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

Vivienne Toal
Director of HROD
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

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

Chair's Notice

[No 49 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:

Vivienne Toal
Director of HROD
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

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

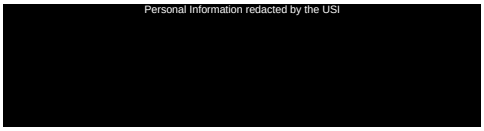
APPLICATION TO VARY OR REVOKE THE NOTICE

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

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

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

Dated this day 29th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 49 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 contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, 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.

Your position(s) within the SHSCT

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

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

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

Policies and Procedures for Handling Concerns

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

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

9. In your role as Director HR & Organisational Development what, if any, training or guidance did you receive with regard to;

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

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

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

II. Decision making by the Clinical Manager as to whether to adopt an informal approach or initiate a formal investigation.
III. Considerations of imposition of Immediate Exclusion or restrictions under Section I paragraphs 18-27 of MHPS.
IV. The conduct of Formal Investigations under Section 1 paragraphs 28-38 of MHPS

11. Fully describe your role with regard to the establishment, responsibilities and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines. Further, please outline how your role differed from that of other regular attendees at the 'Oversight Group' namely:

I. Assistant Director – Medical Directorate;
II. Service Director;
III. Medical Director; and
IV. Medical Staffing Manager.

Handling of Concerns relating to Mr O'Brien

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

I. When did you first become aware that there were concerns in relation to the performance of Mr O'Brien?
II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?
III. Who communicated these matters to you and in what terms?
IV. Upon receiving this information what action did you take?

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

I. From what source did the concerns and information discussed at that meeting emanate?
II. What do you understand to have been decided at that meeting?

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

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

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

I. Patient "Patient 1" (RCA Personal Information redacted by),

II. The care of five patients (RCA Personal Information redacted by); and

III. Patient "Patient 16" (RCA Personal Information redacted by).

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

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

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

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

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

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

18. With regard to the Return to Work Plan / Monitoring Arrangements dated 9th February 2017, see copy attached, outline your role, as well as the role of any other responsible person, in monitoring Mr O'Brien's compliance with the Return

to Work Plan and provide copies of all documentation showing the discharge of those roles with regard to each of the four concerns identified, namely:

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

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

20. With specific reference to each of the concerns listed at (17) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

21. On what basis was it decided that Dr Khan, Case Manager, and Dr Wright, Medical Director, would respond to representations lodged by Mr. O'Brien with the designated Board member on 7th February 2017 and 6th March 2017 respectively.

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

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

Outline and provide all documentation relating to any interaction which you had with any of the following individuals with regard to any delays relating to matters (I) – (IV) above, and in doing so, outline any steps taken by you in order to prevent or reduce delay:

i. Case Manager;
ii. Case Investigator;
iii. Medical Director;
iv. Designated Board member;
v. the HR Case Manager;
vi. Mr Aidan O'Brien; and
vii. Any other relevant person under the MHPS framework and the Trust Guidelines.

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

MHPS Determination

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

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

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

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

i. Who was responsible for the implementation of each of these actions?
ii. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and
iii. If applicable, what factors prevented that implementation.
iv. If the Action Plan as per 27(I) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

Implementation and Effectiveness of MHPS

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

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

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

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

An addendum to this witness statement was received by the Inquiry on 27/02/23 and can be found at **WIT-91883 to WIT-91918**. Annotated by the Urology Services Inquiry.

USI Ref: Notice 49 of 2022

Date of Notice: 29th April 2022

Witness Statement of:

Mrs. Vivienne Toal, Director of Human Resources & Organisational Development, Southern Health & Social Care Trust

I, Vivienne Toal, will say as follows:

General

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

1(i) I, Vivienne Toal, am employed as the Director of Human Resources & Organisational Development (HR & OD) in the Southern Health & Social Care Trust. I commenced this role on 21st September 2016. I have been employed in the HR & OD Directorate since the inception of the Southern HSC Trust in 2007, and prior to that in the HR Directorate of the legacy Craigavon Area Hospital Group HSS Trust from June 1998. As Director, I report to the Chief Executive, I am a member of the Trust's Senior Management Team, and I am

required to be in attendance and contribute at meetings of the Trust Board of Directors and associated Board committees. My responses to Q5 and Q6 below include further detail on my roles and responsibilities, my line managers and those who I have responsibility for managing.

1(ii) As a member of the Trust's Senior Management Team, I work collectively with my Director colleagues with regards to the Trust's corporate agenda. I work with Directors and their teams to resource, manage and develop their workforce to deliver safe, high quality care for patients and service users. I have worked with the Medical Director, Dr O'Kane and my Medical Staffing Manager, Zoe Parks, to improve professional medical governance through enhancing arrangements for addressing performance concerns relating to Doctors. My response at 27(i) provides more detail on this issue.

1(iii) The Trust's Litigation Service is included within my remit. This includes Clinical & Social Care Negligence claims, Employer Liability claims, Occupier Liability claims, General Liability claims, Coroners' Cases and Medico-Legal Subject Access Requests. I have had responsibility for this service since I took up post in September 2016. Whilst as HR & OD Director, I carry responsibility for the Litigation Team, the Litigation Manager, Lynne Hainey reports to the Medical Director for all Clinical & Social Care Negligence Claims handling. As a member of the Governance Committee, the Medical Director and myself provide a report at every meeting on all litigation activity, costs, trends, coroners' cases and medico-legal case load. **These can be located at Relevant to HR / Reference no 2g.** My Litigation Manager, Lynne Hainey attends the weekly Governance Meeting, chaired by the Medical Director, to provide input on all Litigation Activity in the preceding week and any emerging issues. This information forms part of the detailed Governance Report reviewed by all Directors at the weekly Senior Management Team meeting. The Litigation Team also respond to Directorate's information requests and requests from the Medical Director's Office on litigation activity as part of Clinical & Social Care Governance and Professional Medical Governance arrangements.

1(iv) My remit also includes responsibility as Lead Director for Raising Concerns under the Trust's Policy & Procedure for Raising Concerns (Whistleblowing). I have responsibility for ensuring the implementation of the Trust's whistleblowing arrangements. I present bi-annual reports to Governance Committee on case activity, themes, case studies, and lessons learned. **These can be located at Relevant to HR / Reference no 2v**. I also meet with the Trust's designated Non Executive Director lead for Raising Concerns to discuss in more detail on-going cases, timescales for cases, resource capacity issues, training requirements and ways to further grow and promote the Trust's See Something, Say Something campaign. I seek to ensure when concerns are raised that there are arrangements in place to independently investigate concerns raised and so that staff members coming forward to raise concerns are supported throughout the process. I have in the last year secured non-recurrent funding to pilot a specific Senior Raising Concerns Band 7 lead to support the Raising Concerns work, and have also been given approval in June 2022 to progress a number of Freedom to Speak Up Guardian roles across Directorates within the Trust, similar to NHS Trust roles in England. This is to enable additional capacity across the Trust to promote and raise awareness of the importance of raising concerns in the interests of safe, high quality care, and to support individual staff to feel psychologically safe to raise concerns. It is anticipated these roles will be in place in Autumn 2022.

CONCERNS IN RESPECT OF UROLOGY SERVICES and MHPS PROCESS

September 2016 to January 2017

1(v) As outlined in my response to Q12 below, I first became aware of concerns within the Urology Service around late August 2016 or early September 2016. These concerns were in respect of Mr Aidan O'Brien's administrative practices, and were drawn to my attention by the then Medical Director, Dr Richard Wright, in the context of my role as Acting Director to support him in the handling of concerns about Doctors / Dentists. Prior to this, I had no

knowledge of any concerns or complaints within the Urology speciality from an HR or Whistleblowing perspective; and no concerns or complaints were brought to my attention prior to this period.

1(vi) Within Maintaining High Professional Standards Framework (MHPS), the role of the Director of HR is defined in Section I Para 8 as a support role to the Medical Director and Chief Executive. As at September 2016, when the concerns relating to Mr O'Brien came to light, there were Trust 2010 Guidelines for Handling Concerns about Doctors' and Dentists' Performance in place which were to be read in conjunction with a number of documents, including the MHPS Framework, DOH, 2005. It was in the context of implementing the MHPS Framework and the Trust 2010 Guidelines, that I became involved with this Urology Services case.

1(vii) As Director of HR & OD, I was involved in four key Oversight Group meetings convened under the Trust 2010 Guidelines regarding the administrative practices of Mr O'Brien, the first on 13th September 2016, the second on 12th October 2016, the third on 22nd December 2016 and the fourth on 10th January 2017. I was a member of the Oversight Group, as Acting Director of HR & OD for the meeting on 13th September 2016, and thereafter Director of HR / & OD. I have provided in my responses below to Q12, 13, 15 and 16 a chronology of the detail of what was raised with me, what was discussed at the meetings I attended, and the actions and decisions taken by me and others to seek to address the concerns relating to these four meetings. It was at the Oversight Group Meeting on 22nd December 2016 that the decision was made to commence a formal investigation into Mr O'Brien's administrative practices. I fully supported that view. The decision was also taken at the 22nd December 2022 Oversight Group meeting to immediately exclude Mr O'Brien, as my response at 15(vi) outlines. Mr O'Brien was notified of the immediate exclusion on 30th December 2016 in a meeting with Dr Wright and Lynne Hainey, Acting HR Manager.

January 2017 to September 2018

1(viii) Whilst not directly involved in the MHPS case investigation process, my response to Q23 below, sets out the steps I took during the MHPS investigation from January 2017 until its conclusion in June 2018, and the extent to which I kept myself appraised of developments during the MHPS investigation. My response to Q24 below sets out my involvement in advising Dr Khan in respect of his Case Manager Determination in September 2018. Dr Khan's Case Determination concluded that the concerns relating to Mr O'Brien's administrative practices should be put forward to a Conduct Panel under MHPS.

October 2018 to November 2018

1(ix) As outlined in my response in 25(iii), 25(iv), 25(v) and 25(vi) below, steps were taken to establish the Conduct Panel during October and November 2018; Siobhan Hynds, then Head of Employee Relations and Dr Khan, Case Manager took these arrangements forward. Legal advice sought by Siobhan Hynds resulted in the need to seek a medically qualified independent panel member from outside of the Trust given the concerns were deemed to be classified as professional misconduct, as per MHPS Section III, Para 3. This delayed confirmation of the panel arrangements to Mr O'Brien until an appropriate external medical representative was sought. Dr Khan emailed Mr O'Brien on 28th November 2018 to advise him that work was ongoing to identify a suitable date for the MHPS Conduct Hearing.

December 2018 to June 2020

1(x) In response to Dr Khan's email of 28th November 2018, Mr O'Brien replied on 2nd December 2018 to advise that he had submitted a formal written grievance on Friday 30th November 2018, in person, to the Chief Executive, Shane Devlin. Mr O'Brien's extensive grievance submission contained a specific grievance about what he believed to be the 'misclassification of concerns as

concerns relating to misconduct' in Dr Khan's Case Determination. I met with the Chief Executive on Tuesday 4th December 2018 to review the content of the grievance and to discuss with him how to proceed. Due to the nature of Mr O' Brien's grievance, I decided at the time it was appropriate to pause the establishment of the Conduct Hearing in January 2019 to allow his grievance to be heard.

1(xi) On 3rd December 2018, Dr O'Kane, the Trust's new Medical Director took up post in the Trust. Dr O'Kane sent me an email on 8th December 2018 (**this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181208 Email from Dr OKane to VT)** to advise me that she had reviewed Mr O'Brien's case, and that she would like the opportunity to talk to me about it. I met with Dr O'Kane on the evening of 10th December 2018 to brief her on the MHPS case, and the recent submission of grievance. I am aware that Dr Khan had also briefed Dr O'Kane as part of his hand over as Acting Medical Director, and from recollection he had provided copies of the MHPS investigation and his Case Determination to Dr O'Kane.

1(xii) Siobhan Hynds forwarded me an email **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190109 Email from S Hynds to VToal_ELA GMC advice to note 1)** on 9th January 2019, which had been sent by Joanne Donnelly, GMC Employment Liaison Advisor (ELA) to Simon Gibson, Assistant Director, Medical Directorate. This email contained Joanne Donnelly's advice that 'Dr Urology Consultant' had reached the threshold for referral to the GMC. It was clear from the email trail that Dr O'Kane and Simon Gibson had discussed the case with her at their ELA meeting on 4th December 2018. I was subsequently copied into an email from Dr O'Kane on 13th February 2019 to Siobhan Hynds, Dr Khan as Case Manager and Simon Gibson, with a request for Siobhan Hynds to draft a letter to Mr O'Brien regarding the referral, and for Dr Khan to arrange to meet with Mr O'Brien to advise him of the plan to refer

his case to the GMC. I understand this meeting took place on 4th April 2019 with Dr Khan, who was accompanied by Siobhan Hynds.

1(xiii) Mr O'Brien had requested a range of detailed information requests at the end of his grievance submission on 30th November 2018 and in a separate follow up extensive information request dated 12th March 2019. The information requests related to Mr O'Brien's grievance. My responses from Q25(xi) to Q25(xviii) below set out the chronology of events from December 2018 explaining the measures taken to address Mr O'Brien's information requests and the reasons for the delay in forwarding the documentation to him. I fully acknowledge there was a very lengthy delay in responding to the information requests, largely due to the scale of the requests, the number of staff who needed to search for information and the pressures of existing workloads. This was particularly exacerbated by the significant impact of industrial action led by all health Trade Unions from October 2019 to mid-January 2020 on my normal workload personally and on continuity of services for patients. Regrettably, I did not then turn immediately to ensuring Mr O'Brien's outstanding information requests were followed up, before the onset of Covid-19 in mid-March 2020 diverted everyone's attention away from normal work to respond to the emergency public health emergency. The delay in hearing Mr O'Brien's grievance resulted in the conduct hearing being held in abeyance. Mr O'Brien's employment with the Trust had ceased in June 2020 prior to the grievance hearing being convened. A conduct hearing was not convened on the basis that the grievance hearing took place after Mr O'Brien's employment with the Trust had ended. I refer to the grievance process in my response at 25(xix).

1(xiv) During June 2020, I corresponded with Mr O'Brien in relation to his retirement application, the Trust's decision not to permit him to return to work post-retirement, and his subsequent letter advising he was rescinding his notice of intention to retire. I wrote to Mr O'Brien on 18th June 2020 to confirm that he could not unilaterally withdraw his notice of termination and that the Trust

considered that his employment would terminate on 30th June 2020. Mr O'Brien's employment terminated on this date.

LEARNING POINTS

1(xv) In respect of the MHPS framework, Trust Guidelines and processes, both generally and specifically in the case of Mr O'Brien, my responses set out in Q26, Q27 and Q28 detail my reflections and learning already undertaken, improvements currently being worked through and my suggestions for further areas of improvement.

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 contact the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

2(i) All documents relevant to my responses below are referenced under each response and sign posting included.

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.

3(i) Please see below, my responses to each question.

Your position(s) within the SHSCT

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

4(i) I graduated from Queen's University, Belfast in 1996 with a BSc Hons (2:1) in Business Administration and Computer Science.

4(ii) I obtained a Postgraduate Diploma with commendation (2 years) in Human Resource Management from University of Ulster in 2001. I was an employee of the legacy Craigavon Area Hospital Group Trust whilst undertaking this Postgraduate Diploma.

4(iii)

Employer name	Position held	Dates – From / To
South & East Belfast HSS Trust	Clerical Officer Grade 2	21.4.1997 – 7.6.1998
Craigavon Area Hospital Group HSS Trust	HR Officer Grade 4	8.6.1998 – 31.8.1999
Craigavon Area Hospital Group HSS Trust	HR Officer Grade 5	1.9.1999 – 31.8.2000
Craigavon Area Hospital Group HSS Trust	HR Services Manager (Senior Manager II)	1.9.2000 – 1.7.2007

4(iv) Under the Review of Public Administration, legacy Craigavon Area Hospital Group HSS Trust transferred to the Southern Health & Social Care Trust on 1st July 2007.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your

duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5(i)

Position held in Southern HSC Trust	**Dates – From / To**
Head of Employee Engagement & Relations Band 8a Head of Employee Engagement & Relations Band 8b (following regrading)	2.7.2007 – 31.5.2011 1.6.2011 – 31.1.2016
Duties & Responsibilities	
Responsible to the Director of Human Resources & Organisational Development (HR&OD) for the planning, delivery, and development of the HR service across the following functions: • Employment Law & Case Management • Terms and Conditions • Job Evaluation • Staff involvement and employee engagement • Staff health and wellbeing and attendance management Development and maintenance of a positive employment relations climate ensuring effective consultation, negotiation and partnership arrangements with Trade Unions. Delivery of national and regional changes and updates to terms and conditions of service by advising on local plans for implementation. This included acting as the Trust's representative in the development of regional	

negotiations in respect of terms and conditions, and Departmental circulars.
Reason for leaving
Internal transfer to the vacant role of Head of Education, Learning & Development Band 8b
Job Descriptions & Accuracy of Job Descriptions
Band 8a Job Description Head of Employee Engagement and Relations Band 8a Vivienne Toal". **This can be found at Attachment folder S21 49 of 2022- Attachment 1.** **Band 8b** Job Description Head of Employee Engagement and Relations Band 8b Vivienne Toal. **This can be found at Attachment folder S21 49 of 2022- Attachment 2.** **Accuracy:** Each of these Job Descriptions accurately describes the role for the relevant time period.

5(ii)

Position held in Southern HSC Trust	**Dates – From / To**
• Deputy Director HR & OD • 2 periods of Acting Director of HR & OD:	1.2.2016 – 20.9.2016 Mid Feb to 31st March 2016 15th Aug to 20th September 2016

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Duties & Responsibilities

Deputy Director of HR & OD from 1st February 2016

I became the Trust's designated deputy for the Director of Human Resources & Organisational Development on 1st February 2016, which meant I deputised for the Director, Kieran Donaghy at Trust and other regional meetings when he was not available. This was not a separate role to my Head of Education, Learning & Development role as outlined below in 5(iii). There was separate no job description for this role, and no additional remuneration.

Mid-Feb to 31st March 2016 - Acting Director of HR & OD

Being designated as deputy meant that I covered for Kieran Donaghy for a number of weeks during mid-February to end of March 2016 whilst he in turn covered the role of Chief Executive in advance of Paula Clarke, Interim Chief Executive leaving the Trust at the end of March 2016.

My response at 5(iv) for the substantive post of Director of Human Resources & Organisational Development addresses this period from mid-February to end of March 2016 in terms of my job role, duties and responsibilities, and job description.

15th August 2016 to 20th August 2016 – Acting Director of HR&OD

As designated Deputy Director, I also covered annual leave for Kieran Donaghy prior to his official retirement date of 31st August 2016. His annual leave dates were 15th August 2016 to 31st August 2016. I then covered the vacant Director of HR&OD post from 1st September 2016 up until my permanent appointment to the role on 21st September 2016.

My response at 5(iv) for the substantive post of Director of Human Resources & Organisational Development addresses this period from 15th August 2016 to 21st September 2016 in terms of my job role, duties and responsibilities, and job description.

Reason for leaving
Promotion to Director of Human Resources & Organisational Development
Job Description & Accuracy of Job Description
Deputy Director of HR & OD There was no separate job description for this role; the deputy role sat alongside the Head of Education, Learning & Development role. **Acting Director of HR & OD** The job description for the acting Director of HR & OD role is the same as the permanent Director role in 5(iv). This Job Description is an accurate outline of the responsibilities of the role in respect of the two acting periods in 2016.

5(iii)

Position held in Southern HSC Trust	**Dates – From / To**
Head of Education, Learning & Development (See also above at 5(ii) re Deputy Director and two periods of Acting Director of HR&OD during this period of time)	1.2.2016 – 20.9.2016
Duties & Responsibilities	
Responsible to the Director of HR &OD to facilitate the development of individuals, teams and the organisation to deliver a patient and client focused service.	

Identification and implementation of education, learning and development opportunities to deliver on the objectives of the strategy, e.g. leadership development, succession planning, corporate mandatory training, essential profession specific training, vocational qualifications, Service Level Agreement with HSC Leadership Centre etc.

Lead on a range of organisational and management development initiatives to support the Trust's values and culture and provide specialist advice on workforce learning and organisational development to senior managers e.g. management development programmes, performance appraisal, team development support, staff survey programme, development of civility in the workplace programme and roll out to teams etc,

Reason for leaving

Promotion to Director of Human Resources & Organisational Development

Job Description & Accuracy of Job Description

Job Description Head of Education, Learning & Development Band 8b Vivienne Toal. **This can be found at Attachment folder S21 49 of 2022- Attachment 3.**

Accuracy:

Whilst the Job Description is an accurate description of this Head of Service post, given the short time I was working in the role (including the two periods of acting Director), I did not cover all of the duties and responsibilities, in particular the strategy development work: duties 1.1, 1.2 and 1.3 of the Job Description. The Trust's E-learning strategy / policy was already in place when I took up post (1.4). Duty 7.1 – I did not implement IIP programme. Some of the other development aspects of the role had already been commenced before I took up post e.g widening participation programme, management development programmes, succession planning programmes etc.

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5(iv)

Position held in Southern HSC Trust	Dates – From / To
Director of Human Resources & Organisational Development (HR&OD)	21.9.2016 - present

Duties & Responsibilities

I am responsible to the Chief Executive for the development and delivery of the HR & OD service.

I provide HR&OD advice to the Trust Board, share corporate responsibility for the governance of the Trust and compliance with legal requirements and contribute to the development, delivery and achievement of the Trust's Corporate Plan.

I am responsible for the development and implementation of HR management policies, procedures and good practice, and ensuring that the directorate work plan and the Trust People Plan are integrated with the Trust's strategic direction and service objectives.

I support the Chief Executive in the development and maintenance of organisational structures and systems for the management of staff.

I am also accountable for the Trust's Corporate Bank (flexible staffing) arrangements, Occupational Health and Wellbeing Service, Equality, Diversity & Inclusion Unit, and Litigation Team (Clinical & Social Care Negligence & Employer / Occupation / General Liability, 3rd party claims, and coroners' cases).

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Job Description and Accuracy of Job Description

Job Description Director of HROD Vivienne Toal. **This can be found at Attachment folder S21 49 of 2022- Attachment 4.**

Accuracy:

Following the retirement of Stephen McNally, Director of Finance & Procurement, the Chief Executive re-profiled the remit of this post to include responsibility for Estates Services (including Health & Safety) and Fire Safety. Following Helen O'Neill's appointment to the Director of Finance, Procurement & Estates in 2018, responsibility for Estates, Health & Safety and Fire Safety transferred from me to Helen O'Neill in 1st November 2018. From this date, I no longer carried this responsibility.

When my post was advertised in 2016, it did not include any reference to responsibility for the Litigation Service (Clinical & Social Care Negligence, Employer Liability, Occupier Liability, General Liability, Coroners' Cases and Medico-legal work). The Litigation Service transferred from the Medical Directorate to the HR &OD Directorate in July 2015. I have therefore had responsibility for this service since I took up post in September 2016. Whilst as HR&OD Director, I carry responsibility for the Litigation Team; the Litigation Manager is accountable to the Medical Director for all Clinical & Social Care Negligence Claims handling. This responsibility was not directly reflected however in the Job Description at the time of recruitment.

I have also had responsibility as Lead Director for Raising Concerns (Whistleblowing) for the Trust since I took up post in September 2016. This is a designated role under the Trust's Raising Concerns Policy & Procedure. This responsibility was not directly reflected however in the Job Description at the time of recruitment.

From various points in 2020 to end of June 2022, I was also the Trust's

designated Lead Director for Covid-19 services – staff and public vaccination, staff and patient testing, staff contact tracing and community testing team in care homes and other similar facilities.

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

6(i)

Position held in Southern HSC Trust	**Dates – From / To**
Head of Employee Engagement & Relations Band 8a/b	**2.4.2007 – 31.1.2016**
Manager:	• Mr Kieran Donaghy Director of Human Resources & Organisational Development From 1.4.2007 to 31.1.2016
Departments, services, systems, roles, individuals whom I managed or had responsibility for:	• Employment Law, HR Case Management & Attendance Management Team (non-medical) • Terms and Conditions Team (non-medical) including responsibility for HRPTS system (HR, Payroll, Travel & Subsistence system) • Litigation Services (from July 2015) • Staff involvement and employee engagement programme • Staff health and wellbeing programme • Raising Concerns (Whistleblowing)

	programme / investigations • Agenda for Change Job Evaluation Scheme (non-medical) Staff in post report for 31st December 2015 attached, details the staff and their job roles in the teams under my remit at that date. **(This can be located at Attachment folder S21 49 of 2022 Attachment 5 - 2015.12.31 Staff in Post Employee Relations.pdf)**

6(ii)

Position held in Southern HSC Trust	**Dates – From / To**
Head of Education, Development & Learning Band 8b	**1.2.2016 – 20.9.2016**
Manager:	• Mr Kieran Donaghy Director of Human Resources & Organisational Development From 1.2.2016 until his retirement on 31.8.2016 • From 1st September 2016, I reported directly to Francis Rice, Interim Chief Executive, as Kieran Donaghy had retired.
Departments, services, systems, roles, individuals whom I managed or had responsibility for:	• 2 main teams / departments - Education, Learning & Development Team - Vocational Workforce Assessment Team • Non-medical appraisal / development

	review programme • Corporate Mandatory Training programme • Induction programme • E-learning training platform • Work Experience programme • Leadership and management development programmes Staff in post report for 31st August 2016 attached, details the staff and their job roles in the teams under my remit at that date. **(This can be located at Attachment folder S21 49 of 2022 Attachment 6 - 2016.8.31 Staff in Post Education Learning Development.pdf).**

6(iii)

Director of Human Resources & Organisational Development (HR&OD)	**21.9.2016 – present** **(also 2 periods of acting:–** **mid February 2016 to 31st March 2016** **1st September to 20th September 2016)**
Manager:	**Mr Francis Rice** Acting Chief Executive From 13.4.2016 to 24.1.2017 ([redacted]) **Mr Stephen McNally** Interim Acting Chief Executive ([redacted])

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	From 23.1.2017 to 9.7.2017 **Mr Francis Rice** Acting Chief Executive From 10.7.2017 to 14.11.2017 **Mr Stephen McNally** Interim Acting Chief Executive ([Personal Information redacted by the USI] [redacted]) From 15.11.2018 to 17.3.2018 **Mr Shane Devlin** Chief Executive From 19.3.2018 to 13.2.2022 **Dr Maria O'Kane** Temporary Accounting Officer / CX cover until permanent recruitment process concluded. From 14.2.2022 to 30.4.2022 **Dr Maria O'Kane** Chief Executive From 1.5.2022 to present
Departments, services, systems, roles, individuals whom I manage or have responsibility for:	**September 2016** On appointment to the Director role, I had 12 direct reports and 1 Personal Assistant. Mrs Heather Mallagh-Cassells has been my Personal Assistant Band 4 since I commenced in post in September 2016 and has reported directly to me. Heather was

	Personal Assistant to the previous Director of HR &OD, Kieran Donaghy from the commencement of Southern HSC Trust in 2007. The HROD Directorate Structure Chart that was relevant in 2016 at the time I took up my Director post can be located at **Attachment folder S21 49 of 2022 Attachment 7 - HROD structure in 2016 with names.** This structure chart sets out the roles that reported directly to me and includes the names of the individuals who held those roles at that time. From commencement in my Director post, I had responsibility for the Estates Services Division (including Health & Safety and Fire Safety), until it transferred to the newly appointed Director of Finance, Procurement & Estates, Helen O'Neill on 1.11.2018. **2019 to current** During 2018, I undertook a restructuring exercise in my Directorate, which resulted in an alternative structure with the creation of 2 Divisions in January 2019: HR Services Division and Workforce & Organisational Development Division, with 2 new Deputy Director posts. In 2020, I assumed Lead Director responsibility for Covid-19 Testing Service for staff and outpatients, Staff Contact Tracing

	and the Vaccination Programme for staff and public. The public Vaccination Programme and public Testing Programme has transferred to the Promoting Wellbeing Team under the remit of the Public Health Nurse Consultant in the Directorate of Older People & Primary Care with effect from 1st July 2022. For this period, I had a lead nurse for Covid-19 reporting directly to me, Sharon Kerr. The HROD Directorate Structure Chart that is relevant currently is located at **Attachment folder S21 49 of 2022 Attachment 8-Current HROD structure from 2022 with names.** This structure chart sets out the roles that report directly to me, and the names of the individuals who currently hold those roles. Former post holders for each role are noted on page 2 structure chart.

Policies and Procedures for Handling Concerns

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

7(i) Yes, I was aware of the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance published 23 September 2010.

