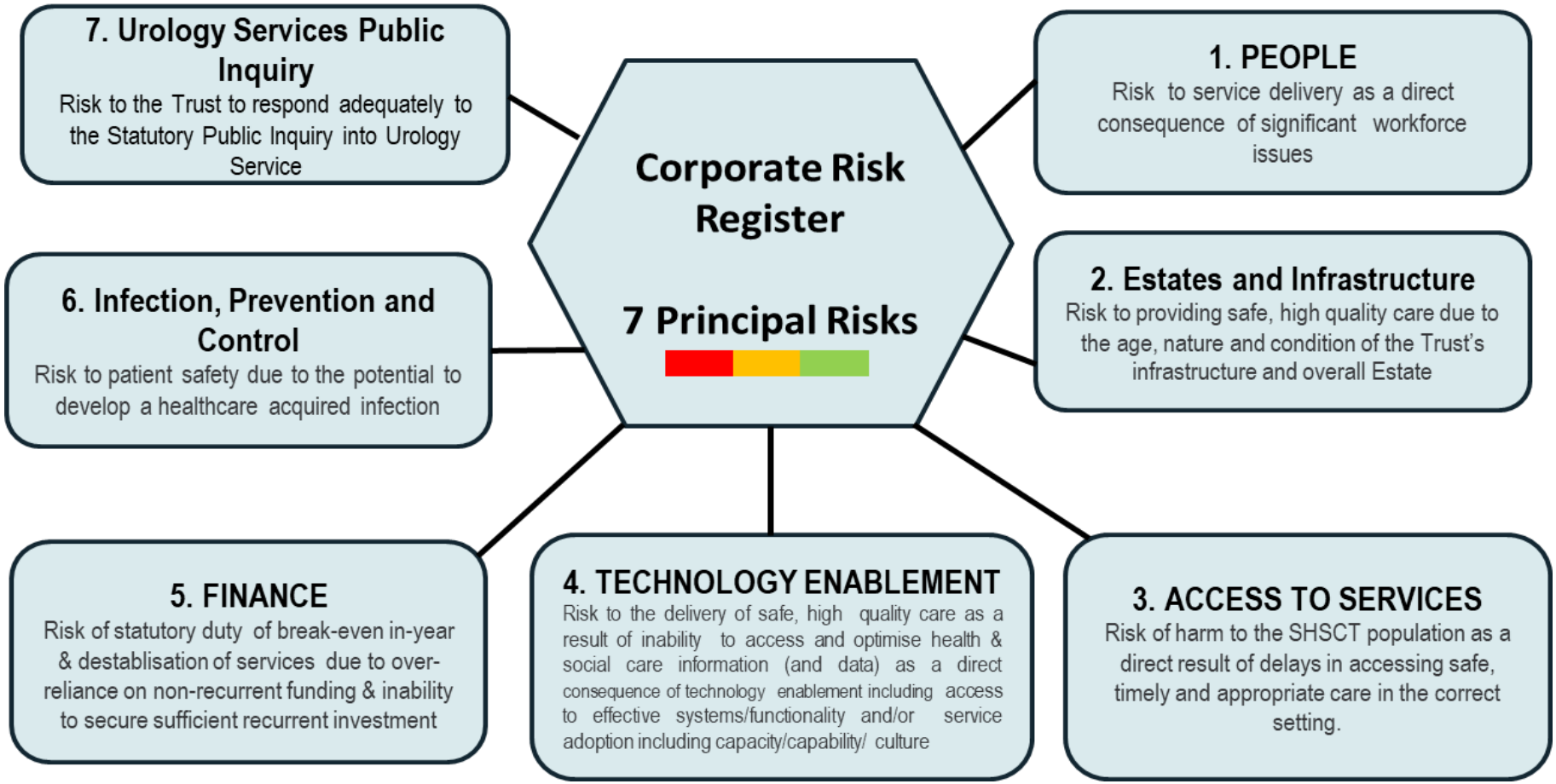
Risk No. 7 Risk to the Trust's potential to respond adequately to the Statutory Public Inquiry into Urology Services (USI) (agreed by SMT on 1.2.2022).

Risks removed:-

SMT agreed on 12.4.2022 to remove 'Risk to the management of the Trust's statutory responsibilities under the Mental Health (NI) Order 1986 due to insufficient numbers of Approved Social Workers to provide a robust rota covering emergency assessments for detention.'
This risk will be managed on the Operational Directorates Risk Registers (CYP; MHD and OPPC).

The diagram overleaf provides a snapshot of the risks on the Corporate Risk Register

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1. People

Corporate Objective Alignment:
Promoting Safe, High Quality Care

Lead Risk Owner

Risk:
Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.

Director of HROD

Original Risk Rating	Key risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
15 (5 x 3) HIGH	1.1	Risk to the consistent provision of high quality, safe medical care due to **medical** workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	**15 (5 x 3) HIGH**	1. Continued mprovements in metrics / dashboards to demonstrate progress with vacancy fill rates. Further work to be commenced on producing metrics. 2. Workforce Plannings meetings for Medicine CAH/DHH and Emergency Medicine with Planning to finalise IPTs in order to seek to secure additional funding. 3. Development of Job Plans for Physician Associates. 4. Ongoing International Recruitment using new framework and seek to secure agreement to fill posts at lower level and train up through Southern Academy. 5. Apply for IMT3 level training post to replace current MTI / CF to enhance sustainability in DHH. 6. Forward planning through Royal College for replacement MTIs for August 2022. 7. Set in place Task & Finish Group to review the rotas at risk and work with BMA regarding their Fatigue Charter to work through actions to help recruit and retain doctors. Rotas to be reviewed in conjunction with charter to ensure thet meet with requirements. Updated rotational junior doctor portal with information about rest and rotas. 8. Work with two new clinical leads to identify other initiatives to recruit to medical shortages. Plan to create updated video and publicity with communications to be used in advertising materials.	**9 (3 x 3) MEDIUM**
	1.1a	Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to **consultant psychiatry workforce shortages.** Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022		1. Taking account of risks and patient safety concerns, temporary reduction of beds and relocation of the Gillis service from Armagh to co-locate on the Willows Ward, Bluestone site is the preferred option. Although not resolving the Consultant Psychiatry issue, it will allow the multi-disciplinary team to access on-site medical input and support. 2. To enable the safe and effective provision of care to inpatients currently in Gillis and allow for a smooth transition to Willows ward, the Trust has suspended admissions to Gillis ward. Bed availability in Willows ward will also be reducing to allow for the transfer of patients from Gillis. 3. The co-location of Gillis and Willows Ward will see provision of 10-beds for dementia assessment and treatment and 10-beds for functional mental illness / POA assessment and treatment. This will be a reduction in dementia beds by 7, functional mental illness / POA by 6 beds and general adult psychiatry by 4 beds. 4. Discussions ongoing regarding this interim contingency arrangement with staff in Gillis and Willows ward and individuals and families in Gillis.	
	1.2	Risk to safe, high quality care due to a high volume of **medical locum** engagements for different periods of time with varying levels of experience/training and often in hard to fill posts.		1. Embedding of arrangements for established Locum Oversight meetings including development of dashboards, datasets etc. to manage locum usage 2. Locum rate proposal - continue to engage regional direction on next steps following recent presentation to DoH 3. Review of Clinical Fellow pilot and impact on locums 4. Improve oversight of EWTD of locums and reminders of safe working to be published with assistance of new clinical lead 5. Review options of attracting temporary international Consultants without CCT into Consultant roles with support from Trust to obtain GMC certification (Radiology/Urology).	
	1.3	Risk to the consistent provision of high quality, safe nursing care due to **nursing and midwife** shortages and vacancies across all Directorates, and high **nursing agency usage** (exacerbated due to Covid-19)		1. Resourcing dashboards for each acute ward, in first instance, to be finalised - vacancies, ML, SL, bank / agency, new starts / leavers along with heatmap of red areas to enable targeted recruitment and retention action plans to be developed 2. Pilot of new Exit Interview approach - delayed due to HR teams in Business Continuity 3. Agency reduction taskforce group to be established for acute services in first instance 4. Revised N&M Workforce Action Plan to be finalised with Year 2 actions (post covid) - underway in light of new regional Retention Implementation Plan. 5. Open recruitment exercise ongoing for Band 5 staff and regular alignment of Band 3 recruits to posts. 6. Bespoke International Recruitment exercise to commence to increase supply of nurses.	

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1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Lead Risk Owner**
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.					**Director of HROD**
Original Risk Rating	**Key risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	1.4	Risk to staff **engagement, morale and health & wellbeing** due to workforce capacity / demand pressures. (exacerbated due to Covid-19).		1. Seek final approval of designed People Plan and associated plan and launch in June 2022. 2. Recruit staff for Long Covid staff service in Occupational Health. 3. Launch the final Health and Wellbeing Framework for 2021 - 2024 linked to the People Plan. 4. Continued roll-out of Creating a great place to work initiative (focusing on health and wellbeing, relationships and behaviours) supporting all our people, our managers / team leaders and teams. 5. Continuing initiatives focusing on supporting workforce groups - disability, age and race to include establishing Minority Ethnic Staff Network 6. Focused efforts on increasing appraisal compliance & development of reviewed appraisal system for Agenda for Change staff 7. Launch of new staff support pathway into Occupational Health & Wellbeing Team	
20 (5 x 4) Extreme	1.5	Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	**20 (5 x 4) Extreme**	1. Continued prioritisation of child protection and LAC cases, in particular safeguarding visits. 2. Prioritisation of allocation of work across the Directorate in line with action plan. This includes re-deployment of non-front line staff, overtime payment and an external workforce appeal, local and regionally. 3. Skill mix continues to be increased (recruitment of family support workers) within the FIT teams to support social workers in non-social work tasks. 4. Regional recruitment initiatives remain ongoing, however these are unlikely to bring about substantive social work recruitment within Gateway and FIT service, given the limited pool of social work new entrants regionally. 5. Ongoing engagement with the HSCB and DoH on a regional basis.	**12 (3 x 4) HIGH**
12 (4 x3) MEDIUM	1.6	Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and non-executive Director level.	**12 (4 x 3) MEDIUM**	1. Two Non Executive Director vacancies - Chair has raised with Department of Health on 3 occasions and will continue to do so. 2. Recruitment process for new Chief Executive to be finalised. 3. Restructuring (3 new posts to be advertised - 2 reconfigured, 1 new). 4. Permanent recruitment of Director of Performance and Reform and Medical Director to be completed.	**6 (3 x 2) LOW**

REVIEW HISTORY

Review Date:	**Apr-22**

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care				**Lead Risk Owner**
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.				**Director of HROD**
Original Risk Rating	**Key risks**	**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**

Summary of SMT Discussion:

1.1

a) Workforce planning meetings for Medicine CAH and DHH and Emergency Medicine are ongoing and Workforce planning papers have been developed for Medicine CAH and Medicine DHH. IPT bids to be finalised to seek additional funding to support more consultant and SAS posts.
b) Contingency plan put in place from 28.2.2022 moving Emergency and General Surgery to CAH to facilitate a single site model.
c) Rotas at Risk summary has been updated to reflect current situation across service areas.
d) Agencies assigned to International Medical Recruitment Project have been advised of current hard to fill vacancies and are working on CV's
e) Recently appointed 3 Physician Associates from 2022 cohort who will be due to commence soon.

1.2

a) 3rd Locum Oversight meeting for Medicine/Unscheduled took place on 4 March 2022. Work in meantime to progress review locums in use and possible alternatives to be explored. Actions from the meeting will drive future direction of the meetings and workforce planning.
b) Metrics have been produced for Medicine/ED to highlight areas of high locum usage and high levels of rate escalation. Over the next 3-6 months, we will aim to expand these metrics to illustrate trends and patterns in other service areas also.
c) Regional Locum rates proposal paper has been presented to regional Human Resources Directors and Medical Directors and presented to DoH on 28 March 2022. Awaiting direction from DoH.
d) Ongoing Regional work to develop the Medical and Dental Agency Framework to ensure that it is fit for purpose. CAG meetings ongoing in conjuction with agency reduction steering group.
e) Two clinical leads have been appointed (1 Consultant/1 SAS) with oversight responsbility for Medical Locums governance and International doctor appointments. This will provide greater focus and clinical oversight for these important areas.

1.3

a) Safe staffing data is shared weekly at SMT meetings.
b) All data has been collated and is currently being prepared into dashboard style for presentation for Nursing & Midwifery Steering Group for ongoing informed discussion on actions to be taken with regards recruitment and retention activity in targeted areas. Linkages have been made with Informatics to develop QLIK dashboards - work continues by Corporate Nursing Team.
c) Agency reduction taskforce group yet to be established for acute services in first instance. However work is progressing regionally with Innovation Lab and regional reduction group to progress programme of work to inform the overarching work associated with eliminating off contract agency usage.
d) N&M Workforce Action Plan to be finalised with Year 2 actions (post covid) - corporate nursing staff diverted to supporting covid surge pressures - this work has now commenced post covid and will incorporate actions from regional retention implementation plan.

1.4

a) Band 7 CBT Therapist now in post. Band 8a readvertised - no applicants. Reprofiling the role to 8b in order to recruit.
b) Structure of People Plan developed, workshop and public meeting with Trust Board has taken place. People Plan is now with design company for graphic design - launch in June 2022. Marcomm engaged through HSC Leadership Centre to lead on engagement/communications plan.
c) Review of Collective Leadership currently underway in Trust by HSC Leadership Centre. Report expected in June 2022 on recommendations for further embedding of collective leadership and development.
d) BAME network underway, Menopause cafe, disability training, progressing mental health awareness training with Recovery College team.
e) Recognition Paper presented and approved through SMT. Recognition group now established to bring forward the actions identified in paper during 2022.
f)Succession planning programme launched for band 7 and 8a and aspiring directors. Initiative started and underway.

Any change to risk rating following review? **No**

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2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources					**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					**Director of Finance, Procurement and Estates**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
16 (4 x 4) HIGH	2.1	Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate.	**16 (4 x 4) HIGH**	* Plans to improve Equipment Management function The Equipment Management Committee (Cross Directorate) held its first meeting on 1.6.2021 and subsequent meetings are held quarterly to drive forward an overall body within the Trust in relation to equipment management. Sharepoint has also been utilised to provide a comprehensive outline resource under Estates Medical devices. The Estates Equipment Manager has also taken over the Trust's equipment priority list from Acute Directorate to provide a Trustwide list of equipment needs which is presented to Capital Allocation Group for funding allocation, when available. *Development of Annual Capital Plans via Capital Allocation Group * Ongoing submission to DoH to influence 10 Year Capital Strategy Director of Finance and Estates is a member of the DoH Strategic Capital Development and Estates Oversight Group, one of the main objectives is to provide strategic oversight, leadership and direction setting for capital development and estates related functions in pursuit of regional service delivery objectives. Director of Finance and Estates met with DoH officials to discuss a range of potential schemes that would facilitiate improved ventilation, increased sanitary facilities at ward levels of prioritised areas. £8.7m capital investment has now been secured for these schemes to complete March 2022	**9 (3 x 3) Medium**

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2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources	**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.	**Director of Finance, Procurement and Estates**

Original Risk Rating (Likelihood x Impact)		Key Risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
				Develop estate to provide more single side room provision, toilet facilities, improved ventilation Develop estate to provide facilities that meet the requirements for social distancing. There is a shortfall in MRI capacity which presents a safety risk. There are currently 2 scanners and require 3 to meet demand. There is broad support from commissioner and they are actively seeking an IPT. We would place the 3rd scanner in DHH. The Trust has sought the funding needed to address the infrastructure/power issue in DHH. Short term solutions including provision of a modular MRI scanner nearby DHH is being scoped. .	
	2.2.	Risk of significant disruption to clinical services and clinical risk due to loss of electrical power (LV) to main Craigavon Area Hospital block		A further sum of capital was obtained in October 2021 to progress the design of Phase 2 so the Trust will be in a position of readiness to procure works early in 2022/23 should funding be made available	

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2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources	**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.	**Director of Finance, Procurement and Estates**

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	2.3	Risk to the Trust's potential to respond adequately to Covid-19 and other transmissible organisms due to the inadequate number of single rooms across both acute hospitals to deal with the volumes of infectious patients requiring admission and care		£8.7m capital investment has been secured for schemes to faciltate improved ventilation, increased sanitary facilities and storage facilities and storage at ward levels - these schemes to be completed March 2022. These works will assist in addressing some of the deficiencies in wards, however, due to the design of wards i.e. based mainly in 4 and 6 bed wards, issues will not be fully addressed until redevelopment of wards to modern design standards has been achieved. Until the redevelopment can be achieved (a number of years away), the Trust will bid for further annual funding to take forward a series of interim schemes to continue to try and address risks in relation to nosocomial spread including negative ventilation rooms, new ward accommodation and ventilation upgrades to risk areas.	

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2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources	**Risk Owner**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.	**Director of Finance, Procurement and Estates**

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	2.4	i) Risk to the supply of clean linen to SHSCT, BCH & MPH due to the age and condition of existing equipment. This is causing a lot of breakdowns resulting in downtime and difficultity fulfulling orders		£1.2m Capital secured for the purchasing of a replacement tunnel washer and drying line. Installation of this equipment is due to be completed by June 2022. There are other equipment requirements on the CAG priority list.	
		ii)Risk to the Trust due to overdue servicing of medical equipment as highlighted in Internal Audit of Management of Medical Equipment 21/22. 2 priority 1 recommendations and 10 priority 2 recommendations to be implemented. Audit outcome was Limited		Priority 1 recommendation number 1 - The Trust should put in place an action plan to ensure that scheduled servicing of all medical devices are brought up to date this should focus initially on those Red or Amber devices which have not been serviced from 2019. Action being taken by Trust - Three additional engineers have joined the team over the past 4 months, Head of Service meets with team leads every two weeks. It is planned that all High risk equipment in use will be up to date by Mar 2022 and that +90% of Amber by June 2022. Implementation date March/ June 2022 Priority 1 recommendation number 2 -The Trust should ensure that there is a complete and up to date register of all medical devices DECs should regularly be required to	

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2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources					**Risk Owner** **Director of Finance, Procurement and Estates**
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
				medical devices. DECs should regularly be required to validate listings of medical devices under their control and provide a response to Estates. Action being taken by Trust - When BackTraq was initially implemented data was imported from several databases covering differing areas. Some of this data was incorrectly coded e.g. equipment allocated to CSSD, this has now been rectified. Equipment used in Cardiac Rehabilitation has been removed from use (due to COVID) these four devices are now in storage and have been condemned. Assets are at times sent with patients after they have been discharged, details are recorded at ward level. Completed implementation date was 30 September 2021	
REVIEW HISTORY					
Review Date:	**Apr-22**		**Risk Rating after review: High / Medium / Low**		
Summary of SMT Discussion:					

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
16 (4 x 4) HIGH	3.1	Clinical risk associated with delay in accessing planned services for assessment, diagnostics and treatment in accordance with clinical need	**16 (4 x 4) HIGH**	Regional clinical prioritisation of operative / theatre capacity to ensure available capacity directed to those most in need on an equitable basis. Continual review of service waiting lists to ensure those with greatest need are allocated capacity and routine users are offered access to available capacity on a chronological basis. Areas of risk will continue to be escalated to Directorate Senior Management Team meetings, SMT and HSCB. Continued monitoring of outpatient clinics and elective procedures - red flags reviewed weekly; other referrals reviewed monthly. Given correlating delay within Cancer Pathways, there will be an increase in monitoring of sharing of reports to support improved compliance with 31/62 day targets. Opportunities continue to be identified to seek to increase capacity via sourcing of additional capacity, both internally and externally, via Independent Sector.	**9 (3 x 3) MEDIUM**

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3. Access to Services

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Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
				Continue to scope Innovative approaches/new ways of working to service delivery. Development of Service Delivery plans for core services to seek to increase capacity back to pre-Covid levels.	
	3.2	Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)		Continued use of Phone First Development of ambulatory services to reduce attendance/ capacity within EDs. Review of current GP OOH provision with temporary consolidation of current bases to reflect current available resources	

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3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	3.3.	Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health or Paediatric services		No More Silos Local Implementation Group will focus on development of alternatives to inpatient, improvement on control room functions/oversight and focus on flow and discharge Improved access to surgical beds within CAH site with change to Surgery contingency plan - provision of Emergency and General Surgery on single site, CAH. Continued use of up to three times daily, joint Directorate (Acute and OPPC) meeting to review inpatient delays and promote effective flow through both Acute Hospitals	
	3.4	Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domicilary care, day care centres etc.)		Seek to increase capacity in IS for day centres	

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3. Access to Services

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Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	3.5	Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain (GB) will not, with implications for both the supply and regulation of medicines in NI. Key issues include: • Medicines licensing; • Medicines supply chain • Medical Devices.		DoH led EU/Northern IrelandProgramme Board continues to address issues, including at an operational level, to ensure there is minimal impact to NI customers and suppliers in relation to medicine and medical device availability, supply and pricing. There is also a need to ensure that there is equitable access to new medicines in line with GB.	

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3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					**Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	3.6	Risk to the provision of food for patients & staff due to Suppliers having difficulities sourcing and supplying some food produce. As a knock on effect, Suppliers are reducing the number of deliveries per week resulting in larger orders being placed and needing storage. There are also procurement risks and need to increase frozen and storage space. The Trust has also had issues with the meats contracts due to EU Brexit standards and procedures. The same supplier supplied both raw and cooked meats. As a result of these issues the main kitchens in the hospitals had to purchase additional supplies and there was the potential of cross-contamination risks. This also led to an increased reliance on one food supplier.		Senior managers attending workshop regarding food procurement strategy going forward in HSC. Reviewing current areas along with estates to identify any protential solutions as there may be a need for more freezer capacity. Community facilities are continuing to purchase fresh fruit and vegetables locally and the Assistant Director of Finance has been informed of this risk.	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care	**Risk Owner**
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.	**Operational Directors**

Original Risk Rating (Likelihood x Impact)	Key Risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	There have been other issues with contracts including minimum order values and minimum quantities and the bakery items contract ending before its expiry date. When the fresh fruit and veg contract is re-tendered there may be restrictions with the number of delivery points. Food supply issues impact on menu planning both in the hospitals and Community facilities and there is the potential for increased complaints from service users due to limited menu choices.			

REVIEW HISTORY

Review Date:	Apr-22	Risk Rating after review: High / Medium / Low

Summary of SMT Discussion

3.6 Discussions have been held with Hendersons to reduce the cross-contamination risks from the delivery of raw and cooked meats and this appears to have resolved.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

4. Technology Enablement

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture).					**Performance & Reform and Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
16 (4 x 4) HIGH	4.1	There is a risk to the HSC network and organisations in the event of a cyber attack on HSCNI or a supplier/partner organisation resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk of the Organisation being able to continue to deliver services to Patients/service users/Customers, loss of personal and organisational information and loss of public confidence as a result of a Cyber attack	**16 (4 x 4) HIGH**	We are aiming to move into prevention rather than reaction to cyber risks. The following is in progress: • Vulnerabilities software management (Tenable) has been installed and a governance structure is in place to review and prioritise actions that are identified as risks. • Licences have been purchased to detect devices on the network (Forescout) and paired with vulnerabilities software, helps us understand critical and high risk vulnerabilities. This helps us to prioritise our risk management as part of our prevention strategy. • Cyber incidents detected via phishing emails continues to increase month on month. There were 64 in February and 101 in March 2022. • Uptake of e-learning will continue to be encouraged. There is a continued increase in staff undertaking e-learning across the Trust with 8613 staff having now undertaken their cyber awareness e-learning which also helps with prevention. • There are 8 Regional tactical recommendations which all Trusts have been asked to prioritise in terms of mitigating cyber risk. Southern Trust continues to progress well with these tactical recommendations but remains an outlier in one area which is patch management. 55% of all of our servers and applications are patched within one month of patch release. The aim is to increase	**9 (3 x 3) MEDIUM**

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

4. Technology Enablement

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture).					**Performance & Reform and Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
				this to 100%. Additional resources have been agreed at risk by the Trust and recruitment is in progress to help address this. • There are 8 projects in flight in the Trust with the aim of improving protection and prevention from cyber risk and a further 8 programmes in pipeline. Projects have been prioritised to make best use of resources.	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

4. Technology Enablement

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture).					**Performance & Reform and Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	4.2	Risk of achieving implentataton of Regional Technology implementation.There are a range of Regional programmes – Encompass, Labs replacement, HRPTS encompass, PACs upgrade, EQIP (HRPTS replacement) as well as digital shared services. The agenda is very large and diverse with limited additional resources in either the IT team or to help front line services with the business change. The risk is fundamentally that the Trust will not have the capacity to effect the change required to implement the digital initiatives.		There continues to be a high volume of Regional projects in the pipeline and in flight, as below, as well as a range of internal inescapable upgrades such as Flow Electronic Whiteboards. • TEP Regional upgrade of Microsoft Office including implementation of Microsoft Teams • Labs Replacement • PACS Replacement • Equip Replacement • Cyber prevention and detection projects • Digital Shared Services • Encompass The Informatics Division continues to experience pressure in engagment planning and implemention. The Trust continues to engage in all regional groups <u>Encompass</u> The wider services also experience pressure in engaging on Encompass preparation associated with competing pressures and the high volume of workgroups. A number of key IT posts are now in place for Encompass which will assist and the Trust will establish a dedicated project manager on a full time basis.	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

4. Technology Enablement

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Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture).					**Performance & Reform and Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
				The Trust has bid for additional resources (March 22) to support additional requirements including key professional posts. Proposals are ongoing to fund dedicated PA's for Medical Staff and to help release them to engage in this important electronic record. The next 3 - 4 years will continue to bring significant challenges to frontline staff , management and the Informatics Division in relation to planning, engagement and implementation of large transformational change ICT projects.	
	4.3	Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.The risk of loss of access must be minimised to defend the Trust against loss of access.		The Informatics Division continues to engage with external suppliers to review backups, test failovers and provide assurance on BCP and resilience. Funding has been secured to help improve awareness to the frontline ICT staff on the helpdesk regarding signs of potential cyber threat. The Cyber Oversight Group in the Trust is in place to encourage Directors to consider threat, raise awareness and the need to review their BCP's and test these. Network segregation project has kicked off internally on the Craigavon Area Hospital site to aim to minimise the spread of computer viruses across the network and devices in the event of a cyber attack.	

REVIEW HISTORY

Review Date:	**Apr-22**	**Risk Rating after review: High**

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

4. Technology Enablement

Corporate Objective Alignment: Promoting Safe, High Quality Care				**Risk Owner**
Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture).				**Performance & Reform and Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**	**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
Summary of SMT Discussion **4.1** Regional delays continue. Regional security group has still not been established. Whilst the Trust has made good progress in local cyber security Internal Audit recommendations, the regional recommendations remain outstanding. This is being monitored by the Regional Security Programme Board.				

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

5. Finance

Corporate Objective Alignment: Making best use of resources					**Risk Owner**
Risk: Risk of financial stability and breach of statutory duty of break-even in-year .					**Director of Finance, Procurement and Estates and all Operational Directors**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
12 (4 x 3) MEDIUM	5.1	Risk of breach of statutory duty of break-even in year	**12 (4 x 3) MEDIUM**	• Indicative allocations for the financial year 2021/22 have been released to Trusts, however, work continues with HSCB and DoH to understand the potential implications of the budget settlement on Trusts. Once further clarity is received in relation to the actual budget for the Trust, DoF will prepare an updated briefing for SMT and Trust Board. It is expected that this will be around September/October 2021. • Finance will complete a mid-year hard close, the purpose of which is to inform the finance strategy for the remaining months of the financial year. This is good practice. The hard close will be as at September 2021. Results from this will be known in November 2021 and findings from this will inform forecasts for the remainder of the financial year.	**6 (3 x 2) LOW**

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5. Finance

Corporate Objective Alignment: Making best use of resources **Risk:** Risk of financial stability and breach of statutory duty of break-even in-year .					**Risk Owner** Director of Finance, Procurement and Estates and all Operational Directors
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
				• During 2021/22 The Director of Finance, prepared an update on “Return to Balance” – this document reminded all of the Trust’s statutory duty to break-even and that as a Trust we do not have the authority to spend in excess of the budget. It set out the key findings and recommendations from the Acute phase and also sought approval to move to the second phase which is within Mental Health and Disability. All recommendations were accepted and approved and work has now commenced within Mental Health and Disability. It is expected that this work will be reported on in Quarter 3 of the financial year.	