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7(ii) In 2010, I was employed as Head of Employee Engagement & Relations. At that time, the Medical Staffing Manager in the HR&OD Directorate was Zoe Parks, who reported to Kieran Donaghy, Director of HR & Organisational Development on all medical staffing issues. I did not have responsibility for the Medical Staffing Team in 2010. When Zoe Parks went on Personal Information redacted by the USI [redacted] in March 2010 to November 2010, Malcolm Clegg, Assistant Medical Staffing Manager acted up to cover Zoe Parks' role.

7(iii) On 4th August 2010, Kieran Donaghy sent me an email, which I subsequently forwarded to Siobhan Hynds on 9th August 2010 **(This can be found at Attachment folder S21 49 of 2022- Attachment 9-2010.08.09 a Email V Toal to S Hynds re Guidelines for Managing MHPS).** This email included a request to review two draft documents developed by two separate members of staff. These documents detailed guidance on how to deal with underperforming doctors / managing poor clinical performance. Anne Brennan, then Senior Manager in the Medical Director's Office developed the first document **(This can be found at Attachment folder S21 49 of 2022- Attachment 10- 2010.08.09 d A Brennan doc Att to email from A Brennan to Dr P Loughran re handling concern)**. The Medical Director at that time was Dr Patrick Loughran. Debbie Burns, then Assistant Director of Performance Improvement in the Directorate of Performance & Reform developed the second document. **(This can be found at Attachment folder S21 49 of 2022- Attachment 11- 2010.08.09 b D Burns doc Att to V Toal's email to S Hynds re Guidelines for Managing MHPS")**. In Kieran Donaghy's email of 4th August 2010, he *states "At a meeting with Mairead & Paddy this morning we agreed Debbies (sic) paper with a number of amendments."* Kieran went on in the email to ask for my and Siobhan Hynds' comments.

7(iv) Anne Brennan, Siobhan Hynds, and I met together to review the content of the two sets of draft guidelines on 11th August 2010. I have an email **(This can be found at Attachment folder S21 49 of 2022 Attachment 12 - Email from A Brennan to V Toal_S Hynds re meeting that date with att.pdf)**

from Anne Brennan sent to Siobhan Hynds, Debbie Burns and I on 11th August 2010. I cannot recall if Debbie Burns attended the meeting. The email from Anne Brennan had a copy of her draft Guidelines attached **(This can be found at Attachment folder S21 49 of 2022 Attachment 13 - Att to Email from A Brennan to V Toal_S Hynds re meeting that date.pdf)** and an accompanying message "*For our meeting today*".

7(v) Whilst I have no recollection of the meeting of 11th August 2010, nor can I find any notes of it, I assume I took an action to work up a further draft of the Trust guidance. I base this assumption on an email **(This can be found at Attachment folder S21 49 of 2022- Attachment 14a - 2010.08.14 a Email from V Toal to S Hynds re MHPS guidance to check with K Donaghy with att)** with an attached draft procedure document **(This can be found at Attachment folder S21 49 of 2022- Attachment 14b - 2010.08.14 b Att doc to Email from VToal to SHynds re MHPS guidance to check with K Donaghy.pdf),** which I sent to Siobhan Hynds on 14th August 2010 asking her to do some further work on it and to liaise with Kieran Donaghy. I was then on annual leave from 16th August 2010 to 6th September 2010 so I wanted Siobhan to take this forward in my absence.

7(vi) On 16th September 2010, Kieran Donaghy sent an email to Senior Management Team members with the version of the Trust Guidelines which had been discussed and agreed on the previous day at the Senior Management Team meeting. Kieran Donaghy advised that these guidelines would form the basis of training with NCAS on 24th September 2010. I was not present at the Senior Management Team meeting on 15th September 2010, but Kieran Donaghy was.

The email can be found at: **(Folder: This can be found at Attachment folder S21 49 of 2022- Attachment 15- 2010.09.16 a Email from KDonaghy to SMT re MHPS Trust guidelines with att")**

The Trust Guidelines attached, dated 16th September 2010, can be found at: **(Folder: This can be found at Attachment folder S21 49 of 2022- Attachment 16- 2010.09.16 b Email from KDonaghy to SMT re MHPS Trust guidelines")**

Minutes of SMT minutes in September 2010, can be found at: **(Folder: This can be found at Attachment folder S21 49 of 2022- Attachment 17- 2010.09.08 SMT notes)**
And
(Folder: This can be found at Attachment folder S21 49 of 2022- Attachment 18- 2010.09.15 SMT notes)

7(vii) On the same day, 16th September 2010, Dr Patrick Loughran, Medical Director, sent an email to Dr Colin Fitzpatrick, NCAS, thanking him for agreeing to lead training at the Medical Leadership Network on 24th September 2010. The Medical Director usually attended this Network, along with the Senior Management Team members as appropriate to the particular agenda items, Associate Medical Directors and Clinical Directors. Dr Loughran attached a copy of the agenda for the training session and a copy of the Trust Guidelines agreed at Senior Management Team meeting the day before.

The email can be found at: **(Attachment folder S21 49 of 2022- Attachment 19- 2010.09.16 a Email from Dr Loughran to Dr C Fitzpatrick re NCAS session at ML Network 24.9 with atts)**

The agenda can be found at: **(Attachment folder S21 49 of 2022- Attachment 20- 2010.09.16 b Att agenda to Email from Dr Loughran to Dr C Fitzpatrick")**

The Trust Guidelines, dated 16th September 2010, can be found at: **(Attachment folder S21 49 of 2022- Attachment 21-2010.09.16 c Att Trust Guidance to Email from Dr Loughran to Dr C Fitzpatrick")**

7(viii) From my email archive, I can see that Siobhan Hynds sought comments on the draft guidelines from the Trust's Associate Medical Directors (AMDs). Siobhan emailed Anne Brennan on 23rd September 2010, copied to Kieran Donaghy and me, with a further amended version of the Trust Guidelines attached. In that email, Siobhan asked Anne Brennan to check her amendments were reflective of the AMD comments before she issued out the final document. This is why I believe that Siobhan must have met with the AMDs to seek their comments.

The email can be found at: (**Attachment folder S21 49 of 2022- Attachment 22- 2010.09.23 a Email from S Hynds to A Brennan re amends to MHPS Trust Guidelines AMD comments with att).**

The Trust guidelines attached, dated 23rd September 2010, can be found at: (**Attachment folder S21 49 of 2022- Attachment 23- 2010.09.23 b Att Trust Guidelines 23.9.2010 attached to Email from S Hynds to A Brennan AMD comments").**

7(ix) From my email archive I can see that Siobhan Hynds and I were emailing each other on the night of the 23rd September 2010 / early morning of 24th September 2010 with slides for the training session referred to above in 7(vii) taking place on 24th September 2010 for the Medical Leadership Network. Siobhan Hynds and I were presenting the session on the Trust Guidelines. A mix of Clinical Directors, Associate Medical Directors, Medical Director and Senior Management Team Directors were invited to this session on 24th September 2010. I do not have the list of attendees who attended on that date.

The emails and attachments can be found at:
(**Attachment folder S21 49 of 2022- Attachment 24- 2010.09.23 a Email from S Hynds to V Toal re slides for ML Network next day with att)**

(Attachment folder S21 49 of 2022- Attachment 25- 2010.09.23 b Slides att to Email from S Hynds to V Toal re ML Network next day)

(Attachment folder S21 49 of 2022- Attachment 26- 2010.09.23 c Email from VToal to S Hynds with slides for ML Network next day)
(Attachment folder S21 49 of 2022- Attachment 27- 2010.09.23 d Slides att to Email from VToal to S Hynds _ ML Network next day)

(Attachment folder S21 49 of 2022- Attachment 28- 2010.09.24 e Email from VToal to S Hynds re ML Network slides with att)
(Attachment folder S21 49 of 2022- Attachment 29- 2010.09.24 f Slides att to Email from VToal to S Hynds re ML Network presentation)

7(x) The Trust Guidelines 2010 were intended to sit alongside and be read in conjunction with "Maintaining High Professional Standards in the Modern NHS" DHSSPSNI (2005) **This can be located at Relevant to HR / Reference no 67 / TC8 6.2005 Maintaining High Professional Standards** and the NCAS 2010 guide "How to conduct a local performance investigation" **This can be found at Attachment folder S21 49 of 2022 - Attachment 30 - 2010.01.01 NCAS publication_ How-to-conduct-a-local-investigation.pdf,** as per para 1.8 of the 2010 document. Their purpose was to set MHPS as a framework into the Southern HSC Trust context in terms of clarification of who fills which roles within the Trust, and was in response to para 11, page 3 of MHPS, which refers to HSS bodies having procedures in place for dealing with concerns about an individual's performance. It was never the intention to replace MHPS with the Trust guidelines.

7(xi) I do not believe I obtained legal advice on the Trust Guidelines in 2010. I do not have any email record of a draft being sent to the Directorate of Legal Services. To be clear for the purposes of being definitive in my Section 21 response I asked Siobhan Hynds by telephone on 23rd May 2022, if she sought legal advice, and she advised me that she did not have any email record of having done so either. On reflection, I should have requested that

legal advice be sought on the Trust Guidelines. I can only assume that the upcoming NCAS led training session at the Medical Leadership Network and the short timescale leading up to it prevented us from seeking advice before hand, however, I regret not seeking advice even after the training session on 24th September 2010. My usual practice would be to seek legal advice for documents such as this.

7(xii) I have reviewed the informal and formal cases relating to concerns about Doctors which I had an involvement with, and which were within the time period covered by the 2010 Trust Guidelines – i.e. September 2010 up until the 2010 Trust Guidelines were formally replaced by 2017 Trust Guidelines in October 2017. The cases relating to performance concerns about doctors, which I was involved with, are set out below in a) to k). **I would draw to the attention of the USI, the sensitive information contained within the cases outlined below, and whilst I have referred to the Doctors by number, many of the Doctors are likely to be identifiable by the information I have outlined.**

a) Dr 1

The first medical case I was involved in related to a clinical performance case involving a Doctor who had been subject to NCAS assessment. GMC had placed a number of restrictions on the Doctor via an Interim Order. The Doctor had been [redacted] and subsequently appealed the decision. I chaired the [redacted] panel in [redacted], and the other panel member was the Medical Director, Dr Simpson. [redacted] I had no previous involvement in this case, and therefore I have no knowledge of how the Trust 2010 Guidelines were applied.

7(xiii) I was then involved with a number of cases from January 2015, when Zoe Parks was [redacted]. Zoe Parks was off work on that period of

Personal Information redacted by the USI until 9th November 2015. Zoe Parks had a further period of Personal Information redacted by the USI and annual leave from March 2016 to end of February 2017. During this period, I dealt with the following cases:

a) Dr 2

This was a case relating to performance concerns about the practitioner following Personal Information redacted by the USI. Zoe Parks had been involved in this case from the outset Personal Information redacted by the USI, and I took over the HR Case Manager role from Zoe Parks to the Associate Medical Director, Mr S O'Reilly, who was the Clinical Manager for the case. Zoe Parks, prior to her absence in 2015, had already supported the Clinical Manager to screen the performance concerns under Para 2.4 of the 2010 Trust Guidance, and as per Para 2.6 of the 2010 Trust Guidance, informal remedial action commenced, following an NCAS assessment of the practitioner which included clinical, behavioural and occupational assessment. I supported the Clinical Manager to manage and monitor the action plan as per Para 2.7 of the 2010 Trust Guidelines; Para 2.7 was adhered to. I have reviewed my emails regarding this case during 2015, and have email evidence of updating the then Medical Director, Dr John Simpson, the then Director of HR & OD, Kieran Donaghy, and the then Acting Director of Acute Services, Debbie Burns, as Oversight Group members. Two meetings of the Oversight Group met during 2015; the Clinical Manager was an apology for one of the meetings, but was in attendance at the other. I followed Para 2.6 and sought Occupational Health advice during April 2015. The practitioner's performance was successfully remediated at a different Trust site from where they had previously been based, following a number of reasonable adjustments in line with Disability Discrimination Act (DDA). During the time I supported this case up until January 2016, I engaged with: Medical Protection Society and British Medical Association representatives in line with Para 3.5 of the 2010 Trust Guidelines, the Practitioner, Clinical Manager, Medical Director, Director of HR&OD, Acting Director of Acute Services as the Operational Director, Trust appraisal / revalidation team to ensure they

were updated with regards to progress with the case, and Medical Director's Office to enable them to update the GMC Employment Liaison Advisor. Having reviewed my involvement with this case from the point I became involved, I consider that I followed the Trust's 2010 Guidelines.

b) Dr 3

This was a case relating to Personal Information redacted by the USI of a Doctor when employed in another Trust before moving to Southern HSC Trust. I was asked by Kieran Donaghy, Director of HR&OD to provide advice to the Clinical Manager, Dr Scullion, to assist him undertaking the screening / initial verification of the issues raised Personal Information redacted by the USI [redacted], in line with Trust 2010 Guidelines Para 2.4. I accompanied Dr Scullion to a meeting with the Doctor in Personal Information redacted by the USI to establish the facts regarding the incident Personal Information redacted by the USI, which had taken place outside of the workplace of the Trust they had previously worked in. I took notes at the meeting, and then I assisted the Clinical Manager prepare the screening report for discussion with the Associate Medical Director which enabled them to consider the most appropriate course of action. The Associate Medical Director in conjunction with the Clinical Manager determined that there was no action required by the Trust in respect of this Doctor (in line with Para 2.6 of the Trust 2010 Guidelines); he notified his rationale for this to members of the Oversight Group, Kieran Donaghy, Director of HR&OD, Dr John Simpson, Medical Director, and Debbie Burns, Acting Director of Acute Services, in line with Para 2.8 of the 2010 Trust Guidelines. Both Dr Simpson and Kieran Donaghy replied to the Associate Medical Director's email and were content with this course of action. During the time I supported this case from May to June 2015, I engaged with: British Medical Association representative in line with Para 3.5 of the 2010 Trust Guidelines, the Practitioner, Clinical Manager, Medical Director, Director of HR&OD, Acting Director of Acute Services as the Operational Director, and Medical Director's Office to enable them to update the GMC. Having reviewed my

involvement with this case from the point I became involved, I consider that I followed the Trust's 2010 Guidelines.

c) Dr 4

This case had commenced in [redacted] when Zoe Parks was still at work, and related to an allegation [redacted] against a Doctor from another member of staff. [redacted] The Medical Director assumed the role of Case Manager [redacted] given the sensitivity with the case. I drafted the monthly exclusion review letters for the Medical Director as Case Manager for issue to the Doctor, in line with Appendix 5 of the Trust 2010 Guidelines, however [redacted], it was not possible to adhere to the requirements for an initial investigation during the period of immediate exclusion as outlined in Appendix 5 of the Trust 2010 Guidelines. [redacted] I drafted correspondence for Kieran Donaghy, as Director of HR&OD to send to the Doctor in [redacted] to advise the Doctor of the names of the MHPS Case Investigator (Dr Philip Murphy) and Case Manager (Dr Charlie McAllister). I also drafted correspondence for the Medical Director, Dr Wright to send to the GMC by way of updates on various dates [redacted]. Lynne Hainey was the

designated HR Case Manager support to the Case Investigator and Case Manager in relation to the formal investigation process under MHPS once it commenced [redacted]. I accompanied Kieran Donaghy to a meeting with the Designated Board Member, Elizabeth Mahood on [redacted] to update on the developments [redacted], and to advise her of the commencement of the Trust's MHPS investigation. [redacted] at that time on behalf of the Medical Director and Director of HR & OD in relation to how that decision affected the Trust's MHPS investigation which had commenced. [redacted] I was then involved in preparing correspondence for the Medical Director to issue to GMC at this stage to update them [redacted]. On review of this case against the Trust 2010 Guidelines, I can confirm that my involvement related to the drafting of correspondence on behalf of the Director of HR & OD and Medical Director as requested by them. This was not specifically covered in the content of the Trust 2010 Guidelines due to the nature of the case [redacted]. I was involved in calls with the Trust's solicitor in this case at various points, along with the Director of HR & OD and Medical Director. Depending on the correspondence I was drafting, I also sought legal advice on the content of correspondence before issue to the Doctor or their legal representative.

d) Dr 5

The Trust's Medical Director, Dr Simpson was notified in [redacted] that a Trust Doctor [redacted] following an incident at that workplace. The incident had relevance to the Doctor's employment in the Trust. I attended a meeting of the Oversight Group during the afternoon that the incident was reported to the Trust, and this involved Dr Simpson, Medical Director,

Kieran Donaghy, Director of HR & OD, Dr Stephen Hall, Associate Medical Director and Debbie Burns, Acting Acute Services Director as per Para 2.5 of the Trust 2010 Guidelines. I took the notes of the Oversight Group meeting on [redacted]. The decision from that Oversight Group meeting was that the Doctor needed to be excluded. Dr Simpson and Kieran Donaghy updated the Acting Chief Executive, Paula Clarke immediately after the Oversight Group meeting in respect of the need to exclude the Doctor, and I forwarded her a copy of the notes of the Oversight Group meeting that afternoon as per Para 2.9 and Appendix 5 of the Trust 2010 Guidelines. I have an email copy of the NCAS letter that confirmed that Dr Simpson had contacted the NCAS Advisor to discuss the need for immediate exclusion on the same day the Oversight Group met [redacted], in line with Appendix 5 of the Trust 2010 Guidelines. I also have email copies of the correspondence sent by the Medical Director to the Chief Medical Officer for the purposes of requesting an alert letter and the GMC in line with Appendix 5 of the Trust 2010 Guidelines. Kieran Donaghy drafted the letter to the Doctor to advise of immediate exclusion. [redacted], it was not possible to adhere to the requirements for an initial investigation during the period of immediate exclusion as outlined in Appendix 5 of the Trust 2010 Guidelines. I took the notes at a further meeting of the Oversight Group on [redacted] to review the immediate exclusion. The same individuals were present at this oversight meeting, as outlined above. On the basis of the nature of the alleged incident, [redacted] and the fact that GMC had put in place an Interim Order of Conditions, the Oversight Group agreed to formally exclude the Doctor. The Oversight Group at the meeting considered alternatives to exclusion; however, it was not possible, [redacted] for the doctor to state their case in line with Appendix 5 of the Trust 2010 Guidelines. I drafted the letter to the Doctor advising them of this decision, and accompanied the Medical Director to a meeting with the Doctor on [redacted] to explain the decision and that the Trust, [redacted],

would commence an investigation under MHPS. I drafted the monthly exclusion review letters for the Medical Director as Case Manager for issue to the Doctor, in line with Appendix 5 of the Trust 2010 Guidelines. [redacted]. The HR Case Manager supporting the Case Investigator and Case Manager was Helen Walker, Assistant Director of HR in Acute Services. My role was to advise and prepare draft communication to various legal correspondence from the Doctor's solicitor, with the assistance of the Trust's solicitor. I took notes of a further Oversight Group meeting on [redacted] to review progress with the investigation process. The stance taken by the Doctor on the advice of their solicitor resulted in a lengthy time period to bring the MHPS investigation to a conclusion by the Case Investigator; [redacted]. I discovered in [redacted], that I had not included confirmation of the Designated Board Member in my draft letter from the Medical Director, Dr Wright to the Doctor dated [redacted]. I had drafted the letter with details of the Case Investigator, Dr Scullion, the Case Manager, Dr Chada, and the HR Case Manager, Helen Walker, but unfortunately, I omitted to include details of a Designated Board Member. Raymond Mullan was the Designated Board Member as confirmed by the Chair, Roberta Brownlee on [redacted]. This omission was rectified in a letter from Dr Chada to the Doctor in [redacted], which I drafted for her. The Doctor, nor their solicitor, did not seek at any time to make representations to the Designated Board Member, about the Trust's investigation, however, in [redacted] the Doctor's solicitor wrote to the Medical Director requesting postponement of a scheduled investigation meeting with the Case Investigator to take their statement. I recall obtaining legal advice, and I subsequently drafted the response on behalf of the Medical Director back to the solicitor to advise that the meeting was to proceed as planned.

My other involvement with this case was to seek legal advice on behalf of the Case Manager about proceeding to a conduct hearing following her determination that there was a case to answer in respect of misconduct, Personal Information redacted by the USI. The hearing proceeded, following legal advice, and I was the Senior HR advisor to the Disciplinary Panel. Finally, I was involved along with Dr Wright and Helen Walker in considering legal advice from the Trust's solicitor in relation to the Doctor's request for a delay in convening a disciplinary appeal hearing Personal Information redacted by the USI On review of this case against the Trust 2010 Guidelines, I can confirm that not all of my specific involvement as outlined above was covered in the content of the Trust 2010 Guidelines due to the nature of the case Personal Information redacted by the USI

e) Dr 6

This case involved a Doctor who had been referred to the GMC by a private patient and had received a warning. Following notification of the GMC warning to the Trust's Medical Director, Dr Wright in Personal Information redacted by the USI, I was involved in assisting a Clinical Manager, Dr Moan to undertake a screening of the concern that had given rise to the GMC warning. This was to determine if there were any concerns, which the Trust needed to be aware of in respect of NHS patients. Dr Moan undertook a review of a sample of patient records and the Doctor's appraisal records for the previous 3 years. Dr Moan and I met with the Doctor to enable them to provide their input to the process, and to ask them to outline their learning and reflection since the GMC warning. I provided administrative support to the Dr Moan as Clinical Manager in terms of preparation of correspondence, liaised with the Doctor to arrange a meeting with them and shared, and assisted Dr Moan to prepare the Screening Report. My part of the process as HR Case Manager, in respect of this case was carried out, in my view, in accordance with Para 2.4 and 2.6 of the Trust 2010 Guidelines; no further action was required in respect of this Doctor.

Dr Moan did not consider the involvement of NCAS was necessary in this case, nor was Occupational Health input required.

f) Dr 7

I attended an Oversight Group meeting on [redacted] in relation to Dr 7, following a number of clinical and behavioural concerns reported to the Operational Director, Angela McVeigh about the Doctor. I attended the Oversight Group meeting to take notes. Kieran Donaghy, then Director of HR & OD, Dr Wright, then Medical Director and Angela McVeigh, then Director of Older People & Primary Care were present. The Associate Medical Director Dr P Murphy, was not in attendance at the Oversight Group meeting on [redacted], however Dr Wright undertook to update him later the same day regarding Oversight discussions. It was agreed that the concerns required screening, and this was taken forward by a Consultant from another Directorate, Dr Hogan, Associate Medical Director, along with HR Case Manager support from Sarah Moore to produce the report in line with Para 2.6 of the Trust 2010 Guidelines. [redacted] there was a delay in completing the verification of facts as per Para 2.4 of the Trust 2010 Guidelines until Occupational Health determined fitness to do so. Oversight Group Meeting was convened on [redacted]; Dr P Murphy, as Associate Medical Director and the Senior Clinical Manager attended to present Dr Hogan's screening report in her absence in line with Para 2.8 of the Trust 2010 Guidelines. Informal remedial action with the assistance of NCAS was put forward by Dr P Murphy as the appropriate action in line with Para 2.6 and 2.7 of the Trust 2010 Guidelines at the Oversight Group meeting, and the members of the Oversight Group were in agreement with this approach. There was no need for any formal action once the Practitioner completed the NCAS action plan.

g) Dr 8

Urology Services Inquiry

I attended an Oversight Group meeting in respect of this case on [redacted] on behalf of Kieran Donaghy, then Director of HR&OD, along with Dr Wright, then Medical Director and Esther Gishkori, then Director of Acute Services. The case was in connection with a Doctor about whom concerns were raised [redacted]. The relevant Head of Service, Kay Carroll, provided information to the Oversight Group members on [redacted], and it was based on this preliminary information that it was determined that a formal investigation was required by members of the Oversight Group. Whilst those preliminary enquiries were undertaken in accordance with Para 2.4 and 2.6, they were not undertaken by the Clinical Manager, but by the Head of Service with management responsibility for the service. [redacted]. Siobhan Hynds was involved in meeting with the Doctor, along with the Medical Director, Dr Wright in [redacted], the HR Case Manager support role to the Case Investigator, Dr R Brown, was assigned by Siobhan Hynds to Sarah Moore. This was a [redacted]. I have archived emails indicating that I was following up on progress with the case with Sarah Moore and Siobhan Hynds during early [redacted]. The final report along with Case Manager Determination was presented by Dr P Murphy to a meeting of the Oversight Committee on [redacted]. The Case Manager, Dr Murphy discussed his determination with members of the Oversight Group as per Para 2.8 of the Trust 2010 Guidelines, that informal disciplinary action was appropriate based on the findings of the investigation. On review of this case for the purposes of this response, I cannot ascertain if a Designated Board Member was assigned to this case, and I can only assume that the absence of this being confirmed to the Doctor in any correspondence,

means that there was no Designated Board Member sought, and this was an unfortunate omission in this case.

The following cases (Dr 9, Dr 10 and Dr 11) arose in Personal Information redacted by the USI Personal Information redacted by the USI after I was appointed as Director of HR & OD and therefore my response below is in my capacity as Director of HR & OD.

h) Dr 9

Personal Information redacted by the USI

. Following a formal complaint about the Personal Information redacted by the USI, the concerns were reported by the Medical Director at an Oversight Committee meeting on Personal Information redacted by the USI, Ronan Carroll, Assistant Director Acute Services, Dr Wright, then Medical Director, and myself as Director of HR &OD. At that meeting, it was considered, as per my advice, that the case required investigation using the Trust's Personal Information redacted by the USI Policy; however, it was also agreed that Maintaining High Professional Standards still needed to be the overarching framework under which the case was managed. As the Trust 2010 Guidelines did not cover circumstances when there were Personal Information redacted by the USI (nor does the MHPS Framework itself), the Trust 2010 Guidelines were not used when the concerns first came to my attention. Siobhan Hynds took forward establishing the investigation team under the Personal Information redacted by the USI Procedure; I did not personally liaise with either of the investigators - Dr Dermot Hughes, Medical Director, Western Trust and Lynne Hainey, Acting HR Manager. The Personal Information redacted by the USI investigation report was considered by Case Manager, Dr Charlie Martyn, Medical Director in South Eastern Trust (due to requirements of MHPS) and Siobhan Hynds as Head of Employee Relations (due to the requirements of the Personal Information redacted by the USI Policy), to determine the appropriate action required in line with Maintaining High Professional Standards, which in this case was referral to a conduct hearing.

i) Dr 10

At a meeting of the Oversight Group on [redacted], Malcolm Clegg, Assistant Medical Staffing Manager, raised a request on behalf of a Consultant [redacted]. Dr Wright, Medical Director advised that he had recently read an [redacted], which included a reference to the Doctor, [redacted]. Dr Wright asked Simon Gibson, Assistant Director to draw together further information [redacted] for the next meeting of the Oversight Group. Simon Gibson provided further information at the Oversight Group meeting on 12th October 2016. [redacted] it was not possible to address the concerns using the Trust 2010 Guidelines. Dr Wright addressed the concerns with the Doctor separately.

j) Dr 11

This case related to an anonymous letter received in [redacted] into the Chief Executive's Office about a Doctor, highlighting concerns about their [redacted]. I was on annual leave when the Oversight Meeting on this case took place on [redacted], and Helen Walker, then Assistant Director of HR in Acute Services deputised for me. Dr Wright, then Medical Director, and Esther Gishkori, then Director of Acute Services were present. Simon Gibson, Assistant Director – Medical Directorate attended and took notes of the meeting. Mr Haynes, as Associate Medical Director was not present at the Oversight Group meeting but had been sent a copy of the anonymous letter. Given the nature of the issues raised it was agreed by the Oversight Group members that the appropriate way forward was to carry out an audit of the Doctor's patient case load to seek to verify or refute the issues raised in the letter as per Para 2.4 of the Trust 2017 Guidelines. No patients of this Doctor were classed as private patients. The audit, whilst not taken forward by a Clinical Manager, was progressed as an action by Ronan Carroll and Amie Nelson in Acute Services, and the outcome of the Audit was considered at

a further oversight meeting of the same members on Personal Information redacted by the USI as outlined above. I was an apology for the September meeting also; however, Siobhan Hynds attended, in addition to Helen Walker. It was determined by the Oversight Group members that there was no evidence of any substance to the concerns raised in the anonymous letter. Given I was an apology for both meetings I was not directly involved in this case; I received verbal updates from Helen Walker and Siobhan Hynds and was copied into emails with notes of the meeting from Simon Gibson.