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5. Finance

Corporate Objective Alignment: Making best use of resources	**Risk Owner**
Risk: Risk of financial stability and breach of statutory duty of break-even in-year .	**Director of Finance, Procurement and Estates and all Operational Directors**

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	5.2	Risk of destabilisation of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment.		• Director of Finance is continuing to work with HSCB and Department of Health in relation to the capitation inequity gap. To date this work has been successful in ensuring that the Trust has not had to make £25m of recurrent savings. In addition the "Return to Balance" work identified a range of current expenditure areas that do require funding support and discussions have commenced with HSCB re same. • Director of Finance sought DoH approval for capitation to be discussed at the Strategic Finance Forum in November 2019 – a healthy debate took place and DoH agreed that whilst they had endeavoured to address some of the imbalance by not applying a savings target, the gap remained. Work on the equity gap continues with HSCB/DoH	

REVIEW HISTORY

Review Date:	**Apr-22**	**Risk Rating after review:** **High / Medium / Low**
Summary of SMT Discussion:		

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

6. Infection, Prevention and Control

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C.difficile etc.					**Medical Director**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
12 (3 x 4) HIGH	6.1	The Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk) Risk associated with:- ED/Secondary Care Bed capacity/ICU bed capacity constraints AGP including continuous positive airway pressure (CPAP) non-invasive ventilation Laboratory testing capacity for respiratory viruses is limited locally and there is a delay in turnaround time for samples going to RVL to allow for	**12 (3 x 4) HIGH**	Review and update of IPC/AMS Strategy Develop audit team to provide assurance on all aspects of IPC Develop a case to further develop an MDT infection service Further develop diagnostic capacity to facilitiate early diagnosis to facilitate isolation and timely appropriate treatment to prevent AMR	**6 (2 x 3) MEDIUM**

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6. Infection, Prevention and Control

Corporate Objective Alignment: Promoting Safe, High Quality Care					**Risk Owner**
Risk: Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C.difficile etc.					**Medical Director**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
		prompt identification and isolation/cohorting of patients Increased workload of the IPC/microbiology/clinical/Functional support services staff with the management of Covid-19 surges and outbreaks Increased antimicrobial resistance			
Review Date:		**Apr-22**		**Risk Rating after review: High / Medium / Low**	
Summary of SMT Discussion:					

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

7. Response to Urology Services Public Inquiry

Corporate Objective Alignment: Promoting safe, high quality care: Supporting people to live long, healthy lives; Improving our services; Making best use of our resources; Being a great place to work; Working in partnership					**Risk Owner** Programme Director of the Public Inquiry
Risk: Risk to the Trust's potential to respond adequately to the Statutory Public Inquiry into Urology Services (USI)					
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
16 (4 x 4) **HIGH**	7.1	Risk that due to capacity issues, the Trust may be unable to respond in a timely and complete way to Section 21 requests from the USI.	**16 (4 x 4)** **HIGH**	The Public Inquiry Team will provide targeted support for staff receiving individual Section 21 notices Ongoing work by the Public Inquiry Team to identify a cohort of experienced staff, likely recently retired, who can provide assistance to individuals responding to Section 21s. The Trust will seek to employ paralegal support to analyse, collate and assess information which has been so far retrieved.	**6 (2 x 3)** **MEDIUM**

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

7. Response to Urology Services Public Inquiry

Corporate Objective Alignment: Promoting safe, high quality care: Supporting people to live long, healthy lives; Improving our services; Making best use of our resources; Being a great place to work; Working in partnership	**Risk Owner**
Risk: Risk to the Trust's potential to respond adequately to the Statutory Public Inquiry into Urology Services (USI)	**Programme Director of the Public Inquiry**

Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	7.2	Risk to service continuity as a result of Section 21 notices with strict deadlines. (On 28/29 April 2022, a total of 40 Section 21 notices were issued by the USI. This is in addition to five notices issued immediately before Easter weekend, and more than 160 questionnaires issued to nursing and some medical staff working in Urology Inpatients and Outpatients issued at the same time.		The Trust continues to liaise with the USI to achieve a workable timeframe for response of S21s, and has highlighted the operational impact of the on-going discovery process.	
	7.3	Risk to health and wellbeing of staff and the potential impact on staff sickness.		Occupational Health Support Psychologist has been briefed and is available for staff support. External staff support is also currently being sourced. Proactive regular group check in sessions for PI Team and others as required, will be available. Ongoing availability of Inspire.	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

7. Response to Urology Services Public Inquiry

Corporate Objective Alignment: Promoting safe, high quality care: Supporting people to live long, healthy lives; Improving our services; Making best use of our resources; Being a great place to work; Working in partnership					**Risk Owner**
Risk: Risk to the Trust's potential to respond adequately to the Statutory Public Inquiry into Urology Services (USI)					**Programme Director of the Public Inquiry**
Original Risk Rating (Likelihood x Impact)	**Key Risks**		**Current Risk Rating (Likelihood x Impact)**	**Summary Priority Actions Planned for next 3 months**	**Target Risk Rating**
	7.4	Risk that there will be issues identified through the discovery process which may impact on the reputation and function of the Trust. This includes the look back of patients under the care of Consultant A		Consultations with staff and review of discovery information The Public Inquiry Team will develop support systems for discovery phase and preparation for open hearings to be developed in conjuction with staff Royal College of Surgeons currently reviewing 100 patients and this report will determine the need for a further extended lookback of Consultant A's patients	
Review Date:		**Apr-22**		**Risk Rating after review: High / Medium / Low**	

Summary of SMT Discussion:

Significant work ongoing as a result of USI processes - learning, look back and implementation of quality improvement initatives which has potential impact on service delivery.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

20190704
Q7.38 A1

From: Haynes, Mark [redacted]
Sent: 04 July 2019 09:50
To: McClements, Melanie; Carroll, Ronan; OKane, Maria; Magwood, Aldrina
Subject: Bed modelling
Attachments: Southern Trust Bed Modelling 3 July 2019 - V2.2.pptx

Morning

Following on from yesterday morning. I have concerns the modelling presented is significantly underestimating requirements, particularly from a surgery and elective care perspective.

As is stated in the pre-amble, the model is based on actual activity over a 5 year period. It is also acknowledged that elective activity has fallen by 10% per year over this period (Slide 5). As we well know, this fall is not due to a fall in demand but a fall in delivery due to a lack of capacity. The projections therefore fail to account for this inherent lack of capacity. They also fail to account for rising demand for elective surgery. The projected bed requirements, by the nature of the model in its current form, will mean that the model projects an ongoing fall in elective activity, as this is what has happened over the past 5 years (Slide 14 '...The models assume that the trends and patterns are stable and will continue at the same rates in the future...'). Therefore, the model in its current form will result in inadequate capacity to deliver the needs of patients in the Southern Trust for elective surgery.

In order to overcome this, the model needs significant additional data input. Firstly to correct for the lost capacity due to lack of beds and more recently lack of theatre staff. This would then project for us meeting our current commissioned capacity. However, as we know, commissioned capacity does not meet patient demand and if we want to be in a position to have the bed capacity to meet the population demand for elective care, a further correction is required to project bed requirements to deliver population demand for elective treatments. Without this we will perpetuate the current situation of growing numbers of patients waiting unacceptable lengths of time for elective surgical treatments. Some information projecting forwards to meet demand may have already been considered in various surgical manpower papers (Gillian Rankin did the urology one), this may be very approximate, but if the projection for urology was a need for an additional 8 consultants across the region on 4 sites, then we can make a reasonable assumption that for urology, 2 consultants worth of elective activity per week are needed to meet Southern Trust demand. I am aware T&O have had a similar manpower paper prepared and would imagine similar work was done in other specialities. This can give us a quick estimate of additional capacity requirements to reach a position where we meet population demand.

Secondly, I maintain concerns that modelling to 89% capacity does not enable us to cope with peaks of unscheduled care activity, particularly on smaller sites, as was acknowledged in the presentation. I recognise that the 89% level came from outside of the trust but feel this sets us up to fail while trying to deliver unscheduled care on 2 sites. Daisy Hill, being smaller is particularly vulnerable to this.

Mark

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

20200127
Q7.38 +2

From: Haynes, Mark <[redacted]>
Sent: 27 January 2020 11:45
To: McClements, Melanie; Corrigan, Martina; McNaboe, Ted; Carroll, Ronan
Subject: RE: WL for information

Morning

Update for February...

24 hours of operating available to manage patients on RF those on GA bladder cancer surveillance, and stented/stones, which require a total of 59 hours. I will only be able to manage RF cases and this means stented patients will continue to be delayed beyond the time in which they should be changed (resulting in a risk of emergency admission or more complicated surgery) or definitively managed (resulting in an increase risk of sepsis at time of treatment and risk of more complicated surgery), or delay in identification of recurrence / progression in high risk bladder cancer patients.

This does not include any patients on the clinically urgent WL, within which there are 24 upper tract major cases (nephrectomy, hemi nephrectomy, pyeloplasty). These patients are all at risk of infective complications of their benign pathology and loss of renal function.

Mark

From: Haynes, Mark
Sent: 02 January 2020 13:13
To: McClements, Melanie; Corrigan, Martina; McNaboe, Ted; Carroll, Ronan
Subject: RE: WL for information

Urology only in CAH so limited cross trust, we are 5 with a vacant locum post and no suitable short term locums (very careful regarding appointments as previous appointments have created more problems than solving). IPT to expand service to DHH has been written including additional consultant post but provision of new service will be reliant on staffing of new theatre sessions. Most across NI in same boat. IS in NI has been done before but was not a great success. Don't know if IS in RoI has been explored.

Most important is continuing highlighting and recognition of risk (see recent SAI's re urology treatment delays).

Next sounds V defensive but is fact... another surgical speciality in another NI trust have come under significant criticism for treatment delays and subsequent adverse outcomes for not highlighting the waiting times to the trust (genuinely bizarre given that the waiting times were known to the trust) and therefore in order to protect ourselves we have been advised to highlight treatment delays!

Mark

From: McClements, Melanie
Sent: 27 December 2019 15:03
To: Haynes, Mark; Corrigan, Martina; McNaboe, Ted; Carroll, Ronan
Subject: RE: WL for information

Mark
I am open to discussing any options to address this. Is there any cross-Trust or IS referral potential or is everyone in same boat? mel

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

From: Haynes, Mark
Sent: 18 December 2019 15:36
To: Corrigan, Martina; McNaboe, Ted; Carroll, Ronan; McClements, Melanie
Subject: WL for information

Afternoon

I know i have raised this previously but wanted to highlight my current WL position. In January I have an available 28hrs of operating with 65 hrs of surgery needing done to manage just red flags, bladder cancer surveillance, stented patients (planned changes and definitive stone management), and patients with obstructed kidneys secondary to stones.

I have been able to accommodate most of the RF procedures and one stented stone patient. There remains one red flag laparoscopic nephroureterectomy which was listed on 12/12/19 who will not get a date until February, a number of patients with overdue bladder cancer surveillance (longest due November 2019) overdue stent changes (longest due September 2019). In total there are 24 patients who I cannot accommodate from this group of patients. This does not include patients on either my urgent or routine WL.

I am aware you know the waiting lists in urology place patients at risk, and that there is no simple fix to the underlying issue of insufficient capacity, but want to highlight that those patients I am not able to accommodate a. at risk of delayed detection of recurrence (bladder cancer surveillance), increased risk of gram negative sepsis (delayed stent procedures) and loss of kidney function (obstructed kidneys).

Mark

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

20200529
Q7. 38 A3

From: Haynes, Mark [redacted]
Sent: 29 May 2020 13:25
To: Leeman, Lesley; OKane, Maria
Cc: Magwood, Aldrina; McClements, Melanie
Subject: RE: contract capacity in the IS for electives

Hi Lesley

Currently we are not in a position to increase our onsite capacity and so certainly we will need this capacity albeit in a planned manner. The cases we are currently operating on do not include all urgent procedures and there is significant unmet demand of 'urgent but not urgent enough to do now' work, and I would hope that if IS capacity is available to augment our on site capacity, we can utilise this as part of team / consultant job plans.

From urology perspective we have already discussed with Lisa and David about continued IS access, accepting that BT are in a better position (because of numbers of consultants) to take on these sessions than either ST or SET. Urology are using the largest numbers of IS lists currently (15 per week planned for June in KB / UIC). The demand is for urgent work – Stones, Catheterised TURP, pyeloplasty etc, much of this has not yet been filtered into the work being done but once we have sorted the TURBT's (BT have approx. 50 to do) we will be looking to broaden out to include these. Almost all of these patients had been waiting well beyond the 3 month window for category 3 cases pre-COVID. I hope each team would be able to provide detail of what volume of IS capacity they would like to take up post 30th June.

Similarly our endoscopy need pre-COVID was beyond that which we were able to provide. We will not be in a position to match this pre-COVID delivery on site and so would also require additonal capacity and again if this is delivering capacity that would have been normally job planned then I would hope it could conotinue to be delivered in the IS as part of standard JP's.

Mark

From: Leeman, Lesley
Sent: 28 May 2020 18:53
To: Haynes, Mark; OKane, Maria
Cc: Magwood, Aldrina; McClements, Melanie
Subject: contract capacity in the IS for electives

Mark/Maria
Just testing your thoughts on continuation of the arrangements with IS hospital contracts for urgent work.

I'm not sure if we need the whole contracted capacity, just wonder as our in-house capacity grows and we restart function will clinicians be as available to uptake sessions in IS? Perhaps there is some scope for a number of contracted sessions reserved by Trust.

Mark – from CRG perspective whats your view on ongoing need for this space in light of demand

Lesley

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Lesley Leeman
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Southern Health and Social Care Trust
68 Lurgan Road Portadown Craigavon Co Armagh BT63 5QQ

[redacted]
Directline: [redacted]
Mobile: [redacted]

From: Paul Cavanagh [redacted]
Sent: 28 May 2020 18:12
To: Gillespie Mark; neil.martin[redacted] Leeman, Lesley
Cc: Dermot McAteer
Subject: FW: HSC Body with Corvally Healthcare - North West Hospital,Ballykelly;

"This email is covered by the disclaimer found at the end of the message."

Colleagues

Dermot McAteer was trying to get in touch today regarding your view if the arrangement with the 3 independent hospitals should continue beyond end of June. As you know we are currently carrying most of the costs of the hospitals and have not really maximised the capacity to date. While it is an option to continue with the arrangement (although DoH seems unlikely to approve this level of funding), we can also end the contracts or we might find an intermediate position more akin to elective contracts.

I would appreciate if you would let me know your thoughts by return and no later than tomorrow morning. A decision is required 30 days before the end date (i.e. 1 June) and Dermot and I need to take a paper through Silver and Gold urgently.

Regards

Paul

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Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

20201220
Q7.38 A4

From: Haynes, Mark [redacted]
Sent: 20 December 2020 06:58
To: Diamond, Aisling; Carroll, Ronan; OKane, Maria; McClements, Melanie
Cc: Young, Michael
Subject: Urology team

Morning

Following from previous conversations regarding the urology team, one aspect that I hadn't raised was regarding the urology consultant on-call rota.

The trust have 7 funded consultant posts. However, we continue to work a 1:6 rota. I am aware that in other services within the trust, rota frequency was changed when it was recognised that that there needed to be a reduction in the on-call frequency, and the vacant slots filled as locums (critical care for example).

Can the urology consultant on-call rota frequency be moved to 1:7 with immediate effect, reflecting the funded posts in the service, with the vacant slots on the on-call rota being filled on a locum basis (it is most likely these slots would be filled by the incumbent team).

Mark

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

APPENDIX 1 – TRUST RISK ASSESSMENT

/SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM		Risk ID No
Directorate: **Acute / SEC**	Facility/Department/Team: **Ward 3 South**	Date: **18/12/2018** **Review Date 5.8.19** **Review Date 4.9.19**
Where is this being carried out? (E.g. Trust premises/home of client/staff/ private nursing home etc) **Trust Premises: Craigavon Area Hospital**		Objective(s) i.e. Corporate, Legislative requirements etc.: **Corporate**

Risk Title: (Threat to achievement of objective)

Objective is to deliver safe, effective, compassionate, patient centred care to all service users within ward 3 South at all times.

Introduction

Having the right number of appropriately qualified, competent and experienced nurses protects the public, nursing profession and the employer. The right number of registered nurses leads to improved patient outcomes, reduced mortality rates and increased productivity. But insufficient numbers of registered nurses has potentially life-threatening consequences for patients (Royal College of Nursing 2017).

3 South (3S) is one of 5 in patient surgical wards on the Craigavon Hospital site. 3S has recurrent nurse funding for 31 beds.
However in approximately 2014 as part of winter resilience planning 3S had its bed compliment increased to 36 beds.
3S admits both emergency and elective patients. From April 2019, 3 South reduced its bed complement to 32 Beds (4 closed)

Table 1 Normative Recurrently Funded

Hospital Site	Specialty	Ward	Bed Compliment	Required Normative NBR	Normative % Reg (excluding Ward Sister backfill)	Total Normative Nursing Requirement wte
CAH	SEC	3S	31	1.49	70%	**47.19 +WS (32 RN/ 14.16 HCA)**

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CAH	SEC	3S	36	1.49	70%	**54.64 +WS (38.3 RN/16.34 HCA)**
CAH	SEC	3S	32	1.49	70%	**47.68 +WS (33.4 RN/ 14.28 HCA)**

Current Staffing position as of 4.9.19

Funding based on 31 beds (currently staffing 32) NPR 1:49									
	FSL	***ACTUAL***	***DEFICIT***	***AVAILABLE***	***LTS***	***MAT***	***SEC / CB***	***BANK***	***LEAVES***
Band 7	1.00	1.00	0.00	1.00					
Band 6	3.00	4.72	2.00	2.72	2.00	1.00			2.00
Band 5	29.03	11.24	-17.79	9.34	0.61		1.29		0.87
Band 3	6.49	5.86	-0.63	3.86			1.00		1.00
Band 2	6.49	7.21	0.72	6.35	0.86			0.57	0.57
TOTALS	***46.01***	***30.03***	***-15.98***	***22.27***	***3.47***	***1.00***	***2.29***	***0.57***	***4.44***

Staffing Position as of 5.8.19

Funding based on 31 beds (currently staffing 32) NPR 1:49									
	FSL	***ACTUAL***	***DEFICIT***	***AVAILABLE***	***LTS***	***MAT***	***SEC / CB***	***BANK/BB***	***LEAVES***
Band 7	1.00	1.00	0.00	1.00					
Band 6	3.00	4.92	1.92	1.92		1.00			3.00
Band 5	29.03	14.29	-14.74	11.14	1.29		1.00		0.86
Band 3	6.49	4.66	-0.83	4.66			1.00		
Band 2	6.49	7.21	+0.72	10.29	0.86			0.57	0.57
TOTALS	***46.01***	***32.08***	***-12.93***	***29.01***	***2.15***	***1.00***	***2.00***	***0.57***	***4.43***

The last column outlines the leavers from the ward pending in September X2 band 6 Clinical Sisters are leaving, x1 moving as band 5 to Day Surgery, x1 moving as band 5 to Cathlab and x1 Band 6 has applied for Elective and Outpatient posts.

X1 Staff Nurse moving to Recovery. Applied to advert. Attempting to retain at present as senior nurse

Once these staff leave, out total SN WTE will 8.47 (plus 1.52 of Band 6)

4 North Funding based on 34 beds NPR 1.38									
	FSL	ACTUAL	DEFICIT	AVAILABLE	LTS	MAT	SEC / CB	BANK/BB	LEAVES
Band 7	1.00	1.00	0.00	1.00					
Band 6	3.70	3.70	0.00	2.7		1.00			
Band 5	31.08	29.95	-1.13	23.23	1.00	1.57	1.00		
Band 3	7.45	5.44	-1.86	3.40	1.60	0.80			
Band 2	7.45	5.44	-1.86	3.40				0.43	
TOTALS	**50.68**	**45.52**	**-4.85**	**33.73**	**2.60**	**3.37**	**1.00**	**0.43**	

4 South Funding based on 36 beds NPR 1.48									
	FSL	ACTUAL	DEFICIT	AVAILABLE	LTS	MAT	SEC / CB	BANK/BB	LEAVES
Band 7	1.00	1.00	0.00	1.00					
Band 6	3.70	3.70	0.00	3.70					
Band 5	33.70	30.23	-3.47	24.09	0.57	1.57	1.00	1.00	
Band 3	7.99	6.63	-1.36	5.99	0.00	0.57			
Band 2	7.99	6.63	-1.36	5.99				1.00	
TOTALS	**54.38**	**49.54**	**-6.19**	**40.14**	**0.57**	**2.14**	**1.00**	**2.00**	

In addition we have lost x4 senior nurses (equating to 3.66 WTE) in the past 3 months. The reasons for this vary. Pursuing new opportunities in Theatres/ Outpatients in CAH. Transfer to Belfast to specialist area and to accommodate specific Work Life Balance requirements.

The current staffing levels are a result of vacant posts, x1 maternity leave, x3 Long Term Sick, one of these is a recently returned from Mat leave who is simply overwhelmed by the lack of core staff and is struggling to cope, and x1 Career Break and x1 unpaid leave. There has been significant difficulty in securing new Pre Reg Staff Nurses, to date 2 have been confirmed (x1 withdrew) they are pending start dates in September/ October. Of the current staffing available from Band 5, approximately 50% of them are considered Junior and are qualified approximately 1 year. With the pending Band 6/ Band 5 leavers, this will increase dramatically. Our OU Student has declined his post on 3 South and will be taking up a post in Lurgan Hospital. They state they live beside Lurgan Hospital and for handiness they will take a post there. An open

advert for 4 weeks, specific to 3 South Band 5 received zero applications. The Band 6 (x2 posts) are now out to advert and will close on the 14th September.

Whilst the ward has maintained it staffing requirements on eroster. This was to allow the core staff opportunity to address training and competencies etc. Currently they work with 1 nurse to 4 patients, whilst this undoubtedly is not the norm in other areas, the concern remains with the standard of nursing care and the core to agency ratio. The skill mix affects the ability for patient needs to be fully met. The concern is that we find ourselves in a position not able to manage patients requiring speciality nursing care for eg Laryngectomy/ Tracheostomy patients because we wont have the staff to do so.

Block Bookings

Block Bookings/ Regular Agency & Bank make up a significant amount of the daily allocation on 3 South. As of July/ August we have an average of 9.5 WTE Band 5 and 1.9 WTE of Band 2 cover. Out of these 2 WTE are newly allocated Agency block bookings from England due to start in the next 2 weeks. They are coming with skills in airway management which are essential to the ward.

From August to September the amount of regular agency staff has reduced. With an average of 5.4 WTE of Band 5 nurse cover and 1.7 WTE of band 2/3 cover. The new nurses that came from England were not sustainable. One left after 2 shifts and the other had a formal complaint from a family made against them on their 2nd shift.

Allocations of Staff

An average Day duty in August/ Sept Rota indicated that of the staff available on the ward (2 Band 5 Long Day shifts were unfilled) 60% were agency and 40% core staff. Of our own staff, half of the nurses were considered junior. Night duty 50% were Agency, 50% own staff. The major issue with Staff allocations is trying to ensure an airway trained nurse is present on each shift, day and night, 7 days a week. Whilst training percentages for airway training are satisfactory (78%) losing the senior nurses at the end of the month will have a massive impact on this skill. There is an additional pressure when new airway patients require 1:1 nursing care for the first 48 hours post operatively, and sometimes established airways require 1:1 nursing care due to high secretion and airway obstruction risk. These skills are not easily available on the bank, or even with agency staff so the ward has to cover these patients firstly.

A particular day in August/ Sept when sickness and lack of staff came to crisis point, we had 2 core staff nurses on duty. The Lead Nurse and a Band 6 from another Surgical ward had to take charge of the ward. The remaining band 5 staff on duty were all agency. On an average day the skill mix remains 50-70% agency staff for band 5 cover. Night duty continue to be staffed with 1-2 staff nurses (predominately one) and the rest agency. Therefore there are nights were a full side of the ward is staffed purely by agency nurses. If the ward happens to have a number of patients for airway management, the need to have more core nurses increases to ensure those needs are met.

It is a daily, sometimes multiple times in a day, for all staff not on duty to be contacted to come into work, work overtime, swap shifts etc. Staff on annual leave have also had to be contacted to come in. Staff do assist but this is not sustainable as an option as staff are burning out, and short term sickness/ long term sickness is peaking. Agency staff that make up the approx. 5.4WTE of regular shifts, ranging from a half day shift (6.25 hours) to 3 long days per week (37.5.hours) cannot be considered as stability for the ward, they have the option to leave at a days notice. This has happened and leaves an already very stretched rota completely unmanageable. Staff often don't even turn up for shift. Skills are severely lacking in what the ward needs. Night duties are becoming extremely difficult to manage as cancellations are frequent and often last minute. We cannot pull staff off days as this further depletes the skill mix and the offer of overtime to those staff who are full time has been exhausted. We have often be in the position where we have had to offer any hours of night duty…even 10pm-2am or twilight shifts but pick up of this has been zero.

What does 3S do?

The surgical specialties aligned to this ward have the following bed compliment 19 Urology beds, 7 ENT beds and 5 General Surgery beds (31 beds). Patients with urological conditions include those with complex urosepsis, acute urinary retention, renal calculi disease treatments including percutaneous nephrolithotomy, major renal cancer surgery (open and laparoscopic nephrectomies and partial nephrectomies), bladder outflow surgery, bladder tumour resection and those undergoing urinary tract reconstruction. Patients with ENT conditions range from quinsy, tonsillectomy, grommet insertion, adenoidectomy to tracheostomies & laryngectomies. With the increase up to 36 beds to cover winter pressures, the ward has a very mixed patient load daily covering multiple specialities. With the decrease to 32 beds, the ward has been predominantly ENT/ Urology patient, but medical outliers do persist. In the past 8 months, there has been consistent scheduling of patients for Laryngectomy and Tracheostomy. In addition the process in the hospital has been at admit any patient with any form of airway in place to 3 South (including those under medical care). These patients booked to come in, are very high risk, require 1:1 nursing care for 72hours at least and need trained and skilled nurses to care for them, the 1st 24 hours requires a nurse to be deployed from 3 South to recovery for the 24 hour post op period.There has also been an increase (x3 cases in 2 weeks) of emergency Trache cases which has added to the need for airway trained nurses. Repatriation of complex patients from Belfast Trust awaiting Regional Brain Injury Unit admission has also added to the additional requirement for skilled airway nurses.

Urology and ENT are at the opposite ends of the discharge volumes ie ENT admit high volumes of patients but with short lengths of stays as opposed to urology which admits lower volumes of patients post operatively but these patients have a greater length of stay. 3S admits and discharges a high volume of patients each week. Table 4 demonstrates this activity for the last 3mths. This does not include the patients attending treatment room on 3 South for minor procedures etc which also requires availability of nursing staff. Whilst 3 South have generally avoided having to take the extra patient when the ED department is in "Code Black", the ward still has to manage the ward attenders and could have up to 3 patients awaiting treatment room at any time.

Table 4 Admissions and Discharges on 3S

	May 19	June 19	July 19	August 19	Average Per Wk
Adms/transfer in	195	205	215	226	52.6 pts
Discharges/Deaths	144	152	168	159	39.8 pts

Note this was when ward was running at 36 bed capacity.

	Sept 18	Oct 18	Nov 18	Dec 18	Average per wk
Adms/transfer in	227	251	217	224	57.5pts
Discharges/Deaths	163	162	148	168	40pts

Table 5 shows the percentage bed occupancy for all acute services in-patient wards.