7(xiii) In early 2017, Siobhan Hynds, then Head of Employee Relations, and I had a discussion about needing to review the 2010 Trust Guidelines. I believe this conversation was linked to our reflections on the case involving Mr O'Brien, and in particular the difficulties at the early stages of the process involving the oversight group, which had led to confusion about roles and responsibilities in the management of the concerns. I refer to these difficulties in my response at 26(iii) below. On the back of this conversation in early 2017, Siobhan Hynds emailed Annette Murphy, HR Assistant in Employee Relations on 21st February 2017 to arrange a meeting to "*review recent MHPS cases and to review our Trust Guidance"*. **This can be found at Attachment folder S21 49 of 2022- Attachment 31.** Annette Murphy emailed Siobhan Hynds, Zoe Parks (Medical Staffing Manager), Lynne Hainey (HR Manager), Helen Walker (Assistant Director of HR aligned to Acute Services) and myself on 22nd February 2017 to confirm the date of the meeting as 2nd March 2017. **This can be found at Attachment folder S21 49 of 2022- Attachment 32.** Zoe Parks had just returned from Personal Information redacted by the USI at the end of February 2017. I can recall working through the 2010 Trust Guidelines at the meeting and the main discussion was about the need to remove any reference to the 'oversight group' to ensure our implementation of it for managing concerns was entirely in line with MHPS framework. I refer to our concerns regarding the Oversight Group being part of the process in more detail in my response to Question 26(iii) below.

7(xiv) Following this meeting, on 5th April 2017, Zoe Parks emailed a revised draft version of the Trust Guidelines to Siobhan Hynds, Helen Walker and myself for review. **This can be found at Attachment folder S21 49 of 2022- Attachments 33a, 33b, 33c**. To assist in my response, I asked Zoe Parks on 6th June 2022 when she sent the revised draft Trust Guidelines to our solicitor for legal advice. Zoe Parks confirmed on 6th June 2022 that she did this on 16th June 2017. **This can be found at Attachment folder S21 49 of 2022- Attachment 34**. Our solicitor replied with her comments marked on the document on 4th August 2017 **(This can be found at Attachment folder S21 49 of 2022- Attachment 35)**, and these were incorporated into the draft Guidelines.

7(xv) On 24th November 2017, the revised draft guidelines were sent to the Associate Medical Directors (AMDs) for their review **(This can be found at Attachment folder S21 49 of 2022- Attachment 36)** by Andrea McNeice in Medical Staffing on behalf of Zoe Parks. I know this because I contacted Zoe Parks on 6th June 2022 by telephone for the purposes of completing my Section 21 response and asked her to check if the revised draft was issued to AMDs. Zoe forwarded me the email from Andrea McNeice to the AMDs on 6th June 2022. On 1st December 2017, the guidelines were included on the agenda for the Joint HR Directorate and Medical Directorate meeting for discussion (the 31st October 2017 scheduled meeting had been cancelled). The notes **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20171201 Notes of medical_HR directorate meeting)** of the 1st December 2017 meeting confirm the following:

*"**MHPS revised guidelines***

It was agreed that the revised guidelines should be added to the next LNC agenda – for information only. Zoe advised that the oversight process had been removed from the guidelines and decision making powers were now with the Case manager.

***Action:** Zoe to add to next LNC agenda"*

Zoe Parks, forwarded the final guidelines to Local Negotiating Committee (LNC) BMA members on 2nd March 2018 for information, following the LNC informal meeting on 27th February 2018. I know this because I contacted Zoe Parks on 6th June 2022 by telephone for the purposes of completing my Section 21 response and asked her to check if the revised draft was issued to Local Negotiating Committee. Zoe forwarded me the email on 6th June 2022, which confirms that the Trust Guidelines were sent to LNC members on 2nd March 2018. **This can be found at Attachment folder S21 49 of 2022- Attachment 37.**

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

8(i) As outlined in my response to Question 7, I was aware of the Trust Guidelines.

9. In your role as Director HR & Organisational Development what, if any, training or guidance did you receive with regard to;

I. The MHPS framework

9(i) I have not had formal specific training in relation to MHPS framework either before or after taking up my role as Director of HR&OD. In 2010, when Siobhan Hynds and I were asked to progress the development of the Trust Guidelines linked to MHPS, I had knowledge of MHPS framework as a result of reading it only. I also had knowledge of the NCAS 2010 Guide on How to Conduct a Local Performance Investigation from reading it, and it provides useful supplementary guidance. As per my response to Q7 above, and my response below at 9(ii), Siobhan Hynds and I were the ones leading the training session for Associate Medical Directors and Clinical Directors on the Trust 2010 Guidelines, but I had not received any formal training on the

MHPS framework. Dr Colin Fitzpatrick from NCAS input to the session on 24th September 2010, and his session provided me with detailed guidance on the role of NCAS in MHPS processes. **This can be found at Attachment folder S21 49 of 2022- Attachment 38.** I have read a copy of the training slides used by DLS to train our Non-Executive Director colleagues on 29th August 2017. **This can be found at Attachment folder S21 49 of 2022- Attachment 39.** Finally, on 15th October 2020, Zoe Parks, Head of Medical Staffing forwarded myself, Siobhan Hynds, Dr Maria O'Kane, then Medical Director and Dr Aisling Diamond, Deputy Medical Director, a link to a webinar from Hempsons, entitled "MHPS - a refresher and look at recent case law". I watched that webinar **(This can be found at Attachment folder S21 49 of 2022- Attachment 40),** which included Q&A session, at some point shortly after Zoe Parks' sent the link via email; I do not know the exact date I watched it.

II. The Trust Guidelines

9(ii) In relation to training with regard to the Trust Guidelines 2010, I was involved in the development of these guidelines in 2010 so I was not trained in their use. In drafting them, I had used the MHPS 2005 Framework, and the NCAS 2010 guide "How to conduct a local performance investigation" as two key reference documents. As outlined in 7(xi) legal advice was not sought by me or Siobhan Hynds in relation to the draft Trust Guidelines in 2010; it should have been in my view as this guidance could have been helpful. In 2017, Zoe Parks sought advice from the Trust's solicitor and received comments, which were fully taken on board.

III. The handling of performance concerns generally

9(iii) My Postgraduate Diploma in Human Resource Management provided me with general academic grounding in the handling of performance concerns. Whilst it did not deal with medical staff specifically, it did relate to the general principles of addressing performance concerns in the form of misconduct,

capability and when there are health concerns impacting on performance. Accessing online resources from Chartered Institute of Personnel & Development and Labour Relations Agency, employment law updates from Legal Island (last one attended on 10th & 11th November 2021), as well as articles relating to MHPS and other case law for example, keep my professional knowledge current. I also access guidance in the form of legal advice for specific employment cases as necessary.

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

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

10(i) I have never received any specific training in relation to the above. NCAS 2010 Guide on How to Conduct a Local Performance Investigation only contains a short section 1.2, but this does not go into any significant detail.

I have assisted a Clinical Manager to undertake preliminary enquiries on one occasion, as outlined in 7(xiii) Dr 6.

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

10(ii) I have never received any specific training in relation to the above. The Guidance I have been aware of since 2010 is contained in sections 1.3, 1.4 and 1.5 of NCAS 2010 Guide on How to Conduct a Local Performance Investigation.

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

10(iii) I have never received any specific training in relation to the above.

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

10(iv) I have never received any specific training in relation to the above.

11. Fully describe your role with regard to the establishment, responsibilities and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines. Further, please outline how your role differed from that of other regular attendees at the 'Oversight Group' namely:

I. Assistant Director – Medical Directorate;
II. Service Director;
III. Medical Director; and
IV. Medical Staffing Manager.

11(i) My response to 7(iii) assists with this response. The Oversight Group was introduced in the 2010 Trust Guidelines, as a result of discussions between Debbie Burns, former Assistant Director Performance Improvement, Dr Patrick Loughran, former Medical Director, Kieran Donaghy, former Director of HR &OD and Mairead McAlinden former Chief Executive. The NCAS 2010 Publication "How to conduct a local investigation" **(This can be found at Attachment folder S21 49 of 2022- Attachment 30)** referred to a Decision-Making Group (DMG); however, this was in the context of concerns about a Doctor arising in a Primary Care context. I note from Debbie Burns' draft document **(This can be found at Attachment folder S21 49 of 2022- Attachment 11)** that she referred to a Decision-Making Group. At the meeting on 4th August 2010 between Mairead McAlinden, Debbie Burns, Dr Loughran and Kieran Donaghy, the references to a Decision-Making Group were tracked out of the document and replaced with references to 'Oversight Group'. I do now know who replaced the references to 'Oversight Group'; it is

likely to have been Debbie Burns. I can recall from discussions with Kieran Donaghy around that time in August 2010 that there was a view from the Chief Executive and Directors that a form of oversight arrangement would be needed to assure consistency of approach, and fairness across MHPS processes. Therefore, the concept of the 'Oversight Group' was included by me in the Trust Guidelines which were eventually published on 23rd October 2010, based on the tracked changes within Debbie Burns' document.

11(ii) The role definition and responsibilities of the Oversight Group were detailed in Appendix 6 of the Trust Guidelines 2010:

"This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns."

11(iii) The role definitions for and responsibilities of the Director of HR & OD, Medical Director and the Operational Director in the Oversight Group were not detailed in Appendix 6. They should have been, and on reflection now, if I had sought to document these responsibilities in Appendix 6, this may have led me to consider in more detail the appropriateness of having an Oversight Group at all as part of the Trust processes for implementing MHPS. This may subsequently have resulted in me having a discussion with Kieran Donaghy back in 2010 when I was involved in drafting the Trust Guidelines.

11(iv) It was intended from the 2010 Trust Guidelines that an Oversight Group would be established for each specific case as per para 2.5 of the document. The Chief Executive was responsible for appointing the Oversight Group for the case. In early September 2016 when I was covering for the vacant Director of HR & OD role and after 21st September 2016 when appointed permanently to the Director role, I worked in close proximity to both the Medical Director, Dr

Richard Wright and Interim Chief Executive, Mr Francis Rice in Trust Headquarters at Craigavon Area Hospital. Our offices were next to each other in the same corridor, which meant there were opportunities to have ad hoc conversations without requiring diary appointments with each other. In my time working alongside Dr Wright in my capacity as Director of HR &OD, it is my understanding and recollection that Dr Wright, as Medical Director and Responsible Officer, alerted the Chief Executive to any concerns in relation to the performance of doctors and the need for an Oversight Group meeting.

11(v) In terms of the practical outworking of the Trust 2010 Guidelines, there was never any documented communication issued from either Francis Rice or Stephen McNally, as interim Chief Executives, directly to me about the establishment of any Oversight Group. Instead, the Medical Director would have alerted me to any emerging concerns, and either my Personal Assistant, Mrs Heather Mallagh-Cassells or Dr Wright's Personal Assistant, Mrs Laura White, would have arranged the establishment of the Oversight Group meeting, depending on which one of them was available.

11(vi) The Medical Director acted as Chair of the Oversight Group meeting and led the discussions about concerns relating to Doctors. The Medical Director usually outlined the nature of the concerns at the initial Oversight Group Meeting brought to his attention and invited the Operational Director to add any further background if appropriate. The Assistant Director – Medical Directorate, was usually in attendance at Oversight Meetings, and he took forward any relevant actions to the Medical Director's Office, and may have been the note-taker at the meeting.

11(vii) Having been involved in drafting the 2010 Guidelines, I understood my role as Director of HR & Organisational Development during the Oversight Meetings, and outside of Oversight Meetings, to be primarily a support role to the Medical Director in terms of professional HR advice in relation to their responsibilities under MHPS. The Medical Staffing Manager was usually in attendance at Oversight Meetings, to take forward any actions relevant to the

Director of HR &OD's office, and may have been the note-taker at the meeting.

11(viii) Similar to the Medical Director and the Operational Director, I also had a role to ensure progress with local action plans, where these were in place, was maintained, as referenced in para 2.7 of the Trust 2010 Guidelines.

11(ix) Further, in line with para 2.8 of the Trust 2010 Guidelines I had a role to *"quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification."* This was in line with Section I of MHPS para 15, which *states, "As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary…."*

11(x) On reflection, the use of the term '*informal assessment*' in para 2.8 of the 2010 Trust Guidelines was confusing. The *'informal assessment'* was the same as the '*initial verification of the issues raised'* referenced in para 2.4 of the same Guidelines. Both of the terms referred to the part of the MHPS process in MHPS Section I para 15 known as *'preliminary enquiries'*, and on hindsight the Trust Guidelines should have referred to 'preliminary enquiries' to avoid any confusion.

11(xi) The Operational Director (same as the Service Director) was present at Oversight Group meetings as the Director representing the Directorate where a Doctor who was the subject of the Oversight Group worked. The primary intention of including the Operational Director was to ensure they had an awareness of an ongoing MHPS process regarding performance concerns of a Doctor in their Directorate. The Operational Director had a role as outlined

in 11(viii) above in respect of ensuring local action plans were progressed. According to the wording in para 2.8 of the 2010 Guidelines, the Operational Director also had the same role as the other members of the Oversight Group i.e. quality assurance of Clinical Manager decisions following initial assessment / preliminary enquiries, and ensuring fairness, transparency and consistency of approach to the process of handling concerns, as outlined in 11(x) above.

11(xii) In 2017, when the HR Directorate and Medical Directorate were reviewing the September 2010 Trust Guidelines, we removed references to the Oversight Group, and the Group did not form part of the processes for managing MHPS processes in the October 2017 Trust Guidelines. See my response at 26(iii) below.

Handling of Concerns relating to Mr O'Brien

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

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

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

12(i) I first became aware that there were concerns in relation to Mr O'Brien in either late August 2016 or very early September 2016. Prior to this, I only knew Mr O'Brien to see as I had been working on the Craigavon Area Hospital site for a number of years. I recall Dr Richard Wright, Medical Director had a conversation with me in late August or early September in either my office or his office to tell me he had concerns about Mr O'Brien's administrative practices and that he had been made aware of them earlier in the year but that the situation had not improved. I remember he told me he was seeking more information as to the extent of the problem and would speak to me again. I do not know the exact date when Dr Wright advised me of this, as I recall it was an ad hoc conversation and not a planned meeting. I

do know for sure, however, it took place after Kieran Donaghy started his annual leave in the last 2 weeks in August prior to his retirement date of 31st August 2016, or in very early September. I believe it was during this conversation that Dr Wright made me aware that Mr O'Brien was a friend of Mrs Roberta Brownlee, Chair of the Southern HSC Trust. As part of the same conversation, I can recall asking Dr Wright if Francis Rice, Chief Executive knew about the concerns. I cannot recall if Dr Wright said if the Chief Executive had already been alerted or that this still needed to be done, but we definitely discussed the need for the Chief Executive to be aware of the concerns given the possibility that MHPS may need to be implemented.

12(ii) On 6th September 2016, Dr Wright forwarded me an email **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160906 Email Confidential Screening Investigation_Dr R Wright)** that Mr Simon Gibson, Assistant Director – Medical Directorate had sent to him on 5th September 2016. Simon Gibson's email to Dr Wright stated that he had attached *"as requested"* a *"screening report on Dr A O'Brien"*. Simon Gibson went on to ask Dr Wright in that email if he would like him to convene an oversight meeting. Dr Wright forwarded me the email with the screening report **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160906 Attachment_AOB Screening Report)** so I could review in advance of an Oversight Group meeting that was to be convened as per the Trust 2010 Guidelines.

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

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

12(iii) I became aware that there would be a formal investigation into matters concerning the performance of Mr O'Brien on 22nd December 2016. Simon Gibson contacted me by telephone on 21st December 2022 to advise that a meeting of the Oversight Group would be needed the following day. Please

refer to my responses at 15(i) to 15(vii) below for my full response to these questions.

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

12(iv) On the night of 6th September 2016, having read the Screening Report, I forwarded an email **(This can be found at Attachment folder S21 49 of 2022- Attachment 41)** to Dr Wright and Mrs Esther Gishkori, then Director of Acute Services to check if they were free to meet to discuss a number of medical issues following the Governance Committee meeting on 8th September 2016. I listed in the email one of the issues as *"Mr A O'Brien – potential MHPS case'*. The time suited Dr Wright **(This can be found at Attachment folder S21 49 of 2022- Attachment 42)**, but not Esther Gishkori **(This can be found at Attachment folder S21 49 of 2022- Attachment 43),** so I subsequently emailed **(This can be found at Attachment folder S21 49 of 2022- Attachment 44)** my Personal Assistant, Heather Mallagh-Cassells to arrange another date for the Oversight Group meeting. There were four items that were relevant for an Oversight Group meeting, and two issues that were general medical staffing related issues. On 8th September 2016, Heather Mallagh-Cassells confirmed the date of this meeting for 10am on 13th September 2016 **(This can be found at Attachment folder S21 49 of 2022- Attachment 45).**

12(v) I do not recall having any other conversations about the concerns relating to Mr O'Brien until the Oversight Group meeting on 13th September 2016.

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

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

13(i) Please see my responses at 12(i), 12(ii) and 12(iv) as they are also relevant to my response to this question.

13(ii) The notes of the Oversight Group meeting **(this can be located at Relevant to HR / Reference no 1 / Oversight documentation Mr O'Brien / 2016 9 13 Oversight Group Notes Action Points)**, taken by Malcolm Clegg, Assistant Medical Staffing Manager on 13th September 2016, state the following: *"The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later."* While the notes do not make it clear who 'informed' those at the Oversight Group meeting about the concerns raised by letter to Mr O'Brien in March 2016, I assume that both Dr Wright and Mrs Esther Gishkori contributed to the sharing of this information by way of background. I do not recall reading a copy of the letter of 23rd March 2016 **(this can be located at Relevant to HR / reference no 33 / GRIEVANCE PANEL 1 / 20160323 - Grievance Panel 1 Tab 8 Letter from EM and HT to AOB)** at the meeting on the 13th September 2016, nor do I recall that a copy of the letter was actually available at the meeting. For my own clarity and in the interests of thoroughness in relation to my advice as Director of HR &OD, I should have asked to see a copy of the letter at the Oversight Group meeting.

13(iii) The process by which we were discussing the concerns about Mr O'Brien on 13th September 2016 was as per Oversight Group arrangements outlined in para 2.5 of the Trust 2010 Guidelines. As outlined above in 12(ii), on 6th September 2016, Dr Wright had forwarded me an email that had been sent to him from his Assistant Director, Simon Gibson the day before. The email contained a copy of a document entitled 'Screening Report on Dr O'Brien'. Mr Gibson, at Dr Wright's request, summarised the concerns in respect of Mr O'Brien, and I recall he did so with the assistance of staff within Acute Services Directorate, although I do not know who exactly he worked with to

collate the detail. Given the numerical patient and clinic activity detail in the Screening Report, input would have been required from Acute Services managers.

13(iv) As outlined above, Simon Gibson documented the summary of concerns as at August 2016 in the 'Screening Report on Dr O'Brien' **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160906 Attachment_AOB Screening Report)** . It is unusual that Simon Gibson as an Assistant Director in the Medical Director's office would have been the author of a screening / preliminary enquiries report given that the person responsible for this role in both MHPS and the 2010 Trust Guidelines is the Clinical Manager. In this case, the Clinical Manager of Mr O'Brien would have been Mr Colin Weir, Clinical Director. My recollection is Dr Wright had been seeking assurances from managers in Acute Services in August 2016 that the concerns raised with Mr O'Brien earlier in 2016 had been addressed. My understanding is that when he did not receive satisfactory assurances, he then asked Simon Gibson to take forward some enquiries on his behalf. Simon Gibson may be able to confirm who he liaised with in Acute Services to enable him to complete the screening / preliminary enquiries report, and to confirm the involvement, or not, of Mr Colin Weir, the Clinical Manager. Given the opportunity to now reflect on this part of the process, the report to Oversight Group should have been undertaken by Mr Colin Weir, the Clinical Manager and not Simon Gibson as per para 2.4 of the Trust 2010 Guidelines and MHPS Section 1 Para 15. I have no doubt, however, as Clinical Manager, Mr Weir would have needed to have relied on Acute Services Managers to provide the activity data in respect of Mr O'Brien's untriaged referrals and outpatient review backlogs in order to complete such a report. As far as I can ascertain, Simon Gibson did not seek the advice of any HR Case Manager in relation to the screening / preliminary enquiries process, as per para 2.4 of the Trust 2010 Guidelines.

13(v) The same four concerns included in the 23rd March 2016 letter were outlined in the Screening Report prepared by Simon Gibson in September 2016,

namely – (1) untriaged referrals, (2) review backlog, (3) patient notes at home, and (4) lack of recorded outcomes of consultations / discharges with potential to lead to delayed or no follow up organised for patients. Revised activity data was included for (1) and (2) in the screening report, as at August 2016.

13(vi) The first advice letter from Dr Colin Fitzpatrick, NCAS Senior Adviser, dated 13th September 2016, was sent to Simon Gibson, and referred to a telephone conversation between the two of them on 7th September 2016. **This can be located at Relevant to HR / reference no 33 / GRIEVANCE PANEL 1 / 20160913 - Grievance Panel 1 Tab 12 letter from NCAS CF to S Gibson.** On reviewing the notes of the Oversight Group meeting at 10am on 13th September 2016 to assist in this response, I found it strange that neither the NCAS letter nor any NCAS advice was referred to. For the purposes of completing this response, I carried out a search in my email archive to determine if the NCAS letter of 13th September had been sent to me from Simon Gibson, and I could not find it. In order to complete my response to this question, I made contact with Simon Gibson by email on 5th June 2022, to seek confirmation of the time on 13th September 2016 when he received the letter. Simon Gibson replied on 6th June 2022 to confirm it had been sent from NCAS via encrypted email at 16.31 on 13th September 2016. The NCAS letter of 13th September 2016 had not been received in time for the Oversight Group meeting earlier that day at 10am. I further followed up this response with Simon Gibson on 6th June 2022 by return to ask him to whom he forwarded the NCAS advice letter. He responded on the same day to confirm that he had forwarded the NCAS letter to Dr R Wright and copied to Mrs E Gishkori, Director of Acute Services, Dr Charlie McAllister, Associate Medical Director – ATICS and Surgery, and Mrs Gishkori's Personal Assistant, Emma Stinson on 28th September 2016. Simon confirmed that he had not forwarded the NCAS letter to me and indicated that this must have been an oversight on his part. **This can be found at Attachment folder S21 49 of 2022- Attachment 46.** I did not receive a copy of the 13th September 2016 NCAS letter until Siobhan Hynds sent it to me on 7th September 2020. **This can be found at Attachment folder S21 49 of 2022- Attachment 47a and 47b.**

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

13(vii) The notes of the Oversight Group Meeting on 13th September 2016 refer to the Trust's intention to proceed with an 'informal investigation' at that point in time. Reviewing the wording in these notes now, I find that the terminology of 'informal investigation' is entirely misleading, and at odds with both the 2010 Trust Guidelines para 2.6 and MHPS Section I para 4. The existence of the letter sent to Mr O'Brien in March 2016 was known by me at the Oversight Group meeting on 13th September 2016 on the basis of what Dr Wright had advised me prior to the meeting and because it was referenced in Simon Gibson's Screening Report that Mr O'Brien had been written to in March 2016. As outlined above, I did not see a copy of the letter at the Oversight Group meeting, nor regrettably did I ask to see it. However, I am entirely clear that there was agreement at the meeting that the issues raised in March 2016 were still unresolved and they needed to be picked up and fully addressed, given they had not been resolved in the intervening period. I am also clear that at that stage, we were seeking to deal with the outstanding matters identified in the Screening Report informally, without immediate recourse to formal processes under MHPS. I believe the term 'informal investigation' arose because it was clear to us that there needed to be immediate actions agreed by the clinical managers, senior managers and Mr O'Brien to assess what was contained within those backlogs and to address them. I also remember, given it was reported at the meeting that no progress had been made to address the concerns highlighted in March 2016, Dr Wright and I were both keen to ensure there were timescales given to Mr O'Brien by when the necessary improvements would have to be made, otherwise formal action would be taken under MHPS.

13(viii) Dr Wright asked Simon Gibson to draft a letter to be given to Mr O'Brien by Mr Colin Weir, Clinical Director and Mr Ronan Carroll, Assistant Director of Surgery, outlining what was expected of him to deal with the issues of

concern. It was also agreed that Esther Gishkori was to meet with Simon Gibson, Mr Weir and Ronan Carroll to go through the draft letter to ensure there was shared understanding of the actions associated with each of the issues. The meeting between Mr Weir, Ronan Carroll and Mr O'Brien was to take place the following week – week commencing 19th September 2016. Progress against the agreed actions communicated to Mr O'Brien was to be reviewed in four weeks, and if insufficient progress was made in that time, a formal investigation may then commence. This was to be communicated in the letter to Mr O'Brien.

13(ix) There is no record in the notes of the Oversight meeting of what the verbal NCAS advice received by Simon Gibson was. I cannot recall the detail of the discussion at the Oversight Group meeting about NCAS advice. I note, however, from Simon Gibson's email on 28th September 2016 to Dr Wright and Esther Gishkori **(This can be found at Attachment folder S21 49 of 2022- Attachment 48)**, which contained a copy of the 13th September 2016 NCAS letter, he stated:

"Dear Richard / Esther

You will recall that as part of the collation of evidence in relation to the above, I sought advice from NCAS which was discussed when the Oversight Committee met.

The written advice from NCAS has now come in and is attached….."

13(x) Having reviewed the 13th September 2016 NCAS letter, for the purposes of my Section 21 response, I am concerned when I read paragraph 6 page 1 of the letter – *"To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology."* In my view now, if this letter had been available at the Oversight Group Meeting, this line in particular could and should have served to reinforce the importance of the urgency of addressing the concerns and reviewing if any actual harm had occurred with patients in the backlogs.

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

13(xi) The actions emanating from the Oversight Group meeting were allocated to individuals other than me.

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

13(xii) Simon Gibson sent a draft of the letter for Mr O'Brien on 13th September 2016 after the Oversight Group meeting, to Dr Wright, Esther Gishkori, Malcolm Clegg, and myself, and asked for comments back **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160913 Ltr_draft to AOB).** I have no record of commenting back to Simon Gibson via email and I can only assume that this was due to meetings in the diary that afternoon and the following day. The draft letter would have needed some amendments by me. In particular, the reference in the last paragraph to an 'investigation team' taking four weeks to conclude their investigation made no sense in the context of the informal approach to be taken by Ronan Carroll and Mr Weir. There was no investigation team. What was to be reviewed however, in four weeks was Mr O'Brien's progress against the actions outlined for him in the earlier part of the letter.

13(xiii) On 15th September 2016, Esther Gishkori emailed Dr Wright and I **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160915 Email Esther Gishkori_re oversight meeting re AOB)**. She advised that following the Oversight Group meeting on 13th September 2016, she had spoken to Dr Charlie McAllister, Associate Medical Director for ATICS and Surgery and Ronan Carroll, Assistant Director about the plan agreed at Oversight Group meeting to address the concerns relating to Mr O'Brien. She stated in that email that Dr McAllister and Mr Weir *"have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that."* Esther Gishkori proceeded in her email to state *"Now that they both work locally with him, they*

have plenty of ideas to try out and since they are both relatively new into post, I would like to try their strategy first.

I am therefore respectfully requesting that the local team be given three more calendar months to resolve the issues raised in relation to Mr O'Brien's performance."

13(xiv) On 15th September 2016, Dr Wright responded to Esther Gishkori by email **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160915 Email Dr R Wright to EG_re oversight meeting re AOB)** and indicated to her that before he would consider conceding to any delay in moving forward with the plan agreed at 13th September 2016 Oversight Group meeting, he would need to see the plans to address the issues and understand how progress would be monitored over the 3-month period.

13(xv) I forwarded Dr Wright's email to Mr Malcolm Clegg on the morning of 16th September 2016 **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160916 Email Vivienne Toal to M Clegg re oversight meeting re AOB)** with a request that he type up the notes from the oversight Group meeting on 13th September 2016. I commented to Malcolm Clegg in that email that *'we are definitely going to need notes going forward particularly if goalposts keep trying to be changed'.* I also emailed Esther Gishkori on 16th September 2016 morning, as I knew she was going off on leave that day, asking how she wanted to handle Dr Wright's request from the day before. I was concerned that Esther Gishkori would go on leave without responding. I copied Dr Wright into that email to Esther Gishkori. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160916 Email Vivienne Toal to EG re oversight meeting re AOB.**

13(xvi) Dr Wright replied to my email to Esther Gishkori at lunch time on 16th September 2016 **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/**

20160916 Email Dr R Wright to VT re oversight meeting re AOB) to advise me that he had been in a scheduled meeting with Mr Francis Rice, Interim Chief Executive and Esther Gishkori that morning and the *"topic"* was discussed. He advised me that Esther had agreed in principle to provide the information he had requested the day before and to ensure that there was a documented meeting with Mr O'Brien outlining the implications of not getting the concerns addressed within 3 months. He went on to advise me that Francis Rice was keen to address the matter in this way but not to let it run further than the three months if still non-compliant. Dr Wright ended his email to advise that he was happy to discuss further with me. I do not recall if we did discuss the matter further, however it is possible we would have had an ad hoc conversation given the proximity of our offices in Trust HQ. Esther Gishkori also replied to me around the same time on 16th September 2016 to confirm she had spoken with Dr Wright that morning and he was *"happy with the direction of travel"* she had outlined, and that she would be asking the Associate Medical Director (Dr C McAllister) and Clinical Director (Mr C Weir) *"to record their plans and actions"*. Esther Gishkori went on to advise that work would *"begin immediately to address the backlog"*, she promised Dr Wright a written plan and asked for a period of 3 months to address. I did not take any further action following this email exchange. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20160916 EMail E Gishkori to VT re oversight meeting re AOB.**

13(xvii) Given that the plan agreed at the Oversight Group meeting on 13th September 2016 had changed as outlined above, I did not make any amendments to Simon Gibson's letter, as it was no longer going to be sent.

13(xviii) I attended the next Oversight Group meeting arranged for 12th October 2016, arranged by Ms Laura White, PA to Dr Wright. At this meeting, Esther Gishkori advised that Mr O'Brien was about to commence a period of sick leave for planned surgery at the beginning of November and would be off work for a period of time. Esther Gishkori also reported that a meeting with Mr

O'Brien had not yet taken place to speak with him about the concerns regarding his administrative practices and backlogs. Esther Gishkori did not wish to speak with Mr O'Brien in advance of his planned sick leave as she thought it would cause him distress in advance of surgery. Esther Gishkori gave assurances to Dr Wright that plans for the backlogs were in place to clear these during his absence. I cannot recall the detail that Esther provided in relation to those plans at the meeting.

13(xix) To assist with my Section 21 response, I asked the Trust Public Inquiry Team on 15th June 2022, if there were any emails in relation to the plan developed by either Dr McAllister or Mr Weir; I was provided with two emails later that day, which outline discussions on the Acute Directorate's plan to address the concerns. The first email was drafted by Mr Weir to Dr McAllister dated 16th September 2016 and outlines an 8 point plan; Dr McAllister replied to that email on 21st September 2016 indicating he was in agreement with the plan, and he copied Esther Gishkori and Ronan Carroll into his response. **This can be found at Attachment folder S21 49 of 2022- Attachment 49.** The second email contained Ronan Carroll's comments on the plan back to Esther Gishkori, Mr Weir and Dr McAllister on 21st September 2016 in respect of suggestions for how the actions could be monitored. **This can be found at Attachment folder S21 49 of 2022- Attachment 50.** I do not know when or if this plan was emailed to Dr Wright. I have checked my email archive and I did not receive a copy.

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

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

14(i) I became aware that there was an SAI Review involving Mr O'Brien on 30th November 2016. Dr Wright emailed Esther Gishkori on this date and copied me into the email **(This can be found at Attachment folder S21 49 of 2022- Attachment 51).** This email indicated that Esther Gishkori had informed Dr Wright that there were emerging issues in relation to Mr O'Brien from an *"ongoing SAI"*. I was not made aware of the patient's name at the time, but I later came to know as part of the MHPS investigation in 2017 that this first SAI was in respect of the care provided to Patient Patient 10. Dr Wright and I may well have spoken to each other about the fact there was an SAI involving Mr O'Brien after he sent it, but I do not recall any conversation, if one took place in Trust HQ or by telephone. Mr O'Brien was on sick leave at that point in time. I then recall receiving a telephone call from Simon Gibson just prior to Christmas 2016. I know from my email archive that this must have been on the morning of 21st December 2016, as I have an email from Simon Gibson which he forwarded to me from Dr Wright to him which indicated that Esther Gishkori had contacted him about *"worrying developments and lost notes"* in relation to Mr O'Brien **(This can be found at Attachment folder S21 49 of 2022- Attachment 52).** Dr Wright advised in this email that he did not believe he could wait until the 'formal completion of the SAI'. Simon Gibson was ringing me to check if I was free to join a meeting the following day to discuss the issues that were emerging. This was the background context to an Oversight Group meeting, which took place the next day on 22nd December 2016 relating to Mr O'Brien, which subsequently led to his 4-week immediate exclusion from work and MHPS investigation.

14(ii) In respect of the care of five patients (RCA Personal Information redacted by the, I was in receipt of some emails in March, April and May 2017 originating from managers in Acute Services Directorate in relation to patients requiring SAI reviews. After Patient Patient 10, the next patient I became aware of was a patient who I now conclude is Patient Patient 13, who was one of the five patients who was included in RCA Personal Information redacted by. Siobhan Hynds forwarded me an email from Ronan Carroll on 3rd March 2017, indicating in red font that *"1 patient (Personal Information redacted by the USI) with confirmed High Grade Urothelial cancer, G3 pT4a. cancer (path confirmed today)"*. **This**

can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170303 Email from S Hynds. This was the second patient whose care was referred for SAI review. The next patient I became aware of was Patient 14. I was included in an email **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170406 email from Ronan Carroll Urology escalation** Patient 14 **)** from Mr Ronan Carroll on 6th April 2017 along with Esther Gishkori and Dr Wright, in which he was advising that Patient 14 was patient number 3 with a confirmed cancer whose referral had not been triaged. I forwarded Ronan Carroll's email to Dr Wright and Siobhan Hynds on 11th April 2017 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170411 Email to SH and Dr Wright re SAIs)**, and enquired if there were to be SAI's in relation to each of the patients. Siobhan Hynds replied on 12th April 2017 and asked Dr Wright if Dr Khan, as Case Manager, should be advising Mr O'Brien of these cases **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170412 Email Response from SH to VT and Dr Wright re SAIs)**. Dr Wright emailed Dr Khan and included me in the email and requested that Dr Khan arrange to meet Mr O'Brien 'ASAP' to advise him of the two further SAIs; these would have been patients Patient 13 and Patient 14. On 11th May 2017, I knew there were 5 cases for SAI Review due to confirmed cancer following non triage, inclusive of the index case, patient Patient 10. I knew this from an email trail sent to me from Esther Gishkori, which stated there were five patients with confirmed cancer. I understand that these five patients included patient Patient 10; the four other patients I now know to be identified as Patient 14, Patient 11, Patient 13, Patient 12 from reading page 17 of the 2017 MHPS investigation report **(this can be located at Relevant to HR / Reference no 1 / MHPS Investigation Report / MHPS Investigation / Report of Investigation - MHPS Mr A O'Brien - FINAL June 2018).** RCA Personal Information redacted by, however also included patient Patient 15. I have no record of having been advised of this patient but I understand from reading the RCA Personal Information redacted by report that this patient was discovered later at an outpatient clinic, and also not triaged and had a confirmed cancer diagnosis. The first time I had

access to the RCA Personal Information redacted by report was when it was included along with Appendices to a GMC letter concerning Mr O'Brien sent by email from Stephen Wallace, Assistant Director in the Medical Director's Office on 17th August 2020. Stephen Wallace was assisting Dr O'Kane with correspondence to the GMC, and he was seeking comments via email on 17th August 2020 from a range of Trust staff, including me, on the letter to the GMC, which was one of the attachments to his email. **This can be located at Attachment folder S21 49 of 2022 Attachment 52b.**

14(iii) In respect of Patient "Patient 16" (RCA Personal Information redacted by) **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20200203 Email from M McClements to VT with SAI attachment 2)** , I do not have any records in my email archive regarding this case, except for a copy of the completed RCA report Personal Information redacted by the sent to me by Melanie McClements on 3rd February 2020, who was covering as Interim Director of Acute Services. I do not remember at all the context in which Melanie McClements was sending me the report, as the email does not make it clear **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20200203 Email from M McClements to VT with SAI attachment 1).** It would be very unusual for me, as Director of HR & OD to be sent any RCA reports following SAI Review.

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

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

15(i) As outlined above in my response at 14(i), on 30th November 2016, Dr Wright emailed Esther Gishkori and copied me into the email. **This can be found at Attachment folder S21 49 of 2022- Attachment 51.** This email indicated that Esther Gishkori had informed Dr Wright that there were emerging issues

in relation to Mr O'Brien from an *"ongoing SAI"*. This was the SAI in respect of patient Patient 10. Mr O'Brien was on sick leave at that point in time. I then recall receiving a telephone call from Simon Gibson just prior to Christmas 2016. I know from my email archive that this must have been on the morning of 21st December 2016, as I have an email from Simon Gibson which he forwarded to me from Dr Wright to him which indicated that Esther Gishkori had contacted him about *"worrying developments and lost notes"* in relation to Mr O'Brien. **This can be found at Attachment folder S21 49 of 2022- Attachment 52.** Dr Wright advised in this email that he did not believe he could wait until the *"formal completion of the SAI"*. Simon Gibson was ringing me to check if I was free to join a meeting the following day to discuss the issues that were emerging. This was the background context to the Oversight Group meeting, which took place the next day on 22nd December 2016 relating to Mr O'Brien.

15(ii) In respect of the process, the meeting on 22nd December 2016, was held in the context of the Oversight Group arrangements at that time as referenced in the 2010 Trust Guidelines. In essence, it was a follow on meeting from the 13th September 2016 and 12th October 2016 meetings. A Screening Report had been reviewed at the Oversight Group meeting on 13th September and it was confirmed there were concerns to be resolved in relation to Mr O'Brien's practices. A plan had been agreed at that meeting, as outlined in my response at 13(viii) and 13(ix) above, to address the concerns informally, which was then subsequently changed to an alternative plan by Esther Gishkori after discussion with Francis Rice and Dr Wright involving Dr McAllister and Mr Weir. That alternative plan, outlined in my responses at 13(xii), 13(xiii), 13(xv) and 13(xvi), was not subsequently communicated to Mr O'Brien by either the Clinical Director, Mr Weir, or the Associate Medical Director, Dr McAllister, prior to Mr O'Brien beginning sick leave, the commencement date of which I now know to be 16th November 2016. When Dr Wright received an update from Esther Gishkori on or around 21st December 2016 that there were worrying developments in the SAI case (Patient 10) involving Mr O'Brien, the Oversight Group meeting was re-established by Simon Gibson following an

email to him from Dr Wright. Esther Gishkori was on annual leave on 22nd December, the date of the Oversight Group meeting; Ronan Carroll, Assistant Director in Acute Services, deputised for her.

15(iii) The notes of the 22nd December 2016 Oversight Group meeting contained an error which was not picked up at the time, after they had been circulated. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161223 Doc attachment Notes of oversight meeting 22.12.21.** The following paragraph was included:

"Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October."

The reference to 'formal' investigation was an error; it should have read 'informal' investigation as per the notes of the 13th September 2016 Oversight Group meeting.

This error was picked up as part of the Grievance process following Mr O'Brien lodging a grievance in November 2018 after the completion of the MHPS investigation. Mrs Shirley Young, Associate of the HSC Leadership Centre and Dr Aisling Diamond, Deputy Medical Director, addressed this grievance in 2020.

15(iv) In December 2016, both Clinical Managers, Dr McAllister and Mr Weir, were [redacted]. I do not know who, clinically, Dr Wright engaged with in relation to the concerns, which were becoming known as part of the SAI Review in respect of patient Patient 10; it may have been Mr Mark Haynes who at that time was the Clinical Director – General Surgery and Trauma &

Orthopaedics, and who is a Consultant Urologist. Dr Wright referenced Mr Haynes in his email of 21st December 2016 **(This can be found at Attachment folder S21 49 of 2022- Attachment 52)** to Simon Gibson as someone who should come to the Oversight Group Meeting. Mr Haynes, however, was not in attendance at the meeting on 22nd December 2016. Due to the absence of both Dr McAllister and Mr Weir Personal Information redacted by the USI, the delay in addressing the concerns from the first Oversight Group meeting on 13th September 2016, (and indeed from earlier in the year in January 2016 when Dr Wright first heard about the concerns from Heather Trouton, Assistant Director) and the fact there were now concerns being raised through an SAI process indicating actual harm may have been caused to a patient, my view then and now is that Dr Wright considered he had to act. I knew from the meeting on 22nd December 2016, he was becoming increasingly concerned in relation to patient safety.

15(v) Dr. Tracey Boyce, Director of Pharmacy, and at that stage Acute Governance Lead, was in attendance at the Oversight Group meeting on 22nd December. Tracey Boyce provided a verbal summary of the position at that time regarding the SAI relating to patient Patient 10, and reported that the patient may have had a poor clinical outcome due to a delay in the triaging of the GP referral. The SAI was still ongoing at that point so there was no written report available at the meeting. Ronan Carroll, Assistant Director of Acute Services, who was also at the meeting, verbally reported a triage backlog of 318 letters from between July 2015 and October 2016 – a delay of between 4 and 72 weeks. This was a significantly worse position than was reported at the 13th September 2016 meeting, when it was reported there were 174 untriaged letters dating back 18 weeks. Ronan Carroll also reported that there were a number of patient notes tracked out to Mr O'Brien on the Patient Administration System (PAS), and advised that it was thought that these were in Mr O'Brien's home. Ronan Carroll advised that the notes of the patients seen by Mr O'Brien in South West Acute Hospital were thought to be in his home. Given that the notes were in Mr O'Brien's home there was a concern that the clinical plan for these patients might not be known to anyone else in

the Trust, and therefore the plan may be delayed for these patients. The final concern raised by Ronan Carroll was the backlog of 60 undictated clinics going back over 18 months resulting in approximately 600 patients for whom their clinical management plan may be unknown to anyone else in the Trust, and may be delayed. In summary, the three concerns raised on 22nd December 2016 were the same concerns that were reported to Oversight Group meeting on 13th September 2016. On 22nd December 2016, however, there was tragically also the update coming out of the ongoing SAI Review, that a patient was likely to have come to harm, and that a delay in triage by Mr O'Brien was likely to have been a contributory factor.

15(vi) Both Dr Tracey Boyce and Ronan Carroll reported verbally from their own records at the Oversight Group meeting, and there was no written report presented due to the Oversight Group meeting being called by Dr Wright just the day before.

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

15(vii) There were a number of actions agreed at the Oversight Group meeting of 22nd December 2016 and are outlined in the notes of the Oversight Group meeting **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161223 Doc attachment Notes of oversight meeting 22.12.21):**

a) Action in respect of non-triage of letters and the associated backlog

A written action plan to address this issue, with a clear timeline, was to be submitted to the Oversight Group Meeting, which was to be convened on 10th January 2017. The two identified leads for this action were Ronan Carroll and Mr Colin Weir.

b) Patient notes

A case note tracking exercise was to be undertaken to quantify the volume of notes tracked to Mr O'Brien, and a check made to whether these were in his office in Craigavon Area Hospital. An update was to be reported back on 10th January 2017 to the next Oversight Group meeting. The lead for this action was Ronan Carroll.

c) Undictated clinics

A written action plan to address this issue, with a clear timeline was to be submitted to the Oversight Group meeting on 10th January 2017. Leads for this action were identified as Ronan Carroll and Mr Colin Weir

d) Previous incident reports / complaints

It was also agreed to undertake a check for any Incident Reports (IR1's) and complaints involving Mr O'Brien to identify if there were any historical concerns raised. Lead for this action was Dr Tracy Boyce as lead for Governance within Acute Services as she had access to the Governance systems.

e) Formal Investigation and exclusion and meeting with Mr O'Brien

Given the concerns raised in both September and December 2016, and in light of the additional information emanating from the SAI Review, that a patient had a poor clinical outcome, Dr Wright felt strongly that a formal investigation under MHPS was required. I fully supported that view. We discussed whether there was a need to exclude Mr O'Brien from work, as we were aware that he was due back to work from sick leave immediately following the New Year. The emerging information from the SAI Review meant that there was some evidence that Mr O'Brien's administrative practices had led to the strong possibility that patients may have come to harm, and given this, it was considered too big of a risk to have Mr O'Brien return to work immediately after Christmas. Dr Wright and I both considered that if Mr O'Brien returned at the start of January 2017, there was the strong likelihood that his continuing administrative practices could impact on the clinical outcomes of patients. My clear recollection of our discussion was

about the need to ensure, given the volumes being reported at the meeting, that there was a very robust analysis of the exact extent of the backlogs and missing charts, and the impact of each of these concerns in relation to patient safety. Until there was more clarity on this, we considered exclusion was the more appropriate course of action than restriction of duties. It was agreed that Mr O'Brien would need to be contacted before his planned return to work date in January 2017 to communicate the decision to move to formal investigation, and my understanding, based on what is reflected in the notes recorded by Mr Simon Gibson, was that 30th December 2016 was the date Dr Wright was aiming to meet with Mr O'Brien. I understand from Mr O'Brien's grievance on page 1 section 2.1, which he submitted in November 2018, that there is a dispute around the date originally offered by the Medical Director's Office for the meeting **(this can be located at Relevant to HR / Reference no 33 / Grievance Panel 1 / 20181127 - Summary of Comments on Grievance Submission)**. However, the 30th December 2016 date was included in the notes by Simon Gibson that were typed up and sent via email on 23rd December 2016 to those who attended the Oversight Group meeting the day before.

f) NCAS advice

Dr Wright indicated he would take NCAS advice in relation to the intended course of action as outlined in e) above.

g) Identification of Case Investigator & Case Manager

Mr Colin Weir, Clinical Director was agreed as Case Investigator, and Dr Ahmed Khan, Associate Medical Director for Children and Young People's Services was agreed as Case Manager. Dr Neta Chada, following representations made by Mr O'Brien in February 2017, replaced Mr Weir as Case Investigator – see my response at 22(iii) below.

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

15(viii) My section 21 notice (No. 49 of 2022) refers to the Medical Director in this question. For clarity, my answer below refers to my role as HR Director in relation to any involvement I had in ensuring the actions from the 22nd December 2016 Oversight Group Meeting took place.

15(ix) Actions identified above in 15(vi) a, b, c, d, f, and g were all actions assigned to other leads outside of my HR Directorate. I did not take any action as HR Director to ensure these actions were followed up, however, progress with actions outlined in 15(vi) a,b,c above were reported back at the next Oversight Group meeting on 10th January 2017. Actions outlined in 15(vi) f and g above were taken forward by Dr Wright and did not require any follow up from me. I do not know the outcome of 15(vi) d and I did not follow this up with Dr Tracey Boyce. In respect of 15(vi) e, I understand a member of the administrative staff, possibly Ms Laura White, in Dr Wright's Office, made contact with Mr O'Brien to ask him to meet with Dr Wright. On 28th December 2016, while I was on annual leave, I emailed Ms Lynne Hainey, Acting HR Manager, to ask her to accompany Dr Wright to the meeting with Mr O'Brien **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161228 Email from Vivienne Toal to Lynne Hainey re request to meet with AOB to exclude).**

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

16(i) I first became aware that this may have been a concern at the Oversight Group Meeting on 10th January 2017. I recall Mr Ronan Carroll advised that following a review of TURP patients since the Oversight Group meeting on 22nd December 2016, it had been identified that nine patients who had been seen privately by Mr O'Brien as outpatients, subsequently had their procedure within the NHS. The waiting times for these patients appeared to be significantly less than for other patients. It appeared at that stage that there

was an issue of Mr O'Brien scheduling his own patients in non-chronological manner. This matter was recorded in the notes of the meeting of 10th January 2017 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170120 Attachment_ Oversight meeting notes 10.01.2017).** This matter was subsequently included in the Terms of Reference for the formal investigation.

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

17(i) The two HR Directorate staff involved in the MHPS case were Lynne Hainey, who at the time of Mr O'Brien's exclusion was Acting HR Manager and Siobhan Hynds, who at the time of the investigation was Head of Employee Relations.

17(ii) At the Oversight Group meeting on 22nd December 2016, the decision to commence a formal investigation and to place Mr O'Brien on immediate exclusion was agreed. I was not party to any discussion between Dr Wright and Francis Rice, Acting Chief Executive in relation to the need for immediate exclusion following the Oversight Group meeting; Dr Wright may be able to clarify this. In Section I, para 22 of MHPS, the Clinical Manager is the one who explains to the practitioner why the exclusion is justified. As both Mr Weir and Dr McAllister were [redacted], Dr Wright was, in effect, the Clinical Manager of Mr O'Brien for the purposes of the meeting on 30th December 2016 when he was informed of the immediate exclusion. Lynne Hainey was the HR Manager who accompanied Dr Wright to the meeting on 30th December 2016. Whilst an exact date of a follow up meeting, in line with Section I para 22, of up to a maximum of four weeks was not agreed at the meeting, the timescale of four weeks was stated in the notes of the meeting of

30th December 2016 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170105 Attachment to Email from Lynne Hainey _notes of 30.12.2016 meeting with AoB).** Lynne Hainey took notes at the meeting and documented them in accordance with Section I para 24. The notes of the 30th December 2016 meeting were sent to Mr O'Brien on 18th January 2017 also in line with Section I para 24. I know this as this is referenced in Dr Wright's letter to Mr O'Brien dated 23rd January 2016 (letter was dated 2016 in error – it should have stated 2017) **This can be located at Relevant to HR / reference no 33/ GRIEVANCE PANEL 1/20160123 - Tab 21 Dr Wright letter to AOB Letter in response to letter of 17 Jan 2016**. My response at 23(i) provides more detail in relation to the steps Lynne took associated with this meeting of 30th December 2016.

17(iii) As per my response later at 23(ii), Siobhan Hynds was designated as the HR management support for the MHPS process on or around 9th January 2017. This role involved the following:

a) In line with MHPS Section I para 25, Siobhan Hynds assisted Mr Weir, the original Case Investigator, to undertake the initial investigation in order to determine a clear course of action. Siobhan Hynds was involved in supporting Mr Weir by drafting the Preliminary Report for him to present at the Case Conference on 26th January 2017. Siobhan Hynds provided support to Mr Weir at the meeting with Mr O'Brien on 24th January 2017 convened in line with MHPS Section I para 23 to enable him to state his case and propose alternatives to exclusion. In line with Section I para 24, Siobhan Hynds noted the meeting with Mr O'Brien, and provided him with a copy of the notes on 6th February 2017.
b) Siobhan Hynds assisted Mr Weir, the original Case Investigator with drafting and finalising the Terms of Reference for the formal investigation during January 2017.
c) Siobhan Hynds assisted Mr Weir to develop the Return to Work Plan as an alternative way to manage risk, and thereby avoiding the need for formal

exclusion. This was in line with MHPS Section I para 5. Siobhan Hynds accompanied Mr Weir to a meeting with Mr O'Brien on 9th February 2017 to discuss his return to the workplace as per the Return to Work Plan dated 9th February 2017.

d) MHPS Section I paras 31, 32 and 33 set out the role of the Case Investigator. In this context, Siobhan Hynds provided support to Dr Neta Chada, (who replaced Mr Weir, as Case Investigator - see 22(iii) below) in terms of advice relating to how the investigation was carried out (MHPS Section I para 33). In addition, Siobhan Hynds provided all of the administrative support for the investigation including note taking, typing of statements and issuing of statements for accuracy checking (para 31), following up on information requests from Acute Services to assist with the investigation and preparation of the investigation report. Siobhan Hynds also provided support to Dr Chada in preparing the investigation report with its conclusions (para 31).

e) Updates to the Case Manager, Dr Khan were also provided by Siobhan Hynds on behalf of Dr Chada, to enable Dr Khan to update John Wilkinson, the Designated Board Member so that he could review the progress of the case (para 31).

f) MHPS Section I paras 34, 35 and 36 outline the Case Manager's role. On 16th March 2017, an initial list of seven witnesses were provided to Mr O'Brien by Siobhan Hynds in accordance with MHPS Section I para 35. Siobhan Hynds also issued to Mr O'Brien, copies of statements of all witnesses, and provided him with time to comment on these statements. Mr O'Brien was afforded the opportunity to put his version of events to the Case Investigator on two occasions in August and November 2017, and given the opportunity to be accompanied; Siobhan Hynds corresponded with Mr O'Brien in respect of these arrangements.

g) Siobhan Hynds assisted Dr Khan as Case Manager to issue the Case Investigation Report to Mr O'Brien on 12th June 2018 for comment in line with Section I para 37. Siobhan Hynds prepared the accompanying letter for Dr Khan to issue with the Report.

h) As Case Manager, Dr Khan's role was to review the Case Investigation report and comments from Mr O'Brien, in order to reach a determination on the case, in line with Section I para 38. Siobhan Hynds assisted Dr Khan in the preparation of the Case Determination report in line with Section I para 38.

i) Siobhan Hynds was also involved in assisting with the preparation of draft letters for comment and amendments by Medical Directors, Dr Wright and Dr Khan, and Case Manager, Dr Khan prior to issue to Mr O'Brien.

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

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

18(i) My response to Q.18 has been compiled with the assistance of Mrs. Martina Corrigan, Head of ENT, Urology, Ophthalmology & Outpatients, and Miss Emma Stinson, Document Librarian, Trust Public Inquiry Team.

18(ii) I did not receive a copy of the Return to Work Plan dated 9th February 2017, attached to my Section 21 notice. I had a copy of the Return to Work Plan dated 9th February 2017 in documents provided to the Inquiry as part of Notice S21 2 of 2021, so I have therefore referred to it when responding to this question. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170209 - Attachment - Return to Work Action Plan February 2017 FINAL**

18(iii) I had no identified role as Director of HR & Organisational Development in monitoring Mr O'Brien's compliance with the Return to Work Plan covering the four concerns listed above. In order to respond to Q18, I requested access to emails relating to monitoring of the Return to Work Plan, and I spoke with Mrs. Martina Corrigan to clarify aspects of my answer.

18(iv) On 9th February 2017, Mr Weir, accompanied by Siobhan Hynds, met with Mr O'Brien to discuss the Return to Work Plan dated 9th February 2017. Staff within the Acute Services Directorate undertook the monitoring of Mr O'Brien's compliance with the Return to Work Plan i.e. Martina Corrigan and Ronan Carroll. Martina Corrigan as Head of ENT, Urology, Ophthalmology and Outpatients, confirmed to me during a telephone conversation with her on 24th June 2022 that it was her responsibility to monitor Mr O'Brien's compliance relating to each of the four concerns. I have been provided with a copy of an email dated 4th October 2018 by the Trust's Public Inquiry Team, from Martina Corrigan to Ronan Carroll **(This can be located Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Martina Corrigan/20181004-email return to work action plan.pdf).** In that email, it sets out how the monitoring process was undertaken by Martina Corrigan, and this is summarised below:

I. Un-triaged referrals to Mr Aidan O'Brien – Concern 1

Martina Corrigan checked NIECR to look at all outstanding triage for all consultants and then filtered for Mr. O'Brien. On a week that Mr O'Brien was on-call Martina stated she checked daily to ensure that the red flag referrals were triaged and also on the Monday following Mr O'Brien's on-call week to ensure it was all up to date.

II. Patient notes tracked out to Mr Aidan O'Brien - Concern 2

Martina Corrigan checked PAS to see how many charts were case note tracked to Mr O'Brien, and then she went to his office on a Friday

morning to check that the charts in the office matched those tracked out to him on PAS.

III. Undictated patient outcomes from outpatient clinics by Mr Aidan O'Brien – Concern 3

The Health Records Team, under the management of Mrs Katherine Robinson, Booking & Contact Centre Manager, provided Martina Corrigan with reports on backlogs with discharges awaiting dictation, discharges to be typed, clinical letters to be dictated and the oldest date of clinic letters to be dictated.

IV. The scheduling of private patients by Mr Aidan O'Brien – Concern 4

Martina Corrigan checked all theatre lists for all consultants to ensure that the patients had been appropriately listed.

18(v) Martina Corrigan confirmed to me by telephone call on 24th June 2022, that she monitored the position on a weekly basis, after Mr O'Brien returned to work in February 2017, with the exception of the period end of June 2018 to October 2018, [redacted]. Martina Corrigan also indicated to me that there was some disruption to the monitoring arrangements around April 2020, when the Covid-19 Pandemic commenced, given the impact of the Pandemic on hospital services at that time. An example Martina Corrigan gave me of this disruption was that she could not attend Mr O'Brien's office on a Friday morning to check patient charts, due to the PPE requirements, and the necessity to reduce footfall in patient areas in the hospital.

18(vi) The Return to Work Plan dated 9th February 2017 stated at the end of the three page document, that 'Any deviation from compliance with this action plane (sic) must be referred to the MHPS Case Manager immediately'. On

that basis, I interpret that as meaning there was no stated requirement for regular reporting to the Case Manager, Dr Ahmed Khan, if Mr O'Brien had complied with the Action Plan, but rather immediate referral to him if he deviated from it.