	3 South	4 North
May 19	93.9%	88.1%
June 19	96.7%	87%
July 19	94.7%	91.8%
August 19	94.4%	89.03%
Average	94.9%	88.9%

As all elective surgery is undertaken during the week demand for beds is high but reduces towards and during the weekend. For surgical services the result of this is that these empty beds over the weekend are utilised to accommodate medical patients, either as outlying or direct admissions. As part of the winter resilience plan for winter 17/18 the decision was taken to temporality re-designate half of the beds on 3S to become medical beds. Whilst this was meant to be temporary and to be reviewed April 18, unfortunately this review has not occurred and the beds remain as is. As one can appreciate this also poses challenges in the morning and evening when multiple consultant ward rounds are happening.

Patients also attend the ward for both ENT and urology assessments, procedures. ENT patients can range from being post-op, removal of foreign bodies, removal of splints or packing to epistasis & quinsy. For urology patients are mainly trail removal of urinary catheters. All patients attending the ward as an out-patient basis are recorded. Table 6 shows the ward attenders in past 3 months:

Table 6

	May 19	June 19	July 19	August 19	Total	Average per Week/Day
Ward Attenders	68	90	74	89	321	20.1/ 2.9

Comparison to Same Time period Last Year	May 18	June 18	July 18	Total	Average per Week/Day
Ward Attenders	76	74	71	221	18.4/2.6

. Click Here for SharePoint Link.

So how is 3S able to provide nursing cover?

The answer to the above question is simply an over reliance on nursing agencies. Studies have evidenced that recognising the sick patient was encapsulated in four themes: (1) assessing the patient; (2) knowing the patient (3) education and (4) environmental factors. Agency labour is notorious for its problems. Staff are not working in familiar circumstances, there is invariably a high turnover and it is an expensive way of providing care. In delivering care all nurses can and have made mistakes, the difference being the ability of the employer to support and develop the nurse on the ward who is not progressing. Agency nurses often have little or no connection to the patients they care for, their care is transient. There is often scant ongoing training, no ethos of working in a team nor of striving for excellence. The over reliance on agency nurses is a symptom that all is not well.

As stated the available permanent nursing compliment on 3S is 11.06WTE (B6 & B5). Table 7 shows the volumes and hours requested by 3S for the last 7 Months. What is clear is that on an average per month 60%-70% of the shifts are filled by an agency nurse or HCA. The average unfilled rate of 7.5%-11%. And the total fill rate is 89-92%

Table 7 3 South Unfilled Roster Hours sent to Bank/ Agency

		Bank Filled		Agency Filled		Overall Fill Rate	Unfilled	
Month	Hours Requested	Hours	%	Hours	%		Hours	%
Jan19	3890.95	755.62	19.4%	2559.83	65.8%	85.2%	575.50	14.8%
Feb19	3178.00	706.25	22.22%	2085.5	65.6%	87.8%	386.25	12.2%
March 19	4238.59	1007.92	23.8%	2649.7	62.5%	86.3%	581.	13.8%
April 19	3765	897.25	24%	2498.8	66%	90.1%	369	9.9%
May 19	3753.15	878.5	23%	2594.5	69%	92%	280.15	7.5%
June 19	4185.65	928.5	22%	2798.75	67%	89%	458.40	11%

July 19		1012.75	26%	2601.75		92%	334.30	8.5%
August 19		779.5	17.8%	3001.1		86.4%	595.30	13.6%

From Jan 19 to March 19, 3 South has requested a total of 11,307.54 hours.
From April 19 to June 19, 3 South has requested a total of 11,703.8 hours.

Comparison Ward 4North

		Bank Filled		Agency Filled		Overall Fill Rate	Unfilled	
Month	Hours Requested	Hours	%	Hours	%		Hours	%
April 19	1761.65	571	32%	1054.5	59.9%	91.9%	136.15	7.7%
May 19	2312	764	33%	1322	57.2%	90.2%	227	9.8%
June 19	2673.95	710.25	26.6%	1582.25	59.2%	85.8%	381.45	14.3%
July 19	3108.75	932.25	30%	1799.5	58%	88%	377	12%
July 19	3108.75	932.25	30%	1799.5	58%	88%	377	12%
August 19	3678.55	931.5	25%	2309.75	62.8%	87.8%	437.30	11.8%

From April 19 to June 19, 4 North has requested a total of 9856.35 Hours

Sickness Reports for April- August 2019 (trained and untrained)

	April 19	May 19	June 19	July 19	August 19
% Sickness	17.2%	17.5%	20.1%	17.4%	27.5% (19% Trained)

How can the risk be quantified?

"Pilots don't take off if they don't have the tools to do the job and that includes adequate cabin crew…"

Appropriate nursing staffing levels are critical to the delivery of safe and effective care. The planning and delivery of safe and effective care is complex, and is dependent on the constantly changing circumstances of patients' diagnosis and treatment. When we refer to "safe and effective staffing", we mean:

1. the right numbers
2. with the right skills
3. in the right place
4. at the right time.

As stated in the introduction having the right number of appropriately qualified, competent and experienced nurses protects the public, nursing and employer alike. The evidence is clear: sufficient numbers of registered nurses lead to improved patient outcomes, reduced mortality rates and increased productivity.

Training

Staff competency and training: staff are unable to attend training due to reduced staffing levels within the ward along with some unavailability of training dates for staff to attend. Staff cannot physically be released to attend, no backfill to cover ward and the dependency of patients for example airways needs the core staff present to manage

> The percentages of staff trained was well below a satisfactory level in order to provide the high level of care required within this ward and in particular within the two areas of ENT (Head and Neck Care) & Urology TURP's and catheter care etc. Ward sister has worked hard to get core staff trained in Trach/ Laryngectomy care, competencies ongoing on ward. Currently 1 Head and Neck specialist nurse off on mat leave and limited availability to assist on ward with training.

Table 8Training Figures As of Dec 2018

Trache/ Lary	Fire safety	safeguarding	IPC	manual handling

CAH 3 South - Short Stay Surgical Ward	65%	73%	84%	27%	30%

Training Figures As of August 2019

	Trache/Lary	Fire safety	safeguarding	IPC Theory	manual handling
CAH 3 South - Short Stay Surgical Ward	60%	88%	81%	89%	78%

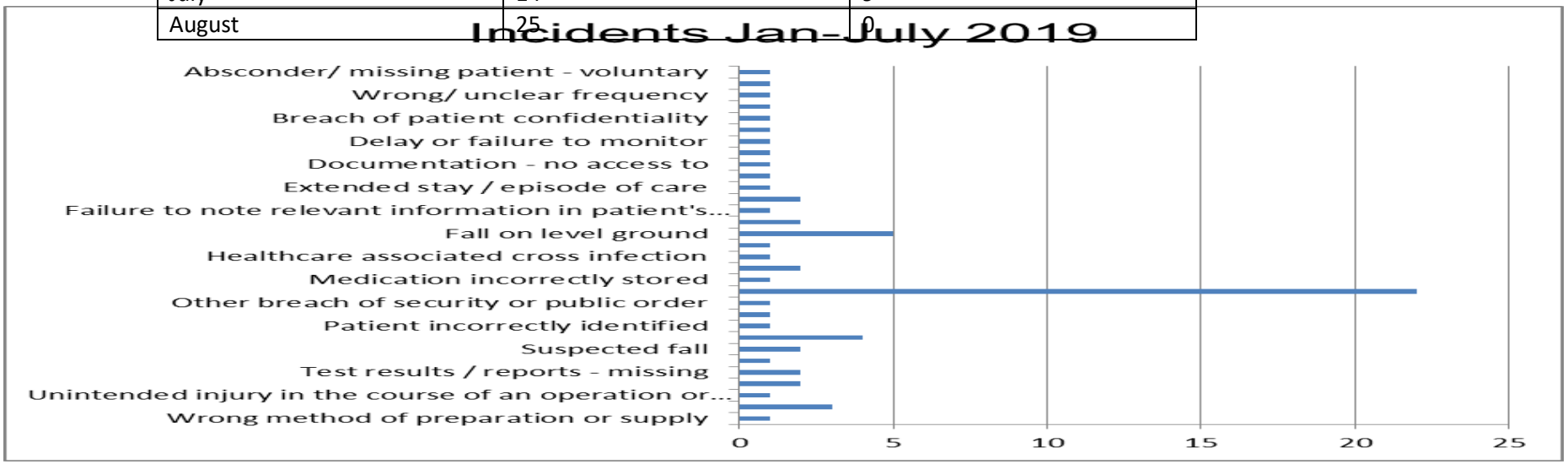
1. A high volume of datix reported- From Jan 19 to August 19 we have 179 .
2. Due to the high volumes of datix reported and the unavailability of staff, sisters on the ward have little or no time to investigate the incidents reported, devise action plans, implement changes and learn from incidents reported as they are filling in band 5 workforce gaps. In comparison to similar sized wards, see below table where this depicts that the datix volume is high for 3 South:

Table 12 3 south datix

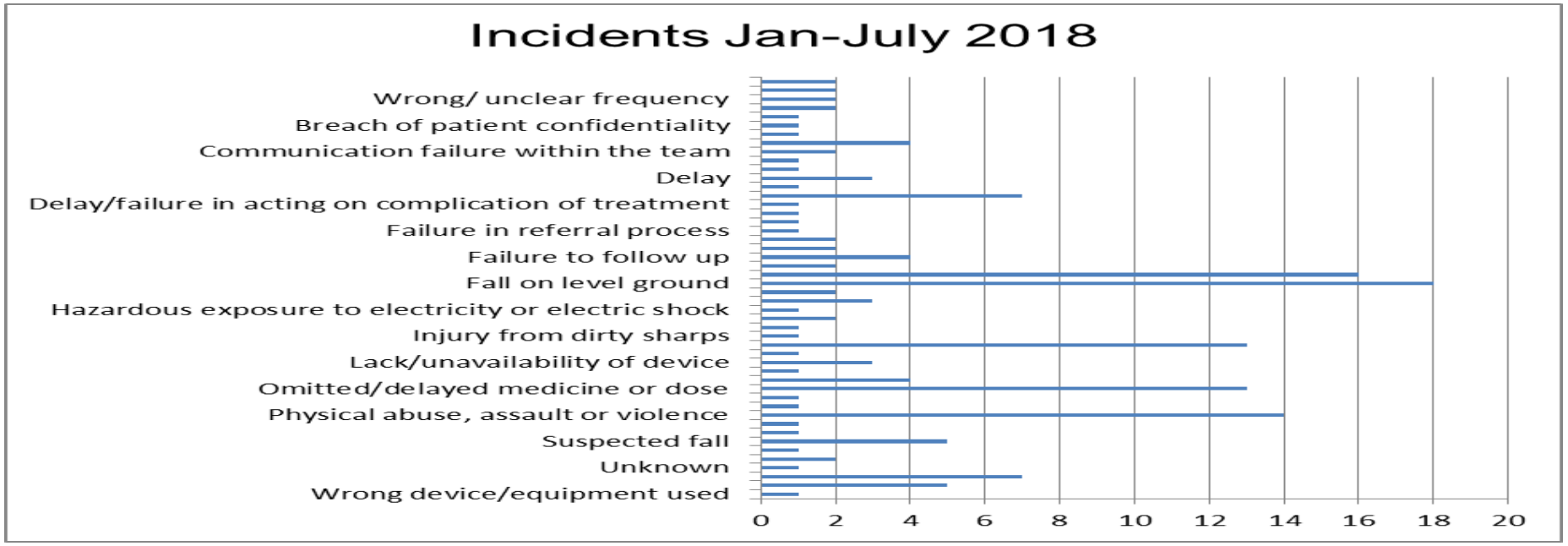
Jan	**21**
Feb	16
March	19
April	20
May	46
June	17
July	15
August	25

Month	4 north	4 south
Jan	13	11
Feb	6	7
March	15	11

April	9	12
May	5	7
June	18	8
July	14	9
August	25	0



Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.



In the month of May 19 there were 46 Datix submitted. 30 were medication related, primarily missed medications. The remainder were 2 due to staffing level concerns, 2 pressure sores, 4 falls and the remainder due to absconding, aggression and blood samples. The majority of these medication errors were due to Agency/ bank staff. These have all have record of concerns completed and actioned with nurse bank or agency. Some staff have been declined shifts on the ward due to ongoing/ numerous issues. X2 staff of core compliment have been through HR process and have warnings in place due to medication errors. There has been 2 SAI in the past 5 months, due to management of airway patient, and management of sepsis patient. The outcomes are pending.

1. Complaints- there has been 5 written complaints in the past 5 months. There has also been 2 telephoned complaints and complaints forwarded by other trusts. The complaints are regarding communication, poor discharge process, medication and standard of care.

2. Poor NQI results in comparison to the rest of the Trust (Falls, Skin Bundle , NEWS, MUST) - data compiled from April to August 2019, and below is the comparison between 3 South of the same time period last year and Trust-wide Bundle compliance:

BUNDLE	April 18		May 18		June 18		July 18		August	
	3	Trustwide	3	Trustwid	3	Trustwi	3	Trustwi		

	South		South	e	South	de	South	de		
NEWS	60%	86%	70%	82%	100%	77%	92%	76%		
Falls	0%	61%	0%	64%	67%	75%	54%	78%		
Skin Bundle	0%	76%	0%	66%	0%	51%	50%	70%		
MUST	70%	87%	70%	93%	83%	90%	85%	91%		
BUNDLE	**April 19**		**May 19**		**June 19**		**July19**		**August 19**	
	3 South	**Trustwide**	**3 South**	**Trustwide**	**3 South**	**Trustwide**	**3 South**	**Trustwide**	**3 South**	**Trustwide**
NEWS	20%	82%	0%	82%	33%	86%	57%	87%		
Falls	10%	79%	60%	72%	44%	79%	71%	82%		
Skin Bundle	33%	83%	0%	72%	0%	83%	0%	79%		
MUST	90%	93%	80%	89%	78%	94%	29%	88%		
Average Score	38.3%	84.3%	35%	78.8%	38.8%	85.5%	39.3%	84%		

Difficulty recruiting and retaining staff to the ward area. **21 staff have left their post in 3 South from Dec 17 to Dec 18.**(46% of Funded Staff) (12 staff nurses and 9 HCA's) **and From April to August 2019 6 Staff have left their posts in 3 South**. And in Month of August we now have a further Nurse leaving post. Of this 1 Band 6 took Band 5 post in another surgical ward. 2 nurses transferred to posts through waiting list to Recovery and Electives ward. 2 Nurses have left substantive posts to go work for agency and 1 transferred to Belfast Trust to specialist ENT unit.

- Of concern is that a further 3 Band 6s are leaving (One left In July) 1 is going to Band 5 post in Cathlab, 1 is going to Band 5 post in Day Surgery and 1 is in Band 7 Patient Flow.2 Band 6s leave in the next 4 weeks, and the last remaining band 6 has applied for 2 posts in other areas. There will be one Band 6 available for 3 South, 1 remains on Maternity Leave. EOI has secured x2 Band 6 posts. One starting this week and the 2nd approx. week beginning 16th Sept. Posts out to BSO and are out to advert until 14th September.
- **In total 3 South will have lost 11 staff in 6 months.**

Particular attention needs to be focused on the following key areas:

- Ward rounds- numerous, different specialities and often lengthy. Ward sisters report numerous hours per day spent on rounds.
- Lack of action for agency errors. Needs to be collaborative approach to managing across all areas.
- Making the Ward attractive- how can we sell it as a good learning/ supportive environment

Key concerns

- *Lack of consistency from block bookings, secured then quit after a short time or not reliable to turn up for shifts. Availability of agency staff with airway training is extremely poor. Block bookings don't stick around long enough to avail of the training.*
- *Reduction of students on ward, lack of opportunity to recruit these nurses. Don't have the support structure to manage students.*
- *Training- whilst improving, this is not going to be consistent and we will certainly face significant challenges once the planned staff to leave do.*
- *Safety- the risk to patients especially airways patients is significant. Trying to spread core staff with skills over the 7 days, day and night including recovery leaves this responsibility to one nurse for potentially multiple airways.*
- *Lack of airway awareness in other wards, 3 south has to accommodate all specialities because they have an airway, even those well established airways that are managed by the patient. An eg is a Medical patient admitted with an MI secondary to Anaemia, was admitted to 3 South but was independent with his airway care.*
- *Amount of medication incidents and volume of missed critical medicines. Whilst ward sisters ensure safety brief is carried out daily, individual staff are reminded at handover, they do not have the capacity to be able to check 32 kardexes to ensure medications are all given. More so they shouldn't have to as a registered nurse regardless of core or agency has the same accountability but unfortunately there is no repercussions for those outside core staff. Lead Nurse completes spot checks weekly and issues are still arising and being addressed directly with the nurse.*
- *Ward sister- issues are well known and whilst measures have been commenced to address overwhelming issues, the core problem remains unchanged. There are not enough core staff to lead by example and establish a high standard culture within the ward so that when agency workers are in they are not making up the majority of the workforce. Ward sister needs the structure behind her to enable solid changes to be implemented and the ward built up. The stress it is causing will inevitably lead to sickness and the potential for more staff to leave.*
- *RQIA- the ward is by no means RQIA ready, the major concern is that should they visit the evidence provided by datix etc demonstrates a real issue with patient safety.*
- *Consultants- there is a lack of awareness for safety the ward can provide. Consultants whilst appreciated they need to operate for the patients interest, we are placing that patient at risk bringing them in when we know we cannot provide the cover essential to them. These risks are being escalated well in advance of the patient being brought in.*
- *Staff are being brought in on annual leave, even resorted to asking a nurse to do a Keeping in Touch day to offer some core cover to the ward.*
- *Short term sickness is increasing.*

Summary of current control measures to date:

1. Staffing review completed
    a. Outstanding vacancies for band 5 and band 3 with BSO for recruitment (no interest in these posts at present).
    b. New staff recruited receiving induction /preceptorship aligned to a senior band 5/ band 6 clinical sister staff member.
    c. Existing staff encouraged to stay in post and reassurance given that the Senior Management Team is reviewing the staffing crisis that the ward is currently experiencing and options available. This has so far proved a failure. Senior staff are leaving

2. Plan to continue to recruit trained staff from agency as block booking to fill gaps in roster with suitable skills. Whilst this was done, the standard of nurses was poor, little to no ENT/ Urology experience and some left with 1 days notice or simply didn't turn up.
3. Block booked staff will be provided with e-learning log ons to enable compliance with SHSCT processes, core staff cannot even complete training never mind allocating bank/ agency staff time to do elearning.
4. Additional/overtime hours granted to core 3 south staff when agreeable to work over their contracted hours. Has been done, however given the current situation staff are losing motivation and cannot continue to work overtime and not get their annual leave.
5. All staff is fully aware that they can avail of the Trust's Stress Toolkit/ Call/ Inspire/ Occupational Health, should they identify potential stressors and report same to nursing management immediately.
6. Roster reviewed to have suitable trained staff on roster to ensure /priority to manage deteriorating patients. Must be a sister on duty (band 6 or 7) each day 07.30-16.45 hrs Monday to Friday and a registered nurse (must be on duty) who can take charge of the ward outside of these hours. For Night Duty and Weekends there has to be at least two core Band 5 staff on duty (one for each side of the ward and one of these core staff are clearly identified to take charge). This is proving impossible given the amount of airway managed patients, often 2 core staff are needed to cover these airways, leaving the rest of the workforce covered by agency.
7. It has also been added as a condition to the e roster that there should always be a suitably trained registered nurse on duty who is competent in managing tracheostomy and laryngectomy patients. Issues as above. Means that spread of staff may be poor at times as x2 nurses required for the immediate 72hr post op period, which means they will have worked their hours and leaves core staff gaps on days.
8. Patients need to be admitted to the correct ward depending on the admitting complaint. Ie if patients admitting complaint is cardiology they need admitted to that area regardless of airway. Staff in all areas need to have airway management training. If the patient is admitted with airway issues then they go to 3.
9. Staff patient safety briefing, handover sheet and general daily communication among staff on duty reviewed. Wording in relation to diabetic patients to be simplified (patient is diabetic on Insulin or diabetic medication or diet only) and critical medicines highlighted at handover. This is done, implemented and NIC is verbally highlighting to staff
10. Sisters/ Nurse in charge of each shift to provide additional support to bank/agency/ new/ junior staff during medicine rounds/ insulin administration in a bid to reduce omitted medicines. Sisters are making up the staff numbers. They are not in a position to support as they have a heavy workload themselves.
11. 2 Hourly communication 'huddles' to take place in the ward to ensure that all staff are kept up to date with ongoing changes in patients care. At present not feasible due to the volume of ward rounds, and conflicting demands.
12. Action plan put into place to improve staff training with an immediate focus on 7 key areas: Diabetes, Administration of Meds, Hyponatraemia, Anaphylaxis, RPRB, DNO then MAPA training.
13. Lead Nurse to meet with sister weekly to review until training percentages improve, we cannot sustained improved percentages currently due to covering the ward is priority
14. Clinical sisters (5 available) to divide nursing team evenly among themselves so that each sister can take responsibility for a small group of staff with a focus on KSF, Clinical supervision and mandatory training. Again they are making up core staff and have no time to complete managerial duties. This is done, however the band 6s make up the daily staffing compliment so time to actually complete this is impossible.

15. Link Nurse roles re-established for the team to provide the ward with feedback in key areas, promoting learning and sharing of evidence based practice resulting in improved patient outcomes. Not enough senior staff to take on, juniors are still learning
16. Open door policy with ward sister and lead nurse along with monthly staff meetings for staff to raise concerns and share good practice. In place, staff are vocal but it is becoming demoralising
17. Consideration of transferring RN's from other surgical wards. Challenging to get RN to transfer and this would place other Surgical wards in a worsening workforce position. Staff do not want to move and the concern is forcing a move will create a negative attitude and atmosphere on the ward and may lead to increased sickness

Recommendations.

This ward needs to reaffirm and regain its identity and to break the downward spiral and return its reputation so the following recommendations are offered

1. If the Trust is to attract consultants in ENT and urology, having a ward which is dedicated to their surgical specialty needs is essential. 3S must return to being a full surgical ward.
2. Redesign of the pathway for patient having to attend the ward. As work is pending in Outpatients, we are awaiting Estates work to be commenced. The plan would be to create a hot clinic and redirect all ward attenders to this area.
3. A reduction in the bed compliment to better match the available RN compliment. A systematic reduction should be considered, and a systematic increase as we secure staff. Proposal to reduce to 24/26 beds. Telford to be completed based on the cohort of staff left after current known leavers. To allow for high dependency of airway managed patients, given that ward has at least 1 high risk airway per week, upwards of 4+ depending on situation requiring x1 1:1 nurse for 24hr cover for at least 72 hours post procedure.

4. To roll out airway management training to all areas. Outreach team will be established once 1 CNS nurse returns off mat leave in oct 2019. Ongoing regular training session provided by current CNS nurse and Doctor, well received by ward staff but poorly attended by other areas. To focus on recovery staff getting training to facilitate their own staff to nurse these 1:1 patients for their 1st 24 hours in recovery instead of a nurse being deployed from 3 south.

5. To ensure the ward provides the required level of expert nursing care plus supervision and support all members of the nursing team, but in particular these new registrants, the appointment of an practice educator (practice educator have been appointed to our ED and critical care services) This would be a selling point to the ward, and would encourage staff in knowing that support structure was there and specific training can be addressed at ward level.

REVENUE BUSINESS CASE PROFORMA COVER

Name of organisation	Southern Health and Social Care Trust
Project Title	Expansion of Urology Clinical Nurse Specialists
Total Cost	FYE £122,382, CYE £61,191 (2019-20)
Start date	01 October 2019
Completion date	Recurrent

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Y
How much total funding required?	FYE £122,382
How much funding required per year?	FYE £122,382, CYE £61,191 (2019-20)
Is this funding to be made recurrent?	Y

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	N
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Is this business case	*Y/N*
(a) Standard	Y
(b) Novel	N
© Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d) , requires Departmental & DoF approval. Is Departmental / DOF approval required	

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions)

Name Printed Melanie McClements **(signed)** [redacted]

Grade/ Title Interim Director of Acute Services

Date 14/8/19

Trust Director of Finance Signature (required if bid is over £100k)

Name printed Helen O'Neill **(signed)** [redacted]

Date 20/8/19

Trust Chief Executive Signature (required if bid is over £100k)

Name printed Shane Devlin **(signed)** [redacted]

Date 21/8/19

Complete this section if Department / DOF approval required

Date submitted to Department
Department/ DOF approval (y/n)
Date approved

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

In 2008/09 A Regional Review of (Adult) Urology Services was undertaken by a multi-disciplinary and multi-organisational Steering Group in response to service concerns regarding the ability to manage growing demand and maintain quality standards. The regional review was followed in 2013/14 by a stock-take to assess progress to date. Since the completion of the stocktake, the HSCB has met with Trusts to explore how service redesign could help address the key challenges facing the service. These challenges include:

- There are regional variations in pathways for both new outpatient assessments and treatments, including cancer;
- There are regional variations in waiting times for outpatients and surgical procedures, with significant numbers of patients waiting for core urology procedures;
- There has been a significant change in referral patterns. The total number of urology referrals have increased by 7.5% since 2015, with red flag and urgent referrals increasing by 26% and 15% respectively. This has a direct impact on the cancer waiting times and those referrals classified as routine;
- A regional capacity gap across both outpatient assessments and treatments which continues to grow as demand increases;
- Across the region there are continued challenges for the recruitment and retention of clinical staff at all levels;
- There are infrastructure constraints and in particular limited access to operating theatre sessions which has resulted in excessive waiting times for routine core urology procedures;

The following IPT aims to make the urology service more sustainable by expanding the Urology Clinical Nurse Specialist Workforce. The IPT will allow:

- the recruitment of one Non-cancer Clinical Nurse Specialist (CNS) who will provide 8.5 clinical sessions for urodynamics and a nurse-led LUTs service.
- the recruitment of one Cancer Clinical Nurse Specialist who will provide 8.5 clinical sessions for prostate biopsies and a nurse-led PSA follow-up service.
- the recruitment of 0.5 WTE admin support worker (0.25 per CNS)

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SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To reduce routine Outpatient assessment waiting times	**Target** By March 2019, 50% of patients should wait no longer than 9 weeks for a first outpatient appointment, and no patient should wait longer than 52 weeks. **Baseline** At 31st December 2018 16.4% of those waiting for a first time consultant-led outpatient appointment were in the Southern Trust (46,150 patients). As at 31st December 2018, within the Southern Trust 75.2% of patients waited longer than 9 weeks and 25.1% (11,570) were waiting longer than 52 weeks. As at 31st December 2018, within the urology specialty in the Southern Trust there were 3,383 patients waiting for a first consultant-led outpatient appointment. Of these 709 patients were waiting less than 9 weeks (21%) and 1754 patients were waiting longer than 52 weeks (52%).
2. To improve urology cancer waiting times by 31st March 2020.	**Target** At least 95% of patients should begin their first treatment for cancer within 62 days following an urgent GP referral for suspect cancer. **Baseline** In December 2018 Urology achieved 54.85% of patients commencing their treatment within 62 days of a decision to treat.
	Target At least 99% of patients should begin their first treatment for cancer within 31 days following an urgent GP referral for suspect cancer. **Baseline** In December 2018 Urology achieved 99.37% of patients commencing their treatment within 31 days of a decision to treat.
3. Increase new and review outpatient capacity for urology.	**Baseline** July 2019 - there are currently 3,983 New outpatients and 3,271 Review outpatients awaiting appointments.