18(vii) I have been given access by the Trust Public Inquiry Team to an email thread originating from Dr Khan, dated 12th April 2017, to Esther Gishkori and Ronan Carroll, with a copy to Siobhan Hynds, in which Dr Khan requested an update regarding Mr O'Brien's adherence to the Return to Work Plan. Ronan Carroll forwarded that email to Martina Corrigan and Mr Weir on 12th April 2017, requesting that Martina Corrigan *"provide this update asap pls"*. Martina Corrigan replied to Ronan Carroll with the update on 14th April 2017, confirming Mr O'Brien's compliance with the plan at that time **(This can be located at Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Martina Corrigan/20170414-email confidential MC to RC on action plan.pdf).** On 4th May 2017, Dr Khan sent an email to Ronan Carroll, with a copy to Siobhan Hynds, requesting *"Please send the monthly update by end of next week (12th May)."* **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170504 - Email - RE MHPS case.** On 8th May 2017, Ronan Carroll sent an email to Martina Corrigan, with a copy to both Siobhan Hynds and Dr Khan, stating, "I would wish our auditing to continue weekly the reason being if anything starts to slip we can act quickly". Martina Corrigan replied to Ronan Carroll's email stating, *"This is ok and I have a rolling reminder in my calendar for every Friday".* **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170508 - Email - RE MHPS case update on 5 May 2017 2.**

18(viii) Siobhan Hynds, who was the HR support to the MHPS Case Investigator, Dr Neta Chada (who replaced Mr Weir – see response at 22(iii) below), did not have an identified role in monitoring Mr O'Brien's compliance with the Return to Work Plan. However, I can see from the emails provided to me from the Trust's Public Inquiry Team, that Siobhan Hynds was copied into a number of

emails from Martina Corrigan to Dr Khan and Ronan Carroll from 25th May 2018 to 23rd June 2018, which provided weekly confirmation regarding Mr O'Brien's adherence to the Return to Work Plan. **These can be located at:**

Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180525 - Email - Return to Work Action Plan - Mr O'Brien.pdf

Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180601 - Email - RE Return to Work Action Plan - Mr O'Brien.pdf

Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180611 - Email - FW RE Return to Work Action Plan - Mr O'Brien.pdf

Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180615 - Email - Return to Work Action Plan - Mr O'Brien.pdf

Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Martina Corrigan/20180623-email return to work action plan.pdf

18(ix) Martina Corrigan was [Personal Information redacted by the USI] from June 2018 to October 2018. During this period, I understand from an email from Ronan Carroll, which has been provided to me from the Trust's Public Inquiry Team, dated 18th October 2018, that monitoring did not take place during this period in her absence. Ronan Carroll's email of 18th October 2018, sent to Simon Gibson, Mr Weir, Dr Khan and Mr Haynes, states "With Martina having been off since June the overseeing function has not taken place and in the day to day activities was overlooked". Martina Corrigan confirmed with me during a telephone conversation on 24th June 2022 that she was off work much longer than the 8 weeks originally anticipated. She confirmed to me that no one undertook the monitoring of Mr O'Brien's compliance with the Return to Work plan during her absence from work.

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

19(i) My response to Q.19 has been compiled with the assistance of Martina Corrigan, Head of ENT, Urology, Ophthalmology & Outpatients.

19(ii) My understanding of the period of time during which the Return to Work Plan / Monitoring Arrangements remained in operation was from the date Mr O'Brien returned from sick leave on 20th February 2017 until the date of his retirement on 30th June 2020. My responses to Q18 above, set out the persons responsible for overseeing the operation of the Plan during this time frame, and identifies that monitoring arrangements broke down from June to October 2018. Martina Corrigan confirmed that my understanding of the monitoring time frame was correct during our telephone conversation on 24th June 2022.

19(iii) During my conversation with Martina Corrigan on 24th June 2022, she advised me that she had received a letter from Mr O'Brien on 7th November 2019. Martina Corrigan emailed me a copy of this letter after our telephone conversation **(This can be found at Attachment folder S21 49 of 2022- Attachment 53).** Mr O'Brien's letter was in response to Martina Corrigan's request to meet with him on 8th November 2019 along with Mr Ted McNaboe, Clinical Director, Surgery & Elective, Urology & ENT regarding deviations from the Return to Work Plan. Martina Corrigan advised me that these deviations related to Concern 1 – delay in triage and Concern 3 – delayed dictation of letters. I refer to these deviations in more detail in Q20(x) below. In Mr O'Brien's letter of 7th November 2019, he refers to Dr Khan's Case Manager Determination (28th September 2018) following the MHPS investigation, which stated on page 8 that the purpose of the Return to Work Plan was *"to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process"*. Mr O'Brien went on to outline in his letter to Martina Corrigan that a recommendation in the Case Manager's

Determination had not been implemented; this was the recommendation relating to a further action plan to be put in place with the input of Practitioner Performance Advice for an agreed period of time, along with an accompanying agreed balanced job plan. Mr O'Brien's purpose in writing to Martina Corrigan was to state that *"It is evident that the issues that you wish to discuss, cannot be considered deviations from a Return to Work Plan which expired in September 2018"*. My interpretation of Mr O'Brien's view expressed in his letter was that the Return to Work Plan expired in September 2018. Further, as the Trust had not implemented Dr Khan's recommendation to put in place a further action plan following the conclusion of the formal investigation process, that Mr O'Brien considered that Martina Corrigan and Mr McNaboe were not entitled to address his lack of timely triaging of red flags and timely dictation of letters. It was however clear that following the commencement of Martina Corrigan's Personal Information redacted by the USI in June 2018, Mr O'Brien's compliance with the Return to Work Plan was already beginning to lapse in the absence of Martina Corrigan undertaking monitoring.

20. With specific reference to each of the concerns listed at (17) (i)-(iv) above, indicate if any divergences from the Return to Work Plan were identified and, if so, what action you took to address and/or escalate same.

20(i) My response to Q.20 has been compiled with the assistance of Martina Corrigan, Head of ENT, Urology, Ophthalmology & Outpatients, and Emma Stinson, Document Librarian, Trust Public Inquiry Team.

20(ii) The Trust's Public Inquiry Team has given me access to an email from Siobhan Hynds to Martina Corrigan and Ronan Carroll dated 18th May 2018, in which Siobhan Hynds was checking if Mr O'Brien had fully adhered to date to the 9th February 2017 action plan. Siobhan wanted to confirm if this was the case for the purposes of the MHPS investigation report she was assisting Dr Chada to prepare **(This can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20180518 - Email -**

Return to Work Action Plan February 2017 FINAL.pdf). Martina Corrigan replied to Siobhan Hynds and Ronan Carroll on 22nd May 2018. She advised that *"Apart from one deviation on 1 February 2018 when Mr O'Brien had to be spoken to regarding a delay in Red Flag triage and he immediately addressed it, I can confirm that he has adhered to his return to work action plan, which I monitor on a weekly basis."* Siobhan Hynds forwarded Martina's response email of 22nd May 2018 to me on 23rd May 2018, and on the same day I forwarded it to Dr Khan for information. In my email of 23rd May 2018, I asked Dr Khan if he had been getting updates on a regular basis in terms of assurance. Dr Khan replied to me on 24th May 2018 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180524 Email to VT from Dr Khan re monitoring plan)** stating that he had been until earlier in the year from Ronan Carroll, but that he *"haven't received it in few months now. Have spoken to him recently & he will forward this to me".*

20(iii) On 5th February 2018 I sent an email to Siobhan Hynds relating to a number of matters regarding Mr O'Brien's MHPS case **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180205 Email to SH re AOB MHPS update)**. In the body of that email I asked Siobhan Hynds to ring Ronan Carroll. This was because Mr Mark Haynes, Associate Medical Director, in a meeting about an unrelated medical staffing matter with Dr Wright and myself on 1st February 2018, had mentioned that Mr O'Brien's triage was slipping. Whilst it was not my role to monitor or deal with escalations regarding the Return to Work Plan, my purpose in asking Siobhan Hynds to ring Ronan Carroll was to ensure if there needed to be any escalation to Dr Khan as Case Manager, that this was actually done in line with the Return to Work Plan. I do not know if Dr Wright followed this matter up with Dr Khan as Case Manager, however, I considered at the time that a phone call to Ronan Carroll from Siobhan Hynds was important to ensure any escalation was followed through in the interests of patient safety.

Urology Services Inquiry

20(iv) From the emails provided to me by the Trust's Public Inquiry Team, it is clear that between 4th and 18th October 2018 Martina Corrigan and Ronan Carroll were aware that Mr O'Brien had not been adhering to the Return to Work Plan **(These can be located Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/reference 77 - Martina Corrigan/20181004-email return to work action plan.pdf.**
Relevant to PIT/Evidence Added or Renamed 19 01 2022/Evidence no 77/No 77 - Colin Weir CD/20181018- E Return to work action plan February 2017 Final 3aa.pdf
Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/20181018 Return to Work AP.pdf
Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/no 77 - emails Mr Mark Haynes -AMD and Consultant Urologist/20181018-return to work.pdf)
This non-adherence is linked to Martina's [redacted] referred to above in 18(ix) when monitoring did not take place. On 18th October 2018, Ronan Carroll requested that Wendy Clayton, Acting Head of Service for General Surgery, Breast and Oral Services, speak with Mr Weir in Craigavon Area Hospital in order to address Mr O'Brien's non-compliance with the Return to Work Plan. Approximately an hour after Ronan Carroll sent the email to Wendy Clayton on 18th October 2018, Mr Weir emailed Simon Gibson and Dr Khan at 11.33, to alert them to concerns that Mr O'Brien had *"accumulated a large backlog of dictated letters and large numbers of charts in his office"* **(This can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/no 77 - emails Mr Mark Haynes -AMD and Consultant Urologist/20181018-return to work.pdf).** These concerns relate to Q17 II and Q17 III above. Ronan Carroll, Wendy Clayton and Mr Haynes were also included in the email. In October 2018 Dr Khan was Acting Medical Director (as well as Case Manager for the Mr O'Brien MHPS case), due to Dr Richard Wright's (Medical Director) retirement. On 18th October 2018, an email from Wendy Clayton to Ronan Carroll confirmed that there were 91 letters in the dictation backlog with the longest date with no dictation back to 15th June 2018 **(This can be located at Relevant to PIT/Evidence**

after 4 November 2021 PIT/Reference 77/no 77 - emails Mr Mark Haynes - AMD and Consultant Urologist/20181018-email return to work followup att1.pdf) A further email from Ronan Carroll on the evening of 18th October 2018 to Simon Gibson, Mr Weir, Dr Khan and Mr Haynes confirmed again the backlog of 91 undictated letters (Q17 III), and also confirmation that there were 74 charts tracked to Mr O'Brien (Q17 II) **(this can be located at Relevant to PIT/Evidence after 4 November 2021 PIT/Reference 77/no 77 - emails Mr Mark Haynes -AMD and Consultant Urologist/20181018-email return to work followup.pdf).** The email provided confirmation that there was no concern relating to delayed triage (Q17 I) or the scheduling of Mr O'Brien's private patients (Q IV). Dr Khan, on 18th October 2018, emailed Simon Gibson and Ronan Carroll and indicated he was meeting with Siobhan Hynds the following day, and asked if they could attend the same meeting in Daisy Hill Hospital. Ronan replied that evening to advise he would be in London the following day and that he had sent Simon Gibson some information on the backlog **(this can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20181018 - Email - RE Return to Work Action Plan February 2017 FINAL.pdf)** I do not know if Simon Gibson met with Dr Khan the next day.

20(v) It was Siobhan Hynds who alerted me to the concerns regarding Mr O'Brien's non-compliance to the two parts of the Return to Work Plan via email on 21st October 2018 i.e. Patient notes tracked out to Mr Aidan O'Brien - Concern 2 **(**Q17 II) and Undictated patient outcomes from outpatient clinics by Mr Aidan O'Brien – Concern 3 (Q17 III). **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181021 Email from S Hynds re Investigation.**

20(vi) On 22nd October 2018, the Acting Service Administrator in Surgery & Elective Care, Collette McCaul, emailed Katherine Robinson, Booking & Contact Centre Manager, to confirm that 'there was nothing overly concerning so far' with regards to the charts in Mr O'Brien's office. Collette McCaul outlined the

reasons for this – for example, deceased charts, patients transferred to Belfast and no follow up required in the Trust.

20(vii) I cannot recall if it was me or Dr Khan who alerted Shane Devlin, Chief Executive to the concerns regarding the compliance to the Return to Work Plan, however a video call meeting was set up by Siobhan Hynds for 23rd October 2018 11.30am to 12.30pm presumably to brief the Chief Executive regarding this matter, and to give him a general update on the case **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181023 Video call date re MHPS case)**. I have no notes of this meeting. At 15.02 on the 23rd October 2018, an update email sent by Ronan Carroll to Dr Khan, Siobhan Hynds, Simon Gibson and myself, confirmed that the letter dictation had reduced to 16 awaiting dictation dating back to 28th September 2018, with 54 patient charts in Mr O'Brien's office. Ronan Carroll emailed Simon Gibson, Dr Khan, Siobhan Hynds and myself, on 23rd October 2018 at 15.34 to enquire regarding the outcome of the meeting and if they were to continue to monitor Mr O'Brien against the four elements of the Return to Work Plan. Dr Khan replied to Ronan Carroll at 16.08 that afternoon to confirm *"The action plan must be closely monitored with weekly report collected as per AP."* (AP stands for Action Plan). **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181023 Email from Dr Khan re monitoring.**

20(viii) On 23rd October 2018 at 16.57, Dr Khan emailed Mr O'Brien (copy to John Wilkinson, Designated Board Member and Siobhan Hynds), in response to an email sent by Mr O'Brien to him on 21st October 2018 about other matters **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / /20181023 - Email - RE Information Request)**. In Dr Khan's email he finishes his email by asking, *"Aidan, I take this opportunity to ask if you are adherent to agreed MHPS action plan (attached)?"* Dr Khan attached the Return to Work Action Plan, dated 9th February 2017 to him email. On 2nd November 2018, Mr

O'Brien responded to Dr Khan **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181102 Email from AOB to Dr Khan)** and stated *"I also note your enquiry as to my adherence to the Return to Work Plan. I will address your enquiry in a separate email in coming days"*. I do not have a copy of any further correspondence from Mr O'Brien in relation to adherence to the Return to Work Plan, and I do not know if he ever emailed Dr Khan as indicated.

20(ix) The emails provided to me from the Trust's Public Inquiry Team indicate that Martina Corrigan re-commenced weekly emailing to Dr Khan, Siobhan Hynds and Ronan Carroll on 10th November 2018 regarding Mr O'Brien's compliance with the Return to Work Plan. Dr Khan emailed Martina Corrigan on 23rd November to say *"Please note I would only need monthly reports or earlier only if any issues"*. **This can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20181123 - Email - RE AOB Action plan 2.pdf**

20(x) On 18th September 2019, Siobhan Hynds forwarded me an email from Martina Corrigan to Dr Khan dated, 16th September 2019, with Subject: 'AOB concerns – escalation'. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email from S Hynds to V Toal re AOB escalation with attachments.** This email outlined Mr O'Brien's non-compliance with Concern 1 – delayed triage (relates to Q17(I) above), and Concern 3 – delayed dictation (relates to Q17 (III) above). Siobhan Hynds included a number of attachments that Martina Corrigan had forwarded to her for information to provide examples of the delays she was experiencing. These attachments were emails from Martina Corrigan to Mr O'Brien seeking responses from him in relation to delays in returning triage and delays in responding about a specific female patient. **These can be found at the following location:**

Urology Services Inquiry

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 1 to Email from S Hynds to VToal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 2 to Email from S Hynds to V Toal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 2(i) to Email from S Hynds to VToal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 2(ii) to Email from S Hynds to V Toal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 3 to Email from S Hynds to V Toal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 4 to Email from S Hynds to VToal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 5 to Email from S Hynds to VToal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 6 to Email from S Hynds to VToal re AOB escalation

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190918 Email attachment 6(i) to Email from S Hynds to VToal re AOB escalation

Siobhan Hynds' email to me on 18th September 2019 stated *"FYI – can we chat urgently tomorrow about this"*. I cannot recall the detail of a conversation with Siobhan Hynds, nor can I confirm when or if a conversation took place. Given the close working relationship and very regular contact I

would have had, and continue to have, with Siobhan Hynds, I believe it is very likely we did have a conversation about her email of 18th September 2019.

20(xi) I do not recall taking any action personally to address or escalate the concerns on the back of Siobhan Hynds email to me on 18th September 2019. However, on 18th September 2019 Dr Khan as Case Manager had already escalated an email to Dr O'Kane, Medical Director, informing her that he had requested an urgent meeting with Siobhan Hynds and Simon Gibson to discuss the issue and other updates regarding the MHPS case **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 /20190923 - Email - RE AOB concerns – escalation)** Dr Khan emailed Dr O'Kane again on 23rd September 2019 **(this can also be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 /20190923 - Email - RE AOB concerns – escalation)** to advise that he and Siobhan Hynds had discussed the case the previous week and that Siobhan Hynds had requested *"more information / clarification"* from Martina Corrigan. On 28th September 2019, Siobhan Hynds followed up with Martina Corrigan by email to check if she had received any more information on the backlogs. Martina Corrigan replied to Siobhan Hynds on 29th September 2019 to advise *"With the current operational pressures with beds and short staffed wards I didn't get to look properly at the backlog. I did do a check on a clinic of all of the other consultants and all dictated, and I did look at 2 AOB clinics in July and both have letter dictated on. I will delve deeper when I get back from my leave."* Later that evening, 29th September 2019, Siobhan Hynds emailed Dr Khan with the update from Martina Corrigan and advised him that until Martina had time to give more of an update, she was suggesting that he would need to ask Mr Haynes as AMD to have a conversation with Mr O'Brien about the current status of his work and backlog details. **This can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20190929 - E-mail Action Plan - A O'B.msg.**

20(xii) From a review of the emails provided to me by the Trust's Public Inquiry Team, I understand Dr O'Kane organised a meeting for 8th October 2019 to discuss the escalation of the concerns regarding Mr O'Brien's non adherence to the Return to Work Plan **(this can be located Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20191008 - Email - AOB OVERSIGHT MEETING – UPDATED).** The meeting diary entry was sent on 8th October 2019 from Dr O'Kane to Mr M Haynes, Dr A Khan, Melanie McClements and Siobhan Hynds. My attendance was not requested for that meeting, and I do not know what was discussed.

20(xiii) The above responses to Q 20 outline what I either knew to be the divergences at the time they occurred because I had been informed via email from February 2017 to June 2020, or those divergences that I have been able to deduce from a review of relevant emails provided to me by the Trust's Public Inquiry Team. My view is that Martina Corrigan and Dr Khan would be best placed to provide a comprehensive overview of the divergences given Martina's monitoring role and responsibility, and Dr Khan's Case Management role.

21. On what basis was it decided that Dr Khan, Case Manager, and Dr Wright, Medical Director, would respond to representations lodged by Mr. O'Brien with the designated Board member on 7th February 2017 and 6th March 2017 respectively.

21(i) I was on annual leave week commencing 13th February 2017. On 15th February 2017, Mr John Wilkinson, Designated Board Member for the MHPS case relating to Mr O'Brien emailed me referencing the fact that Siobhan Hynds had emailed him to explain a delay in commencing the MHPS investigation **(this can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 77 for John Wilkinson NED/20170215 - E - J Wilkinson to V Toal).** I replied to Mr Wilkinson's email to advise that Mr O'Brien had made a number of representations to him and

that care needed to be taken to consider them carefully **(this can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 77 for John Wilkinson NED/20170215 - E -V Toal to J Wilkinson)**. I was referring to the representations made by Mr O'Brien to Mr Wilkinson on 7th February 2017 **(this can be located at Relevant to HR / Reference no 33 / Grievance Panel 1 /20170207- TAb 23 AOB Concerns Regarding Investigation Process).** I explained that the Trust's solicitor was on leave also for the early part of the week, but that a call had been organised with her for Friday afternoon, which was 17th February 2017, and I was happy to join the call. During that telephone call with the Trust's solicitor, she reminded us of the role of the Designated Board Member as outlined in MHPS and the role of the Case Manager. The Trust's solicitor, did not consider that Mr Wilkinson as the Designated Board Member was the appropriate person to respond to the representations made, as he would not have had knowledge of many of the issues raised in the 7th February 2017 correspondence. Rather, the Trust's solicitor felt that the Case Manager, as the clinician leading the case, would have knowledge of the issues, and be more appropriately placed to respond with the information requested. Dr Khan, as Case Manager, replied to Mr O'Brien's representations on 24th February 2017, and copied his reply to Mr Wilkinson.

21(ii) The content of the second document from Mr O'Brien dated 6th March 2017 to Mr Wilkinson, Designated Board Member, included 47 questions which related to the early handling of the concerns relating to his administrative practice in 2016 before his exclusion. As Dr Wright was involved in this stage of the process, and not Mr Wilkinson or Dr Khan, either Siobhan Hynds, or I or both of us, considered it was appropriate for Dr Wright to respond, given that we knew what our solicitor's legal advice had been when the first representations were received on 7th February 2017. Siobhan Hynds may well have taken further legal advice in relation to this; however I personally have no record of doing so.

21(iii) I consider that the role of the Non-Executive Director within MHPS is not clear in respect of the handling of representations about the investigation. MHPS gives no other guidance other than what is included in MHPS paragraph 8 of Section I i.e. *'to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation.'* Given the nature of the questions asked by Mr O'Brien on both occasions, it is difficult for me to see how the role of the Designated Board Member could have done anything other than ensure responses were provided to Mr O'Brien by those who had the knowledge to respond. I am still of the view that Mr Wilkinson fulfilled his role under MHPS by considering the representations and ensuring the responses were made to Mr O'Brien. I am, however, very open to learning if Mr Wilkinson's role should have gone further in terms of considering the responses to Mr O'Brien's representations provided to him by Dr Khan and Dr Wright respectively.

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

I. The conduct of the investigation;

22(i) At the meeting of the Oversight Group on 22nd December 2016, I was very clearly of the view that the formal investigation was not going to be one that could be completed within four weeks as per Section I Para 37 of Maintaining High Professional Standards. The reason I knew this was at that stage, there were three concerns that required further exploratory work within Acute Services Directorate to understand the extent of the backlogs and missing notes. The four-week period of immediate exclusion during January 2017 allowed for the initial investigation and exploration of what the extent of the concerns were at that stage. This period led to the identification of a fourth

concern in respect of the scheduling of Mr O'Brien's private patients for NHS care. Dr Wright, Medical Director, in his correspondence to Mr O'Brien dated 23rd January 2016 (incorrectly dated, and should have been dated as 23rd January 2017), stated *"Whilst the guidance creates an expectation that investigations are completed within 4 weeks, it is my experience, and that of local NCAS colleagues, that this rarely is the case…."* **(this can be located at Relevant to HR / reference no 33/ GRIEVANCE PANEL 1/20160123 - Tab 21 Dr Wright letter to AOB Letter in response to letter of 17 Jan 2016)**. My view is that Mr O'Brien's case, given the extent of the backlogs and range of concerns, had 'exceptional circumstances' as per Section I Para 37 MHPS, which would prevent the investigation being concluded in four weeks.

22(ii) Paragraphs 20 and 23 of Section I Maintaining High Professional Standards were adhered to in terms of the preliminary situation analysis / initial investigation, meeting with Mr O'Brien to state his case and propose alternatives to exclusion, and convening of a case conference within the 4-week period of immediate exclusion.

22(iii) Mr O'Brien met with the Designated Board Member, John Wilkinson on 7th February 2017, and received a written document from him at that meeting with several **questions (this can be located at Relevant to HR / Reference no 33 / Grievance Panel 1 /20170207- TAb 23 AOB Concerns Regarding Investigation Process)**. As outlined above in my response to Q21(i), Dr Khan, as Case Manager, responded to Mr O'Brien's questions in a letter dated 24th February 2017 **(this can be located at Relevant to HR / Reference no 33 / Grievance Panel 1 /20170224 - Tab 25 Letter from Dr Khan addressing issues raised)**. On page 2 of Dr Khan's letter, second paragraph under Section 2 Formal Investigation, Dr Khan advised Mr O'Brien of his decision to replace Mr Weir as Case Investigator. This decision was made following legal advice to Dr Wright, Esther Gishkori and I on 17th February 2017 and was based on the representations made by Mr O'Brien about lack of management follow up to the 23rd March 2016 letter sent to him by Heather Trouton, Assistant Director Acute Services and Mr Eamon Mackle,

Associate Medical Director. Dr Khan advised Mr O'Brien that given Mr Weir was in post as Clinical Director following the issue of the 23rd March 2016 letter Mr Weir was likely to be asked to provide information on the management follow up, or lack of, as part of the formal investigation. Dr Khan advised at that stage that Dr Neta Chada, Associate Medical Director – Mental Health & Disability would take over the role as Case Investigator. Consideration of Mr O'Brien's representation regarding the process took time to consider and for legal advice to be sought. Dr Wright, following the legal advice to appoint a new Case Investigator to replace Mr Weir, made contact with Dr Chada, and confirmed this in an email to Dr Khan as Case Manager on 21st February 2017 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170221 - Email – Confidential).**

22(iv) On 21st February 2017, Siobhan Hynds made contact with Dr Chada and Dr Khan with a request for them to meet to discuss progressing the formal investigation. Dr Chada replied to state that she could meet on 1st March 2017 and Dr Khan replied to say he could meet on that date also **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170221 - Email - Re MHPS Case 1).** Siobhan Hynds replied to say that she could not meet as she had a disciplinary hearing on that date, and enquired if Dr Khan and Dr Chada wished to meet themselves, and she would arrange to talk separately to Dr Chada **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170221 - Email - RE MHPS Case).** Dr Chada and Siobhan Hynds met on 2nd March 2017 to discuss the case, and Siobhan Hynds forwarded a range of background information to Dr Chada regarding the case on this date also **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170302 - Email - MHPS Case Correspondence).** In Siobhan Hynds' email to Dr Chada, she advised her to make a call to Mr O'Brien to introduce herself and to reassure him that they were moving forward with the investigation. Siobhan Hynds, as HR support to

the Case Investigator, Dr Chada, commenced arranging meetings with witnesses on 6th March 2017; the first staff member she contacted was Ronan Carroll, Assistant Director – Acute Services.

22(v) From 15th March 2017 to 5th June 2017, there were 13 witnesses interviewed by Dr Chada as Case Investigator, supported by Siobhan Hynds. Dr Chada was a practising senior clinician and medical leader within the Trust at the time of the investigation, and was undertaking this investigation in addition to the demands of these other roles. The reality is that it is virtually impossible to release practising clinicians to focus only on a formal MHPS investigation; witness interviews take place when there are times in the clinician's job plan when direct clinical care is not being delivered. This was the case with Dr Chada. In addition, Siobhan Hynds at that time had a senior management remit within the Employee Relations function of my Directorate. This is a busy role, with responsibility for a range of services under the Employee Relations remit, and managerial oversight of a caseload involving a range of other Employee Relations cases including other non-medical cases. Both Siobhan Hynds and Dr Chada would have needed to have been released from their other roles to focus only on Mr O'Brien's case in order to progress more quickly with this case. This was not achievable, given ongoing clinical workloads for Dr Chada and ongoing Employee Relations caseloads and management commitments in respect of Siobhan Hynds. On many occasions, email correspondence was sent from Siobhan Hynds at night and weekends to keep on top of the investigation. The reality is that resources did not exist to step in and take their place. In addition, there is always a challenge when there are witnesses who are clinicians. The range of dates that suit the Case Investigator and HR Support do not always align with clinician's non-clinical time. Mr Haynes' limited availability is an example of this as outlined in his reply to Siobhan Hynds on 12th April 2017 outlining his difficulty meeting with Dr Chada and Siobhan Hynds on the suggested dates due to his clinical commitments **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds**

no 77 / 20170412 - Email - RE STRICTLY CONFIDENTIAL - TO BE OPENED BY ADDRESSEE ONLY).