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	Target • Increase the number of clinical sessions for urodynamics and nurse-led LUTs Service by 31st March 2020. • Increase the number of clinical sessions for prostate biopsies and nurse-led PSA follow up service by 31st March 2020.
4. Increase capacity for diagnostic treatments (Flexible Cystoscopies/TRUS biopsies) by 31st March 2020, which will help shorten the length of the cancer pathways	To achieve the 62 day cancer pathway patients are required to have their initial Outpatients appointment or "straight to test" within 14days of RF referral: **Baseline** Currently First Out-patient appointments are (July 2019): Prostate – 82 days Haematuria – 44 days Other – 49 days **Target** • Increase number of weekly clinics with increased capacity to undertake diagnsostics ie flexible cystoscopies • Decrease the length of time on the cancer pathways.
5. To ensure that every patient diagnosed with cancer are provided with a key worker and given a Holistic Needs Assessement by 31st March 2020.	**Target** • Develop key worker role for renal cancer patients • Ensure timely follow-up on all patients diagnosed with an urological cancer

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SECTION 2 (b) : CONSTRAINTS

- **Availability of recurrent funding** – delivery of the objectives and associated benefits will be dependent on sufficient funding being available.
- **Accommodation** – clinics and theatre sessions will need to be factored into available accommodation in the Trust
- **Staffing availability** - there is a workforce deficit in nursing in Northern Ireland so recruiting to these posts will be a challenge either internally or externally

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	**Status Quo - continue with existing arrangements**
2	Appoint the following: • 1.00 WTE Band 7 - Non-cancer clinical nurse specialist • 1.00 WTE Band 7 Cancer clinical nurse specialist • 0.50 WTE Band 3 Admin Support - 0.25 per Clinical Nurse Specialist (CNS) See detail over
3	Appoint the following: • 0.50 WTE Band Non-cancer clinical nurse specialist • 0.50 WTE Band 7 Cancer clinical nurse specialist • 0.25 WTE Band 3 Admin Support - 0.25 per CNS See detail over

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Option 2 – Appoint

- 1 WTE Band 7 Non-cancer clinical nurse specialist and
- 1 WTE Band 7 Cancer clinical nurse specialist
- 0.50 WTE Band 3 Admin Support (0.25 per CNS)

Below is Job Plan for CNS posts

	Cancer Clinical Nurse Specialist	**Non-Cancer Clinical Nurse Specialist**
Independent nurse led clinics	**Clinical Activity sessions x 3** • Prostrate Biospy x 1 • Holistic Needs Assessment x 1 • Flexible Cystoscopies x1	**Clinical Activity sessions x 5.5** • Lower Urinary Tract Review Clinic x 1 • Urodynamics x 2 • Botox injections x 1.5 • Telephone Review x 1
MDM Clinics	1.5 (Keyworker)	1 x Trial Removal of Catheter/ Complex catheter change
MDM ward rounds (Meeting)	1	0.25
MDM Case management discussions	0.5	N/A
Provision of direct care recovery/ward attenders	0.5	0.5
Telephone consultations	1 (Prostrate Biopsy preparation/ PSA Tracking)	0.25
Clinical Admin / Validation	1.0	1.0
Sub-total	**8.5**	**8.50**
Supporting Professional Activity		
Teaching	0.25	0.25
Clinical Governance including audit and research	0.25	0.25
Admin – organisational requirement	0.5	0.5
Contribution to service planning / policy development	0.25	0.25
Professional development / CPD	0.25	0.25
Sub-total	**1.5**	**1.5**
Total	**10**	**10**

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Option 3 – Appoint

- 0.5 wte Band 7 Non-cancer clinical nurse specialist and
- 0.5 wte Band 7 Cancer clinical nurse specialist
- 0.25 wte Band 3 Admin Support (0.125 per CNS)

Below is Job Plan for CNS posts

	Cancer Clinical Nurse Specialist	**Non-Cancer Clinical Nurse Specialist**
Independent nurse led clinics	**Clinical Activity sessions x 2.5** • Prostrate Biospy x 1 • Holistic Needs Assessment x 0.5 • Flexible Cystoscopies x1	**Clinical Activity sessions x 2.5** • Lower Urinary Tract Review Clinic x 1 • Urodynamics x 0.5 • Botox injections x 0.5 • Telephone Review x 0.5
MDM Clinics	1 (Keyworker)	1 x Trial Removal of Catheter/ Complex catheter change
MDM ward rounds (Meeting)	0.5	0.25
MDM Case management discussions	0.25	N/A
Provision of direct care recovery/ward attenders	0.25	0.25
Telephone consultations	0.25 (Prostrate Biopsy preparation/PSA Tracking)	0.25
Clinical Admin / Validation	0.25	0.25
Sub-total	**5.0**	**5.0**
Supporting Professional Activity		
Teaching	0	0
Clinical Governance including audit and research	0.25	0.25
Admin – organisational requirement	0.25	0.25
Contribution to service planning / policy development	0	0
Professional development / CPD	0.25	0.25
Sub-total	**0.75**	**0.75**
Total	**5.75**	5.75

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SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo – continue with existing arrangements	**Year 0 19/20 £ 000**	**Year 1 20/21 £ 000**	**Year 2 21/22 £ 000**	**Year 3 22/23 £ 000**	**Year 4 23/24 £ 000**	**Year 5 24/25 £ 000**	**Totals £ 000**
Capital Costs							
Capital Cost	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	11,331.0
(b) Total Revenue Cost	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**11,331.0**
(c) Total Cost = (a) + (b)	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**1,888.5**	**11,331.0**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**1,888.5**	**1,824.7**	**1,762.9**	**1,703.2**	**1,645.6**	**1,590.1**	**10,415.0**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate of the SHSCT.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal place.
6. Total Net Present Cost (NPC) equates to £10,415.0k for this option.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Option 2 – Appoint: • 1.00 WTE Band 7 Non-cancer clinical nurse specialist • 1.00 WTE Band 7 Cancer clinical nurse specialist • 0.50 WTE Band 3 Admin Support (0.25 per CNS)	**Year 0 19/20 £ 000**	**Year 1 20/21 £ 000**	**Year 2 21/22 £ 000**	**Year 3 22/23 £ 000**	**Year 4 23/24 £ 000**	**Year 5 24/25 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Recurring revenue baseline	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	11,331.0
Payroll Cost	56.9	113.8	113.8	113.8	113.8	113.8	625.9
Payroll Related G&S	4.3	8.5	8.5	8.5	8.5	8.5	46.8
(b) Total Revenue Cost	**1,949.7**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**12,003.7**
(c) Total Cost = (a)+(b)	**1,949.7**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**2,010.8**	**12,003.7**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**1,949.7**	**1,942.8**	**1,877.1**	**1,813.5**	**1,752.2**	**1,693.1**	**11,028.4**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate .
3. The staff identified in Section 3 are costed according to the HSCB - General Costings - 2019/20, Draft 30.04.2019.
4. An allowance has been made for Employee related G&S but no allowance has been made for unsocial hours payments.
5. The expected start date is 01/10/2019 so a six month effect is assumed in 2019/20.
6. No capital costs are identified in this case.
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £11,028.4k for this option.

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Option 3: Appoint • 0.50 WTE Band 7 Non-cancer clinical nurse specialist • 0.50 WTE Band 7 Cancer clinical nurse specialist • 0.25 WTE Band 3 Admin Support (0.125 per CNS)	**Year 0 19/20 £ 000**	**Year 1 20/21 £ 000**	**Year 2 21/22 £ 000**	**Year 3 22/23 £ 000**	**Year 4 23/24 £ 000**	**Year 5 24/25 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Recurring revenue baseline	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	1,888.5	11,331.0
Payroll Cost	28.5	56.9	56.9	56.9	56.9	56.9	313.0
Payroll Related G&S	2.1	4.3	4.3	4.3	4.3	4.3	23.6
(b) Total Revenue Cost	**1,919.1**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**11,667.6**
(c) Total Cost = (a)+(b)	**1,919.1**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**1,949.7**	**11,667.6**
(d) Disc Factor @ 3.5%pa	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	
(e) NPC = (c) x (d)	**1,919.1**	**1,883.8**	**1,820.0**	**1,758.4**	**1,699.0**	**1,641.6**	**10,721.9**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate.
3. The staff identified in Section 3 are costed according to the HSCB - General Costings - 2019/20, Draft 30.04.2019.
4. An allowance has been made for Employee related G&S but no allowance has been made for unsocial hours payments.
5. The expected start date is 01/10/2019 so a six month effect is assumed in 2019/20.
6. No capital costs are identified in this case.
7. A discount factor @3.5% pa has been applied to calculate the NPC.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £10,721.9k for this option

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SECTION 5: NON-MONETARY BENEFITS

The Urology department in the Southern Health and Social Care Trust currently have 3 Clinical Nurse Specialists (CNS) @ Band 7 (one is funded by Macmillan). Two of these nurses are aligned to Cancer Services and the third is for benign urological disease .

Cancer Clinical Nurse Specialist

The role of the CNS in contributing to high quality cancer care is now well acknowledged. The CNS is the main point of contact for patients (key worker) . The Urology Service in SHSCT received 3,409 red flag referrals (April 2018-March 2019). From this volume of referrals 720 patients were diagnosed to have cancer. With only two Cancer CNS (one only appointed in February 2019) this means that they are unable to provide their key worker role and follow-up to a large number of patients. With this additional Cancer CNS the urology service will be able to increase the number of nurse-led clinic appointments (face to face/ telephone/ Holistic Needs Assessment).The impact of which will significantly improve patient experience and deliver services for individual patients according to their needs and choice.

Benign Clinical Nurse Specialist

Currently there are a large number of patients on the New Outpatient Waiting list awaiting lower urinary tract consultations which this CNS could see, treat and follow-up. Therefore with the appointment of the second CNS this will lead to an increase in nurse led clinics, which will help reduce waiting times and will also enable consultants to deal with the more urgent/complex patients on these waiting lists for New outpatients/Review backlogs and urodynamics.

Another benefit wll be that the service will have enough staff to provide outreach services to Daisy Hill/South Tyrone and Armagh Hospitals thus meaning patients will not have to always travel for their appointments.

SECTION 6: PROJECT RISKS & UNCERTAINITIES

- Availability of nursing staff to take up post
- Insufficient funding available to implement preferred option

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is Option 2: Appoint:

- 1.00 WTE Band 7 Non-cancer clinical nurse specialist
- 1.00 WTE Band 7 Cancer clinical nurse specialist
- 0.50 WTE Band 3 Admin Support (0.25 per CNS)

Although both options 2 and 3 meet all the objectives option 2 enables more clinical sessions to be carried out and more patients seen, reducing waiting times and providing an improved patient experience.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 2019/20 £ 000	Year 1 2020/21 £ 000	Year 2 2021/22 £ 000	Year 3 2022/23 £ 000	Totals £000's
Required					
Capital required	0.0	0.0	0.0	0.0	0.0
Revenue required	1,949.7	2,144.2	2,286.4	2,438.0	8,818.3
Existing budget :					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	1,888.5	2,013.7	2,147.2	2,289.6	8,339.0
Additional Allocation Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	61.2	130.5	139.2	148.4	479.3

AFFORDABILITY ASSUMPTIONS

Finance Assumptions:

1. Year 0 is 2019/20 Financial Year.
2. The baseline costs for this case is the recurrent opening 2019/20 budget for the HoS for Urology (CA7830) within the Acute directorate.
3. The staff identified in Section 3 are costed according to the HSCB - General Costings - 2019/20, Draft 30.04.2019.
4. An allowance has been made for Employee related G&S but no allowance has been made for unsocial hour's payments.
5. The expected start date is 01/10/2019 so a six month effect is assumed in 2019/20.
6. No capital costs are identified in this case.
7. Costs have been uplifted by 6.63% for inflation from 2020/21.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.

SECTION 9: MANAGEMENT ARRANGEMENTS

It is proposed to implement the organisation and management of this scheme in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management.

The following key roles have been identified:

Project Owner: Ronan Carroll, Assistant Director of Acute Services (Surgery, Elective Care Division and ATICs)

Project Manager: Martina Corrigan Head of ENT, Urology, Opthamology and Outpatients

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	Martina Corrigan Head of ENT, Urology, Opthamology and Outpatients
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	Acute Head of Service (independent to the project) will undertake post project evaluation.
What other factors will be monitored and evaluated?	Appointment and commencement of posts.
When will this take place? (preferably 4 to 12 months after project closure)	A post project evaluation will be undertaken 12 months after implementation.

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specifiy activity, e.g. IP, DC OPN, OPR, Contacts etc

	IP	DC	OPN	OPR		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Hospital Site or Community development	CRAIGAVON
Scheme Title	Expansion of Urology Clinical Nurse Specialists - 2019/20
Pay and Price Levels	2019/20

Commissioner Use only
Sign and Date for TRAFFACS u

Pay Costs	Description	Base Case - option 1 months claimed	wte	fye	cye	Option 2 months claimed	wte	fye	cye	Option 3 months claimed	wte	fye	cye
	BASELINE -			1,888,519	1,888,519			1,888,519	1,888,519			1,888,519	1,888,519
Band 7	Non-cancer clinical nurse specialist			0	0	6.00	1.00	50,744	25,372	6.00	0.50	25,372	12,686
Band 7	Cancer clinical nurse specialist			0	0	6.00	1.00	50,744	25,372	6.00	0.50	25,372	12,686
Band 3	Admin Support					6.00	0.50	12,355	6,178	6.00	0.25	6,178	3,089
Non-AFC posts please detail below				0	0			0	0			0	0
Allowances for posts noted above - please detail below													
Unsocial Hours payments													
G&S Costs associated with the above posts													
Employee Related G&S													
Band 7	Non-cancer clinical nurse specialist					6.00		3,796	1,898	6.00		1,898	949
Band 7	Cancer clinical nurse specialist					6.00		3,796	1,898	6.00		1,898	949
Band 3	Admin Support					6.00		947	473	6.00		473	237
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)					0				0				0
					0				0				0
TOTAL PAY COSTS			0.00	1,888,519	1,888,519		2.50	2,010,901	1,949,710		1.25	1,949,710	1,919,114
Non-Pay Costs - please detail below													
OTHER GOODS & SERVICES					0				0				0
					0				0				0
					0				0				0
					0				0				0
TOTAL NON-PAY COSTS				0	0			0	0			0	0
GRAND TOTAL				1,888,519	1,888,519			2,010,901	1,949,710			1,949,710	1,919,114
								122,382	61,191			61,191	30,595

Phasing/Timescale	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*
PROGRAMME OF CARE	acute	acute	acute
SUB-SPECIALTY INFORMATION eg inpatients,			
LCG	Southern	Southern	Southern
If more than one LCG in option above please give details			
LGD			
If more than one LGD in option above please give details			

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

2022/2023 IHA IS Activity - Volume and Funding Allocation

QUARTER 1 2022/2023 BIDS TEMPLATE

									2022/23 Allocation and Volume				Q1 Actual Reported Activity at 06/06/22 (Cumulative to Date)	Additional Q2 Volumes Requested	Update as required
Directorate	Division	HOS	Specialty	Appointment Type	Activity Type	Category	Funding Allocation Period	Recording Methodology	Volume to be delivered (Patients/ Sessions)	Current Total Funding Allocated	Current Cost per Patient	Comments/Notes			Operational Update/Comments
Acute	ATICS & SEC	Wendy Clayton	Urology	Outpatient	Review	Red Flag/Urgent	Q1 2022	IHA	111	£18,646.89	£167.99	Mr Glackin 2 x sessions a month - 10 pts x per clinic - To see his own patients. Mr Tyson 3 x sessions a month - 10 pts x per clinic - To see Jacob/Fe/Omer/ Brown and his own patients.	10	0	Transfer monies for virutal x 11 pts and hand back the rest as Urology Consultants not available to do additionality now as short staffed at present and also have additional work with Urology PI
Acute	ATICS & SEC	Wendy Clayton	Urology	Outpatient	Virtual	Red Flag/Urgent		IHA					11	0	See above need monies to cover 11 x virutal pts
Acute	ATICS & SEC	Wendy Clayton	Urology Mega Clinic (Pre Assessment)	Outpatient	New	Urgent	Q1 2022	IHA	54	£6,529.14	£120.91	Mr Glackin	0		Roll over Quarter 1 monies to Quarter 2 - Saba plans to do Mega Clinics for TURPS Aug/Sept
Acute	ATICS & SEC	Wendy Clayton	Regional Urology - Hermitage	Inpatient/Daycase	New	Urgent	Q1 2022	IS	90	£68,384.09	£759.82	£7178 Euro per case	17	60	Lynn/Elaine - ST can send more patients , if other Trusts are not going to send TURPS ST can send more and meet planned volumes. ST - 42 %, BT - 29%, SET 9%, WT 20 %.
Acute	ATICS & SEC	Wendy Clayton	Urology - 352	Outpatient	New	Red Flag/Urgent	Q1 2022	IS	1200	£285,048.00	£237.54	May & June - (400 pts a month) .	969	1,200	Qtr 2 - 400 pts a mth (Jul-Sept) - BT sending 100 pts a month from June 2022. Need Region to be sending 250 pts a mth as we do not have the patients on ST WL to send. Can This be discussed and arrangments made?
Acute	ATICS & SEC	Wendy Clayton	Urology Washthrough - 352	Washthrough	Radiology	Washthrough	Q1 2022	IS	350	£0.00		Jane if you can please advise washthrough and associated Costs	667	700	Radiology costs 1st Apr to 9th June to date = £103,468.00 -See e-mal sent Re: Urology Washthrough
Acute	ATICS & SEC	Wendy Clayton	Urology Washthrough - 352	Washthrough	Day Cases	Washthrough	Q1 2022	IS	250	£0.00		Jane if you can please advise washthrough and associated Costs	340	350	Total cost = £467,085.00 - Apr 06/06/2022 - See e-mail sent Re: Urology Washthrough
Acute	ATICS & SEC	Wendy Clayton	Urology Washthrough - 352	Washthrough	Inpatient/Daycase	Washthrough	Q1 2022	IS	100	£0.00		Jane if you can please advise washthrough and associated Costs			No Inpatients to date in Quarter 1.
Acute	ATICS & SEC	Wendy Clayton	Urology Washthrough - 352	Washthrough	Diagnostics	Washthrough	Q1 2022	IS	300	£0.00		Jane if you can please advise washthrough and associated Costs			

20210322
Q7.45 A3

From: ONeill, Kate [redacted]
Sent: 22 March 2021 20:46
To: McClements, Melanie
Subject: RE: RE: Outcome

No problem Melanie, see you then.

As Jenny was on leave last week we haven't had an opportunity to share this info with the other CNS members as yet. We may get an opportunity later in the week.

Kate

From: McClements, Melanie
Sent: 22 March 2021 17:29
To: ONeill, Kate
Subject: RE: RE: Outcome

thanks for coming back to me Kate.

I am delighted and good for you to be recognised for the great work you do. I'm sure that is welcome news.

I look forward to your further progression and developments, my focus now is trying to retain our experienced, expert staff like you and your colleagues.

I'll see you in our morning zoom ☺ Melanie

From: ONeill, Kate
Sent: 16 March 2021 09:11
To: McClements, Melanie
Subject: RE: Outcome

Morning Melanie,

I just wanted to let you know that I have received positive feedback from the AfC team yesterday.

Thank you for taking the time to meet/listen to me last month, it was much appreciated.
I hope that now this is resolved I can concentrate on further progression & developments within the unit.

Regards,
Kate

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES
HR/FINANCE/PLANNING MEETING

Date: Tuesday 15th February 2022
Time: 1pm
Venue: Zoom

A G E N D A & NOTES

1.0	Apologies – Ann McCorry
2.0	Chair's Business: Pressure on USC - Swabbing issue and lack of covid beds. Workforce gaps and medical risks. This weekend feels unsafe if no additional staff coming forward. Need to get to better place.
3.0	Finance issues:- • Month 9 financial position ACUTE Financial Position Mth 9 Dece Trust 5.2m over Acute 13.7 m over. Trends same on payroll. Nursing agency 2.9m up even though covid response shifts taken out. Issues re vacancies and absences have increased that are covid related. ACTION: Linda-Jayne to check out details of CRR spend. Mel advised that likely to have level budget this year and no permissions for new at-risk posts. ACTION: Issues to be raised at Board re pressures meeting this Friday.
4.0	HR issues:- • Medical Locum rates. Zoe to join meeting at 3pm for presentation of data and discussion. ACTIONS: Zoe to present same to SMT. Mel calling a meeting re collective leadership with ADs and DMDs/CDs. Budgetary responsibility and Clinical responsibility for the medical rotas is shared responsibility with operational management .

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

	• Annual Leave Questionnaire For Action & Response by Monday 21 February 2022 Action: ADs to ensure these are returned to Fiona Jones by next Monday and add if relevant/available any A/L that is agreed to be paid under the Voluntary Scheme for the Extra-Ordinary Payment of Unused Contractual Leave Entitlement. • Supporting our People (PowerPoint resource pack including some of the support available for staff) ACTION: ADs to use resource pack to signpost staff and managers as appropriate. Helen to follow up re making pack available on Sharepoint. • On-call/working arrangements for ADs/HOS ACTION: To be discussed at tomorrow's huddle.
5.0	Planning issues: • Planning Update Acute Directorate SMT Planning Upda ACTION: Paula and Ronan to get together to compile some slides from the update paper that was prepared for the HSCB for Mel to present at Trust Board workshop on 24th February.
6.0	Internal Audit (SI) – chris Wamsley working with all re compliance in implementing recommendations.
7.0	Any Other Business A&C support discussed. Caroline advised that in Northern Trust support was allocated as follows:- 8A - 0.2 wte 8B – 0.5 wte 8C – 1 wte ACTION: Helen to check through HR BPs what is allocated in other 3 service Directorates.
8.0	Date of Next Meeting Tuesday 15th March 1pm

MELANIE McCLEMENTS INTERIM DIRECTOR OF ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR – ACUTE SERVICES Surgery & Elective Care and ATICS 1-1 Discussion

DATE: MONDAY 8TH JULY 2019

No	Issue for discussion	Discussed / Actions agreed
1	Capacity/Vacancies	• 3 South - remains unchanged re risk • Surgical beds – Mark Haynes not keen to decrease surgical beds. ENT and Urology need 24-25 ?+Gynae = 1 ward
2	Banding Issue	B5 in ICU x15 appealed Banding – currently 34% B6. May be a 5 year backpay
3	Theatres	• Chronic Pain Service – recruiting CNS Chronic Pain for retirement • Anaesthetic Hub – Meeting tomorrow • DEC – STH – Furniture purchased has been used by GPs –

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

		Following up with Mark and Helen. • Seamus Murphy wishing to ringfence USC Endoscopy in DHH and Bowel Cancer waiting list in STH. Would have fall out for medical side of his role. Ronan scoping. • General Surgeons – 2 off and some off on-call rota for range of reasons. 1 locum from last week. • Issue with Colorectal Surgeons – 2 relocated to CAH. No theatre space. Need clarity – suggest meeting with Melanie, Mark and Ronan
4	Pre-Op Assessment	• Small service but demand increasing. • Internal Audit – May 19 report – Review Pre-Op recommendation • In-patient theatre 82% usage (good) • Emergency Theatre – demand driven. CAH 35% DHH 25% • Nurses redeploy to other theatres and wards – nowhere else in province does this. Working groups/steering group on IA actions
5	Equipment Concern	Action – Melanie to follow up with Aldrina re £2.8m equipment requirement

		Risk assessments – Equipment spreadsheet details age, consequence of failure etc
6	Surgical waiting times	Pension impact will impact Some surgeons suggesting 7 PAs and Locum sessions (4/4.5) Action – Melanie to discuss with Maria clarity re who approves decrease in PAs
7	Paed OP	Plan for ENT/Audiology and other services. Estates involved. Ronan to send final confirmation of spec to Estates to progress and to include on minor works priorities.
8	DATE OF NEXT MEETING	5th August 2019

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

MELANIE McCLEMENTS INTERIM DIRECTOR ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR – ACUTE SERVICES Surgery & Elective Care and ATICS 1-1 Discussion

DATE: Wednesday 16th October 2019

No	Issue for discussion	Discussed / Actions agreed
1	Anaesthetic Hub	Sorted yesterday - staff happy.
2	OPD	No 1 Priority for Acute with Estates
3	Trache Meeting	Agreed for other wards and training/staff support
4	Fracture Hub	25% of all referrals diverted back to AHP/GPs rather than Fracture Clinic. Impact felt but increased referrals/demand. Pathways to be agreed with Medics

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

5	Validated Lists	Good reduction on waiting lists - urology not included
6	Endoscopy	• High DNA rate • Week 2 - DHH pilot - plan to maximise capacity by pulling off inpatients. To use TMS as system • Nurse endoscopists x2 - closed with 2 applicants
7	Surgery Trajectories	• Only risk to the additional money we have been given is endoscopy £270k risk • Out to IS for assistance to address demand in line with ££ • All trajectories performing and over-performing. Any issues related to sickness. • Staff gaps 100 B5 in Theatres (ATICS) and SEC
8	Bowel CA Screening	• Demand driven. SABA met and SSP waiting time 6wks and 12 wks to scope (18 wks v 4 wks expected timeline)
9	Paediatric Endoscopy	No progress from PHA. Probably 12m

10	Consultant posts	• Middle tier HDU - remains an issue to cover rota • Medical wards and HDU - 7-8 SPA. Drs would not provide adequate cover • Ronan to meet Damian and Chris to discuss options for way forward.
11	Royal College Review - Surgery DHH Royal College Review - Paeds	Why are ENT/Orthopaedics and Urology included. Melanie to discuss with Dr O'Kane
12	Children in Need	To do something in Paediatric Theatres
13	Surestore storage	Has cloudy lenses. Being followed up with company
14	Head/Neck centralised	SHSCT not interested due to lack of capacity in theatre space/infrastructure
15	Personal Information redacted by the USI	Redeployed to STH: Personal Information redacted by the USI - dismissed this week

16	Uni knees and hips	• (15 and 20 completed) • Needs resourced properly. Goodwill as staff coming in early/staying late. Prep and Physio etc and follow up support. • Need an orthopaedic co-ordinator B7 (similar to Trauma) • To meet re efficiencies to date and potential to appoint to allow roll-out in Mainstream
17	Rota General Surgery	Funded for 9. 2 doing veins S Yoong leaving. M Gudyma - gone = 2 Alastair Lewis - 12m ££ - likely to be recurrent
	DATE OF NEXT MEETING	4th November 2019

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

MELANIE MCCLEMENTS INTERIM DIRECTOR ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR – ACUTE SERVICES SEC & ATICS 1-1 Discussion

DATE: 2nd March 2020

No	Issue for discussion	Discussed / Actions agreed
1	Finance	Overspend
2	Staffing	8-9 International Nurses for Acute (To discuss with Anne)
3	Revalidations	Due with paper trail completed and professional supervision
4	Hyponatraemia	• 3 yearly training for all will be challenging (1.5 days each) (14-16yr) • To discuss with ?? Nursing Forum re raising compliance • 12 recommendations focus
5	Medical Staff	Surgeon posts ? Maxwell accepted

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

		?Dr McBride
6	Dr Kumar	WLI rates not appropriate PA rate OK – Ronan to ensure he has been informed
7	SWAH	No response from WHSCT
8	Theatres B5-B6	IPT to be progressed to upgrade agreed numbers of staff
9	CAH Deanery Visit 5/6/2020	Medics Attend
10	G McA	To progress and discuss with Consultants
11	AOB	Ronan to read new concerns expressed. Feels all dealt with. Mel to D/w Trudy
12	DATE OF NEXT MEETING	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

MELANIE MCCLEMENTS DIRECTOR ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR – ACUTE SERVICES SEC & ATICS 1-1 Discussion

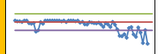
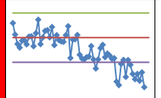
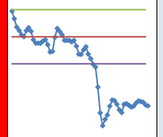
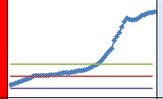
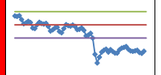
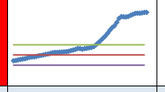
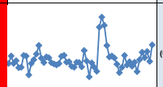
DATE: 15 February 2021

No	Issue for discussion	Discussed / Actions agreed
1	Theatres	UBLs as per Surge 3
2	ICU	Regional CCaNNI Plan. Staff tired and tearful. Ask Anaesthetic staff. Some agreement to support – working through this Ronan to liaise with Chris re Raymond McKee (CCaNNI)
3	OPC and Rebuild Plan	1/3/21 – Business as normal to be restored OPD and Theatres and Phlebotomy 1 bed release from ICE = 6 beds STH – First green site DCC needs a new home to allow endoscopy Ventilation discussion – paper shared – Ronan to attend estates meeting on 18th March. ENT AGP/D&D

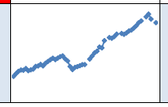
Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

		Peter Leyden back (ENT Consultant) to SHSCT Significant volumes of elective surgery needed to be delivered 20/21 21/22 Surgery model to be a focus – Sandra Waddell returning end Feb to support Ambulatory Assessment space being considered ? Ramone
4	Equipment	Ordered for all specialties with capital agreed
5	Urology	IPT to be submitted Mr Omar Locum to remain and convert June 21 to substantive
6	Orthoderm	Contract live £600k in-year (50 procedures)
	DATE OF NEXT MEETING	30th March 2021 at 12pm

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative	Apr-17	May-17	Jun-17. End of Qtr.1. 2017/18	Jul-17	Aug-17	Sept-17 End of Qtr.2. 2017/18	Oct-17	Nov-17	Dec-17 End of Qtr.3. 2017/18	Jan-18	Feb-18	Mar-18. End of Qtr. 4. 2017/18.	Apr-18	May-18	Jun-18 End of Qtr.1. 2018/19	Jul-18	Aug-18	Sep-18 End of Qtr.2. 2018/19	Oct-18	Nov-18	Dec-18 End of Qtr.3. 2018/19	Jan-19	Feb-19	Mar-19 End of Qtr.4. 2018/19	Apr-19
Cancer	ASD	Cancer Pathway (31 days)	During 2021/22, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.	92.4%		98%	85.8%	Cancer performance is based on those patients who have completed their pathway. Reduced access to surgical capacity means that an increased number of patients remain on the pathway. In January 2022, performance against this target was 74.7% (71 out of 95 patients). As at 14 March 2022, 339 red flag suspect or confirmed cancer patients had their initial admission cancelled between 1 January 2021 and 14 March 2022, with 16 still to be rebooked. Surgical services continue with available core capacity alongside capacity in the Independent Sector, through the Regional process, to equalise access for the most urgent patients. As at 25 April 2022 the Trust is tracking 1404 patients on the active 31 day pathway.	100.0%	99.2%	99.3%	98.5%	100.0%	100.0%	97.2%	96.6%	97.3%	88.0%	89.5%	98.4%	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	98.4%	100.0%	100.0%
Cancer	ASD	Cancer Pathway (62 days)	During 2021/22, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days.	57.1%		95%	49.4%	Cancer performance is based on those patients who have completed their pathway. Reduced access to surgical capacity means that an increased number of patients remain on the pathway. In January 2022, 39.2% (20 out of 51) patients began their first definitive treatment within 62 days. Of the 39 patients that breached the target, 2 were Breast, 4 Gynae, 1 Head/Neck, 2 Lower GI, 3 Lung, 13 Skin, 5 Upper GI and 9 Urology. Reduced access to outpatient, diagnostics and surgical capacity means that an increased number of patients remain waiting on the active pathway and as at 25 April 2022, the Trust is tracking 3572 patients. It is anticipated that performance will continue to be challenged as patients complete their pathway. As noted above internal and Regional theatre capacity continues to be targeted to the patients with greatest need.	84.3%	76.2%	69.6%	67.0%	71.9%	72.2%	69.3%	74.8%	75.0%	68.0%	77.2%	86.7%	69.4%	74.2%	78.8%	79.3%	74.2%	81.5%	68.8%	75.8%	72.3%	71.4%	71.1%	75.8%	82.1%
Elective	ASD	Inpatient/Day Case Treatment	By March 2022, 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment	12.8%		55%	14.2%	At the end of March 2022, only 13.6% of patients were waiting no longer than (less than) 13 weeks (2,362 out of 17,431). The majority of patients waiting longer than 13 weeks are within Orthopaedics (4,056). Reduced theatre capacity associated with the Covid-19 response has seen capacity remain significantly reduced and insufficient to meet red flag and urgent demand, impacting on patients' journey time on the cancer pathways. As at 14 March 2022, 339 red flag suspect or confirmed cancer patients had their initial admission cancelled between 1 January 2021 and 14 March 2022, with 16 still to be rebooked. The Trust continues to engage in the Regional process to prioritise available elective capacity Regionally, between Trusts, to ensure equitable access based on the priority categorisation. The Trust is participating in a Regional waiting list validation exercise, co-ordinated by HSCB. 15 red flag TURPs have recently been sent to SET as part of the regional requirement for equalising red flag surgery.	44.5%	42.1%	39.3%	38.2%	36.8%	36.2%	38.2%	39.1%	38.0%	35.2%	34.1%	34.1%	34.1%	34.8%	35.2%	33.6%	31.2%	31.4%	36.0%	38.9%	37.9%	36.8%	35.0%	35.0%	35.0%
Elective	ASD	Inpatient/Day Case Treatment	By March 2022, no patient waits longer than 52 weeks.	9,880		0	10,724	At the end of March 2022, 61.5% (10,724) patients were waiting longer than 52 weeks. 31% (3,307) of patients waiting over 52-weeks are waiting within Orthopaedics, 23% (2,455) within General Surgery, 14% (1,492) within ENT and 12% (1,263) within Urology. The longest waiter is currently 399 weeks within Urology. Recurrent investment for capacity gaps along with non-recurrent backlog clearance is required to see improvement against this objective. *Note information reported against the 13 week target.*	1,155	1,230	1 371	1 478	1 595	1 748	1 848	1 964	2 087	2 313	2 371	2 357	2 370	2 391	2 361	2 393	2 457	2 458	2 487	2 569	2 662	2 750	2 759	2 700	2 821
Elective	ASD	Out-Patient Appointment	By March 2022, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment	14.6%		50%	16.1%	At the end of February 2022, 15.5% (10,369 out of 67,025) of patients were waiting no longer than 9-weeks for an outpatient appointment. With the ongoing impact of Covid-19, core and additional capacity continues to be directed to red flag/urgent referrals in the first instance with limited capacity for routine waits. Accommodation continues to be key a constraint to further increase face to face clinic activity across all professions. The Trust continues to seek to maintain its virtual capacity and will be taking part in a Regional waiting list validation exercise, co-ordinated by HSCB.	36.9%	36.6%	37 1%	34 7%	32 2%	32 7%	33 7%	32 9%	29 6%	29 3%	31 6%	33 1%	32 3%	32 0%	32 4%	30 6%	27 8%	28 5%	29 6%	30 1%	27 5%	26 7%	29 3%	31 7%	31 0%
Elective	ASD	Out-Patient Appointment	By March 2022, no patient waits longer than 52 weeks.	31,276		0	34,023	At the end of February 2022, 50.8% (34,023) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 316 weeks. A parallel process of recurrent investment for recognised capacity gaps and non-recurrent backlog clearance is required to demonstrate sustainable improvement. *Note information reported against the 9 week target.*	2,644	2,816	3 146	3 483	3 725	4 003	4 396	4 822	5 037	5 161	5 477	5 888	6 068	6 377	6 772	7 017	7 392	7 818	8 094	8 016	8 182	8 256	8 405	8 514	8 771
Elective	ASD	Service Delivery Plans - Cancer	NON-OGI Projected performance against the: 14-day Suspect Breast Cancer; 31-Day Cancer Pathway; and 62-Day Cancer Pathways as part of corporate service delivery planning (rebuild process)	NON-OGI		NON-OGI	February Performance 45% 84% 51%	The Service Delivery Plan projections for Cancer performance includes the 14-Day Suspect Breast Cancer; 31-Day Cancer Pathway; and 62-Day Cancer Pathway. Performance against these areas is based on those patients that have completed their pathways i.e. have been assessed and/or their first definitive treatment undertaken. For February 2022 the projected level of performance for these three areas was 15%; 82%; and 47% respectively. Actual performance was 45%; 84%; and 51%. Therefore, Breast, 31 Day and 62 Day overperformed against projections. Performance against these cancer areas continues to demonstrate variability subject to workforce and infrastructure eg. diagnostic tests; theatre capacity.																									
Elective	ASD	Service Delivery Plans - Diagnostics (Imaging and Physiological Measurement)	NON-OGI Projected delivery of diagnostic activity: CT; MRI; and NOUS; and Echo as part of corporate service delivery planning (rebuild process)	NON-OGI		NON-OGI	99% 102%	The Service Delivery Plan projections for diagnostics include three key Imaging areas (CT; MRI; and NOUS) and one key physiological measurement area (Echo including TTEs; DSEs; TOEs). For February 2022 the projected level of activity was 7,240 (Imaging) and 815 (Physiological Measurement), with actual activity of 7,138 and 830 respectively. Therefore, underperformance of -1% (-102) and10.2% (+15) respectively. Imaging performance has been impacted by the need to remodel CT sessions to increase capacity for red flag CT Colonography and by new best practice guidance in respect of the management of allergic reactions, therefore reducing the amount of in-house general CT examinations that can be performed. CT Colonography has also been outsourced to the Independent Sector which has reduced waiting times. Physiological Measurements performance demonstrates variability as this includes both in-patient Echos and out-patient Echos with in-patient demand being variable to predict.																									
Optimisation of Resources	ASD	Out-Patients Registrations	The volumes of patients with open PAS outpatients registrations and no appointments	13,215		*Non OGI*	11,481	A data validation exercise is ongoing across all Trusts in respect of patients who have a referral noted on the hospital Patient Administration System, and have no active outpatient appointment noted. Whilst some referrals can be routinely 'closed' on-going volumes will require further individual review to eliminate risk. The total number of open OP registrations as at 20 April 2022 is 11,481.																								
Optimisation of Resources	ASD	Hospital Cancelled Outpatient Appointments (%)	By March 2022, to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment, and by March 2020 seek a reduction of 5%.	67.5%		-5%	-21.60%	Cumulatively, at the end of January 2022 there were 5,135 cancelled outpatient appointments, compared to 6,878 in the same period of 2020/2021 and 7,819 in 2019/2020. Outpatient cancellations have been impacted by the response to Covid-19 with limitations on the availability of clinical facilities and face to face contacts which required scheduled appointments to be cancelled. Out-patient activity continues via a mix of virtual and face to face clinics.	3.0%	3.1%	2 4%	3 4%	2 1%	2 1%	3 0%	2 9%	1 6%	2 2%	2 8%	4 9%	4 3%	2 7%	2 4%	3 5%	3 1%	2 7%	2 1%	2 1%	2 8%	2 9%	3 3%	2 7%	Not Available
Optimisation of Resources	ASD	Hospital Cancelled Outpatient Appointments (Number)	By March 2022, seek a reduction of 5% of the number of cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.	7,859		7466 (622 per month)	5,135	The number of cancelled outpatient appointments which resulted in the patient waiting longer in January 2022 was 761, the highest figure since June 2021. Outpatient cancellations have been severely impacted by the response to Covid-19 with limitations on the availability of clinical facilities and face to face contacts which required scheduled appointments to be cancelled. Out-patient activity continues via virtual clinics and face to face clinics.	434	565	435	483	360	367	575	564	232	432	500	599	751	526	450	550	533	446	424	407	432	559	576	456	465
Optimisation of Resources	ASD	Service and Budget Agreement (Day Cases)	By March 2022, reduce the percentage of funded activity associated with elective care service that remains undelivered. **(Day Cases)**	56.0%		>7%	Not available	**Daycases - No Further Update Available:** Performance at April 2021 demonstrates -36.1% (-562) less day case procedures were carried out than the level of commissioned daycase activity as identified in the Service and Budget Agreement (SBA). In comparison cumulative 2020/2021 performance demonstrated -53.2% (-9926) less day cases undertaken in comparison to commissioned levels. The Covid-19 response continues to impact on delivery of daycase procedures.	1%	6%	14%	3%	3%	4%	6%	7%	6%	6%	6%	4%	7%	13%	12%	7%	7%	8%	11%	11%	10%	11%	11%	10%	26%
Optimisation of Resources	ASD	Service and Budget Agreement (Elective In-Patients)	By March 2022, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **(Elective In-Patients)**	80.0%		>-45%	Not available	**Inpatients - No Further Update Available:** Performance at April 2021 demonstrates -76.8% (-430) less elective admissions were carried out than the commissioned level of activity. In numerical terms the top 3 specialties contributing to underperformance in 2021/2022 are General Surgery; ENT; and Orthopaedics. In comparison cumulative 2020/2021 performance demonstrated -77.7% (-5226) less elective admissions undertaken in comparison to commissioned levels. The Covid-19 response continues to impact on delivery of elective admissions with available elective capacity continuing to be directed to red flag/urgent cases in the first instance.	40%	34%	30%	33%	34%	34%	35%	34%	33%	37%	38%	40%	40%	35%	32%	36%	36%	35%	33%	33%	35%	35%	36%	37%	41%

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative	Apr-17	May-17	Jun-17. End of Qtr.1. 2017/18	Jul-17	Aug-17	Sept-17 End of Qtr.2. 2017/18	Oct-17	Nov-17	Dec-17 End of Qtr.3. 2017/18	Jan-18	Feb-18	Mar-18. End of Qtr. 4. 2017/18.	Apr-18	May-18	Jun-18 End of Qtr.1. 2018/19	Jul-18	Aug-18	Sep-18 End of Qtr.2. 2018/19	Oct-18	Nov-18	Dec-18 End of Qtr.3. 2018/19	Jan-19	Feb-19	Mar-19 End of Qtr.4. 2018/19	Apr-19
Optimisation of Resources	ASD	Service and Budget Agreement (New Out-patients)	By March 2022, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **(New Out-Patients)**	74.0%		>-19%	Not available	**New Outpatients - No Further Update Available**: Performance at April 2021 demonstrates -32.7% (-1746) less new outpatients were assessed than the commissioned level of activity. In numerical terms, the top 4 specialties contributing to underperformance are: General Surgery; Dermatology; Orthopaedics; and ENT. In comparison cumulative 2020/2021 performance demonstrates -48.9% (-31356) less new outpatients undertaken in comparison to the commissioned levels. The Covid-19 response continues to impact on delivery of new outpatient assessments with a mix of activity via face to face and virtual clinics.	28%	15%	-6%	11%	-9%	10%	-8%	-6%	-8%	-7%	-7%	-8%	12%	-6%	-5%	-6%	-8%	-8%	-5%	-3%	-5%	-3%	-3%	-4%	-8%
Optimisation of Resources	ASD	Service and Budget Agreement (Review Out-Patients)	By March 2022, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **(Review Out-Patients)**	51.0%		>-18%	Not available	**Review Outpatients - No Further Update Available**: As at July 2020, cumulatively, -25,289 less patients were reviewed than the commissioned level of activity. The volumes reported include 1,790 patients where the service is not managed by the Trust ie. Ophthalmology. Numerically, the General Surgery specialty (-2,436) has contributed to the majority of Trust underperformance. A significant amount of elective activity ceased from March due to the Covid-19 response. Out-patient activity continues with an increase in virtual activity demonstrated.	23%	13%	-8%	12%	12%	11%	-5%	-9%	-9%	-8%	-8%	-8%	10%	-5%	-7%	-8%	-9%	-9%	-7%	-6%	-7%	-7%	-7%	-7%	-9%
Safe Systems of Care	ASD	Inpatient/Day Case Treatment Planned Backlog (Endoscopy)	**NON-OGI** The number of patients waiting in excess of their clinically required timescale for inpatient/day case review (Endoscopy only).	3,128		NON-OGI	3,490	At the end of February 2022, there were 3,490 patients waiting beyond their clinically indicated timescale for planned repeat Endoscopy. This figure represents an increase of +1459 (+71.8%) since December 2019. The longest wait is from February 2018. As patients on the planned repeat waiting list require surveillance of their condition, QFIT testing is not utilised. Endoscopy sessions and wait times have been impacted by the Covid-19 response. The previous Regional IS capacity, that the Trust utilised, has now ceased. Access to services remains a key corporate risk.	1,142	1,266	1,367	1,425	1,413	1,490	1,393	1,432	1,461	1,581	1,600	1,670	1,604	1,720	1,795	1,872	1,941	1,878	1,946	2,006	2,044	1,911	1,820	1,579	1,443

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting - **DRAFT**

Date of Meeting: Tuesday, 22 March 2022 at 2:00

Venue: Melanie McClements' Zoom

Attendees: Melanie McClements (Chair); Mary Burke; Anita Carroll; Ronan Carroll; Flo Fegan; Caroline Keown; Ann McCorry; Sharon Glenny; Lisa McAreavey; Katherine Robinson; Jane Scott; Lynn Lappin

Apologies: Lesley Leeman

Agenda Item	Discussion	Action
1. Apologies	1.1 As above.	
2. Chair's Business	2.1 Melanie welcomed everyone to the meeting.	
3. Matters Arising	3.1 Musgrave House – Ronan to confirm with Niall Eames that we are currently unable to progress. 3.2 Insourcing Contracts – Melanie and Ronan have met with Helena. Melanie also raised at SMT along with Cancer strategy. Ann McC has meeting tomorrow to update. Melanie has asked if the IS Providers provide staff for insourced contracts. Paper to be developed for SMT embracing the key concepts and risks from an Operational and Pharmacy perspective. 3.3 Alliance – Repayment to be made but not in-year. 3.4 Outlying Long Waits – all to review and consider a plan to address. 3.5 Stroke – Lynn to share SSNAP presentation from HSCB / Trust Service Issues and Performance meeting. 3.6 SET Endoscopy capacity – Formally ceased.	3.1 Ronan 3.2 Wendy / Pamela / Ann / Lynn 3.4 A/Ds / HOS 3.5 Lynn

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Agenda Item	Discussion	Action
4. Elective Additionality	4.1 TTEs – Lisa noted 80 patients and hopes to be over within Respiratory. 4.2 Sharon has plans for evening/weekend sessions for Plain Film as contingency for slippage. 4.3 Waiting Times – Discussions around the average; longest; and 75th percentile waits. OSLs confirm that they review the longest waits as part of the GP Access Times report process. Sharon noted longest waits in Diagnostics linked to IS. Lynn agreed that the Performance Team would produce monthly if the information was going to be used operationally. All confirmed that it would. 4.4 WLI Q1 – Cardiac Investigations cannot do WLI due to admin capacity challenges. Katherine advised that there was a backlog of unregistered CI referrals discovered and that there was currently 600 referrals not on TOMCAT. Melanie asked how this will impact WLI. Katherine confirmed that for at least April and ? May the admin staff would not be able to support WLI activity. This issue has not been alerted to HSCB. Lynn to alert HSCB to this. Lynn noted the potential for IS insourcing options for CI and that Kay was working with Pamela McCartney to look at this.	4.3 Performance Team 4.4 Lynn 4.4 Kay / Pamela
5. Service Delivery Plans	5.1 Currently monitoring Phase 8 performance and looking at Phase 9 projections. Melanie enquired about Community Dentistry Day Case projections / information. Lynn to forward to Melanie, Ronan and Helena for tomorrow.	5.1 Lynn
6. Performance Issues	6.1 Scorecard – Lynn highlighted main areas. 6.2 Lynn noted UIC risk of sessions from April onwards. 6.3 Unscheduled Care – Mary noted that it has never been this bad and that DHH performance was now significantly	6.3 A/Ds / HOS

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Agenda Item	Discussion	Action
	decreasing. Melanie noted that the only way to address this is to fix the overcrowding and therefore, the LOS needs to be addressed. Melanie further noted that Red and Green Days were vital and that 'Reds' need to be actioned.	A/Ds / HOS / Lead Nurses
7. Date and Time of Next Meeting	Tuesday, 26 April at 1.30pm	

DRAFT

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

1. Acute Services Directorate

1.1 Unscheduled Care Pathway Pressures

Emergency Departments

- Total attendance levels at Emergency Departments (ED) have not yet returned to pre-Covid levels and are currently at 92% of the 2019/2020 baseline year. Coupled with this level of attendances is a high volume of patients requiring admission, who have to wait in ED for an appropriate bed; and insufficient ED space therefore, increases overcrowding, poor patient experience, operational changes and the management of risk.
- Waits in ED over 12 hours have demonstrated a minimal reduction, however, this is not yet of statistical significance. In January 2022 the Trust had the second highest volume of waits over 12 hours (1779), equating to 24% of the Regional total. Individual wait time for patients waiting over 12 hours continue to be unacceptable. The blue line on chart 1 and 2 below identifying those who waited over 36 hours.

Chart 1

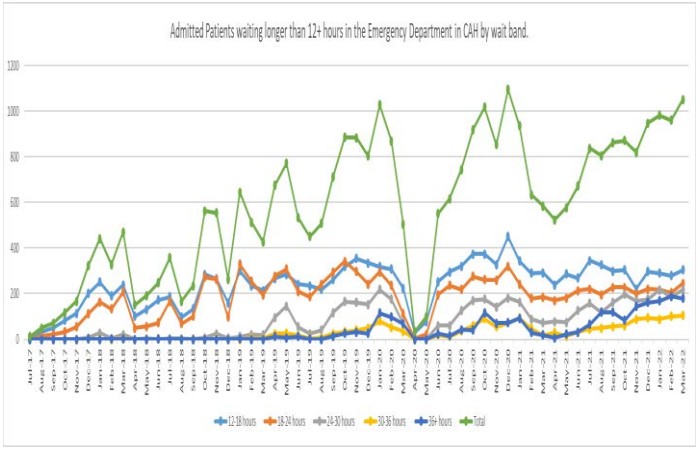
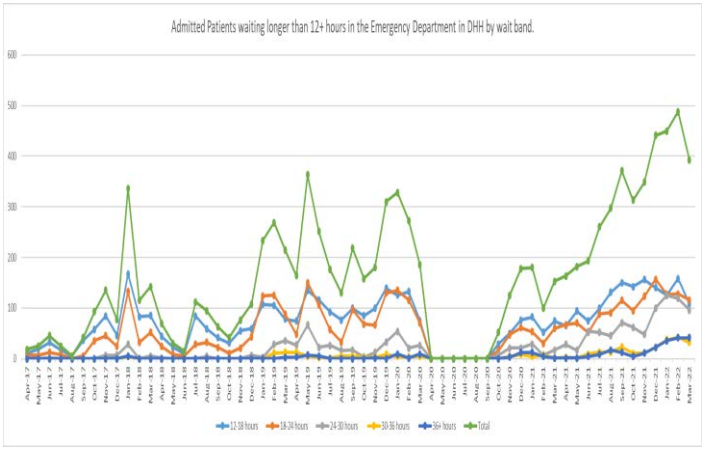


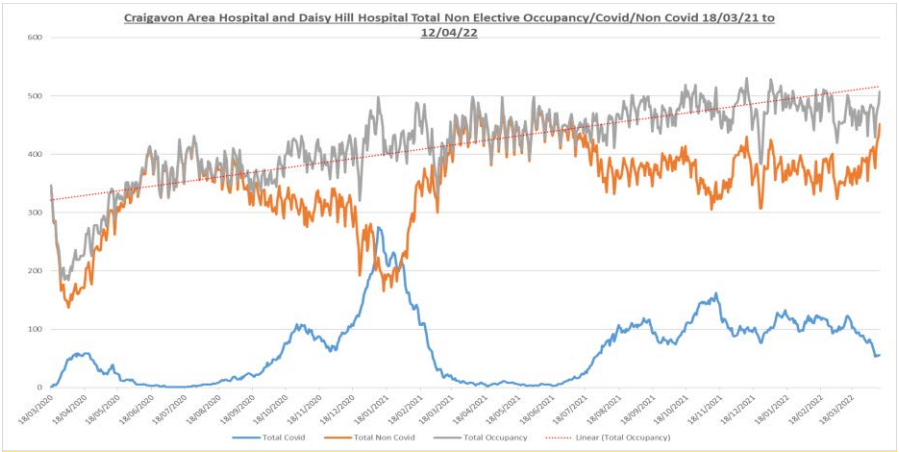
Chart 2



Hospital Bed Capacity

- Total hospital occupancy levels for unscheduled care are increasing, reflected in the top grey line on chart 3 below. This total includes both Covid and non-Covid patients.

Chart 3



- Specific pressures in trauma services has seen inpatient demand increase this year. Whilst inpatient activity only reflects 87% of pre-pandemic levels, it is above the Commissioned level of activity by 435 admissions (+39%). This demand continues to affect elective capacity, as additional theatre capacity is required to meet the urgent trauma patients.
- Hospital bed capacity has been exceeded and the Trust continues to utilise a level of uncommissioned / unfunded beds in the system at risk. Infection Prevention and Control

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management of infection 'outbreaks' and actions to manage nosocomial spread, further increases bed flow pressures.

Discharge Capacity

- Discharge performance against simple and complex discharges within 6 and 48 hours remains challenged. Community capacity is limited with increasing demand for domiciliary care packages and care home placements resulting in delays in complex discharges from acute hospitals and increasing lengths of stay for non-clinical reasons.

  These combined pressures continue to expose the long-standing challenges related to poor hospital infrastructure and lack of capacity. Critical in year estate remedial works, to improve ward ventilation, has further reduced bed capacity, requiring further extra-ordinary measures to be put in place to support patient flow and safety. The Trust has submitted interim capital schemes to the Department of Health to improve its ED facilities, as part of phased plans related to the capital infrastructure of the CAH site.

Actions

- The Trust developed a 'Winter plan' to seek to mitigate, in part, increased pressures albeit in the context of a highly uncertain environment. However, short term options remain limited with the underlying bed capacity gap and workforce pressures. A further surge plan put additional actions in place January 2022 to seek to mitigate the impact of the pandemic in this specific period.
- Additional contingency bed capacity (16 beds) was created on the South Tryone Hospital site for those patients who were deemed medically fit for discharge but awaiting a package of care / home placement. From 13 May 2022 this Nurse Led Unit, with dedicated GP support, is scheduled to close.
- Formal consultation on the Regional Review of Urgent and Emergency care, of which 'No More Silos' action plan is a key tenant, commenced on 16 March 2022 and is scheduled to close on 15 June 2022. The Trust continues to operate a number of projects arising from the No More Silos action plan, including 'phone first' services, urgent care provision and the establishment of ambulatory care pathways. Workforce issues have constrained the expansion of medical ambulatory services and confirmation of recurrent funding is required to seek to embed and further these arrangements.
- Surgical emergency bed capacity has been increased on the CAH site, with reciprocal increase in medical bed capacity on the DHH site, to manage the temporary relocation of emergency surgical services from the DHH site.
- The Trust's interim estates works plan, to improve the environment and reduce nosocomial spread (£8.7m of capital funding secured in May 2021) is ongoing. The Trust has a longstanding capital submission with the Department of Health to seek to increase the footprint of the ED on the CAH site. The Trust met with Commissioners in February 2022 to update the position in respect of current capital requirements.

1.2 Access to Cancer & Elective Services

- The Trust continues to struggle to maintain elective services, particularly inpatient and daycase surgical services, associated with the pandemic and coupled with increased unscheduled care pressures. Inpatient/daycase capacity in March 2022 reflects activity at 89% of pre-pandemic level in February 2020. This is insufficient to meet the red flag and urgent demand.
- Wait times continue to increase for red flag and urgent patients. A high volume of patients c 3600 continue to be tracked live at any one time on the cancer 62 day pathway.
- Performance against the cancer pathway targets reflect increasing journey times for patients, with a lower volume of patients beginning their first definitive treatment within 62 days. This position is not outwith Regional comparators but reflects a deterioration in the Trust position.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Table 1

	14 Day Target - 100%		31 Day Target - 98%		62 Day Target - 95%	
	SHSCT Performance	Regional Performance	SHSCT Performance	Regional Performance	SHSCT Performance	Regional Performance
2018/19	99.4%	92.0%	99.5%	94.0%	74.4%	63%
2019/20	99.9%	86.0%	98.2%	93.0%	60.1%	51%
2020/21	67.7%	71.0%	92.4%	93.0%	57.1%	53%
2021/22 (Apr - Jan)	(@ March 2022) 37%	(@ Jan 2022) 54%	(@ Jan 2022) 85.8%	(@ Jan 2022) 90%	(@ Jan 2022) 49.4%	(@ Jan 2022) 47%

- Waits times for routine patients continue to be at unacceptable levels and a full schedule of routine waits times is provided in Appendix 1 of the CPD Performance Scorecard.

Actions

Regional service reform is required to effect significant longer-term achievement across a number of key areas. Parallel improvements to Trust physical infrastructure is needed in respect of hospital-based services to support a safe return to services, as we continue to manage a pandemic response and post-pandemic.