22(vi) Dr Chada wrote to Mr O'Brien via letter dated 14th June 2017, requesting to meet with him on 28th June 2017 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170614 - Attachment - Letter to A O'Brien from Case Investigator 12 June 2017).** In that letter, Dr Chada outlined that she was giving Mr O'Brien early notification of the date to ensure he was able to secure accompaniment to the meeting if he wished to do so. Mr O'Brien replied to Siobhan Hynds on 15th June 2017 to advise 28th June 2017 was unsuitable due to his son not being free to accompany him, and due to the fact he had a scheduled theatre list. Mr O'Brien was offered two further dates by Siobhan Hynds via email on 16th June 2017 for 29th and 30th June 2017; both were not suitable for Mr O'Brien as he was scheduled to be Urologist of the Week then. Mr O'Brien suggested in his reply of 19th June 2017 an alternative date of Saturday 1st July 2017 to meet. Siobhan Hynds replied to Mr O'Brien on 19th June 2017 to advise that Dr Chada had hoped to be able to meet before July holidays given likely annual leave commitments of individuals involved in the process. In that email, Siobhan Hynds advised that Dr Chada was content to meet with Mr O'Brien on Saturday 1st July in the afternoon. Mr O'Brien replied later on 19th June 2017 to state 'I believe it would be better to defer meeting to later in July.' This was to avoid cancelling clinical commitments. Mr O'Brien proposed week commencing 31st July 2017 to meet. This date was agreed by both Dr Chada and Siobhan Hynds on 19th June 2017 and confirmed to Mr O'Brien on 23rd June 2017 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170623 - Email - RE Meeting on Wednesday 28 June 2017).** On 3rd July 2017, Mr O'Brien replied to state he would be on leave on 1st August to 4th August 2017 and that he normally reviewed his Oncology patients on Fridays. He advised that he had scheduled to do so on Monday 31 July 2017 in order to avoid further delays in reviews. Mr O'Brien gave two options to Siobhan Hynds in that email. The

first was for Mr O'Brien to meet with Dr Chada on Monday 31st July 2017 and reschedule the Oncology Reviews to his usual day for doing so, Friday 4th August 2017. Alternatively, the second option was that he could work Monday 31st July 2017 as scheduled, and, leaving Tuesday 1st August for preparation, meet with Dr Chada on Wednesday 2nd August, Thursday 3rd August or Friday 4th August 2017. Mr O'Brien's preference was the second option **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170703 - Email - Re Meeting on 31 July 2017.pdf).** The investigation meeting eventually took place on 3rd August 2017 with Mr O'Brien.

22(vii) My response at 22(v) above outlines further the challenges an investigation team has in progressing an MHPS investigation. The reasons given by Mr O'Brien on each occasion were linked to clinical commitments or unavailability of his son as his companion under MHPS Section I Para 30.

22(viii) At the investigation meeting on 3rd August 2017, as outlined in point 47 of Mr O'Brien's MHPS statement, he requested information in respect of the concerns raised to him about the scheduling of his private patients before he would answer any questions **(this can be located at Relevant to HR / Reference no 1/ MHPS Investigation Report / MHPS Investigation / Appendix 25 Statement - Mr A O'Brien 030817)** A further meeting with Mr O'Brien was therefore required, which did not take place until 6th November 2017, as hereinafter explained. At the meeting on 3rd August 2017, Mr O'Brien requested copies of all witness statements from the Trust staff interviewed as part of the formal investigation. In the intervening period between Mr O'Brien's first and second investigation meetings, I know Siobhan Hynds had 2 week's annual leave from 21st August 2017 to 4th September 2017. On her return from annual leave in September 2017, Siobhan continued to work on finalising the preparation and agreement of the 13 witness statements taken in the earlier part of the investigation, so they could be sent to Mr O'Brien in advance of the next investigation meeting with him. On 2nd October 2017, Siobhan Hynds wrote to Mr O'Brien offering two dates

to meet – 25th and 27th October **2017 (this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20171002 - Email - Strictly Confidential - MHPS Investigation.pdf).** Mr O'Brien was unable to meet on these two dates due to clinical commitments and the unavailability of his son as his companion. Mr O'Brien offered a range of other dates – 30th and 31st October, 2nd November, with the possibility of 6th and 7th November, subject to his son's availability **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20171009 - Email - RE Strictly Confidential - MHPS Investigation)**. The second investigation meeting took place on 6th November 2017. Again, the same reasons of clinical commitments on the part of both Mr O'Brien and Dr Chada balanced with Siobhan Hynds diary availability, along with the availability of Mr O'Brien's companion, contributed to the delay.

22(ix) At the investigation meeting on 6th November 2017, as outlined in para 3 of the MHPS statement, Mr O'Brien was advised by Dr Chada that this was the final meeting, after which she would conclude the investigation process. **This can be located at Relevant to HR / Reference no 1/ MHPS Investigation Report / MHPS Investigation / Appendix 26 Statement 2 - Mr A O'Brien 061117 (names redacted).**

II. The preparation of the investigator's report;

22(x) Mr O'Brien was required to agree his statements from the two investigation meetings; the second statement of 6th November 2017 states in para 3 that *"Dr Chada outlined that once we have agreed statements, a case report can be provided to the Case Manager."* Mr O'Brien, during the second meeting on 6th November 2017, stated, as outlined in para 3 of the MHPS statement, that he had a number of priorities in November / December including his appraisal, which he wished to complete and advised that he would be concentrating on that in the coming weeks. Also recorded in his 6th November 2017 statement is a reference in para 4 to Mr O'Brien advising that he had a number of issues

with and comments to make on the previously shared notes from the first meeting with Dr Chada, and also with the witness statements shared with him, and intended to provide commentary on both **(this can be located at Relevant to HR / Reference no 1/ MHPS Investigation Report / MHPS Investigation / Appendix 26 Statement 2 - Mr A O'Brien 061117 (names redacted)).** Mr O'Brien received his witness statement from the first meeting from Siobhan Hynds on 28th October 2017.

22(xi) By 15th February 2018, Mr O'Brien had not provided the comments on the statements he had previously advised he wished to make. Siobhan Hynds emailed Mr O'Brien on 15th February 2018 with a reminder on 22nd February 2018 requesting that he return his comments on the statements already issued to him as soon as possible, in order to bring the investigation to a conclusion. On 22nd February 2018, Mr O'Brien replied to advise that he had misunderstood the arrangements and he was waiting for his November 2017 statement to be issued. He also stated: "I have not had time to attend to the process since November 2017" and suggested that when he received his second statement he would then revert by a specified timescale, such as 31st March 2018. Siobhan Hynds replied the next day, 23rd February 2018, confirming that she would send through the notes of the meeting on 6th November 2017, but that as Mr O'Brien had provided at the meeting his own written statement covering the issues they discussed during the meeting, Siobhan Hynds' notes were reflective of what he himself had already provided in writing. Siobhan Hynds advised Mr O'Brien that a further suggested 6 weeks for receipt of the comments was too long, and asked him to work to 9th March 2018 for final submission **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180223 - Email - RE MHPS Process)**. Siobhan Hynds sent through the notes of the second investigation meeting to Mr O'Brien on 4th March 2018 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180304 - Email - Statement 2 - Mr A O'Brien 061117 (names redacted))**. By 9th March 2018, no response had been received from Mr O'Brien. On 16th March 2018,

Siobhan Hynds sent another email to Mr O'Brien advising *"If comments have not been received by return before 4pm on Monday 26 March, Dr Chada will proceed to finalise the investigation report based on the information available."* Mr O'Brien did not reply. Siobhan Hynds sent one further email to Mr O'Brien on 29th March 2018 stating: *"Dr Chada is writing the investigation report from midday tomorrow. I wanted to let you know this to ensure that you have a final opportunity in advance of 12 tomorrow to send through any comments you wish to make. In the absence of this, as previously advised, the report will be based on the statements available."* **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180329 - Email - RE MHPS Process).** Mr O'Brien returned his comments on 2nd April 2018. **These can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180402 - Email – Investigation**
Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180402 - Attachment - Comments concerning the Respondent Statement of the Meeting of 06 November 2017
Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180402 - Attachment - Comments concerning Witness Statements
Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180402 - Attachment - Comments relating to the Respondent Statement of Thursday 03 August 2017.

22(xii) Siobhan Hynds emailed Dr Chada on 4th March 2018 to seek dates for them both to meet to begin to write the MHPS Case Investigator report. Dr Chada's secretary provided dates to Siobhan Hynds on 13th March 2018 **(this can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/ 20180313 - Email - FW Date to meet)**, and according to Siobhan Hynds' diary, they met on 30th March 2018. Siobhan Hynds and Dr Chada worked on the report between 30th March 2018 and 12th June 2018. Siobhan Hynds and Dr Chada arranged to meet on 12th June 2018 with myself and Dr Khan, Case Manager with the purpose of sharing the report **(this can be located at**

Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180608 - Email - CONFIRMATION Meeting with Dr Khan, Dr Chada, S Hynds - note timing change). (At that time, Dr Khan was also Acting Medical Director, due to Dr Wright's [redacted]. Our legal advice obtained at that time, was that Dr Khan should remain as Case Manager during this period of Acting Medical Director to ensure continuity.) At the meeting on 12th June 2018, I can recall that both Dr Chada and Siobhan Hynds took Dr Khan and me through the content of the Case Investigation report. I can also recall that Siobhan Hynds and I also outlined to Dr Khan the steps he now needed to take under MHPS to provide the investigation report to Mr O'Brien to enable him to comment on the factual content.

22(xiii) Given the scope of the investigation undertaken by Dr Chada with support from Siobhan Hynds the five working day timescale within Para 37 of Section I of MHPS was not realistic. As outlined above, neither Dr Chada nor Siobhan Hynds were released from their core roles, and the clinical and Employee Relations workloads for Dr Chada and Siobhan Hynds resulted in not being able to prioritise the preparation of the report alone, with its accompanying appendices within the five working day timescale. I was aware from my discussions with Siobhan Hynds at the time Dr Chada was very heavily reliant on her to draft the Investigation Report for her to comment on and amend.

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

22(xiv) The report was made available to Mr O'Brien to collect from Trust Headquarters in Craigavon Area Hospital from Dr Khan's Personal Assistant, Laura White from 21st June 2018, and a letter was emailed to him to advise of this on that date **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180621 Ltr Attachment to Email from Dr Wrights PA to SH re AOB collection of report).** I do not know the date that Mr O'Brien collected the report from Trust Headquarters, but the said letter to Mr O'Brien outlined the 10 working days

timescale for return of his comments by Monday 12th July 2018. There was a date error in the letter, and it should have read Monday 9th July 2018.

22(xv) On 9th July 2018, Laura White, Dr Wright's Personal Assistant, spoke with me about an email received from Mr O'Brien to her email address on the previous Friday, 6th July 2018 after she had left the office. Laura White spoke with me, as Dr Khan was on annual leave I recall. Mr O'Brien advised that he had emailed Dr Khan on Wednesday (4th July 2018) asking if he could return his comments on Tuesday 10th July, rather than Monday 9th July, as he was in South West Acute Hospital on 9th July. Mr O'Brien had received an out of office from Dr Khan's email account. As it was already Monday 9th July 2018, I gave Laura White permission to advise Mr O'Brien that his comments were to be returned no later than close of play on 10th July 2018 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180709 - Attachment - Email - Investigation Report)**. Mr O'Brien returned his comments on 10th July 2018.

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

22(xvi) Dr Khan on his return from extended annual leave at the end of July 2018 arranged to meet with Siobhan Hynds on 2nd August 2018, to discuss the preparation of the Case Determination **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180801 - Email - RE Re MHPS case- AOB 3)**. Dr Khan wrote to Mr O'Brien on 14th August 2018 to acknowledge receipt of Mr O'Brien's comments and advise him that he would consider the case investigation report and Mr O'Brien's comments in order to make a determination on the appropriate next step in the process **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180814 - Attachment - Letter from Case Manager to Mr A O'B 14 August 2018).** Dr Khan outlined what the available options were in terms of next steps in his letter to Mr O'Brien. On 28th August 2018, whilst Siobhan Hynds was on annual leave, Dr Khan asked

Siobhan Hynds to start *"drafting first discussion recommendations as we discussed in last meeting"* **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180828 - Email - RE Letter from Case Manager to Mr A O'B 14 August 2018).** Siobhan Hynds supported Dr Khan in the preparation of the Case Manager Determination report during September 2018 until its final version **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180928 Doc Attachment to Email from Dr Khan with final Case Manager determination)** was shared with Mr O'Brien at a meeting with Dr Khan and Siobhan Hynds on 1st October 2018.

22(xvii) As outlined above in 22(xii), Dr Khan was not only Case Manager for the Mr O'Brien case, but he also became Acting Medical Director in April 2018. Dr Khan was on a period of extended annual leave for the month of July, returning on 31st July 2018. On his return from annual leave, he was also balancing a busy Acting Medical Director role. Like Dr Chada, Dr Khan was heavily reliant on Siobhan Hynds to draft the Case Determination Report based on their discussions together. I was also aware from Siobhan Hynds at that time, that she would have redrafted or amended the Case Determination as per Dr Khan's requests. This reliance on Siobhan Hynds, given her other workload resulted in not being able to prioritise the preparation of the Case Determination report for Dr Khan, any sooner than early to mid-September 2018. The final version of the Case Determination was dated 28th September 2018.

22(xviii) **i. Case Manager**

On 14th April 2017, Dr Khan emailed Dr Wright and copied me into the email **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170414 Email from Dr Khan to Dr Wright update from AOB meeting and resource).** This email was to advise Dr Wright that he had spoken with Mr O'Brien the day before,

13th April 2017, and informed him that there were two further SAI Reviews to commence, in addition to the index case of Patient Patient 10. In that email, Dr Khan advised Dr Wright that Mr O'Brien had raised a concern about the time taken for the case so far. Dr Khan asked Dr Wright if there was a possibility for some "*dedicated resource for this case…especially as it is becoming more complex."* I do not have a reply in my emails from Dr Wright to Dr Khan, and I do not know if they discussed the feasibility of additional resource. I do not recall a conversation with Dr Wright following this email.

22(xix) The only other email I can locate in my email archive from Dr Khan as Case Manager is one on 24th May 2018 when he asked me was the Case Investigation report ready **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180524 Email to VT from Dr Khan re monitoring plan)**. I have no record of replying to him, however it is very likely we had a discussion about this in person given our offices were next door to each other in Trust HQ.

22(xx) The only conversation I can recall with Dr Khan about delays was linked to his appointment as Acting Medical Director with effect from 1st April 2018. On 7th June 2018, I emailed Siobhan Hynds to ask her to seek some legal advice regarding the continuation of Dr Khan as the Case Manager given he had become Acting Medical Director from April 2018. This request was on the back of Dr Khan speaking to me about this matter in early June 2018. Dr Khan subsequently emailed me on 7th June 2018 about this matter **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180607 Email from Dr Khan to VT re CM role).** Following legal advice, Siobhan confirmed with Dr Khan she had received advice that he should remain as Case Manager for continuity **purposes (this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180611 - Email - RE MHPS investigations)**. I can recall a discussion after this confirmation with Dr Khan who advised that he would remain as Case Manager, however the Case Determination report would have to wait until

after his return from a period of extended leave during the full month of July 2018, as he was returning home to visit his parents. He emailed Siobhan Hynds to this effect on 21st June 2018 to state, *"I have agreed to continue as case manager for this MHPS case on a condition that I will not be in position to go through this report until after returned from A/L (1st week of August) and even then I will have to be freed up to review report and draft recommendations with your support."* At that time, I considered it was wise to retain Dr Khan as Case Manager despite the annual leave period and subsequent delay, rather than disrupt the process by introducing a new Case Manager at that late stage.

ii. Case Investigator;

22(xxi) I had no contact with the Case Investigator, Dr Chada about delays in the completion of the investigation.

iii. Medical Director;

22(xxii) I have no emails with the Medical Director, Dr Wright up until he [redacted] at the end of February 2018 regarding delays. It is likely we would have had conversations in Trust HQ given our offices were next door to each other. Dr Khan, Case Manager, started the Acting Medical Director role covering for Dr Wright in April 2018. I have outlined in my responses above at 22(xix) and 22(xx), my interactions with Dr Khan.

Personal Information redacted by the USI

iv. Designated Board member;

22(xxiii) As outlined in 23(iv) below, I briefed John Wilkinson on 19th January 2017 about the background to Mr O'Brien's case, after Roberta Brownlee, Chair, asked him to fulfil the role of Designated Board Member under the MHPS Framework.

22(xxiv) On 13th February 2017, Mr Wilkinson, as the Designated Board member, wrote to Mr O'Brien to update him about arrangements for replying to the

number of representations made by Mr O'Brien in their meeting on 7th February 2017 **(this can be located at Relevant to HR / Reference no 33 / Grievance Panel 1 / 20170213 - Tab 24 Letter from Mr Wilknson DBM 13 Feb 2017).** That letter referred to planned annual leave of some key individuals and therefore he was advising that it would likely be the early part of week commencing 20th February 2017 before he was in a position to come back to him. Mr Wilkinson emailed me on 15th February 2017 to advise that he had received a note from Siobhan Hynds explaining the delay in furthering the MHPS issue; I do not have that note. Mr Wilkinson in his email to me on 15th February stated *"I would urge the Trust to process these matters as a matter of urgency in consideration of the people concerned and within the realms of securing all the information required in order to make effective deliberations."* I replied to Mr Wilkinson on the same date, and advised, *"Mr AOB has made a number of representations to you and we have to take care to consider them fully. Our solicitor is on leave early part of this week - she is back tomorrow. I am also on leave this week but have said I am very happy to do a teleconference call on Thursday / Friday afternoon with Richard, Esther and solicitor in order to take her advice on how we can best consider his representations made to you. That has now been organised for Friday pm. We are very mindful of needing to respond in as timely a way as possible, however in making his points he needs to give us the time to consider them and respond."* **This can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 77 for John Wilkinson NED/20170215 - E -V Toal to J Wilkinson.**

22(xxv) On 13th April 2017, Mr Wilkinson copied me in to his reply to Dr Khan's MHPS case update of the same date **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170413 Email from J Wilkinson NED in response to DR Khan update)**. Mr Wilkinson thanked Dr Khan for his update, and reinforced *"As the NED associated with this MHPS Case I am charged to ensure that the case is progressing in a timely manner taking into consideration the nature and scope of the investigation. I believe it would be important to keep Dr.AOB*

informed of the progress and to keep him abreast of the expected timeline for completion."

22(xxvi) Between 2017 and 2019, Mr Wilkinson and I would have seen each other at least once a month at either Board meetings or Board Committee meetings. I recall often at these meetings, Mr Wilkinson would have enquired from me informally as to how the case was progressing. In particular, around January, February & March 2018, Mr Wilkinson regularly asked me for updates about when the case investigation was to be concluded. I have emails, which I sent to Siobhan Hynds on 17th and 25th January 2018, which indicate that Mr Wilkinson was enquiring about progress, and in turn I was seeking updates from Siobhan Hynds **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180125 Email trail re MHPS investigation progress).** On 5th, 7th and 16th February 2018 and 26th March 2018, I sought updates from Siobhan Hynds again, in order to keep Mr Wilkinson updated. **These can be located at the following:**

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180205 Email to SH re AOB MHPS update

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180207 Email from VT to SH

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180216 Email SH and VT re AOB update for JW

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180326 Email to SH from VT

v. the HR Case Manager;

22(xxvii) On 11th May 2017 I emailed Siobhan Hynds, as the HR Case Manager, seeking a conversation about the progress with the case, and to check that Dr Khan was planning to update John Wilkinson during the month. Siobhan Hynds replied to me that night to advise she would ring me the following day. Siobhan Hynds advised me in that email that the update for John Wilkinson

would be prepared for the following Monday, and that Dr Chada and her hoped to have all of the witnesses interviewed by early June, so they could then arrange to meet with Mr O'Brien. Siobhan Hynds did indicate *"the statement typing is killing me though"* **(this is located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170511 - Email - RE AOB).** I do not recall the detail of a conversation with Siobhan Hynds the following day; however, it was likely to have been similar to her email update the previous evening.

22(xxviii) Dr Khan sent the May 2017 update report to John Wilkinson on 15th May 2017, and Siobhan Hynds forwarded me a copy later that evening for my information. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170515 - Email - Fw Re MHPS Case update.**

22(xxix) On 20th June 2017, I emailed Siobhan Hynds to ask for an update on the MHPS case, and specifically enquired had Mr O'Brien been met with, and asked if the Case Manager update had gone to John Wilkinson. Siobhan Hynds replied to me on 25th June 2017 to advise of the inability to meet with Mr O'Brien until the end of July, and she confirmed that the update on timescales had been sent to Dr Khan **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170625 - Email - RE AOB).** Siobhan Hynds also emailed Dr Khan again on 26th June 2017 to ask him to update John Wilkinson. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170626 - Email - Update on MHPS Investigation AOB.**

22(xxx) On 10th October 2017, I emailed Siobhan Hynds for an update on the case, and enquired if John Wilkinson had been updated **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20171010 Email VT to SH re progress with AOB case).** I also asked Siobhan if Mr O'Brien's letter had been responded to. This

referred to the letter sent by Mr O'Brien to Dr Khan dated 30th July 2017 detailing his concerns regarding the investigation **(this can be located at Relevant to HR / Reference no 33 / Grievance Panel 1 / 20170730 - Grievance Panel 1 Tab 38 Letter AOB to Dr Khan).** Siobhan Hynds replied on 11th October 2017 indicating that a final date had been offered to meet on 25th October 2017; however, Mr O'Brien had advised that he was unavailable, and alternative dates had been provided for 30th October and 7th November 2017. Siobhan Hynds also advised that she had spoken with John Wilkinson the 'week before last' and also sent the case update to Dr Khan, who in turn had updated John Wilkinson. Siobhan Hynds updated me to say that a response to Mr O'Brien's letter (which was the letter dated 31st July 2017) was almost finalised and some DLS advice was awaited. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20171011 Email from SH to VT re progressing with AOB case.**

22(xxxi) On 1st December 2017, at the joint HR & Medical Directorate meeting, an update from Siobhan Hynds was provided on Mr O'Brien's MHPS case, to indicate that Mr O'Brien wished to respond to some concerns regarding the witness statements, and following that the report would be completed. The need to involve NCAS was noted at that stage, however I am not sure who raised this during the discussion. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20171201 Notes of Medical _HR Directorate meeting.**

22(xxxii) During January – June 2018, I sent a number of emails to Siobhan Hynds on a regular basis to seek updates on the investigation - 17th January, 25th January, 5th February, 7th February, 16th February, 26th March, 7th June 2018 **(these can be located at:**
Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180125 Email trail re MHPS investigation progress
Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180205 Email to SH re AOB MHPS update

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180207 Email from VT to SH

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180216 Email SH and VT re AOB update for JW

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180326 Email to SH from VT

Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180607 - Email – AOB)

For the purposes of completing this response, I emailed Zoe Parks, Head of Medical Staffing, on 26th June 2022 to ask if she could forward me any notes of the HR & Medical Directorate meetings including one dated 2nd May 2018, as MHPS case updates was included on the agenda **(This can be found at Attachment folder S21 49 of 2022- Attachment 54).** Zoe Parks advised me by email on 27th June 2022 that she could not locate any notes. Zoe Parks attached an email to her reply from Andrea McNeice, Medical Staffing Assistant to Siobhan Hynds dated 30th April 2018, in which Andrea McNeice asked Siobhan Hynds for an update in relation to Mr O'Brien's MHPS case as I had requested it for the HR & Medical Directorate meeting at the start of May 2018. In Siobhan Hynds' response to Andrea McNeice on 30th April 2018, she advised that she and Dr Chada had met and planned the report content and findings, and that she was in the process of writing the report. Siobhan Hynds also indicated that she was hopeful of completion of the report mid-May 2018 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180430 - Email - UPDATE REQUEST AOB CASE - required for HR and Medical Directorate Meeting on 2 May at1100am (2)).** On 24th May 2018, Siobhan Hynds emailed Laura White, Dr Khan's Personal Assistant and Heather Mallagh-Cassells, my Personal Assistant asking for a slot in diaries in relation to the Mr O'Brien MHPS report **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20180524 - Email - Meeting with Dr Khan).** I believe diary pressures meant that the report from Dr Chada, Case Investigator could not be handed over to Dr Khan, Case Manager until 12th June 2018. I was at that handover meeting

on 12th June 2018 when Dr Chada and Siobhan Hynds took us through the report. I also have some recall of Siobhan Hynds and I advising Dr Khan on the next steps which he had to take forward in relation to making his Case Determination, as I can remember Dr Khan telling me about returning home to visit his parents and as a result he would be off for an extended period in July 2018.

vi. Mr Aidan O'Brien; and

22(xxxiii) I did not correspond directly with Mr O'Brien during the investigation process.

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

22(xxxiv) I do not recall any discussion with any other person under the MHPS framework and the Trust guidelines, relating to preventing or reducing delays.

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

23(i) I was on statutory / annual leave the week after Christmas Day, week commencing 26th December 2016 until 3rd January 2017. Siobhan Hynds was also on leave at the same time. Lynne Hainey, Acting HR Manager, provided cover for the Employee Relations Team over that period. I contacted Lynne Hainey on 28th December 2016 via email whilst I was on leave, to advise her of the Oversight Group meeting in relation to Mr O'Brien, and request that she accompany Dr Wright to the meeting to advise Mr O'Brien of the investigation and his immediate exclusion from work **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161228 Email from Vivienne Toal to Lynne Hainey re request to meet with AOB to exclude).** Lynne Hainey provided an update email to Siobhan Hynds and me on 30th December 2016 after the meeting with Mr

O'Brien and Dr Wright **(this can be located at Relevant to HR/ Evidence after/ 4 November/ HR/ Reference No 77/ 20161230 Email from Lynne Hainey confirmation of exclusion meeting).** Lynne Hainey had prepared a draft letter confirming the investigation and exclusion, in line with MHPS Section I para 35 and asked Siobhan Hynds and I in her email of 30th December 2016 to approve the letter before it was issued **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161230 Email from Lynne Hainey confirmation of exclusion meeting)**. I replied to Lynne Hainey following receipt of her email on 30th December 2016, to advise I would give her a call, as I had made some amendments to the letter **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20161230 Email from VT to Lynne Hainey)**. Lynne Hainey emailed Dr Wright and me on 5th January 2017 with the notes of the meeting on 30th December 2016 with Mr O'Brien, and in that email she enquired if the formal notification letter she had previously drafted had been sent **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170105 Email from Lynne Hainey re notes of 30.12.2016 meeting)**. When I checked with Dr Wright verbally that day or the next day, I believe by telephone, the letter confirming the investigation and exclusion had not been issued by Dr Wright's office. I therefore emailed my Personal Assistant, Heather Mallagh-Cassells on 6th January 2017 to ask her to print the letter to Mr O'Brien, for Dr Wright to sign to ensure it was posted without further delay. The letter was printed, signed and put in the post that day i.e. 6th January 2017. The notes of the meeting of 30th December 2016 were sent to Mr O'Brien separately on 18th January 2017.

23(ii) On 6th January 2017, I emailed Siobhan Hynds to say that we needed to identify HR support for the Mr O'Brien MHPS case, and asked to discuss this on the following Monday **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170106 Email VT to Siobhan Hynds re alignment of HR support).**

Siobhan Hynds was on annual leave until Monday 9th January 2017. As Zoe Parks, Medical Staffing Manager was Personal Information redacted by the USI at that point, I was very limited in terms of who could be designated as the HR support for the investigation. Designating the HR case manager role to one of the Non-Medical Employee Relations Team members was not feasible given the workload in that service, and I considered that this case would need senior level HR support. After discussion with Siobhan Hynds, my most senior member of staff with Employee Relations experience and in particular, MHPS investigation experience, we agreed that she should be the designated HR Case Manager for Mr O'Brien's case, despite her own workload pressures. I really had no other feasible options.

23(iii) Also on 6th January 2017, I emailed Roberta Brownlee, Chair of the Board, with a copy to Dr Wright, Medical Director and Mr Francis Rice, Acting Chief Executive, to request that she provide a Non-Executive Director as the Designated Board member. According to my email, I knew that Dr Wright had spoken to the Chair about Mr O'Brien's immediate exclusion. Roberta Brownlee replied to me on the same day to advise that she was going to ask John Wilkinson, Non Executive Director. On 9th January 2017, Roberta Brownlee copied me into an email she had sent to John Wilkinson to thank him for agreeing to be the Designated Board Member, and advising that she would call John Wilkinson. **This can be located at Attachment folder S21 of 49- Attachment 55.**

23(iv) According to my diary, I briefed Mr John Wilkinson, Non-Executive Director on 19th January 2017 about the case, after Roberta Brownlee, Chair had confirmed him as Designated Board member. I did not make a record of my brief to Mr Wilkinson, but I would be confident that I briefed him on the background of the case using the notes of the Oversight Group Meetings on 13th September 2016, 12th October 2016, 22nd December 2016, 10th January 2017, and the notes of the meeting with Dr Wright, Lynne Hainey and Mr O'Brien on 30th December 2016.