- The Trust continues to work collaboratively with Regional colleagues to both maximise and target surgical capacity for those most in need, and utilise available additional capacity in the independent sector. In year 327 surgeries have been undertaken in independent sector hospitals by NHS consultants. This is in addition to capacity secured both in-house and in the general independent sector. £10m additional non-recurrent funding to address elective pressures was made available this year. Assurance reporting against the planned activity and financial allocations are reported regularly to SMT.

Table 2

Additional Activity	In-House	Independent Sector/NHS Consultants	General Independent Sector
Inpatients/Daycases	618	327	260
Outpatients	8188	N/A	1171
Diagnostic imaging	11038	N/A	14242
Allied Health Professionals	7874	N/A	380

- Specific capacity has been sourced to support urology elective demands, both in the IS and via an arrangement agreed by the HSCB which sees the repatriation of some new referrals back to host Trusts for management as appropriate.
- Both a Regional Cancer Recovery Plan and Elective Care Framework have been developed and launched by the DoH. Whilst these plans are subject to formal resourcing, work is ongoing to prepare and implement early actions where this is possible including, for example, exploration of text validation and development of plans to facilitate leasing, via in-sourcing contracts, of unutilised capacity to the IS for HSC patients.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

HSCB/SOUTHERN TRUST SERVICE ISSUES and PERFORMANCE MEETING – ACTIONS/ISSUES REGISTER – 22 November 2021

ATTENDEES: **TRUST** – Aldrina Magwood, Lesley Leeman, Melanie McClements, Dr Maria O'Kane, Jan McGall, Louise Devlin, Lynn Lappin, Colm McCafferty, Brian Beattie, Caroline Keown, Wendy Clayton, Brian Conway, John McEntee, Sharon Glenny
HSCB/PHA – Paul Cavanagh, Louise McMahon, David McCormick, Brendan Whittle, Alana Laverty, Caroline Cullen, Sorcha Dougan, Michael O'Hare

Issue	Action	Lead Responsibility / Deadline
OVERVIEW OF PERFORMANCE AGAINST 2021/22 CPD TARGETS		
Welcome and Introductions		
• *NB- In light of the current service pressures experienced by the Trust due to the pandemic, the normal performance updates were not covered- instead, the meeting focused on service issues specifically relating to the Southern Trust. Waiting time positions noted in the sections under Unscheduled Care, Elective Care, and Mental Health Services are for information only, and were not discussed at the meeting.*		
Unscheduled Care		
4 and 12 hours • The Trust's 4-hour performance for October 2021 (55%) had deteriorated compared to October 2020 (64%) and 1,537 patients had waited longer than 12 hours in October 2021 compared to 1,080 in the same month last year.		
Elective Care		
Elective Waiting Times • At October 2021, the number of patients waiting longer than 9 weeks for an OP assessment was 53,507 compared to 42,393 at October2020. • Similarly, the number of patients waiting longer than 52 weeks at October2021 (33,572) had significantly increased compared to the same month in 2020 (22,332). • With regard to IPDCs, 17,718 patients were waiting longer than 13 weeks at October 2021 compared with 14,978 at October 2020. 12,846 patients were waiting greater than 52 weeks for treatment at October 2020 against 8,481 at October 2020.		

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Issue	Action	Lead Responsibility / Deadline
Diagnostics • At October 2021, there were 21,473 patients waiting longer than 9 weeks for a diagnostic test, an improvement in comparison to October 2020 (24,738). • Similarly, the number of patients waiting longer than 26 weeks at October2021 (13,528) had decreased from the same month in 2020 (18,031). *Endoscopy* • At the end of October 2021, 3,926 patients were waiting longer than 9 weeks for endoscopy, a slight deterioration on October 2020 (3,679). • In relation to delivery of core for the period of April-October 2021, the Trust had under-delivered on its commissioned activity: 6,422 SBA v 3,154 actual (-50.9%).		
Cancer Services		
• *[See: Service Delivery Issues- Acute Services]*		
Mental Health Services		
CAMHS • There was an overall improvement in the numbers of patients waiting for CAMHS: at 31 October 2021, there were 8 patients waiting longer than 9 weeks compared to 30 at 30 April 2021. The Trust's performance also was broadly similar to the same month last year (6). *Adult Mental Health* • There was an overall improvement in patients waiting longer than 9 weeks for Adult Mental Health services: at 31 October 2021, there were 623 patients waiting longer than 9 weeks compared to 920 at 30 April 2021. *Dementia* • It should be acknowledged that there was a continual significant improvement in patients waiting longer than 9 weeks at October 2021 (137) since April 2021 (340) and compared to 31 October 2020 (292). *Psychological Therapies*		

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Issue	Action	Lead Responsibility / Deadline
• There was a deterioration in the numbers of patients waiting longer than 13 weeks – 385 waiting at 31 October 2021, compared to 279 at the end of October 2020.		
2021/22 WLI FUNDING		
• *[No business raised]*		
TRUST SERVICE DELIVERY PLANS		
• *[No business raised]*		
STROKE SENTINEL NATIONAL AUDIT PROGRAMME (SSNAP) PERFORMANCE		
• *[No business raised- Fiona Quigg (Stroke Network) to link with Trust colleagues]*	**Action 1:** HSCB to contact the Trust to discuss current Stroke performance issues.	**HSCB** (Fiona Quigg)
ACCESS TO THEATRES FOR COMMUNITY DENTAL SERVICES		
• The HSCB (BH) raised concern as to the lack of theatre access to undertake dental paediatric general anaesthetic treatments. The Trust clinical lead had informed the HSCB that teams were willing to work at weekends if access to theatres was enabled. The HSCB (BH) therefore queried whether this could be considered (or indeed for the potential for private sector funding to accommodate the service). • The HSCB (BH) agreed to link in with the Trust to discuss in further detail. • The HSCB (DMcC) clarified that funding would be available if theatre access could be secured, either through in-house or the independent sector. • The Trust (MMcC) noted that in the interim they had since identified limited elective capacity for paediatric surgery and priority dental extraction.	**Action 2:** HSCB to discuss proposals with Trust colleagues in further detail.	**HSCB/Trust** (Brid Hendron/ Colm McCafferty)
SERVICE DELIVERY ISSUES		
Mental Health Services Adult mental health services – update on PMHC pressures and plans: • The Trust (JMcG) highlighted that PMHC pressures accounted for a significant proportion of patients waiting for mental health services. Given the significant numbers waiting at >9 weeks, the Trust were		

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Issue	Action	Lead Responsibility / Deadline
now engaging with the East London Foundation Trust to look at their IAPT intervention service in seeking to modernise their own front line service. In turn, the aim of this exercise would be to allow the Trust to see patients in a timely manner and enable psychological interventions at an earlier stage, therefore reducing the period of time in which patients undergo their treatment phase. • The HSCB (DMcC) enquired as to an estimate of the Trust's required non-recurrent funding in the following business year, if granted. The Trust (LLe) agreed to provide this information once discussed with the relevant internal colleagues. Daycare/carers supports – challenges in respect of ongoing access: • The Trust (JMcE) noted that despite positive progress made in the recovery of the service following the previous stages of the pandemic, a key challenge that persisted was the reduction in capacity (largely due to social distancing measures). The Trust was exploring how they could expand their estates capacity, and was also presently engaging in a tendering process with the independent sector to support the service. • The Trust (JMcE) also reported on efforts made at all levels to improve quality assurance around the recording/ reporting of carers' assessments. • The Trust (JMcE) noted challenges in respite services, where 18 of the 29 beds in the care home sector were currently not accessible due to the requirement for service users having to isolate. This had caused both a financial strain for the Trust and put pressure on carers that were not receiving adequate respite. The Trust (JMcE) therefore raised concern over the future funding of these beds. • The Trust (JMcE) confirmed that they were in continued discussion with DoH and HSCB colleagues regarding these matters. *Acute Services* Cardiology – commissioning arrangements for Cath lab: • The Trust (LLe) acknowledged the on-going engagement from HSCB colleagues around future commissioning arrangements, however reiterated the challenge of patient demand exceeding supply. • Secondly, the Trust (MMcC) highlighted the need for interim provisions to be made, for example allowing for patients to choose access to the service in other Trusts, and looked to neighbouring Trusts in the region as a means to resolve this. • The Trust (MMcC) also highlighted that clinical staff had raised safety concerns, in particular in relation to the transfer of patients to other providers. • The HSCB (AL) noted that Phase 3 of the Cath Lab Project would be taken forward when the Cardiac	**Action 3:** Trust to link in with HSCB Social Care colleagues to update on ELFT arrangements. **Action 4:** Trust to confirm an estimation of their non-recurrent funding bid in 2022/23. **Action 5:** Trust to arrange internal escalation meeting to ensure cath lab capacity currently offered was being utilised. **Action 6:** Trust to share details of any safety concerns regarding the transfer of	**Trust** (Lesley Leeman) **Trust** (Lesley Leeman) **Trust** (Melanie McClements/ Lesley Leeman) **Trust** (Melanie McClements)

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Issue	Action	Lead Responsibility / Deadline
Network was re-established with the new Clinical Lead in post in the very near future. Capacity and demand would be examined along with evidence and recommendations from recent reports and studies in an open and transparent way and a decision taken on regional requirements. • The HSCB (AL) also agreed that they would be willing to discuss any issues arising from the Trust's efforts to engage with the Belfast and South Eastern Trusts in addressing waiting lists. Furthermore, the possibility remained of using IS providers in the Republic of Ireland to meet capacity needs. <u>Urology/ ESWL proposal</u>: • The Trust (WC) updated that they were at the final stages of completing their IPT to enhance the urology service. This would also be discussed at the forthcoming Urology PIG meeting. The Trust (AM) confirmed that this matter would be discussed offline in further detail with HSCB colleagues. <u>Elective waits (surgical and cancer – operating capacity and ongoing pressures)</u>: • The Trust (LLe) cited the issue of high levels of under-presentation of confirmed cancers and the delay in throughflow of patients, and explained the Trust's need for greater elective capacity. The HSCB (PC) acknowledged this issue, in addition to the number of other issues currently discussed in other fora pertaining to cancer pressures. • The HSCB (DMcC) advised that they were engaging with IS providers to secure additional capacity where possible to include freeing up theatre sessions for cancer specialties. • The Trust (BC) noted the significant numbers of red-flag referrals, and explained that any progress the HSCB could make regarding surgical access in the prioritisation piece would be of crucial help in the Trust's efforts to meet demand. • In terms of breast assessment issues, the Trust (LLe) clarified that aside from present constraints in the radiology service, their main concern was the 1,000 (approx.) patients awaiting breast assessment who were not sitting on the red-flag waiting list. • The Trust (MMcC) updated on the current recruitment drive for theatre nursing, as well as a draft proposal to reform their general surgery model in terms of workforce (in line with the DoH regional group) given theatre utilisation and bed pressure issues. <u>Older People's services</u>: • The Trust (BB) cited challenges in domiciliary care services, where efforts were being made in a number of areas: recruitment of new staff; Trust regional co-operation to support the service; and support from	patients to other providers. **Action 7:** HSCB to provide any relevant updates to the Trust in relation to efforts to engage other Trusts, and the use of IS facilities in RoI. **Action 8:** Trust to contact HSCB (DMcC) to discuss in detail the proposal to increase stones on the basis of the DPC proposal.	**HSCB** (Alana Laverty) **Trust** (Wendy Clayton)

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HSCB Social Care colleagues in their efforts to secure additional funding/ resources within the next year. • The HSCB (BW) noted that the RMB team recently approved a proposal to increase the independent sector domiciliary care rate, and that this was now sitting with the Minister for sign-off. • The HSCB (BW) also updated on efforts to discharge and arrange domiciliary care packages for patients to allow for further admissions. The HSCB and DoH communications teams were also working closely to produce relevant media messaging for the public. • The Trust (BB) advised that recruitment issues in AHP services persisted. The Trust had set up some additional clinics as well as exploring possibilities in the independent sector to assist in meeting the current demand for services. • The Trust (LLe) outlined their concern regarding the significant numbers of patients waiting longer than 13 weeks from referral to commencement of AHP treatment (which had roughly doubled in the wake of the pandemic), and the need to focus on achieving regional equalisation as a means to address this. <u>Children and Young People services</u>: • The Trust (CMcC) highlighted that unallocated social work child care cases was a regional challenge and linked directly to their workforce deficit. Given the need to prioritise child protection and Looked After Children services, this in turn had placed pressure on provisions for unallocated cases. • The HSCB (BW) stated that they would consider in the coming weeks what could be done to utilise staff skill mix and what might possibly be stood down. <u>System-wide</u>: • The Trust (AM) cited MCA/ ASW workforce pressures as an on-going issue for the Trust. • The HSCB (BW) noted that the Trust had under-performed in implementing the MCA in comparison to other Trusts, and suggested that it would be helpful to understand what steps were being taking to address this at a future meeting.	**Action 9:** Trust to provide update on under-performance in the implementation of MCA at the next meeting.	**Trust** (Aldrina Magwood)
AOB		
• *[No business raised]*		

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NICaN 22nd December update: **Proposed NICaN activities 2021/2022**

NICaN priority work areas for 21/22. Priorities to be considered in the context of ongoing COVID response, Rebuilding H SC services, Cancer Recovery Plan (CRP) and NI Cancer Strategy. *Some items are dependent on Cancer Recovery Plan funding (CRP).*

CRGS	Groups	Priorities 2021/22	Update Dec 2021
Clinical reference groups N=12	• Brain CNS • Breast • Colorectal • Gynaecology • Haematology • Head and Neck • Lung • Sarcoma • Skin • Thyroid • Upper GI • Urology	Each CRG has a separate work plan addressing each of the following: • Service planning and development • Service improvement and redesign • Service quality and monitoring • Patient experience and information • Education and Workforce • Clinical Trials **Specifics for 21/22** • Support commissioning of an Advanced Colorectal MDT • Introduction of qFIT to primary care • Introduce single point of entry and e-triage for suspect colorectal cancer • Review of regional SAIs- (Prostate and Lung) • MDT benchmarking and review – agree tool commence phased benchmarking • NICaN CRGs to review Multi-Disciplinary Team (MDT) processes with a view to optimising capacity and streamlining - • Work to look at service improvements on the bladder cancer pathway	Ongoing. Some CRG meetings not as frequent due to Covid pressures. *No meetings for Gynae /H&N/and those with regional MDT only - Sarcoma & Thyroid).* • *Recovery funding dependent* • Delivered • Delayed due to ECR team capacity (*electronic care record).* • Ongoing • Top 5 sites to benchmark (Breast, Colorectal, Lung, Urology, Haematology).Urology completed. Others delayed due to COVID pressures. • Protocolisation pilot for urology ongoing. MDT leads meeting Jan22 • ongoing
Cross themed groups N=7	• SACT • Acute Oncology • Radiotherapy • Teenage & Young Adult • AHP • Pharmacy		
Support to commissioning		• Acute Oncology Clinical reference group to support establishment of Regional Metastatic Spinal Cord Compression (MSCC) coordination service • AOS CRG to advise on AOS /MSCC pathways & monitoring. • Acute Oncology Clinical reference group to agree regional model for Cancer of Unknown Primary (CUP).	• *Funding dependent - Cancer Recovery Plan* • AOS CRG have commenced work to scope CUP model.

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	• Radiotherapy CRG to support development commissioning and development of guidelines for following ➢ Stereotactic Ablative Radiotherapy (SABR) in North West Cancer Centre ➢ Selective Radiation Therapy for Chemotherapy Refractory Intolerant Colorectal Cancer (SIRT) for metastatic patients.	*Funding dependent -Cancer recovery plan*

Primary care	Priorities 21/22	Update Dec 2021
To act as an intermediary to improve primary and secondary care interfaces improve awareness, early detection and referral pathways	• Continue to engage with GPs and liaise with GP federations, Integrated Care Partnerships, RCGPNI, Macmillan GP Facilitators and NIGPC in key service issues / areas for development.	Ongoing
	• To promote and provide primary care advice and engagement to CRGs on all service development and improvement activities-	Ongoing
	• Review NICaN Primary Care Guidelines to identify opportunities to rapidly improve primary care referral pathways and develop a phased plan.	Changes made to Colorectal and Renal/Bladder pathways & communicated to primary care
	• Input to work on development of Regional Diagnostic Centers/Vague symptoms pathways and to engage with CRGs in the redesign of specific cancer referral and diagnostic pathways	Development work has commenced at DOH. NICaN contributing to pathway development
	• Continued work on delivery of qFIT and other work to support effective referral.	Monitoring and evaluation ongoing
	• Develop programme of Primary care lunchtime learning sessions with a focus on appropriate Red flag referrals in partnership with BHSCT cancer services and Macmillan GP Facilitators	Monthly primary care awareness sessions commenced March 2021. *Sites covered include: Upper GI, lower GI & qFIT (x3), MGUS(Haem), brain, gynae, breast and oral cancers. (Av.120 participants per session, mainly GPs)*
	• Contribute to Cancer Strategy steering group	Ongoing
Pathways - colorectal Implement qFIT in Primary Care **(on Cancer Recovery plan)**	• Pathway agreement/ NICaN board approval – agreement from NIGPC/ CMO-agreement • Development of education for primary care • Development of patient information • Logistics – pathology – kits/analysis reporting • Agree secondary care point of referral mechanism • Implementation of new pathway and qFIT testing in primary care. • Development of one point of e- referral – liaison with ECR • Ongoing monitoring and evaluation and reporting to DoH NI	• Complete • Complete • Complete • Complete • Complete • **Delivery commenced 5th July 2021** • Delayed (issues accessing test environment in ECR) • To commence in New Year

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Pathway -Bladder renal pathway (Cancer Recovery plan)	• Introduce revised primary care referral guidance for bladder /renal cancer	Completed July 2021
Targeted lung checks (Cancer Recovery plan)	• Appraise the opportunities and benefits of targeted lung health checks elsewhere the UK with Lung CRG	Early detection lung CRG sub group set up
	• Continue to pilot pathway improvements including straight to CT Scan (lung)	SHSCT continue successful roll out. Opportunities to extend to be scoped Jan –March 22. Funding dependent CRP

NURSING Programme	Priorities 2021/2022	Update Dec 2021
To maximise and further enhance the contribution of current cancer nursing workforce ***Lead Nurse role vacant— Lorna Nevin took up post October 2021**	• Cancer Nurse workforce - Undertake a Cancer Nurse Census and a regional CNS /advanced nurse cancer workforce review to identify gaps in provision	Cancer nurse census completed Dec 2021 – workforce review in progress.
	• Continue recruitment of Chemo Competent Band 5 workforce based on a 6% growth factor of SACT activity.	Number of posts supported via Oncology stabilisation funding.
	• Support implementation of nursing elements of oncology-Haematology stabilisation plan to include development of regional codes to support monitoring of activity delivered.	Onc haem stabilisation -Funding dependent.
	• Agree delivery plan for introduction of Advance Nursing Roles e.g. Consultant Nurses in NICC and NWCC with CNO, HSCB University colleagues and charitable funders Macmillan.	Ongoing: 2 appointed in BHSCT & SET. WHSCT in process
	• Continued use of WOSCaN Tool to inform chemotherapy activity and workforce need	Ongoing
	• Increase and monitor NMP nurse activity across Cancer Services, to include agreement of regional coding	Ongoing
	• Support nursing contribution across all CRGs and Support Cancer Reform work across tumour sites	Recommenced Oct 21
	• Extend opportunities for nurse led initiatives e.g. Introduction of Nurse Led Cytosponge clinics (tool for early diagnosis of upper GI Cancer).	DELTA project/Cytosponge delayed pending recovery funding & due to Covid pressures– re-evaluating potential Jan 2022

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	• Support established CNS fora and develop further fora across tumour sites Continue oversight of Acute Oncology Nursing Service (AONS). Commence delivery on agreed phased expansion of AONS across trusts. Progress introduction of advanced nursing ANP posts and Consultant Nurse within AOS	recommenced Oct 21 funding dependent- Onc haem stabilisation/recovery funding
Patient Pathway Integration Programme		**Update June**
Patient pathway - HNA and Care Planning	• Implement and deliver a regional training plan combined with an implementation and delivery plan for the roll out of electronic Holistic Needs Assessment and care planning across all tumour sites. • Secure recurrent funding for Trust Information and Support services and develop pathways to ensure that all patients are referred to Cancer Information and Support services as standard • Prehabilitation. Ensure consistent implementation of existing guidelines in a phased way across the Trusts. Undertake a scoping exercise of existing prehabilitation resources Identify gaps in existing resources and formulate plan to address gaps in year 2 and year 3 across specific tumour sites. • Begin work to deliver Cancer Patient Experience Survey 2022/23 • Work with Trusts Macmillan Service Improvement Leads to continue roll out of cancer reform and follow up	**Full programme of work recruitment dependent** Post Macmillan funded. Funding secured. JD with HR for job matching.

Overarching regional work - COVID & Rebuild		**Update June 2021**
Cancer Reset cell	Provision of support to Cancer Reset to include: production of agendas and minutes; provision of data / information; follow up of actions between meetings.	Focus on rebuild – weekly meetings to April. Fortnightly to Oct. Now monthly meetings- frequency may increase during winter pressures if necessary.
Early detection	• Work with partner networks in pathology/ imaging and endoscopy to Continue to scope new diagnostic procedures with a view to piloting pathway improvement • In partnership with the RERMG and the Pathology Network, scope potential use of Cytosponge ™together with assessment of patient numbers, staffing requirements and costs • Participation in Cambridge DELTA project (Cytosponge- triage test for endoscopy to identify Barrett's Oesophagus and early oesophageal cancer).	Ongoing Scoping completed DELTA pilot delayed. Roll out funding dependent (Cancer Recovery Plan)

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Early awareness Public Information Campaign (CRP)	• Work with PHA /Others on delivery of phased public information campaign to encourage early detection and early referral • Support PHA with Digital/Press and pharmacy campaign to encourage those with worrying signs and symptoms to contact GP.	Work commenced -CRUK to deliver (funded from Charities Commission) – NICaN working in partnership with CRUK.& PHA . Roll out commences May 2022 Completed – ran from August to Oct 2021
Overarching regional work- Business as usual		**Update Dec 2021**
Peer review programme	Peer review programme 20/21 intended to agree a sustainable model for peer review with recurrent funding and agree process and finalise programme for next 3 years	External Peer review visits formally paused UK wide. NHSE currently developing new framework and piloting new approach in England April 2022. Meeting NHSE March 2022 to review and discuss NI needs.
Regional Information System for Oncology and Haematology (RISOH)	• RISOH workshop with Haematology service stakeholders to : • Develop business case for RISOH Haematology Implementation. • Revise Project group membership to incorporate Haematology Rep. • Develop Implementation plan.	Completed May 2021: agreement secured to implement electronic prescribing *Business case delayed (staffing constraints)*
Encompass	• Ensure effective cancer engagement in the tailoring of the EPIC system to meet local cancer information needs. • NICaN groups will support 'Cancer Care Decision group' nominees	NICaN coordinating identification of nominees across key areas of work by end of June. *Meeting fortnightly- coordinated by encompass*
Cancer Data	Development of various KPIs to support work streams and accompanying data collection/analysis. E.g. CNS and AOS Database. Support Strategy work	Ongoing
NICaN Corporate work		**Update Dec 2021**
Patient Public involvement	Ongoing PP Involvement.	Postponed due to Covid 19
Charities Forum	Maintain quarterly meetings. Convene TYA Charities forum	Maintained Inaugural meeting held June 2021.
NICaN Website	Further development needed particularly in patient /public section.	Ongoing
NICaN Staffing	Recruit clinical coordinators * 2 Recruit: Macmillan Regional Pathway Integration lead*	2 Co-coordinators in place. 3rd at recruitment

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NICaN Board
Wednesday 30 June 2021 DRAFT
Virtual Meeting via Zoom
2pm to 5pm

In Attendance	Michael Bloomfield (Chair), Dr Kathryn Boyd (NICaN, MD), Paul Cavanagh (HSCB), Cara Anderson (HSCB), Dr Louise Herron (PHA), Dr Yvonne McGivern (NICaN PCD), Caroline Leonard (BHSCT),Dr Mike Mitchell (BHSCT), Dr Paula Scullin (BHSCT), Margaret O'Hagan (NHSCT), Paddy Turnbull (Patient rep), Richard Spratt (NICaN Charities Forum), Mary Donaghy (NICaN Charities Forum), David Robinson (SET), Mary Jo Thompson (SEHSCT), Dorothy Byers (Patient Rep), Dr David Alderdice (SET), Heather Monteverde (DOH NI), Gay Ireland (DOH NI), Ceara Gallagher (AHP/PHA), Sinead Hawkins(NICR), Ryan Wilson (DoH), Melanie McClements (SHSCT), Naomi McCay (NICaN),
Apologies	Dr Anna Gavin (NICR), Alastair Campbell (DOH NI), Geraldine McKay (WHSCT), David Calvin (SHSCT)

Discussion Notes & Agreed Actions

	Agenda Item
	Welcome, Introductions and Apologies Mr Bloomfield opened the meeting and welcomed members. Attendance and apologies were noted as above. In particular, Mr Bloomfield welcomed: • Sharon Gallagher, Chief executive of HSCB • Una Cardin, deputising for Geraldine McKay WHSCT • Sinead Hawkins, deputising for Anna Gavin NICR • Mary Donaghy, deputising for Janice Preston Macmillan
1	**Minutes and matters arising** The minutes from the meeting on 21st April 2021 were accepted as accurate. Actions/matters arising from last meeting: 1. Action 1: Update oncology pressures (agenda item) 2. Action 2: Update on photo triage (agenda item) 3. Action 3: Peer review update. Ms McCay updated - NHS England peer review remains paused and not expected to resume until mid-2022. In collaboration with the National cancer programme, an evaluation of the peer review process and standards is underway and expected to bring focus on to the cancer pathway and outcomes. A new plan is to be agreed by September 2021. NHS England will keep NICaN informed. 4. Action 4: NICR to forward pathology report detail to WHSCT. Ms Hawkins updated that investigations into discrepancy in WHSCT data is ongoing. Pathology reporting system in

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	Agenda Item
	Altnagelvin had changed to a new system and an issue was found with lab outputs. The last accurate NICR COVID impact report is Dec 2020 - reports have ceased until IT error has been fixed (BSO responsible for IT fix). Ms Hawkins to ask BSO for timescale and feed to Naomi. Mr Bloomfield offered to expedite if necessary. Need QA check on data before reports resumed. 5. BCH Reconfiguration of Services. Dr Boyd commented on impact of BCH reconfiguration for haematology services means there is no that no cardiology or respiratory medicine on site and that haematology patients would need to be transferred to RVH for cardiac care. Mr Cavanagh agreed this scenario is still challenging, and will pick up offline. 6. RISOH workshop – Haematology rollout. Ms Anderson updated – now have consensus on a way forward. Support for e-prescribing element at this stage not broad support for e-patient record. Haematology implementation requires careful phasing so there is minimal impact on already highly pressured clinics. Aim to submit business case to DOH in autumn, new upgrade of RISOH planned so earliest implementation of haematology aspect will be next FY 2022. HSCB seeking some clarity regarding future SACT prescribing part of Encompass. Concerns remain over ongoing costs to support robust implementation of RISOH. **Action: RISOH haematology Workshop report to be shared with NICaN Board.**
2	**COVID-19** • **Cancer Reset Cell update** *(*Paul Cavanagh) Mr Bloomfield invited Mr Cavanagh to update the Board on the work of the Cancer Reset cell. Mr Cavanagh update as follows: • Cancer Reset Cell continues to meet fortnightly, still in rebuild/reset phase. The situation is still very challenging with unscheduled care pressures putting pressure on cancer services as well as on whole system. We are starting to feel the impact of patients who have delayed coming forward although this has not yet been quantified. • Within SACT, the pressures continue to be considerable. Additionally, there are concerns over NI protocol in terms of availability of medications. There will be a divergence between NI and GB – not clear how this will impact on NICE guidelines and contracts with pharma companies. • Elective care continues to work through prioritising P2 patients and this remains challenging. Mr Bloomfield thanked Mr Cavanagh for the update and agreed that the situation is still very challenging particularly with the impact of patients who were delayed due to the main surge from Oct to March now coming forward. • **Elective update** (Gay Ireland) The Elective Framework was published by the Minister on 15th June to address the growing gap between population need and Health Service capacity to meet it with unacceptable waiting times for diagnosis and treatment. • The framework sets out a 5 yr plan with firm time bound proposals to tackle backlog