23(v) I chaired the meeting of the Case Conference on 26th January 2017, convened in accordance with Section I Paragraph 20 of MHPS. Attending the meeting were myself, Dr Wright, Anne McVey, Assistant Director of Acute Services on behalf of Esther Gihkori - Director of Acute Services, Mr Weir - Case Investigator at that time and Clinical Director, Dr Khan - Case Manager, and Siobhan Hynds - HR case support to the investigation. I chaired the Case Conference, as Dr Wright was attending the meeting remotely by teleconference, and given everyone else was present in the room, it was easier for me to chair than Dr Wright as he couldn't see anyone. I was involved in making amendments to the draft version of the notes. Mr Weir presented to the meeting a preliminary report, which scoped the likely scale of the concerns and the numbers of patients involved **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170126 Attachment FINAL Preliminary report)** Mr Weir also indicated that given the numbers involved, it was not possible to give a definitive date for the conclusion of the investigation, but that it was envisaged it would take a minimum of 12 weeks to complete. The matter of Mr O'Brien's immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017, as exclusion was not deemed required. Instead, Mr O'Brien's return to work was to be managed in line with a clear management plan for supervision and monitoring of key aspects of his work i.e. the Return to Work Plan dated 9th February 2017.

23(vi) On 27th January 2017 Dr Wright and I reported at the Confidential Trust Board meeting that a Consultant Urologist had been excluded on 30th December 2016, and that the case was being addressed under MHPS **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170320 Minutes Attachment to Email from S Judt re accuracy check on TB confidential minutes relating to MHPS).** I reported that the immediate exclusion had been lifted and that the Consultant was able to return to work with a number of 'restrictions'. These 'restrictions' were in the form of the Return to Work Plan that was being

developed at the time of the Confidential Board Meeting on 27th January 2017. In hindsight, my use of the word 'restriction' at the Confidential Board meeting was somewhat misleading, as effectively the Return to Work Plan was intended to be close monitoring of his administrative duties associated with clinical care, relating to the four areas of concern which were to form the basis of the formal investigation into his administrative practices.

23(vii) On 6th February 2017, Siobhan Hynds sent an email to update John Wilkinson with regards correspondence that had been sent to Mr O'Brien i.e. the notes of the meeting with Mr O'Brien, Mr Weir and Siobhan Hynds on 24th January 2017 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170206 - Attachment - Note of Meeting with Mr Aidan O'Brien 24 January 2017),** and the letter of 6th February 2017 to Mr O'Brien confirming the outcome of the Case Conference, from Dr Khan **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170206 Attachment to e-mail - Letter from Case Manager to Mr A O'B 06 February 2017).** Siobhan Hynds copied me into that email, along with Dr Wright, Dr Khan and Esther Gishkori. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170206 Email Update to John Wilkinson NED re AOB MHPS case from S Hynds 1.**

23(viii) I cannot recall if it was Siobhan Hynds or myself who suggested seeking legal advice in respect of the MHPS case. I was on annual leave week commencing 13th February 2017, but had agreed to join the call with the solicitor, which Siobhan Hynds arranged for 17th February 2017. I joined the teleconference call, along with Dr Wright, Esther Gishkori and Siobhan Hynds to seek advice on the handling of the MHPS case and the most appropriate way to respond to Mr O'Brien's letter of 7th February 2017. I refer to my response at Q21(i) above for more information. There was another occasion I asked Siobhan Hynds to seek legal advice in relation to the appropriateness

of Dr Khan continuing as Case Manager when he was took on the role of Acting Medical Director. This is described in Q22(xx) above.

23(ix) On 6th March 2017, Mr O'Brien sent John Wilkinson a document containing 47 questions relating to the process which was followed that resulted in the commencement of the formal investigation and his exclusion from work **(this can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 77 for John Wilkinson NED/20170306 - Questions to be Asked.pdf).** Mr Wilkinson met me in my office on 7th March 2017. I cannot be certain, but I believe John Wilkinson shared the document with me at the meeting on 7th March 2017. On 22nd March 2017, I scanned and emailed the questions to Siobhan Hynds and Dr Wright, and intended to attach a draft response to the questions for Siobhan Hynds to expand, and for Dr Wright to review before sending to Mr O'Brien. I omitted the draft response from my email, but sent it to Dr Wright and Siobhan Hynds on 26th March 2017 following a reminder from Siobhan Hynds **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170326 Email from S Hynds re response to Questions from AOB**

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170326 Ltr draft Attachment to Email from S Hynds re response to Questions from AOB). Siobhan Hynds sent a final draft letter to Dr Wright and me on 28th March 2017 **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170328 Email from S Hynds with draft letter from Dr Wright to AOB**

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170328 Ltr draft Attachment to Email from S Hynds with draft letter from Dr Wright to AOB). On 30th March 2017, I requested my Personal Assistant, Heather Mallagh-Cassells to print the letter for Dr Wright to sign. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170330 Email to VT's PA to print letter to AOB from Dr Wright.**

23(x) At the meeting with John Wilkinson on 7th March 2017, he provided me with a copy of a letter that Mr O'Brien had sent to Dr Wright on 21st February 2017 **(This can be located at Attachment folder S21 49 of 2022- Attachment 56).** Mr O'Brien's letter related to what he considered inaccuracies and omissions from the note of the meeting of 30th December 2016 with Dr Wright and Lynne Hainey. On 7th March 2017, I emailed this letter to Dr Wright and copied it to Lynne Hainey and Siobhan Hynds. I advised in that email that John Wilkinson was seeking to know what had been done with it **(This can be located at Attachment folder S21 49 of 2022- Attachment 57).** Lynne Hainey replied to all on 9th March 2017 to say that she had reviewed her notes, and was content to make amendments to the 30th December 2016 notes **(This can be located at Attachment folder S21 49 of 2022- Attachment 58).** In response, on 10th March 2017, I asked Lynne to *"work with Dr Wright to agree the amendments where appropriate, and draft a response to Mr O'Brien."* **(This can be located at Attachment folder S21 49 of 2022- Attachment 59).** Lynne did so, and she emailed Dr Wright with a draft letter and amended notes on 13th March 2017 for his agreement. Dr Wright replied on 14th March 2017 confirming his agreement to the letter. **These can be located at:**

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/No 77 – L Hainey / 20181219-email confidential information request to siobhan att 6
Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/No 77 – L Hainey /20181219-email confidential information request to siobhan att 5
Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ No 77 – L Hainey /20181219-email confidential information request to siobhan att 4

23(xi) On 6th April 2017, Ronan Carroll emailed Esther Gishkori, Dr Wright and me to advise that an upgraded referral - patient Patient 14 had a confirmed cancer, and

that this gentleman was the third patient to have a confirmed cancer. I sent an email to Siobhan Hynds and Dr Wright on 11th April 2017 to check if there were to be SAI's in relation to each of the patients, and enquired as to what Mr O'Brien knew about these SAIs **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170411 Email to SH and Dr Wright re SAIs).** Siobhan Hynds replied on 12th April 2017, and advised these were two further SAIs, and also stated *"I am assuming Dr Khan as Case Manager should be alerting him formally in a meeting with AOB??"* **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170412 Email response from SH to VT and Dr Wright re SAIs)** Dr Wright forwarded the email trail to Dr Khan on 12th April 2017 and copied me in to the email, and asked him to arrange to meet with Mr O'Brien to inform him of the two further SAIs as soon as possible **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170412 Email from Dr Wright to Dr Khan request to alert AOB to SAIs).**

23(xii) Throughout January, February, March and April 2017 I was included in emails from managers within the Acute Services Directorate, in particular Ronan Carroll, Assistant Director. These emails were to update me, Dr Wright, Siobhan Hynds and others on developments with the administrative concerns relating to Mr O'Brien such as missing notes, operating activity and private patients, red flag triaging, upgrades to referrals not triaged by Mr O'Brien, and cases that required an SAI Review. These updates built a picture of the extent of the concerns relating to Mr O'Brien's administrative practices and the potential or actual impact on patient care.

23(xiii) John Wilkinson copied me into his response to Dr Khan's Case Manager update on 13th April 2017, which was an update on the progress of the investigation. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20170413 Email from J Wilkinson NED in response to Dr Khan report.**

23(xiv) At various points during the investigation I checked with Siobhan Hynds that investigation updates to John Wilkinson, Designated Board Member had been provided by Dr Khan, Case Manager. The first of these was 3rd April 2017 **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20170403 - Email – Aob).** My responses above from 22(xvi) to 22(xxi) provide further details and document signposting.

23(xv) My responses above at 20(ii), 20(iii) and 20(vii) outline the actions I took in relation to escalation of concerns regarding Mr O'Brien's adherence to the Return to Work Plan.

MHPS Determination

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

24(i) To the best of my recollection, the only conversation I had with Dr Khan regarding his Determination under MHPS Section I para 38 was on 27th September 2018 in the office of Shane Devlin, Chief Executive. Dr Khan forwarded a copy of the Draft Case Manager Determination to Shane Devlin and I on 26th September 2018 by email and we then met with Dr Khan the following evening, 27th September 2018 to discuss the report **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180926 Email from Dr Khan re case manager determination).** It was appropriate for Dr Khan to meet with Shane Devlin as Chief Executive given Dr Khan's dual role as Case Manager and Acting Medical Director, to ensure awareness of the Case Determination recommendations at the next level.

24(ii) My comments to Dr Khan centred around checking what the advice from Practitioner Performance Advice (formerly NCAS) had been. Dr Khan

forwarded me the letter from Dr Grainne Lynn, Adviser – Practitioner Performance Advice to him dated 21st September 2018, either during the meeting or after the meeting had ended **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180927 Email from Dr Khan with NCAS report)**. I do recall that Dr Khan did refer to the letter when we met and the advice that it contained. My comments on Dr Khan's report were to ensure that the Case Determination reflected the advice contained within the letter and to explicitly state that he had taken this advice. Dr Khan agreed to take the report away and ensure the necessary changes were made. Dr Khan then forwarded the final version of the Case Determination report on Friday 28th September 2018, with the changes made **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180928 Doc Attachment to Email from Dr Khan with final Case Manager determination).** He indicated in that email that he was meeting with Mr O'Brien on the Monday morning, which was 1st October 2018 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20180928 Email from Dr Khan with final Case Manager Determination).**

24(iii) I do not recall any other conversations with Dr Khan regarding his Determination following this.

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

I. The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr. O'Brien to provide assurance with monitoring provided by the Clinical Director;
II. That Mr. O'Brien's failings be put to a conduct panel hearing; and

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

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

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

25(i)

I.	The implementation of an Action Plan with input from Practitioner Performance Advice, the Trust and Mr. O'Brien to provide assurance with monitoring provided by the Clinical Director.	Dr Khan as Acting Medical Director / Responsible Officer was responsible for ensuring that this action was taken forward. This would have to have been in conjunction with the Clinical Managers – Clinical Director and Associate Medical Director, and with the support of Practitioner Performance Advice. This is my view.
II.	That Mr. O'Brien's failings be put to a conduct panel hearing	Responsibility for progressing the conduct panel lay with the HR Directorate, and therefore responsibility for the establishment of the hearing arrangements ultimately was mine as Director of HR & Organisational Development. Dr Khan as Case Manager liaised with Mr O'Brien in October and November 2017 regarding progress with the conduct panel arrangements, and Siobhan Hynds was involved in making arrangements for the panel and hearing.

III.	That the Trust was to carry out an independent review of administrative practices within the Acute Directorate and appropriate escalation processes.	Given Dr Khan had shared the report with the Chief Executive, Shane Devlin, responsibility for establishing the independent review lay with the Chief Executive to discuss and agree a way forward for implementing the independent review with the Director of Acute Services, Esther Gishkori. This is my view.

ii. To the best of your knowledge, outline what steps were taken to ensure that each of these actions were implemented; and
iii. If applicable, what factors prevented that implementation.

25(ii) In relation to **Action I**. above, I do not believe any action was taken to implement, however Dr Khan would be able to confirm this. Following the Case Determination of 28th September 2018, the Return to Work Action Plan, dated 9th February 2017, continued to apply. I do not recall Dr Khan having any discussions with me relating to any decision he had made to hold off on the development of the Action Plan with input from Practitioner Performance Advice. My view is the delay in being able to progress the Conduct Panel as outlined below in 25(iii onwards) may have had an impact on Dr Khan progressing this action. At the time the Case Determination was issued to Mr O'Brien, on 1st October 2018, a series of information requests and discovery processes from Mr O'Brien were being dealt with, and arrangements for the Conduct Panel were being worked through. Also at the same time, GMC Employer Liaison Advisor discussions on the case were ongoing and information requests associated with those discussions were being addressed. I have a view that the longer those parallel processes took to address, the focus turned away from the Case Determination Action Plan relating to **Action I** and **Action III** towards dealing with those immediate issues at hand. Given the issues in October 2018 relating to Mr O'Brien's non-compliance with the Return to Work Plan (9th February 2017), and the

break down in the associated monitoring arrangements while Martina Corrigan [redacted], my view now is that this was a missed opportunity to put in place a new Action Plan as identified in Dr Khan's Case Determination. This could have resulted in more robust monitoring arrangements with the input of Practitioner Performance Advice.

25(iii) In relation to **Action II** above, steps were taken to establish the misconduct panel during October and November 2018. Siobhan Hynds liaised with Dr Khan, Case Manager to establish the panel and hearing dates. Paul Morgan, Executive Director of Social Work / Director of Children & Young People's Services and Melanie McClements, then Director of Older People & Primary Care, were identified as the panel members for the Conduct Panel, as they were two Directors with no previous knowledge of the case. I do not recall if it was me who made contact with them to request their assistance or if it was Dr Khan or Siobhan Hynds.

25(iv) On 30th October 2018, Siobhan Hynds emailed Dr Khan to advise that she had availability for the panel, the panel advisor and the case investigator confirmed for 23rd November 2018 all day and 28th November all day. In that email she was seeking Dr Khan's confirmation that he could be available on those dates as Case Manager. Siobhan Hynds indicated to Dr Khan that she would draft an email for him to send to Mr O'Brien to secure the dates. A follow up email to Dr Khan from Siobhan Hynds on 30th October 2018 outlined that she would like to forward the panel dates to Mr O'Brien to enable him to secure representation. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181030 - Email - RE MHPS Conduct Hearing Dates 1.**

25(v) Also, on 30th October 2018, Siobhan Hynds sent Dr Khan a draft email for him to send to Mr O'Brien to check his availability for three dates for the conduct hearing – 23rd November, 28th November and 14th December 2018. I do not believe that this email was sent to Mr O'Brien; the reason for this, I recall, was due to Siobhan obtaining legal advice that the conduct panel should have

medical representation as per MHPS from someone not employed by the Trust, as we had been advised that the matters before the panel would be deemed professional misconduct. This legal advice to Siobhan Hynds must have been obtained after 30th October 2018 (when Siobhan Hynds drafted the above email to be sent to Mr O'Brien) and before 12th November 2018, as there is an email from Dr Khan to Siobhan Hynds on 12th November 2018, entitled "Senior external medical panel member required for conduct panel hearing" In that email, Dr Khan advised Siobhan Hynds of two names suggested by Dr Cathy Jack, Medical Director in Belfast HSC Trust, to assist with the panel. On 13th November 2018, Dr Khan emailed Siobhan Hynds to advise that Dr Chris Hagan, who was Deputy Medical Director in Belfast HSC Trust at that time, would be approached by Dr Jack to seek his assistance in fulfilling the external medically qualified panel member role. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181113 - Email - RE Senior external medical panel member required for conduct panel hearing**

25(vi) On 27th November 2018, Siobhan Hynds emailed one of her HR Assistants, Elizabeth Speers to work on obtaining dates for the Conduct Panel in January 2019. In that email, Siobhan Hynds set out the names of the individuals who needed to be available, and advised *"I need quite a number of people and it will be difficult to coordinate so can you please start ASAP. I've already tried for dates in Nov and Dec but had no luck."* **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181127 - Email - Meeting set up.**

25(vii) On 28th November 2018, Dr Khan emailed Mr O'Brien **(This can be located at Relevant to CX Chair's Office/Evidence after 4 Nov 21 CX Chair/ref no 77 for John Wilkinson NED/20181128 - E - A Khan to AOB cc J Wilkinson; S Hynds.pdf)**. In that email he advised him that work was ongoing to identify a suitable date for the MHPS Conduct Hearing. He further advised that there was a significant number of diaries to be co-ordinated and that a number of dates held in November and December were no longer

viable due to the diary commitments of others. Dr Khan advised Mr O'Brien that it was likely to be early January before a date was able to be confirmed and to that end he asked Mr O'Brien to let him know his availability for a full day hearing in the first three weeks in January 2019. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181203 - Email - FW Re MHPS Investigation**.

25(viii) In response to Dr Khan's email of 28th November 2018, Mr O'Brien emailed him on 2nd December 2018 to advise that he had submitted a formal written grievance, dated 27 November 2018, to the Chief Executive, Shane Devlin, in person, on Friday 30 November 2018. Mr O'Brien stated that in submitting his grievance, he had *"requested that the Trust should immediately confirm that no steps will be taken to bring matters to a Conduct Panel hearing until the Grievance has been fully resolved."* Mr O'Brien proceeded to advise in his email: *"For the avoidance of any doubt, I shall not notify of my availability to attend a Conduct Panel Hearing until I have received all documentation previously and repeatedly requested, most recently to you on 02 November 2018, and requested once again on foot of the Grievance, and by Notice of this email, nor shall I do likewise until I have received complete, strict proof of each and all of the contentions made by Ms. Siobhan Hynds, and all documentary proof of same, as detailed in my letter to you, dated 12 November 2018."* **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181203 - Email - FW Re MHPS Investigation.**

25(ix) Mr O'Brien's grievance submitted in person to Shane Devlin, Chief Executive on 30th November 2018, was forty pages in length with forty-nine separate appendices, and contained an information request covering nine points **(this can be located at Relevant to HR/Evidence after 4 November HR / DOCUMENTS WITH NO PASSWORD /Grievance Received 27.11.18)**. Eight of the nine items listed in the Grievance information request had also been requested from Dr Khan on 2nd November 2018. **This can be located at**

Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181102 Email from AOB to Dr Khan.

25(x) Mr O'Brien outlined in his grievance submission a specific grievance about what he believed to be the "*misclassification of concerns as concerns relating to misconduct*". Due to this, steps to establish the Conduct Hearing for January 2019 were paused on 4th December 2018. **This can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181204 - Email - Re Meeting set up.**

25(xi) In December 2018, Siobhan Hynds coordinated the gathering of information to respond to Mr O'Brien's requests of 2nd November 2018 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181102 Email from AOB to Dr Khan)** (which were repeated in his Grievance Submission of 30th November 2018 **this can be located at Relevant to HR/Evidence after 4 November HR / DOCUMENTS WITH NO PASSWORD /Grievance Received 27.11.18)** and in his letter of 12th November 2018 to Dr Khan **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181112 - Attachment - Information Request November 2018).** Siobhan Hynds took advice on the handling and time lines of the information requests both from the Trust's Information Governance Team **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20181104 - Email - Information Request - FOR URGENT ADVICE)** with regards response timescale and process, and I recall she also sought legal advice. I wrote to Mr O'Brien on 14th December 2018 to advise that arrangements were being finalised to set up a grievance panel and that he would be notified as soon as possible. I also advised Mr O'Brien that his information requests dated back a period in excess of two years, and that they rested with a range of individuals within the Trust and were extensive. I further advised Mr O'Brien that work was ongoing to collate information previously requested by him by letter on 12th November 2018 and we were endeavouring to provide the information to

him by 21st December 2018, however it may not be possible to have all collated within the timeframe **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20181214 Ltr from V Toal to Mr Aob).** A partial response to the information requests was made on 21st December 2018, with the remainder provided on 11th January 2019. **These can be located at Attachment folder S21 49 of 2022- Attachments 59b1, 59b2, 59b3, 59b4, 59b5, 59b6, 59b7, 59b8, 59b9, 59b10, 59b11.**

25(xii) On 13th March 2019 at 23.43 Mr O'Brien sent me a letter, dated 12th March 2019 as a follow on to his receipt of the second set of responses to his information requests on 11th January 2019 **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190313 Ltr Attachment 1 to letter from Mr AOB to V Toal)**. Mr O'Brien advised in that letter that since the receipt of the information provided by me on 11th January 2019 that he had submitted all of the documentation arising from the investigation to the Medical Protection Society (MPS) for its consideration, and that at their request he had also submitted the same documentation to Legal Counsel appointed by the MPS. Mr O'Brien attached a further request for further information on the advice of his Legal Counsel. This request extended to 7 pages and 55 points, and was very extensive in nature. The last point on Mr O'Brien's letter stated 'Following its receipt, you will be advised whether any further information is to be requested, and / or whether the Formal Grievance is to be amended'. I forwarded the correspondence to Siobhan Hynds on 19th March 2019 whilst I was on annual leave, and asked to speak with her about it the following week on my return from leave. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190319 Email from V Toal to S Hynds 1.**

25(xiii) In late December 2018 and into early January 2019, arrangements were also being made to establish the panel for Mr O'Brien's grievance. I was seeking to secure grievance panel members through our Service Level Agreement

with the HSC Leadership Centre. Dr O'Kane had enquired of me on 27th December 2018 what steps needed to be taken next with Mr O'Brien's case, and I had replied on 4th January 2019 with a summary of the arrangements I was trying to put in place in in terms of the panel. **(This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190104 Email from VToal to Dr O'Kane).** Dr O'Kane in December 2018 had been seeking to secure a Medical Clinician, Dr Harbinson, who was external to the Trust as the first panel member, and I was seeking to secure the second panel member. On 10th January 2019 I emailed Dr O'Kane to advise I had secured Mr Mervyn Barkley, Associate from the HSC Leadership Centre as the second panel member, and sought clarity if Dr Harbinson had been confirmed **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190110 Email from V Toal to Dr O'Kane).** I cannot recall when Dr O'Kane advised me that Dr Harbinson was unable to participate as a grievance panel member, but I believe it was some time in January 2019. Dr O'Kane assisted me in securing another panel member, however it took some time for an appropriate panel member to be identified who was available and who was not known to Mr O'Brien. Mr Terry Irwin, a retired General Surgeon was identified by Dr O'Kane to be the first panel member along with Mr Mervyn Barkley, and on 14th March 2019, my Personal Assistant, Heather Mallagh-Cassells made contact with Mr Irwin to make arrangements for the transfer of the Grievance papers to him to read **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190314 Email from HMC to V Toal re Mr T Irwin 1).** On the same day, I emailed Mervyn Barkley to advise that Mr Irwin was now the other member of the Grievance Panel **(this can be located at Relevant to HR/Evidence after 4 November HR/Reference 77/S Hynds no 77/20190314 Email from V Toal to M Barkley).**

25(xiv) On 19th May 2019, Siobhan Hynds emailed a number of key individuals in the Trust from whom she would require information to respond to Mr O'Brien's information request **(this can be located at Relevant to HR / Evidence**

received after 4 November 2021 / Reference no 77 – S Hynds no 77 / 20190519 - Email - URGENT Request for Information - Mr A O'Brien). She outlined in her email the following: *"Please see attached information request from Mr A O'Brien. I am seeking a legal view on our obligations however under MHPS we have extensive obligations to provide information and therefore I am sending this to you to being (sic) gathering the information / documentation requested."* Siobhan Hynds had earlier that day emailed the Trust's legal advisors for advice and advised *"I have begun gathering as much information as I can but I would be grateful for your view on our obligations in this regard. As you will see the request is a discovery request and I understand our obligations to provide information under MHPS is wide however I would appreciate your view on whether this type of information request is reasonable in respect of an internal process."* **(this can be located at Relevant to HR / Evidence received after 4 November 2021 / Reference no 77 – S Hynds no 77 / S Hynds no 77/20190520 - Email - RE STRICTLY PRIVATE AND CONFIDENTIAL - MHPS case).**

25(xv) I wrote to Mr O'Brien on 3rd June 2019, advising that his request was extensive in nature and would take significant time and resources to respond. I asked him to define his information requests further **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190603 Ltr attachment to email from HMC to Mr AOB re information requests).** He responded to me on 24th June 2019 with a more refined set of information requests against a number of points and a request for two further pieces of information **(this can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190624 Email from AOB to V Toal with 2 attachments Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190624 Ltr attachment 1 to Email from AOB to V Toal Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20190624 Ltr attachment 2 to Email from AOB to V Toal).** A proportion of the information was provided to Mr O'Brien in October 2019. The delay was because of the workload and acute pressures for a

number of the operational managers impacted by the information request was significant, and in particular Martina Corrigan who had a significant amount of email correspondence to locate.

25(xvi) In October, November, December 2019 and January 2020, balloting for industrial action and strike action was taking place with all health Trade Unions, except British Medical Association (BMA). As Director of HR, I was heavily involved in both pay negotiations regionally and also contingency planning for planned industrial action in November, December 2019 and January 2020. Strike action affected all services, and all staff groups, (except medical staff) across the Trust and in particular, there was significant disruption to services including those in Acute Services. I was designated as the Bronze Command lead for the Trust to manage the industrial action over that period. Industrial action was suspended on 16th January 2020. Industrial action significantly impacted the timescales in the provision of the information requests to Mr O'Brien, due to the work required by Heads of Service and Assistant Directors to maintain safe services. As a result, my attention was not on ensuring all outstanding requests for information were responded to for Mr O'Brien during that time.

25(xvii) I did not immediately pick this matter up again post Industrial Action to check on progress with the outstanding information requests for Mr O'Brien, and by 2nd week in March 2020, preparation for Covid-19 had commenced, which resulted in unprecedented planning pressures to prepare for the Covid-19 response. Workforce resourcing, staff occupational health, safety and wellbeing arrangements, advisory lines for staff queries, absence support were some of the HR related pressures facing my Directorate at that time.

25(xviii) Mr O'Brien wrote to me on 26th April 2020 to advise of the outstanding information requests and requested these by 15th May 2020. The remaining requests that were able to be provided, were forwarded to Mr O'Brien on 25th May 2020. In my letter to Mr O'Brien dated 22nd May 2020, I advised that arrangements were now being made to convene the Grievance Hearing. By

that stage, new Grievance Panel members had to be secured and these were later confirmed as Mrs Shirley Young, Associate HSC Leadership, and Dr Aisling Diamond, Deputy Medical Director in Southern HSC Trust who was very recently appointed at that stage and had no previous involvement in the case. **This can be located at Relevant to HR/ Evidence received after 4 November 2021/ Reference no 77/ V Toal no 77/ 20200525 Att 2 to Email to Mr AOB from V Toal.**

25(xix) Mr O'Brien's employment terminated with the Trust on 30th June 2020; however, the grievance hearing took place after he had left the Trust's employment. The Grievance report from Shirley Young and Dr Diamond was issued to Mr O'Brien on 26th October 2020 **(this can be located at Relevant to HR / reference no 33 / GRIEVANCE PANEL 1/ 20201026 - Grievance Response Report).** Mr O'Brien subsequently lodged an appeal on 2nd November 2020 and following legal advice, a review of the Stage one grievance decision was carried out by Mrs Therese McKernan, Associate of HSC Leadership Centre and Professor Ronan O'Hare, Assistant Medical Director from Western HSC Trust. Their report was submitted to the Trust on 9th July 2021. **This can be located at Relevant to HR / reference no 33 / REVIEW PANEL /20210810 - Final report of the Stage 1 Grievance Mr A O Brien.**

25(xx) In relation to **Action III**, I do not believe any steps were taken immediately after the Case Determination was made by Dr Khan. Dr Khan and Shane Devlin would be best placed to confirm any discussions they had in respect of **Action III**. Again, my view as to what may have contributed to progressing this action is similar to what I outlined in respect of **Action I** above at 25(ii). In addition, a further contributory factor may have been the commencement of Personal Information redacted by the USI of Esther Gishkori, Director of Acute Services in June 2019.

iv. If the Action Plan as per 27(l) was not implemented, fully outline what steps or processes, if any, were put in place to monitor Mr O'Brien's

practice, and identify the person(s) who were responsible for these? Did these apply to all aspects of his practice and, if not, why not?

25(xxi) The Return to Work Action Plan, dated 9th February 2017, remained in place after the Case Determination was made on 28th September 2018. Mr O'Brien continued to be monitored under those arrangements, with Martina Corrigan and Ronan Carroll monitoring, and escalating to Dr Khan as Case Manager, as required. My responses to Q 18, 19 and 20 above provide detail on the implementation of these arrangements after the Case Determination was made. The scope of Mr O'Brien's practice, which was monitored after the Case Determination in September 2018 did not change from the four original areas of concern contained within the Return to Work Action Plan, 9th February 2017. This was because there had been no indication from anyone inside or outside of the Trust that there was any reason to monitor more widely.

Implementation and Effectiveness of MHPS

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

26(i) The case relating to Mr O'Brien became known to me in September 2016, with the 13th September 2016 Oversight Group meeting occurring just over a week before I took up post as Director of HR & OD on 21st September 2016. Whilst I had experience of using the MHPS Framework and the Trust Guidelines in other cases before September 2016 mostly under the direction of HR & OD Director, Kieran Donaghy, Mr O'Brien's case was a complex one to be the first in my role as the newly appointed Director of HR. The complexity, I now believe, was in the most part linked to the fact that his administrative practices had not been addressed over a number of years.