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	Agenda Item
	and meet demands in future. Multiyear approach to include implementation of green pathways, surgeries provided in ring fenced specialist hubs, regional NI wide approach, mega clinics for o/p assessment and pre-op assessment, improved data reporting and accountability, recurrent use of IS. Development of in-house HSC capacity including continued investment in staffing and enhanced rate for targeted shifts • Minister has asked NI executive for £707.5 M additional investment over 5 years. Aim by Mar 2026 no-one should wait no more than 52 weeks for 1st outpatient appointment and inpatient day case treatment and 26 weeks for diagnostic. Recurrent funding a necessity. • Overlap with Rapid diagnostic centres -in both the cancer recovery plan and elective framework. • Cancer Recovery plan published on 24th June; 4 key aims recovery plan – regional approach, create smoother more efficient pathways, invest in Ca services, learn from impact of COVID. • The plan will cost £108 M over 3 years and will align with the Cancer strategy recommendations. Discussion Dr McGivern asked if a workforce is in place to meet the needs of the elective plan. Ms Ireland replied that she understands a range of measures are being look at including; for example reworking shifts, use of IS, enhanced payment, Ms Carr also emphasised the workforce issues are as challenging as funding. Mrs O Hagan recognised DoH understanding and willingness to tackle the issues. Ms Ireland replied that the Minister is aware of importance of recurrent funding. Mr Bloomfield added that our focus in NICaN is to ensure that funding already in system is used as effectively as possible with efficiency and innovation. • **Cancer Strategy** update (Heather Monteverde) - Final amends of Ca strategy are underway. Pre-consultations meetings have taken place over last few weeks and included policy leads in DoH. Minister to launch before end July for full 12week public consultation. • Cancer is complex with cross cutting work across whole areas. Demonstrates the value of networks such as the Imaging board, pathology network and NICaN. Strategy has been developed using a co-production methodology both with HSC staff and living with cancer reps. Engagement across clinical services is to be commended, committed to contributing through pandemic and this is acknowledge and thanked. • Document covers 65 recommendations from prevention through to governance and implementation. Recommending NI cancer programme, clinically led, managerially supported and data driven with need to restructure NICaN to reflect this. • Workforce – there is ministerial agreement to progress multi professional workforce plan. 8 work-streams with recommendations - high level, develop multi-prof workforce looking at skills mix, career progression, all working to the top of their license and regional approach to training, • Data element- needs to align with Encompass however data needs cannot wait, work needs done now including establishment of minimum datasets, data co-ordination, and

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	Agenda Item
	legislation for secondary use of data. • Intended by December to have consultation complete, and to have a high level workforce plan and costed implementation plan. Mr Bloomfield congratulated the strategy team. He welcomed strengthening of NICaN and looks forward to ongoing discussions. Mr Wilson commented on the overlap between the Cancer Strategy the Elective Framework, and added that the Imaging board and pathology network are well placed to join various initiatives together. He added that a lot of work is already happening on workface for both pathology and imaging and noted plans to establish an imaging academy. Ms Monteverde added that it is anticipated a cancer programme board will bring all the various constituent parts together,
3	**Breast Assessment** (Paul Cavanagh) Mr Bloomfield asked Mr Cavanagh to update members on delays in assessment and surgery in Breast. Mr Cavanagh provided the following update: The issue is very challenging with 4 out of 5 Trusts having difficulty meeting the demand for assessment and surgery. Work is continuing and discussions are taking place about possible changes to flow of referral, and how current capacity can be used to deliver the 14 day target for assessment. Surgical capacity issues present a further challenge and the regional surgical prioritisation group is working to even out access. Ms Anderson added that the need for social distancing is also resulting in reduced throughput. Breast referrals did not fall during pandemic and increased in April so there is now a position of reduced capacity and increased demand. She added that the longest wait is 54 days and the average is 17 days. The greater concern is the need to address the 'routine' referral backlog (currently 3,700 patients across region) which is significant given that typically 10% of these are cancers. Dr McGivern provided some information on letters to GPs around breast referral (see section 7).Mr Bloomfield thanked both for the update and added that this issue is not new but COVID has made it more difficult. Ms O'Hagan commented that the pressures were originally highlighted within NHSCT and acknowledged the support of Mr Cavanagh on assessment, Ms McWilliams on surgical side and the commitment from other Trusts to help if necessary. She added that NHSCT have made good progress in addressing the pressures by reforming their breast pathway and triage. Ms McClements (NT) commented that greater flexibility around incentivising part time staff to undertake WLI was required. Mr Robinson (SET) commented that when looking at elective pressures more generally that there is a window of opportunity this summer which cannot be missed and that conversations are ongoing with DoH and HR directors. He added that the blended approach between HSC and Independent Sector is helpful, particularly at weekends.

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	Agenda Item
4	**Cancer funding** *(Cara Anderson)* Ms Anderson' recapped at last board meeting HSCB has just received an allocation of £2.35M Onc/haem stab plan, since then additional funding has been secured through COVID funding bringing the contribution to almost £5 million which should cover on the ground pressures in year. Ms Anderson to get IPTs out in next few days. Ms Anderson provided an overview of how in year funding, both recurrent and non-recurrent, has been aligned to cancer recovery plan priorities.  CancerRec_Plan application in YR fund Mr Turnbull asked what recovery plan funding would achieve in real terms Ms Anderson replied that the actions listed, if funded should lead to improved waiting times particularly in terms of diagnosis, earlier referral and pressures relieved in oncology treatment. She added that oncology/haematology SACT clinics are currently double booked, leading to overcrowding and this could impact on quality of care. Other initiatives if funded could enable pre-habilitation ahead of treatment. Ms Anderson also added that safety netting was also a requirement as many pathways have been disrupted due to COVID so there is need for robust tracking. Mr Turnbull asked about patient communication and support. Ms Anderson added that the CNS acts as keyworker and CNS and support worker expansion is embedded across the recovery plan. Ms Gallagher acknowledged Mr Turnbull's question and agreed it is important that every penny is spent the best way available which is why business cases and IPTS are important in understanding where we put our energies.
5	**Oncology pressures** (*Cara Anderson)* Ms Anderson reported that the Oncology / haematology SACT services remain under significant pressure: • NWCC - losing 1 consultant. Have secured 1 trainee to act up (locum), maintaining 6.8 WTE out of 11 allocation. Also secured medical oncologist starting mid-July bringing complement to 7.8 WTE. However only 3.8 WTE substantive, heavy reliance on locums. Potential for 3 posts to be filled- will improve stability but no net gain. BHSCT are providing support –seeing new urology patients. Waiting list initiatives starting in July for breast, urology, lung and lower GI - will focus on review backlogs • NICC –Consultant's currently working 14 pa job plans and are no longer content to do this. BHSCT have identified need for 4.5 posts, again this will stabilise but not give any additionality • Need for appropriate workforce planning. Consultant trainee places have not been funded. Recommended three medical oncology training places in august 2020 , and two in 2021 as well as two clinical oncology places in 2020, and another two in 2021. Currently 9 training places behind where we need to be. Ms Anderson said that the issue has been flagged with the workforce Dept. in DoH and was advised that they are not able to prioritise the training places due to funding constraints. Ms Anderson added that this is of significant concern for both clinical risk to patients and staff burnout and may lead to waiting list for chemotherapy. Ms Monteverde noted that there was also a requirement to look at haematology training. Ms Anderson has prepared a paper for

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	Agenda Item
	DoH. **Action Ms Anderson to forward briefing paper to Mr Wilson.** Dr Boyd reiterated that a number of consultants are currently working 14 PAs (i,e 7 days a week), Mr Bloomfield agreed this is unsustainable. Ms Leonard emphasised the need to respond as a region to the workforce issues. She indicated the need for an extension and bedding in of RISOH prescribing, a strategic discussion on the SACT model and the requirement for a common platform for radiotherapy planning and delivery. Dr Boyd added that this has been discussed at Radiotherapy CRG. **Action – Dr Boyd to get update feasibility of common platform for Radiotherapy planning.**
6	**Urology SAI regional learning for MDTs** *(Dr Boyd)* Dr Boyd gave the following update on regional learning resulting from the Urology SAI in SHSCT: In May 2021 a root cause analysis report by SHSCT was shared with PHA and NICaN have been asked to consider regional learning from the 11 recommendations made in the report. These recommendations have been shared with Cancer managers and CRG leads - they include issues with the operation of MDTs and information and support for patients. NICaN proposed a regional benchmarking of MDTs against cancer standards. Currently working on Tool with cancer managers. Once tool is agreed Trusts will for top 5 tumour sites Breast, Colorectal, Lung, Urology and Haematology. This will not only benchmark against good practice but will highlight issues already known e.g. • MDT Quoracy (serious problems with oncology /radiology and pathology attendance due to workforce issues) • Data recording and lack of data infrastructure • ability to audit outcomes The report may highlight the need for work on streamlining MDTs and will feed into strategy data issues work started by Dr Michael Quinn. Ms O'Hagan said that there are likely to be significant implications on job planning. Ms Anderson commented that it will be more around MDT support and tracking, also additional information support in trusts. Dr Boyd stressed the need to streamline the MDT process and free up time to discuss more complex cases. Dr Scullin commented on the issues with quoracy at MDTs and added that if staff must attend this will create more pressures in the system. Ms Gallagher added that workface issues in AHP also mean a small number of staff to spread across a number of MDTS. Mr Cavanagh commented that we need to understand resource issues and do our best to follow agreed pathways. Ms McClements added that whilst this SAI has come out of Urology in SHSCT it could happen in any of the teams in any of the Trusts and said there are much wider service improvement issues regionally across all specialities.

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	Agenda Item
7	**Primary Care** *(Dr McGivern)* ▪ Breast service letter to primary care: A number of issues had been brought to the attention of NICaN by Breast service these include referrals received without physical examination and referrals received for breast pain which do not comply with NICaN red flag referral guidance. NICaN issued a letter to GPs focussing on supporting primary care with breast referral , noting NICaN guidelines and encouraging face to face consultation with physical examination. Dr McGivern also met with primary and secondary care representatives from NHSCT. Dr McGivern added that as NICaN do not have access to a mailing list for GPs communications are channelled through Integrated Care team at HSCB. Integrated Care have initially only agreed to put the letter on their website rather than send to GP practices, Dr McGivern expressed concern that it could easily be missed and the issue of NICaN being able to directly communicate with GPs needs addressed. Mr Cavanagh asked Dr McGivern to contact him directly regarding communication with Integrated Care if needed. Mr Bloomfield asked if there is any evidence that the strong recommendation of face to face consultation is happening. Ms Anderson replied that it is too early to know. **Pathways/NG12: qFIT pathway update** • Launch of qFIT into primary care and lower GI suspected cancer pathway -to go live on 5th July. The project was a joint collaboration between NICaN, primary care and secondary care. This is very positive news and will allow GPs to prioritise red flag patients, will have an impact on hospital waiting lists and ensure that the right patients are referred through for colonoscopy. A full suite of information has been developed to help support GPs including information for staff on ordering test kits, FAQs, information for treatment room staff and patients. • The launch of qFIT and the new pathway has been the topic of two GP education sessions the last one of which was recorded. An education session has been held for nurses which was also recorded. The sessions were well attended with good feedback from practices. • Phase 2 of the project is now underway to enable GPs to refer into a single point in secondary care - expected to be completed in September/October. Again this is positive news which will make a significant impact on the service. Mr Bloomfield congratulated everyone involved in the project, added that this is an excellent development. Ms Byers asked if qFIT is part of the bowel screening programme. Dr McGivern confirmed that bowel screening had incorporated qFIT in Jan 2021 and that the same test is used in primary care with different threshold levels. **Photo triage update** • Dr McGivern updated on photo triage project being implemented by Integrated Care team at HSCB. The photo triage team have now secured funding and equipment (a magnifier camera for each GP practice). GP practices have to sign up to use the

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	Agenda Item
	service, which has been well publicised, and practice staff will be trained to take images. GPs will see the patient and electronically send through a referral including the images. A report will then be received by the GP within 72 hours. Photo triage will help address the long waiting lists for Dermatology as 80% of cases are found to be benign lesions. The initiative has already been rolled out in mid-Ulster, South Belfast and Causeway and it is hoped that it will be extended by 3 Federation areas per month with all practices involved by Mar 2022. Mr Bloomfield thanked Dr McGivern for the update and commented that this is exactly the type of initiative needed to tackle waiting lists. Mr Alderdice agreed and added that it will speed things up for patients and he would help promote the initiative if needed. Mr Bloomfield thanked Mr Alderdice and added that the support of clinicians is both valuable and powerful. Mr Mitchell informed members that Breast and Dermatology will be topics on future BHSCT/NICaN monthly primary care education sessions. **GP representation on NICaN groups-** Dr McGivern commented that a number of GP facilitators have retired and posts have not been filled therefore it is increasingly difficult to secure GP engagement on CRGs. Ms Monteverde commented that most GP facilitator posts were Macmillan funded funding should be available. She added that primary care senior nurse facilitators are in place in Scotland and asked if this may be an option for NI. Dr McGivern said that in NHSCT the post is out of funding and in some of the other Trusts posts are waiting to be advertised. Mr Bloomfield added this needs further discussion, possibly with NIGPC and is willing to be part of any discussions. **Action: Dr McGivern to provide an Update on GP facilitator's roles at the next meeting. NICaN to continue to scope ways of improving Primary care engagement in CRGS.**
8	**NICaN work plan and staffing updates** **Review of 20/21 *(paper) (Naomi McCay)*** • Ms McCay presented a review of work implemented over 2021 2021. Mr Bloomfield added there had been a remarkable amount of work achieved by small core team and noted the impact NICaN has had and support given to cancer services.  NICaN board paper 30th June 2021_Revi **Staffing** • PHA are currently recruiting lead Nurse for Cancer. • Recruitment underway for second NICaN coordinator. • Permission for third co-ordinator in discussion. • JD for new Macmillan funded Pathway Integration post with HR for job matching. **NICaN 21/22 work plan priorities & staffing update** Ms McCay presented the proposed 2021/22 work plan, she added that the plan includes more than what would be feasible but activities are included to allow flexibility, Many actions are

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	Agenda Item
	dependent on ongoing COVID impact, several are also dependent on funding via Cancer recovery plan.  NICaN workplan 2021_22 update sept She added that it is hoped that NICaN might return to more regular CRG meetings which had been reduced due NICaN staffing and COVID pressures on service staff. Mr Bloomfield commented that the plan was very ambitious and good to see and for all to be mindful of prioritising if necessary. **Action: Mr Bloomfield asked members to provide comments back to NMcC.**
9	**AOB** : 1. Ms McCay informed the Board that a new Teenage and Young Adult charities forum has been established and added that major developments are needed around TYA service (highlighted in cancer strategy). Ms McCay proposed that TYA charities also have representation on NICAN Board. **Board agreed to invite TYA Charity Representative to join the NICaN Board.** **Action: Extend Board invite to Mr Darren McKinley to represent TYA charity Forum.** 2. Mr Spratt, Cancer Focus informed the Board that Cancer Focus and other cancer charities have formed in informal alliance (including Action Cancer, Macmillan, CRUK Bowel Cancer UK, Friend of Cancer Centre, Cancer Fund for Children. Mr Spratt wished to make the Board aware that the alliance has compiled a response to the Cancer Recovery Plan directed mainly at MLAs. Ms McCay will share this with Board members via email.
10	**Summary of Agreed Actions** **1.** RISOH haematology Workshop report to be shared with NICaN Board**.** 2. Keep board updated breast assessment service 3. Ms Anderson to forward briefing paper on oncology training places issue to Mr Wilson. 4. Dr Boyd to get update on feasibility of Radiotherapy common platform. 5. Dr McGivern to update on GP facilitator's roles across NI and continue to scope ways of improving Primary care engagement in CRGS. 6. Ms McCay to invite TYA Charity Representative to join the NICaN Board 7. Mr Spratt to share Cancer Charity Alliance response to Cancer Recovery plan with board members for information.
11	**Date of Next Meeting** • October 2021.

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Acute Services Directorate Cumulative Expenditure

Month: February 2022

	Actual £'000	Budget £'000	Variance £'000	Variance %
Payroll				
Medical	67,943	59,901	(8,042)	(13)
Dental	70	58	(12)	(21)
Allied Health Professionals	15,141	14,662	(479)	(3)
Professional & Technical	5,375	5,105	(270)	(5)
Nursing	95,232	87,679	(7,553)	(9)
Domiciliary Care	0	0	0	0
Social Services	1,352	1,382	30	2
General Administration	18,015	18,894	879	5
Support Services	16,011	17,345	1,334	8
Corporate Functions	0	0	0	0
Terms and Conditions	0	0	0	0
Demography	0	0	0	0
Apprenticeship Levy	852	852	0	0
Area Services	13,012	12,760	(252)	(2)
Total Payroll	**233,003**	**218,638**	**(14,365)**	**(6.6)**
Goods & Services				
Medical & Dental				
Medical & Surgical	46,430	44,858	(1,572)	(4)
Xray	4,654	3,733	(921)	(25)
Dental	0	0	0	0
Laboratory	6,404	7,201	797	11
Laundry	107	59	(48)	(81)
Patient Appliances	911	1,274	363	28
Sub - Total	**58,506**	**57,125**	**(1,381)**	**(2.4)**
AHP & Paramedical				
Physiotherapy	0	0	0	0
Occ/Rehab Therapy	1	2	1	50
Speech & Language Therapy	0	0	0	0
Podiatry	0	0	0	0
Orthopists	0	0	0	0
Other Departments	0	0	0	0
Sub - Total	**1**	**2**	**1**	**50.0**
Nursing				
Bedding & Linen	308	311	3	1
Staff Uniforms	224	195	(29)	(15)
Patients Clothing	106	82	(24)	(29)
Sub - Total	**638**	**588**	**(50)**	**(8.5)**
Community Care				
Community Care	0	0	0	0
Children & Young People	0	0	0	0
Grant Aid & Vol. Orgs.	0	0	0	0
Res, Nursing & Dom Care	0	0	0	0
Sub - Total	**0**	**0**	**0**	**0.0**
Support Services				
Hotel Services	2,272	2,442	170	7
Computer Services	293	62	(231)	(373)
Heat, Light & Power	5,840	6,412	572	9
Maintenance	0	0	0	0
Rent, Rates, Water & Ins	2,557	2,761	204	7
Administration	685	525	(160)	(30)
Postage & Telephones	523	538	15	3
Patients\Residents Amenities	0	2	2	100
Travelling	398	570	172	30
Staff Training	155	89	(66)	(74)
Transport	621	192	(429)	(223)
General Services	878	529	(349)	(66)
Sub - Total	**14,222**	**14,122**	**(100)**	**(0.7)**
Total Goods & Services	**73,367**	**71,837**	**(1,530)**	**(2.1)**
Income	**(4,989)**	**(5,008)**	**(19)**	**0.4**
GRAND TOTAL	**301,381**	**285,467**	**(15,914)**	**(5.6)**

Acute Services Directorate Narrative

Month: February 2022

Acute Services	Variance		Commentary
	In-Month £'000s	Cumulative £'000s	
Payroll	-605	-14,365	**The Directorate is over £14m in excess of its pay budget of £219m at Mth 11. All costs associated with flexible workforce, which includes agency, bank, locum and overtime etc are included within this cost line. Details of variances in the main areas are outlined below.**
Medical	-414	-8,042	Medical expenditure is £8m over budget year to date, the main pressure being in the area of Medical training grades. Due to recruitment difficulties and the need to safely staff rotas there continues to be a requirement to use high cost flexible staffing. Flexible usage has increased in comparison to the prior year with Medical Agency cumulative expenditure at £14m (growth from the prior year of £0.5m), the areas most reliant on Agency being General Medicine and ED.
Nursing	-396	-7,553	Nursing is £7.6m cumulatively overspent at Mth 11, the areas of pressure being B5 & B6 nursing and B2 nursing support. As with Medical, recruitment/retention issues persist so high cost flexible staffing continues to be heavily utilised in order to safely staff wards hence the rise in Nursing spend of £3.3m from the prior year being driven by growth in Agency costs to £20.4m of the cumulative spend to date (ED and General Medicine are the areas with the largest Agency cost YTD).
Non-Pay	-422	-1,530	**At Mth 11 the Directorate is overspent on non-pay cumulatively by £1.5m The most significant variance is listed below.**
Medical & Surgical	-250	-1,572	Drugs is the main area of overspend at Mth 11, primarily due to two main factors: 1) retraction year to date of £976k (£1.1m FYE) as the recurrent pharmacy savings target under the MORE programme for 21/22 and 2) increased spend in cancer drugs & biologics with higher patient numbers.

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Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES
HR/FINANCE/PLANNING MEETING

Date: Tuesday 12th April 2022
Time: 2pm
Venue: Zoom

A G E N D A & NOTES

1.0	Apologies – Barry Conway
2.0	Chair's Business: CRR rate global circular - reiterate comments on circular regarding thanks to staff. Concerns however as Trust under severe pressure and May commitments may back out if the enhanced rate is pulled. Band 5 to 6 uplift due to end at the end of May. Director to meet with H Trouton for discussions. Still carrying a large number of vacancies, as well as continuing covid and other absence types / isolation. Workforce is a challenge every day.
3.0	Finance issues:- • Month 11 financial position Acute financial position Mth 11 Feb 2 Pay is 14.4 million over and 1.5 million on goods. Noted that CRR was an additional funding stream 2022/23 very uncertain and it's more and more difficult to plan into the future. NIMDTA making 14 junior doctors available but only 30% funded. We will need 30k per doctor to top up, we need to find out a way to ensure we can make the posts work. Patient safety risks will be addressed but plan for posts going forward will have to wait and so message for the workforce needs to be we know we need more resource and we will work through it. IPTs being scoped and submitted

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4.0	HR issues:- • Presentation on Sickness levels from Trust performance committee • Presentation from Trust JNCF on Section 33 – flexible working policy update *(presentations not for wider distribution)*  FlexibleWorking_Presentation_JNCF 28Mar  2022.03.04_Mgt of Sickness Absence_Per ACTIONS: Secure resourcing support to work with hiring manager on UI admin support Clarify and confirm Covid sickness HRPTS coding
5.0	Planning issues: • Planning Update  Acute Directorate SMT Planning Update
6.0	Internal Audit (SI) 4 x Band 5 CSCG posts approved – Chris progressing e-reqs
7.0	Any Other Business None
8.0	Date of Next Meeting Tuesday 10th May 2pm

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Melanie McClements

ACUTE DIRECTORATE GOVERNANCE MEETING

Date: Tuesday 5 January 2021
Time: 11am
Venue: [redacted] Personal Information redacted by the USI

A G E N D A

1.0	**Apologies:** Attendances: Melanie McClements, Tracey Boyce, Barry Conway, Patricia Kingsnorth, Anita Carroll, Anne McVey, Mary Burke and Ronan Carroll	
2.0	**Chair's Business** **Action notes of last meeting** Acute Directorate Governance Action N Melanie discussed the action notes from the previous meetings particularly in relation to the action plans for fraud awareness. All AD to send their evidence/ action plans to Emma and Patricia K, these need to be reviewed annually to ensure compliance. Anita advised her actions are up to date and reviewed regularly. Tracey also assured her actions were up to date. Anne and Mary to forward and Ronan to be advised to do so. Internal audit – Mary and Ronan have completed the two	**Melanie**

	documents to date. Melanie expressed her disappointment from the feedback from staff regarding engagement with the outbreak SAI process and the impact on staff. She advised she was under the impression there was very good feedback to staff. That consultants, and ward managers were informed of the progress. There were support services put into place regarding psych support/ family liaison/ Connie Connolly and line managers. Anne advised she had good engagement with the surgical and haematology wards following the outbreak but she was advised to stand down in view of the SAI review so she wasn't able to provide the same level of support to MMW in DHH. Anne advised that the feedback would have been positive but for a throw away remark from one staff member.	
3.0	**Audit**  1) Clinical audit summary for Acute Cl Reports discussed last month – no new issues	**Raymond Haffey**
4.0	**Patient Safety Report sent separately – no new issues from last month**	**Colm Robinson**
5.0	**Acute Clinical Governance Overview**  Complaints by Division and Date Rec Patricia advised that the majority of complaints relate to communication. There is great difficulty with patients accessing assistance from ward staff – no one answering the phones / lack of updates on family members. Melanie advised that when trying to ring through to switchboard the John Mitchell message is so prolonged and if it could be removed. Anita will discuss regionally. Anita will explore if there is a process for answering telephones to advise about families. This was done during the first covid wave and worked well.	**Patricia**
6.0	**Complaints**	**Patricia**

	• Current Complaints  Current Complaints.xlsx • Weekly reopened complaints  Reopened Complaints Report 10 • **Open 58 (20 overdue responses)** **Enquires** **Reopened- 18** **Ombudsman- 11** Melanie discussed the complaints overview there are 20 outstanding complaints some dating back to 2019. She wants an effort put into completing these reports by the end of play on Friday this week.	
7.0	**Ombudsman Cases**  Ombudsman 10.12.2020.xlsx	**Patricia**
8.0	**Directorate Risk Register** • Quarterly Risk Register Review – Directorate Level  Directorate RR November 2020.xlsx • Divisional Risk Registers  CCS Div.HOS.TEAM RR November 2020.x  FSS Div.HOS.Team RR November 2020.x  IMWH Div.HOS.Team RR November 2020.x  MUC Div.HOS.Team RR November 2020.x  Pharmacy Div.HOS.Team RR No  SEC.ATICS Div.HOS.Team RR No  Emergency Medicine Div.HOS.Team RR Au Risk registers are up to date, Risks associated with ligatures was discussed. This was previously on the MUSC risk register and Mary/ Anne are not sure where it went. PK will search through the risk registers to reinstate it to MUSC. Action PK.	**Patricia**
9.0	**SAIs:** • Summary report – 28	

	• 10 of which are relating to urology Patricia advised we are working through the SAI processes. 10 of the 28 are in relation to urology. She provided some early learning regarding the assurances for the MDM. Recommending regular audits to ensure compliance as the assurances are solely based on the clinician representing a case to the MDT. She advised that assurances were provided to the Trust board that all recommendations provided in the peer review were being actioned and were compliant but we had not evidence to support compliance and we were not complaint regarding the use of a specialist nurse.	
10.0	 Incident review position as at 08.12.2 **Incidents**  November 2020 Acute SMT Governanc • Summary report –  Major & Catastrophic Incidents weekending • Major and above report for AMD Governance meeting Incidents discussed particularly in relation to the increase reporting on staffing issues and covid pressures.	
11.0	**Medication Incidents** • Monthly medication incident report  Copy of November 2020 Acute.xlsx Tracey provided an overview of medicines incidents. Most incident occur with locum and agency staff and during a time of extreme pressures poses a serious risk.	**Jilly Redpath**
12.0	**Implementation of Learning** • Update from Divisions	**ADs**
13.0	**Mandatory training compliance**  Copy of Trustwide CMT Compliance Sum	**ADs**

	Staff reminded about mandatory training for their areas.	
14.0	**Any Other Business** Continous observations mental l **Psych liaison – recommendation from Coroner** PK discussed the outcome from the preliminary coroner's court- the Coroner is interested in the Trusts structures regarding psychiatric liaison for patients in acute setting and wants learning implemented before the inquest review. Maria has asked that a focus group is set up. Melanie suggested Patricia/ Ronan/ Jo Minay/ Sharon Holmes and Laura McAuliffe. Action: Patricia to set up. **Surge Plan for next week** Melanie advised of the current and predicted pressures for the next 3 weeks. She has to present a report to Trust Board at 2pm today to show the gaps in her service and what measures will be put in place to address. Ronan did highlight the inequality of services throughout the province across Trusts and the equitable distribution of health care across northern Ireland regarding regional approach to the pandemic. Ronan – discussed his plans regarding increasing ICU bed capacity from 10 to 14. This would allow the continuation of the urgent bookable list. He suggested rather than using the day surgery ward, that the urgent treatment centre is used instead, thus allowing the patients to be seen on site. He provided a breakdown of his services and were staff could be allocated. Barry advised he has provided his report to date Mary will provide her report by 2pm but discussed where staffing could be redeployed. Anne will speak with her AMD and CD to discuss the plan and forward to Melanie before 2pm. She also discussed a plan for senior staff/ medical staff provision to support the hospital during this critical time. Suggestions were made regarding placement of staff. Patricia to consider what services could be stood down for governance perspective.	

15.0	**Date of next meeting** **Tuesday 2 February 2021 at 11am via Melanie's space**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 9 April 2021

8am Melanie's meeting space. Personal Information redacted by the USI

1.0	**Apologies**: Clare McGahlie, Barry Conway Attendance Melanie McClements, Patricia Kingsnorth, Damian Scullion, Shahid Tariq, Patricia McCaffery, Ronan Carroll, Philip Murphy, Damian Gormley, Maria OKane, Tracey Boyce, Mary Burke , Anne McVey, Seamus Murphy Erskine Holmes, Gareth Hampton, Aoife Currie, Ted McNaboe, Neville Rutherford Jones, Una Bradley	
2.0	**Notes from last meeting** 12.3.021 Action notes Acute Clinical G Notes from last meeting approved for factual accuracy	
3.0	**Chairs business** Melanie advised there were two matters arising, one was electronic sign off and one was in relation to the urology SAI. She handed over to Damian Gormley to address electronic sign off **Dr OKane – to share the learning from urology SAI** Maria to set the scene regarding the learning from the SAI. Important that early learning is out as quickly as can, in particular medical staff working in multidisciplinary teams in a meaningful way. In particular to the management of cancers and the role of the specialist nurse practitioners. Taking it back to ensure there is practical working. To provide safety to the patient and also to provide safety to the practitioner, that staff are aware of the sickest patient. Where there are concerns where clinical staff who don't seem to work within the system that we look at how they can be challenged. There may be some staff who are seen as too important to be challenged. There is a tradition to keep a target of 31 / 62 day targets rather than the quality of care for patients. There is a look back excerise to look at the patients with the DOH/ HSCB to improve patients safety. There are 20 staff trained in SMR and any learning in those cases will be disseminated as soon as possible.	Dr OKane

If there any concerns about isolation or stress- we need to [illegible] posting for support.
Plan will use urology as a test bed for improvement. How can we realign nursing and medical to do this. Have been in contact with the staff in Belfast regarding the neurology enquiring to get learning. She apologised that she can't provide the details.
Dr TS said this was a good opportunity to look at our processes. This is the opportunity to get the resources and we are looking forward to improving our services. This is a great opportunity and we will take it.
Pat – this was review was very surprising about this colleague and how can we assure ourselves that this is not happening in our system. We would need a system of assurance particularly in outpatients to avoid it happening again.
Maria acknowledged this as it is difficult to know, one of the approached from Belfast – they are peer reviewing each other work. A system developed in Social work- monthly take a sample of cases load and discuss it, if there were concerns then they instigate a case review which may not be particularly useful. Randomly take 20 charts and review it. she said she is open to any suggestions to improve this.

Maria advised that she has been in contact with Birmingham about the Patterson's enquiry. Separating out 3 different strands – governance/ revalidation and peer review.
Ted- the key around the MDT- but we need to look at the validity of the MDT as some struggle to get the proper representation on the team – radiology/ oncology and pathology. The regional groups have the proper representation. Local groups have difficulty to look at the proper range of specialities are available for all occasions.
Anne said there is a fine line between clinicians and using evidence based practice. She recalled a meeting from a staff member is working with staff and did we have a proper process on how we can listen to staff were raised concerns and were listened it. she cautioned that we need to manage those concerns and we need to support that challenge when things go wrong.
The audit used in NICAN was not strong enough and we need to develop our own tool to ensure it is robust. To ensure follow advice given to keep the patient safe. The process to quality assure the work.
Ronan made a point- medical working in teams – in NI patients put under the care of one doctor, he offered a suggestion that we would need team job plans to ensure the work is checked by a second consultant to provide checks and balances.
Maria - Recognised there is a importance of continuity of care and how that is shared within the team. she wanted to know how do medical staff get to the point of being comfortable to work within a team.
Seamus liked the point about measuring time standards but less good to measure quality cancer. He referred to rectal cancers and how the services have changed. We are not good at measuring the outcome from those.

	Melanie acknowledged that and said that as we have been commissioned that this is not acceptable and will take this opportunity to improve quality care and improve patient safety. Melanie thanked Maria.	
4.0	**Electronic Sign off** SIGNOFF_2021_02_SHSCT.pdf **Dr Damian Gormley and Dr Andrew Murdock to discuss electronic sign off.** Damian provided update on electronic sign off. We are best in NI regarding electronic sign off. However, we know there were lots of issues discussed last month, Kate's role is missing due to leave and this post will be replaced. Damian- acknowledged a lot of the good work. There is no denominator in the report to look at the percentages. Quite a large number of areas that have a low number of sign off. He acknowledged this doesn't reflect that results are not being looked at. But we don't have assurances that all results are being signed off. He is aware that the NIECR have issues. Abnormal results when patients are discharged are particular risk. Melanie opened the floor for discussion. Gareth said a specialist post would be required to sign off for ED. Pat- said it works reasonably well for inpatients but very difficult for outpatients. The system is very clunky. Damian agreed it is difficult to sign of multiple results, but individually it is easier. Gareth said it is difficult to sign of radiology reports- can be sorted out quickly on paper but electronically results are back later. Philip- process are not robust enough to remove the paper results. Damian advised if there is a robust system then keep going. However there are abnormal results are still not being followed up. He cautioned that were there are electronic sign off these are not being completed despite paperless. Seamus said the system needs improved to be quicker. In preparation for encampass but it is few years away. Damian advised electronic system is the only way to provide assurance. Melanie asked how do we assure ourselves that as some wards are paperless and the electronic results are not signed off – how can be assured the results are actioned. Erskine said that there are still multiple cases of x rays not being followed up. X ray carried out in ED and patient going to the ward. The admitting physician not following up. These need to be followed up. This has been raised before but despite electronic and paper we don't have a good process of dealing with the results.	Dr Gormley

	Damian advised there is a process from radiology but the f[illegible] needs audited. Particularly from outsources. It is the images that flag up a repeat x ray required. These are the issues. The GP colleagues will not follow up on reasonable requests to deal with these x ray follow up. GP will decline the results. This needs to be agreed. Primary care and secondary care need a better process. Anne said it is also an issue with physician of the week to follow up. Gareth Erskine/ radiologist and Rose/ Frances to address the issues. There is an issue for the patient who move from ED and Inpatient doctors. Melanie asked the operational teams to set up please. Shahid and Barry to follow up also.	
5.0	**SAIs** IMWH Aoife - [redacted] SAI [redacted] draft.docx Aoife presented the case of a patient admitted with prolonged preterm rupture of membranes. Antenatal issues with the clinic management. Midwives escalated concerns which were not followed up by medical team. she becomes septic and suffers an intrauterine death. She is very unwell. The report addresses the concerns in the report. Cultural issues, woman raised concerns which were not listened to. Midwives raised concerns but not listened to. She advised there are long term concerns for the baby when preterm rupture, but you must involve the woman in the discussion and make her totally aware of the issues. This didn't happen in this case. The CTG issue is a long term issue and we have worked very hard to address this. Moving to a computerised system called dawes Redmond. Cultural issues – more concern. Escalation did not result in action. The risks and benefits were not discussed with her. Don't know if the outcome could have been different. The recommendations are good. Human factors quality of ultrasound setting up a preterm labour clinic to tighten up on it. Where woman are admitted of preterm labour should be auditing it in the report. Melanie asked what site it is and have some of the recommendations have been actioned.it occurred on the DHH site. Comments- approved. ED SAI report [redacted] comments frc cyp incident will be presented by Ellie McCormick and Phil Quinn	AMDs/ CD

Ellie attended to present the report. Summary of the report was reminded it was well presented last month.
Baby short history of illness reattended ED three days later. There was a long delay for paed assessment and the baby required a rocky course in ICU.
There report didn't address there were two paediatricians talked to the parents that they didn't get antibiotics following a discussion about the provision of antibiotics. This has been added into the report but given may not have done. The doctors could prescribe and give antibiotics and nurses could check. There was some discussion about who can prescribe antibiotics and administration of antibiotics. Phil advised there are safety concerns regarding prescribing and administrating antibiotics. Some paeds will do in practice. But not necessarily best practice to prescribe and administer antibiotics. There was also an opinion as to whether nurses should be prepared to give antibiotics. There is a skill mix and if a doctor can run a resuscitation that nurses should given antibiotics. There are good guidelines to support staff to give antibiotics. There is no recommendations to say antibiotics should be given as soon as possible. Mary advised there is an issue with paediatric trained nurses. All nursing staff will give iv antibiotic in the emergency situation. They may not be the best person to give antibiotics. There is specific training that staff were to attend but the CEC had stopped training. She plans to send all the nurses both to have training and be signed off as competencies. This is more difficult.
The issues have been raised more on the DHH ED. It is very much team work. Erskine advised that it can be very difficult if the nurses are not trained. That someone can give antibiotics.
Gareth – was concerned that the wording in the report – the child was under care of ED this was not accurate – the child was in ED under the care of paediatrician.
The report shows the sepsis was missed and ED
Ellie will change that child was in ED as opposed to under the care of ED.
Advice leaflet is a patient safety issue and should give parents good advice.
Maria summed up some issues – patient is the main concerns. She feels the report is a very defensive report and she doesn't know how the child is doing. From a medical point of view is there is no reason why the doctor could not have given the antibiotics. We should put the patient first. The family won't care who give the antibiotics. The clinical decision was made to admit to the ward and there was antibiotics. the Phil cautioned - The patient factors – normal vital signs. He advised that there was no recognition that the child was ill during the day until the night team took over. The decision was only made by the night team when the child was admitted. The antibiotics were given as soon as the child deteriorated. There was a failure to detect the child had sepsis. Gareth said the plan was to give antibiotics at 20:45. The recommendation should be about recognition.

Plan to relook at the report and amend to not approve.
Anne highlighted there is a lack of paediatric trained nurses – perhaps needs to go on the risk register.
Phil doesn't agree that there are any inaccuracies in the report and he read out the recommendations.

Not approved until final version brought back.
Thanked Ellie and Phil.

1. Level 1 Report Personal Informatio draft for ACG.d - Gareth

Irrelevant information redacted by the USI

Final Draft Pers onal SAI Report v300321 NTC - Erskine on behalf of MHD

Irrelevant information redacted by the USI

[redacted] papers

Irrelevant information redacted by the USI

[redacted]

Philip/ Pat

Personal Information Report - draft for ACG.docx

Level 1 SAI draft report Personal .docx

Personal Information Draft for ACG Approval.docx

Mark/Ted

1. Level 1 Report Personal for March ACG.docx

6.0	**Effectiveness and Evaluation** 4) Clinical audit summary for Acute Cl **Patient Safety Report** Acute Governance Report April21.doc	ADs and AMDs
7.0	**Monthly Acute Governance report** February 2021 Acute SMT Governanc	
7.1	**Complaints Position** – (communication and staff attitudes main	

complaints)

- Current Complaints



Current Complaints.xlsx

- Weekly reopened complaints



Reopened Complaints Report 08

-

Open 36 (13 overdue)
Reopened- 23
Ombudsman- 11



Ombudsman 23.03.2021.xlsx

8.0 **Medicine Incidents**



February 2021 Acute.xlsx

Incident Management Position



Acute Incidents March 2021.xlsx

Major Catastrophic



Major & Catastrophic Incidents March 2021

9.0 **Risk Registers** – additions, amendments and closures to the governance team.

ADs & AMDs



Corporate Risk Register August 2020



Directorate RR February 2021.xlsx



SEC.ATICS Div.HOS.Team RR Jan



CCS Div.HOS.TEAM RR February 2021.xls



FSS Div.HOS.Team RR February 2021.xls



IMWH Div.HOS.Team RR February 2021.xls



Pharmacy Div.HOS.Team RR Fe



ED february 2021.xlsx

10.0	**Mandatory training**  Copy of Trustwide CMT Compliance Sum	
11.0	**Any Other Business**	
12.0	**Date of Next Meeting:** **8.00 am Friday 14 May 2021** **Via zoom link**	

Stinson, Emma M

From: McClements, Melanie
Sent: 20 October 2020 16:56
To: Morgan, Paul
Subject: follow up re SAI offer of support

Paul
Firstly thank you……

Beverley (new Family Liaison person) is commenced with Maria's team and will support the Outbreak SAI. I have asked if there would be capacity to support the "urology SAI" which is still confidential. Apparently there isn't.

You had mentioned Marita to me, having skills in that direction. Would she have any capacity to support the families of urology patients from a family liaison perspective? Not sure yet what is involved or capacity needed but just in principle could it be a goer?
I have also asked Aldrina if Jacqueline Morton could assist or co-work with someone?
Let me know if an option to pursue, thanks mel

Melanie McClements
Interim Director of Acute Services
SHSCT, Admin Floor, Craigavon Area Hospital
Direct Line: Personal Information redacted by the USI
Personal Information redacted by the USI

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Medical Directorate

Memorandum

To:	All Operational Directors
c.c.	Family Liaison Team; Directorate Governance Coordinators
From:	Dr Maria O'Kane, Medical Director
Date:	31st August 2021
Subject:	**Family Liaison Service**

Dear Colleagues,

As you will be aware the Trust has established a Family Liaison Service which for the last period has been supporting the service users and families regarding both COVID-19 and Urology Serious Adverse Incident (SAI) reviews.

As part of the planned continuing roll out of the service from **1st September 2021** the team will commence taking referrals from newly notified SAI reviews. Upon receipt of referral the team will proactively contact those service users and families who are involved in an SAI review to explain what the service offers, initial contact will be followed up by written communications providing more detailed information on the service. Details of the referral process can be found in the attached document.

The team will offer holistic support to the service user / family members not solely regarding the SAI process itself but also to distress of difficulties that may be attributed to the incident circumstances. Service users will be able to opt-out of this service, however they will remain able to request the service to commence again at any stage of the process.

The service offers a range of services to support the emotional and psychological impact that is sometimes felt by families and service users who are affected by the SAI process. The team will provide a central point of contact for them within the Trust at a time when they may be feeling vulnerable and in need of direction. Each liaison officer will also provide a dual service in supporting the staff members involved with SAIs by offering support and appropriate referrals if found necessary.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

In addition to the service opening to new SAIs we have given consideration to those reviews predating September 2021. In order to ensure that there is equity in service provided to these service users and families we ask for you to liaise with your Governance Coordinators to identify persons who may require additional support and provide details to Personal Information redacted by the USI by the **13th September 2021.**

Over the next month's our service will gauge capacity and initiate a second phase roll out to consider offering support to complainants via a structured screening process. More details will be available in due course.

In the meantime liaison officers will contact directorate governance coordinators to progress the roll out of the service.

Yours sincerely

Personal Information redacted by the USI

DR MARIA O'KANE
MEDICAL DIRECTOR

Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion

Liaison service: Standard operating procedure 1: Referral Pathway

Liaison support is a voluntary service available to all those service users, family, carers and staff involved in the SAI process. All of these will be able to consent to liaison service support if they wish to avail of the service. In order to ensure equitable service access, exploration has been completed to the most appropriate and effective referral pathway.

1. The proposed model will commence at the point where SAI notification is given to service users, families, carers or staff. All should be made aware of liaison service: Once this contact has been made, the person who informed the service user, family, carer or staff member, should complete the liaison referral form to notify the liaison service. (Appendix 1)
2. Information regarding the service will need to be sent to all those who may have initial contact with service users, families, carers and staff eligible who can avail of the service. This will include GP's, staff support service and staff side support, liaison chairs, complaints staff and governance leads in each directorate. This information should be sent directly to service users, families, carers and staff ideally upon notification being sent. This information pack will contain an overview of the support. When a GP receives notification from the Southern Trust of a review they will also be sent Liaison information should they wish to discuss this with the family. Professionals such as GP's and SAI Chairs can refer on behalf of a service user, family or carer with consent.
3. Upon receipt of referral the Liaison team will contact the service user, family, carer or staff member to discuss the service and any support needs individuals may have including visual or hearing needs, accessing and understanding information and preference of contact; at this point consent will be sought. Those consenting will be screened by the Liaison team in the identification of best use of resource in line with need.
4. The referral information and telephone call will be recorded and stored on PARIS.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Appendix 1: Liaison Service Referral Form

Liaison Service Referral Form- DRAFT			
Date of referral		**Referrer name:**	
Designation/ Directorate		**contact details:**	
Incident date/s		**Datix reference**	
Department/s involved		**If known:**	**H&C No. _____** **PARIS ID _____** **NICER _____**
Service user Name		**Person to be contacted**	
Known as		**Relationship to service user**	
Address		**Address**	
Contact Number		**Contact Number**	

Brief description of incident

Review type	**SAI 1**		**Date family informed of review**	
	SAI 2			
	SAI 3			
	SJR		**Informed by**	
	Complaint			

Overview of contact with service user, family or carer re incident to date:

Urology Oversight Group Minutes

Tuesday 10th November 2020, 4:30pm

Via Zoom

	Item	Actions
1	**In Attendance** Stephen Wallace — Melanie McClements Martina Corrigan — Mr Mark Haynes Dr Damian Gormley — Dr Maria O'Kane Siobhan Hynds — Ronan Carroll Vivienne Toal Patricia Kingsnorth	
2	**Apologies** Jane McKimm	
3	**Update on Ministerial Statement (24th November 2020)** Melanie stated SMT support for staff during this time and the requirement for the IPT to fully reflect the need. **Communication with AOB** Vivienne updated that a letter has been sent to AOB to advise that the Trust will be naming him in external and internal communications in future. **Communication with GP Practices** Stephen confirmed a correspondence has been sent to all GP practices updating on Urology services. Stephen advised that the statement notified GPs that private patients of AOB may contact them with concerns regarding their care. **Activity on Telephone Information Lines** Martina advised that 36 calls have been received today. There is capacity to manage up to 6 lines consecutively. No GP calls have been received today. Mr Haynes stated that a more robust decision making framework around how clinical actions are taken going forward. Mr Haynes suggested a clinical decision making process is required to evidence how decisions were made, the framework has to be objective and clear in its implementation. **Trust Statement** Copy of the statement shared with the meeting group.	**Clinical decision making framework required – meeting on Thursday 26th November 2020**
4	**DoH Oversight Meeting Update (20th November 2020)** Dr O'Kane updated on Friday meeting with DoH, actions taken forward included formalization of the letter to Tughans regarding private practice and request for patient numbers.	
	Management of Patient Reviews	
4	**Private Practice** - **Private Practice Audit** - **Private Practice Patients transferred to HSC**	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

	Mr Haynes is going to review the first private patient tomorrow, this patient is being the Trust information line.	
5	**Update on Radiology Review** Deferred to next meeting	
6	**IPT for Review Process** Melanie noted the need for the IPT to reflect the full requirement of all areas of service provision to meet the need. Mr Haynes noted the need to be realistic in terms of what is deliverable. Dr O'Kane stated the need to set out what the requirement is in the first instance in order to see what is required.	**Martina Corrigan to revise IPT in light of additional demands**
7	**Additional Subject Matter Expertise / Royal College of Surgeons Engagement** Response to Mr Watson complaint to be followed up by Melanie. Dr O'Kane advised that a meeting with the RCS will take place on Monday to discuss engagement. Stephen advised he has a call booked with Professor Sethia regarding subject matter expertise support.	**Response to** Personal **complaint required- Melanie to follow up**
	Bicalutamide Patient Review NHSCT, WHSCT and SHSCT have been reviewed both for high and low dose medication.	
	Engagement of ISP to undertake waiting list work Mr Haynes asked could another urologist involved for MDM, also highlighted the need for oncology representation and potentially a second oncologist	**Mr Haynes to progress discussions re oncology input**
	Information Telephone Line Calls have been received; calls are of a different nature than previous announcement.	
	Professional Governance	
8	**GMC Discussions** Dr O'Kane advised that a meeting with the GMC will be taking place next week to update on progress. GMC advised today of ministers statement	
9	**Administration Review Update** Review meeting date rescheduled for next week, update to follow.	
	Serious Adverse Incident Review s	
12	**Process for Managing SAI's** SAI chair has asked can he contact AOB to discuss the SAI cases. Group agreed that AOB will be written to meet with the chair via solicitors. Vivienne advised that Inspire contact had been made, contract being finalized today.	**Patricia to progress engagement**
13	**Initial Feedback from SAI Chair** Meeting with chair and Dr O'Kane to take place to discuss family feedback	**Patricia to progress engagement**
14	**Family Liaison Role** One person on waiting list, Patricia to progress with recruitment	**Patricia to progress with waiting list appointment**
	Litigation Group discussed requirements to support litigation processes. DLS have advised that they have found around 20% of patients identified in the neurology work progressed with litigation. Siobhan referenced the need to ensure that the litigation team will require expansion to manage the workload from the inquiry.	**Vivienne to contact June Turkington to speak to team to provide**

	Group discussed the requirement for advice to the Trust on the parameters and remit of the public inquiry. Mr Haynes noted the need for a change of the redaction process to allow the effective processing of notes. Dr O'Kane referred to the use of a 5 question approach regarding clinical reviews to ensure that there is effective oversight of the processes.	**Consideration of approaching the ICO to see if extraordinary arrangements can be made to expedite redaction processes**
	Communications	
17	**Media / Assembly Questions** Trust statement shared with the group	
	Any Other Business	
19	**Any Other Business** External medic required to support for grievance appeal panel Debrief support for telephone handlers required, support to be arranged for team Cross border patients, clarification on communication of information required	**Dr O'Kane to progress** **Martina to progress** **To be raised with DoH**
	Date of Next Meeting	
20	**Via Zoom – 1st December 2020**	

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: OKane, Maria
Sent: 11 June 2020 15:02
To: Haynes, Mark; Carroll, Ronan; Corrigan, Martina; McClements, Melanie
Cc: Toal, Vivienne
Subject: FW: Patients to be added to Urgent Bookable List
Attachments: Personal Information redacted by the USI 001.jpg; Patient 1 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI 001.jpg; Patient 105 001.jpg; Patient 104 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI 001.jpg; Personal Information redacted by the USI 001.jpg

Mark
this is a really concerning email.
I am very concerned that there are red flag patients with potential cancer diagnoses who have been assessed and not include on waiting lists for months.
How can we assure ourselves that these patients are safe?
How can we know that these are the only patients who might have been delayed?
In the spirit of openness might there have to be conversations with these patients to make them aware potentially?
I am concerned that this appears to be a continuation of the behaviours that led to SAIs and the lack of insight into which precipitated a referral to the GMC. I am very concerned. The first time that this occurred Dr Wright excluded the doctor pending further investigation into patient safety. Can we meet urgently to discuss please?
Regards, Maria

From: Haynes, Mark
Sent: 11 June 2020 12:47
To: OKane, Maria; Carroll, Ronan; Corrigan, Martina; McClements, Melanie
Subject: FW: Patients to be added to Urgent Bookable List

Afternoon

Attached are the green forms as mentioned and highlighted are cases in particular that should have been added to the waiting list at the date indicated. Also attached (in addition to the WL forms) is a copy of the full urology WL as of 11/5/20. As far as I can tell the patients highlighted should have been added to the waiting list on the date shown, but are not on the waiting list and I believe have been added to the waiting list more recently (on the back of the email below).

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

While it would appear he has a system whereby he is aware of these cases, standard procedure is that a patient is added to the PAS WL at the time of listing, not at the time of offering a date for surgery and the concern would be that there are other patients who are not administratively on the WL (on PAS) but should be. On the mild side this distorts our WL figures, as a risk I would be concerned that patients get lost.

Mark

Patient 113	Personal Information redacted by the USI	Personal Information redacted by the USI	18/07/2019	Malignant	URO	Replacement of Left Ureteric Stent
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	05/11/2019	? Malignant	URO	Bilateral Ureterolysis, Omental Wrapping & Retroperitoneal Biopsies
Patient 1	Personal Information redacted by the USI	Personal Information redacted by the USI	01/06/2020	Malignant	URO	TURP
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	04/06/2020	Malignant	URO	Bilateral Ureterography, Ureteroscopy & Ureteric Stenting
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	15/09/2019	Benign	URO	Right Rigid & Flexible Ureteroscopic Lithotripsy ? Ureteric Stenting
Patient 105	Personal Information redacted by the USI	Personal Information redacted by the USI	11/09/2019	Benign	URO	Removal / Replacement of Stent & Right Flexible Ureteroscopic Laser Lithotripsy
Patient 104	Personal Information redacted by the USI	Personal Information redacted by the USI	11/02/2020	Benign	URO	Removal / Replacement of Stent & Right Flexible Ureteroscopic Laser Lithotripsy
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	13/05/2020	Benign	URO	Right Ureteroscopic Laser Lithotripsy ? Ureteric Stenting
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	14/05/2020	Benign	URO	Removal / Replacement of Stent & Right Ureteroscopic Laser Lithotripsy
Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	15/05/2020	Benign	URO	Removal of Bilateral Ureteric Stents & Right Ureterography

From: O'Brien, Aidan
Sent: 07 June 2020 22:25
To: Neville, Linda; McIlveen, Jacquleine
Cc: Sector, Independent; Glackin, Anthony; Haynes, Mark; Elliott, Noleen
Subject: Patients to be added to Urgent Bookable List

Dear Linda and Jacquleine,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.
Mark Haynes has already arranged to have the first of those patients, Patient 113, admitted to Kingsbridge Private Hospital on Wednesday 10 June 2020.
I have scanned and attached completed Green Forms for the remaining nine patients.
I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.
Please let me know if I can be of any further assistance.
I hope the above will facilitate their admissions.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Thank you,

Aidan.

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

WIT-34466

Patient Details – Affix Addressograph or write details	
Name:	Personal Information redacted by the USI
D.O.B.:	
H&C No	

Date of Clinic / Decision to list	05/03/2019
Consultant	AO'BRIEN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RETROPERITONEAL FIBROSIS / RETROPERITONEAL SARCOMA
Procedure:	BILATERAL URETEROLYSIS & RETROPERITONEAL BIOPSY
Estimated Duration of Surgery:	3 HOURS
Additional Comments / Instructions:	FOR ADMISSION TO CRAIGAVON AREA HOSP

Urgency *Please tick appropriate box*	
Red Flag	✓
Urgent	
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	CAH
Specific Unit Requirement	1 WCA
Specific Consultant	AO'BRIEN

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☑ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐
- **Aspirin 300mg?** ☐
- **Clopidogrel** or **Prasugrel?** ☐
- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☑ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Personal Information redacted by the USI	**Print Name** AIDAN O'BRIEN	**Date** 07.06.20
Countersigned (Consultant)			**Date**

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.

Patient 1

Personal Information redacted by the USI

WIT-34467

Patient Name: ..... details

D.O.B.: .....

H&C No .....

Date of Clinic / Decision to list	01 JUNE 20
Consultant	ADRIAN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	BLADDER OUTLET OBSTRUCTION DUE TO PROSTATIC CANCER
Procedure:	ENDOSCOPIC RESECTION OF PROSTATE – TURP
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR ADMISSION TO DHHOSPITAL

Urgency *Please tick appropriate box*	
Red Flag	✓
Urgent	
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	DHH
Specific Unit Requirement	Level 4
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☑ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐
- **Aspirin 300mg?** ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

- **Clopidogrel** *or* **Prasugrel?** ☐

Please advise:

a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☐ Yes ☑ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature Personal Information redacted by the USI **Print Name** ADRIAN **Date** 07.06.20

Countersigned (Consultant) **Date**

Received from Melanie McClements on 11/07/2022. Annotated by the Urology Services Inquiry.