There was also, I believe, a view by many that Mr O'Brien was an otherwise excellent clinician, which resulted in a failure to grasp the real significance of the link between poor administrative practices and patient safety. I was not experienced enough to challenge this thinking at the time, and both of these points have provided significant learning for me as a result of this case.

26(ii) In forming an impression of the implementation and effectiveness of MHPS and the Trust Guidelines in Mr O'Brien's case, I have asked myself should MHPS have been implemented earlier? I believe it should have. When it was eventually implemented in December 2016, I knew then that it should have been implemented in September 2016, and the decision should have been made to implement it formally because of the information contained within the Screening Report presented to Oversight Group on the morning of 13th September 2016. Furthermore, based on the fact Heather Trouton, Assistant Director of Acute Services and Mr Mackle, Associate Medical Director were seeking to address the same issues in March 2016, consideration should have been given to the implementation of MHPS at that stage. I also know from reading Heather Trouton's statement (Appendix 22 – para 13 of MHPS report) as part of the MHPS investigation **– this can be located at Relevant to HR / Reference no 1 / MHPS Investigation Report / MHPS Investigation / Appendix 22 Witness Statement - Mrs H Trouton 050617**) she had met in January 2016 with Dr Wright as the new Medical Director to seek his advice in relation to concerns about Mr O'Brien. It was following this meeting on 11th January 2016 that the letter dated 23rd March 2016 was issued to Mr O'Brien. The fact that this meeting took place in January 2016, leads me to conclude that there were, in all likelihood, grounds to consider implementing MHPS in January 2016 rather than issuing the letter of 23rd March 2016. Having reflected on the Case Determination by Dr Khan in which it referenced the period of time before 2016 that concerns were known about Mr O'Brien's administrative practices, I am of the view that the timing of MHPS implementation should have been even earlier than January 2016.

26(iii) The lack of Clinical Management input to the Oversight Group in the 2010 Trust Guidelines was problematic, and meant that the Oversight Group was driving the decision making in relation to the early actions in September 2016, as opposed to the Clinical Manager. Whilst the role of the Oversight Group as outlined in para 2.5 of the 2010 Trust Guidelines, was described as a quality assurance role, the absence of the Clinical Manager at the meetings meant that the Oversight Group determined the actions to be taken. On reflection, this resulted in an approach in September 2016, which was, in effect, contrary to Section I Para 15 MHPS, which outlines that the role of the Clinical Manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. What happened in the Mr O'Brien case was that a non-medical Assistant Director, Simon Gibson took the lead in the Preliminary Enquiries in September 2016 in conjunction with, I assume, Acute Services' staff such as Martina Corrigan and Ronan Carroll, and presented the report at the Oversight Group meeting without the Clinical Manager, Mr Weir, Clinical Director, there. The absence of the Clinical Manager, Mr Weir also permitted a divergence from what was the agreed course of action at the Oversight Meeting on 13th September 2016 by Directors. Those agreed actions were subsequently debated outside of the meeting by the Clinical Managers, Mr Weir, Clinical Director, and Dr McAllister, Associate Medical Director, with Esther Gishkori, Director of Acute Services. As a result, the agreed actions from 13th September 2016 Oversight Group meeting subsequently changed after further discussion between Esther Gishkori, Francis Rice, Interim Chief Executive and Dr Wright, Medical Director, a number of days after. If Mr Weir, as Clinical Manager had been present in the Oversight Group meeting in September 2016 there may have been greater discussion, about not only clearing the backlogs, but also more about checking and reviewing if any of the patients in those backlogs had come to harm. I very much regret that those discussions did not happen robustly enough and there was not more focus on ensuring that work commenced urgently after the meeting on 13th September to check if the patients in the backlogs had come to any harm. This issue was further exacerbated by the fact that both Mr Weir and Dr McAllister were off Personal Information redacted by the

Personal Information redacted by in December 2016, and therefore, Dr Wright as Medical Director was, de facto, the Clinical Manager as well. The existence of the Oversight Group in that format was removed from the Trust October 2017 Guidelines as a key learning point from the Mr O'Brien case and replaced with more definitive guidance for a Clinical Manager undertaking Preliminary Enquiries in section 2 and section 3 of the Trust October 2017 Guidelines.

26(iv) The implementation of MHPS was extremely challenging given the change in Trust personnel in key roles at various points during the process. There were changes in key senior staff with designated roles under MHPS, such as the Chief Executive, which changed five times from the commencement of the Formal Investigation in 2016 until Mr O'Brien's employment ended in June 2020. This lack of continuity, I feel, hampered regular updates and proper Chief Executive overview of the concerns. Further, the change in Medical Director from Dr Wright to Dr Khan and the combined role of Dr Khan as Case Manager and Acting Medical Director from April 2018, was a further challenge, and has made me question if we should have appointed a new Case Manager when Dr Khan was appointed as Acting Medical Director. With the benefit of hindsight, I believe we should have, given the scale of the remit of the Acting Executive Medical Director role, which added to the delay in releasing the Case Determination.

26(v) Given the scale of what was being investigated in Mr O'Brien's case, achieving the timescale of 4 weeks as set out in MHPS was never going to be feasible. That said, the length of the MHPS investigation from January 2017 to June 2018 admittedly far exceeded any extended timeframe that 'exceptional circumstances' would ever have been intended to cover in MHPS Section I Para 37. The extended duration of the investigation process was not all attributable to Dr Chada as Case Investigator and Siobhan Hynds as HR Case Manager. Mr O'Brien contributed significantly to the extended period, and in hindsight was allowed to dictate the pace of the investigation on a number of occasions. My impression of the approach that Dr Chada took was to be very fair and accommodating to Mr O'Brien, and her approach was

also considerate of the clinical commitments of Mr O'Brien and the impact on patient services. Capacity, workload and clinical commitments of Dr Chada and Siobhan Hynds were major contributory factors in the delays.

26(vi) Mr O'Brien's contention through a number of representations he made was that he should never have been immediately excluded or subject to formal investigation. My view is that it was the right course of action to have taken given the circumstances in December 2016 and that there was no other option at that time. The 4 week period of exclusion in line with MHPS Section I para 25 gave some space to carry out the initial investigation to determine the course of action to be taken. I acknowledge, however, that the period of exclusion and formal investigation was traumatic for Mr O'Brien and his family after many years of service to the Trust.

26(vii) Aside from the lengthy duration of the formal investigation, my impression of the quality of the investigation and the report was that it was thorough, of a good standard and was successful in establishing the facts about the four specific concerns as outlined in the Terms of Reference. I am conscious, however, that Dr Chada and Siobhan Hynds had to rely on a 'feed' of information from Acute Services staff via Martina Corrigan and Ronan Carroll in relation to each of the concerns, and therefore their ability to verify the complete accuracy or otherwise of the numbers involved was limited. That said I believe the investigation was able to legitimately conclude there was concern in relation to each of four concerns relating to Mr O'Brien's administrative practices. Given the wider concerns that came to the fore from June 2020 regarding Mr O'Brien's practice, I am however left with an unanswered question as to why the MHPS investigation did not uncover any of the further patient safety concerns which subsequently came to light. I believe the instigation of the MHPS process and the monitoring of Mr O'Brien's administrative practices against the Return to Work Plan prevented harm coming to more patients. The reliance on one person to monitor adherence to the Return to Work Plan was flawed however, leading to a

breakdown in monitoring during periods of [redacted] and therefore a lack of an overall robust monitoring arrangement with appropriate fail-safes.

26(viii) Not enough attention was paid to MHPS Section I, Para 29 which sets out that a 'clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action'. The MHPS framework does not specify to whom that role should be designated, and this is an issue that needs to be covered during the review of the Trust's October 2017 Guidelines – see 27(iii) below.

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

27(i) As a follow on from my response at 26(viii), on 13th November 2019 Zoe Parks, Head of Medical Staffing, emailed Dr O'Kane, Medical Director and me to advise that she had attended the Northern HSC Trust Doctors & Dentists in Difficulty Meeting, as an observer. Zoe Parks' email outlines a summary of the Northern HSC Trust approach to this meeting. **(This can be located at Attachment folder S21 49 of 2022- Attachment 60).** This visit was arranged following discussions between Dr O'Kane, Zoe Parks and me at some point earlier in 2019 about what we, in Southern HSC Trust, could do to structure our review of all ongoing MHPS cases, to track progress and to instil greater accountability in our senior medical leaders for professional medical governance. Zoe Parks in November 2019, subsequently developed a Terms of Reference for the Southern Trust's Doctors & Dentists in Difficulty Oversight Group. I believe the operation of these regular meetings has greatly improved the Southern Trust's approach to managing all cases relating to Doctors and Dentists in difficulty, and enables a more robust tracking of progress with cases including action plans. The Terms of Reference for this group means that the Divisional Medical Director must come prepared with updates on cases and action plans within their Division,

and seek advice as necessary from Dr O'Kane as Medical Director and myself as Director of HR & OD. It serves as an early alert by the Divisional Medical Director to the Medical Director when there are concerns arising in respect of a Doctor. A Medical Staffing Team representative present at the meeting is the designated note-taker.

27(ii) As Director of HR, I have considered the adequacy of training associated with MHPS for my role and other designated roles within the framework. My view is that, as a Trust, we would benefit from a robust training plan, including a review of training content, to accompany the framework, which takes account of tailored content for the various roles along with case studies to reinforce learning and appropriate timescales for training refresh. This would include the supporting roles for HR including note takers to ensure the adequacy of note taking. For Southern HSC Trust, I have asked our Head of Medical Staffing to undertake work on this training plan, for submission to the Trust Board as per MHPS Section VI para 1 in September 2022. I also believe there is merit in sharing what we develop in Southern Trust with other Trusts across the region for input and wider system learning. This is a work in progress, and is not yet available. I will provide this training plan, once complete, to the Urology Services Inquiry as further discovery. It will also be necessary to review any such training plan, in light of any potential future review of MHPS Framework completed by the Department of Health

27(iii) In writing my response to this Section 21 Notice, I would acknowledge that the Trust October 2017 Guidelines require review to incorporate the learning to date, including but not limited to the following points:

a) the designation of responsibility for initiating and tracking progress of MHPS investigations, costs and resulting action to the Doctor & Dentist in Difficulty Oversight Group referenced in 27(i) above (MHPS Section I para 29);
b) use of template for notification from Medical Director to Chief Executive of all concerns (MHPS Section I para 8);

c) use of template from Case Manager, via Case Investigator, for updating Designated Board Member on progress of a formal case (MHPS Section I para 31);
d) Southern HSC Trust MHPS training plan as referenced in 27(ii) above;
e) outline of arrangements for regular summary reporting of cases and lessons learned from cases to Trust Board members; and
f) importance of detailed note taking of meetings relating to performance concerns.

A review of the Trust October 2017 Guidelines to include greater detail such as that outlined above, would strengthen and enhance my role and that of others in managing cases within the Trust under MHPS Framework. Greater detail relating to how the requirements of MHPS is to be implemented within the context of the Trust, including responsibilities of individuals and groups should give greater clarity and assist in more robust implementation of MHPS. I will provide the revised Trust Guidelines, once complete, to the Urology Services Inquiry as further discovery.

27(iv) The nature and complexity of the existing MHPS framework makes adhering to it very challenging. One would expect a "framework" document to be a high-level list of principles and structure to guide local policies. However, the fact that MHPS is almost 50 pages long makes the document too prescriptive to act as a framework. It is a difficult document to navigate. It is easy, in my view, to fall foul of some aspect of the procedures while handling a case, due to the many complexities contained regarding what needs to be done when, by whom, and all within very tight deadlines. The Department of Health in the past commenced two reviews of the MHPS framework; once in 2012 and again in 2018 **(this can be located at Attachment folder S21 49 of 2022-Attachment 61a-d).** The Trust has commented on both occasions; however, the review of the MHPS framework has never progressed. There does appear to be some confusion as to who in the Department of Health takes a lead for any such review over what is a Departmental document. In 2018, the Department of Health's Workforce Policy Unit wrote out seeking comments

from HSC Trusts on the MHPS framework, however it would appear that these comments were collated for the Office of the Chief Medical Officer, so therefore I am not entirely clear who is best placed to take responsibility to progress the review. In my view, it does need to be a joint review from both a professional medical governance perspective and a workforce policy perspective, however, I believe input from HR Directors and Medical Directors would be key to any such review going forward. I believe any review needs to significantly simplify the document, with a logical flow and structure, with greater clarity and definition on all key designated roles within the Framework to make it easier for me and other designated individuals to discharge their responsibilities. The role of the Medical Director is currently not defined, nor is the role of any HR support to any of the designated roles in the Framework.

27(v) The role of the Designated Board Member is particularly difficult in my view to comprehend, which in turn makes my advisory role, as HR Director, difficult to discharge. The role of the Designated Board Member as outlined in Section I para 8 refers to '*consider any representations from the practitioner about his or her exclusion or any representations about the investigation'*. Mr O'Brien made representations to John Wilkinson as the Designated Board Member in the early stages of the investigation in February and March 2017, however, given the detail of those representations, and following legal advice, we considered that the Case Manager, Dr Khan and Medical Director, Dr Wright, were best placed to respond to those representations. This leads me to question what exactly the role of the Designated Board Member can realistically be under the MHPS Framework, as I do not believe that John Wilkinson, as a Non Executive Director, would have had sufficient knowledge to determine or challenge if Mr O'Brien's representations were responded to appropriately. Any review of MHPS, in my view, needs to consider this, and provide greater clarity about what their role is and is not.

27(vi) The timescales contained within MHPS are not realistic, and do not reflect the reality of clinical commitments and day to day operational pressures in the HSC. I fully acknowledge, however, the importance of ensuring that concerns

are investigated quickly given the impact of investigatory processes on the health and wellbeing of any member of staff. The four-week timescale for completion of formal investigation is confusing when set alongside the fact immediate exclusion is itself up to a four-week period to allow '*sufficient time for initial investigation to determine a clear course of action…*' (MHPS Section I para 25). Directly linked to the challenge of meeting the specified timescales is the fact that medical staff undertaking the roles under MHPS are practising clinicians; they cannot be easily released. Supporting HR Teams, in my experience across the HSC, are rarely adequately resourced to provide dedicated support to assist Case Investigators and Case Managers to the level they require. This makes my role more challenging to discharge. In the context of a very constrained financial climate, resources tend to be prioritised for patient and service user facing roles. In writing my response to this Section 21 I have reviewed many emails between myself and Siobhan Hynds, and others. One of the key things that has struck me is the reliance on Siobhan Hynds as the HR Case Manager by a range of people for support, and the timings of when emails were sent, very often late at night and at weekends, from myself and Siobhan Hynds to key individuals with defined roles in the MHPS process. This is reflective of the other workload pressures ongoing at the time and the need to work excessive hours to seek to keep the MHPS process on track. My review of the other cases outlined in my response to Q 7(xii) above, also indicate lengthy investigation timescales for at least two other cases, with similar pressures with Case Investigator and HR Case Manager workloads preventing quicker completion of investigations. What would strengthen and support my role as HR Director is an adequately resourced HR Case Management Team to robustly support investigations and to keep them moving at pace. I believe there needs to be acceptance of this at Department of Health level in terms of the necessary investment required for Trusts. I know my view is reflective of most HR Directors across HSC, and therefore support from the HSC system in the form of investment in supporting functions such as HR is required to recognise the vital role they play in supporting others to ensure the safety of our patients and service users. I also believe, as a Trust and a wider system, there needs to be

considerable thought given to how there can be dedicated medical leadership capacity to progress MHPS investigations. Given the medical workforce challenges at present, this is a considerable ask.

27(vii) I raised the matter of the outstanding MHPS review with Philip Rodgers, Director of Workforce Policy, Department of Health by telephone on 13th June 2022. Philip Rodgers agreed that it would be helpful to have this as an agenda item for discussion at the next meeting of the HR Directors' Forum, which has representation from the Department of Health's Workforce Policy Directorate and the HR Director from each of the HSC Organisations. The most recent meeting of this Forum took place on 4th July 2022, and Philip Rodgers advised that the Department of Health had identified the need to take forward an urgent review of MHPS. Philip Rodgers referred in our meeting to the Neurology Public Inquiry report published on 21st June 2022 having included references to parts of the MHPS Framework requiring review in three of its recommendations. Trusts are now awaiting the establishment of a Department of Health led group to take forward a review of the MHPS Framework.

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

28(i) Having had the opportunity to reflect, I believe the MHPS Framework should have been used earlier than September 2016, as outlined above in 26(ii).

28(ii) At the Oversight Group Meeting in September 2016 there was a focus on the size and nature of the backlogs as outlined in the Screening Report but not enough focus on agreeing arrangements to check whether the patients in those backlogs could have come to harm. I believe this was further exacerbated by the off line discussions and subsequent plan developed within Acute Services following the Oversight Group meeting between Dr McAllister,

Mr Weir and Esther Gishkori. This has been a significant learning point for me as Director of HR, and I am very sorry that my experience back in September 2016 was not at the level it should have been to challenge this in the best interests of our patients.

28(iii) The Return to Work Action Plan, dated 9th February 2017 as a means of protecting the public as per MHPS Section I Para 5, needed to be much more robust in my view, with greater clarity around reporting and escalation arrangements to the Case Manager and Medical Director. The arrangements should not have been dependent on a single person to monitor.

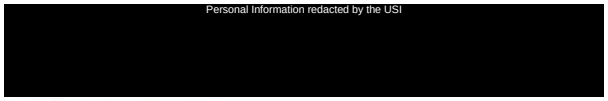
28(iv) I believe greater reporting to the Board of MHPS case data would have added greater accountability into our Trust system, including for example: numbers of cases; case context; timelines; adherence to process; reasons for any suspensions/exclusions; outcomes of cases; impact on patient care and employees; and lessons learnt. The rigor of that type of regular reporting could have assisted in pressing for conclusion of the process in respect of Mr O'Brien's case more quickly. Zoe Parks is currently progressing work for the Medical Director's Office to put in place a report to ensure improved Board level oversight of cases. The template for reporting is currently being developed for September 2022, and I will provide evidence of a Case Report submitted to the Board, when complete, to the Urology Services Inquiry as further discovery.

28(v) Ultimately the conduct panel which was determined as the appropriate action by the Case Manager following the MHPS investigation was never convened. Mr O'Brien was entitled to raise a grievance about the classification of the case under MHPS Section III Para 8. Mr O'Brien exercised his right to submit a grievance and did so by submitting an extensive 40 page grievance on 30th November 2018. That grievance covered many points throughout the lifespan of the process and submitting that grievance along with substantial subject access requests, had the effect of obfuscating the process and thereby delaying the conduct panel. Only one part of Mr O'Brien's grievance related

to the classification of the case, and in hindsight, I could have sought to put the classification part of the grievance to hearing immediately. The remaining aspects of Mr O'Brien's grievance may have been able to be heard later following the outcome of the hearing in respect of the classification. It seems an obvious point to me now, but wasn't at the time in December 2018, however I do appreciate that if I had attempted to proceed in that way at the time, I may well have encountered significant resistance from Mr O'Brien. This approach however would have served to ensure the MHPS process was being visibly driven to its conclusion by the Trust as Mr O'Brien's employer.

Statement of Truth

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



Signed: _____

Date: 25th July 2022

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Attachment 1- Job Description Head of Employee Engagement and Relations Band 8a Vivienne Toal.pdf
Attachment 2- Job Description Head of Employee Engagement and Relations Band 8b Vivienne Toal.pdf
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Attachment 9 -2010.08.09 a Email VToal to SHynds re Guidelines for Managing MHPS.pdf
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Attachment 14a-2010.08.14 a Email from V Toal to S Hynds re MHPS guidance to check with K Donaghy with att.pdf
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Attachment 20-2010.09.16 b Att agenda to Email from Dr Loughran to Dr C Fitzpatrick.pdf
Attachment 21- 2010.09.16 c Att Trust Guidance to Email from Dr Loughran to Dr C Fitzpatrick.pdf
Attachment 22-2010.09.23 a Email from S HYnds to A Brennan re amends to MHPS Trust Guidelines AMD comments with att.pdf
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Attachment 30-2010.01.01 NCAS publication_ How-to-conduct-a-local-investigation.pdf
Attachment 31- 2017.02.21 Email SHynds to AMurphy request to set up meeting to review MHPS guidance.pdf
Attachment 32-_2017.02.22 Email from A Murphy confirming date of meeting to review MHPS guidance.pdf
Attachment 33a-2017.04.05 a Email from Z Parks to VToal, SHynds, HWalker with draft changes to Trust Guidelines with att.pdf
Attachment 33b-2017.04.05 b Att 2010 Trust Guidelines to Email from Z Parks to VToal_SHynds_HWalker.pdf
Attachment 33c-2017.04.05 c Att draft 2017 Trust Guidelines to Email from Z Parks to VToal_SHynds_H Walker.pdf
Attachment 34-2022.06.06 Email from Z Parks confirming DLS advice on 2017 Trust Guidelines.pdf
Attachment 35-2022.06.06 Att to Z Parks email_Trust Guidelines 2017 tracked with DLS comments on 4.8.2017.pdf
Attachment 36- 2022.06.06 Att email to Email Z Parks confirming AMD views sought on revised 2017 Guidelines_24.11.2017.pdf
Attachment 37-2022.06.06 Email from Z Parks confirming revised Guidelines shared with LNC on 2nd March 2018.pdf

Attachment 38-20101021 Powerpoint Presentation Sept 2010 Dr C Fitzpatrick_Anne Brennan discovery.pdf
Attachment 39-2017.08.29 MHPS slides_DLS to NEDS.pdf
Attachment 40-2020.10.15 Email from Z Parks to MDO_VToal_SHynds Hempsons MHPS webinar link.pdf
Attachment 41-2016.09.06 EMail VToal to DrWright_E Gishkori request to meet on 8.9.2016 re oversight meeting.pdf
Attachment 42-2016.09.07 Email from Laura White confirming Dr Wright was free to meet on 8.9.2016.pdf
Attachment 43-2016.09.07 Email from E Stinson confirming E Gishkori was not free to meet on 8.9.2016 after Gov Meeting.pdf
Attachment 44-2016.09.07 Email asking HMCassells to seek a date for the oversight meeting.pdf
Attachment 45-2016.09.08 Email from HMCassells to Dr Wright_E Gishkori_VToal_SGibson re date oversight 13.9.2016 10am.pdf
Attachment 46-13(vi) 49 of 2022_2022.06.06 Email trail VToal and SGibson re NCAS letter atts.pdf
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Attachment 48-2022.06.06 Att2 to Email from S Gibson to V Toal - Email to Dr Wright_E Gishkori with NCAS ltr 28.9.2016.pdf
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Attachment 50- email from RC 220916.pdf
Attachment 51-2016.11.30 Email from Dr Wright to E Gishkori re SAI.pdf
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Attachment 59b1-2019.01.11 Email from HMC to AOB with file atts re info requests.pdf
Attachment 59b2-2019.01.11_Att to Email from HMC to AOB _File 1.pdf
Attachment 59b3-2019.01.11_Att to Email from HMC to AOB _File 2.pdf
Attachment 59b4-2019.01.11_Att to Email from HMC to AOB _File 3.pdf
Attachment 59b5-2019.01.11_Att to Email from HMC to AOB _File 4.pdf
Attachment 59b6-2019.01.11_Att to Email from HMC to AOB _File 5.pdf
Attachment 59b7-2019.01.11_Att to Email from HMC to AOB _File 6.pdf
Attachment 59b8-2019.01.11_Att to Email from HMC to AOB _File 7.pdf
Attachment 59b9-2019.01.11_Att to Email from HMC to AOB _File 8.pdf
Attachment 59b10-2019.01.11_Att to Email from HMC to AOB _File 9.pdf
Attachment 59b11-2019.01.11_Att to Email from HMC to AOB _File 10.pdf
Attachment 60-2019.11.13 Email from Z Parks re visit to NHSCT re their DD arrangements.pdf
Attachment 61a-2012.12.17 Email from Z Parks to Dr J Simpson re revised MHPS re her comments on MHPS framework.pdf
Attachment 61b-2018.03.15 Att to Email from Z Parks to LHynes re review of MHPS _ SHSCT comments.pdf
Attachment 61c-2018.03.15 EMail from VToal to LHynes re review of MHPS.pdf
Attachment 61d-2018.03.15 Email from Z Parks to V Toal cc_ review of MHPS comments to DOH.pdf

88207052

SOUTHERN HEALTH AND SOCIAL SERVICES TRUST

Head of Employee Engagement & Relations

JOB DESCRIPTION

Reports to:
Director of Human Resources & Organisational Development

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

KEY AREAS OF RESPONSIBILITY

1.0 Service Delivery and Policy Development

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

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

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

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

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

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

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

2.0 Organisational and Workforce Development

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

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

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

3.0 Communication and Information Management

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

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

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

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

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

4.0 Quality

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

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

5.0 Financial and Resource Management

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

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

6.0 People Management and Development

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL RESPONSIBILITIES

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

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

June 2007

SOUTHERN HEALTH AND SOCIAL SERVICES TRUST

Head of Employee Engagement & Relations

PERSONNEL SPECIFICATION

Knowledge, skills and experience required:

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

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

OR

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

AND

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

SHORTLISTING

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

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

- Self Belief

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

The following additional clarification is provided:

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

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

June 2007

Southern Health & Social Care Trust

JOB DESCRIPTION

JOB TITLE	Head of Employee Engagement and Relations
BAND	8B
DIRECTORATE	Human Resources & Organisational Development
INITIAL LOCATION	HR Department, Armagh
REPORTS TO	Director of Human Resources and Organisational Development
ACCOUNTABLE TO	Director of Human Resources and Organisational Development

JOB SUMMARY

The post-holder will be responsible for ensuring the development and implementation of policies and procedures that will maximise the contribution of staff towards meeting the aims and objectives of the Trust. He/She will take a lead role in developing and promoting a culture that will promote the health and well being of staff across the Trust. This will involve the development of policies and procedures where the contribution of each member of staff is recognised and acknowledged.

He/She will also develop structures and processes that allow for direct employee participation in decision making along with developing genuine partnership with staff side organisations.

The post holder will also be responsible for leading and managing an employee relations team, ensuring that systems and processes are in place to deal effectively with a wide range of employee relations issues such as industrial tribunal proceedings, application of terms and conditions, disciplinary/grievances, redeployments.

KEY AREAS OF RESPONSIBILITY

1.0 Service Delivery and Policy Development

1.1 To take the lead in the development of policies and practices that promote and establish effective staff engagement.

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

1.3 To ensure that the necessary resources are deployed to undertake a range of investigations such as discipline, grievance, harassment etc, ensuring that any lessons learnt are effectively absorbed within the Trust.

1.4 Act as an HR panel member on disciplinary and grievance panels.

1.5 As the lead manager within the Employee Relations team, act as a source of expertise in determining recommended course of action in relation to complex employment situations.

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

1.7 Ensure that the Trust is in a position to meet statutory obligations in the area of employee engagement both current and in the future.

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

1.9 Ensure collaborative working with regional Employee Relations colleagues and regional Trade Union officials in the development of policies and procedures which impact on all Trust organisations.

2.0 Organisational and Workforce Development

2.1 To ensure that changes within the organisation are being communicated effectively and that they are promoting a culture that maximises the contribution of each individual towards the goals of the Trust.

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

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

2.4 Lead in the development and implementation of longer term strategies to ensure the Trust is transformed into a first class place to work, in line with the Directorate's strategic objectives.

3.0 Communication and Information Management

3.1 To ensure that staff have opportunities to receive information about issues which affect their employment, including objectives and policies, Trust performance, standards to be met.

3.2 Establish mechanisms within the Trust that promote the engagement of staff such as team briefings, staff appraisals, focus groups etc and to monitor their effectiveness.

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

3.4 Develop and implement mechanisms to capture the health of the workforce ranging from attitude surveys, focus groups, exit interviews, questionnaires' etc.

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

3.6 Ensure that the information and filing systems relevant to the Employee Engagement & Relations service are appropriately managed in accordance with data protection principles e.g. Personal File system, Job Evaluation system – CAJE.

4.0 Quality

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

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

5.0 Financial and Resource Management

5.1 Manage the Employee Engagement & Relations budget.

5.2 To assist senior staff in costing specific interventions.

6.0 People Management and Development

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

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

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

6.4 To ensure all staff develop an annual Personal Development Plan and that development needs are met using a variety of methods.

6.5 To contribute as an effective member of the Senior Human Resources Team.

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

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

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

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

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the 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.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE

DIRECTORATE

Ref No: <to be inserted by HR> **<Month & Year>**

Notes to applicants:

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

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

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

QUALIFICATIONS / EXPERIENCE

1. Hold a relevant[1], University Degree or recognised Professional Qualification or equivalent qualification **AND** 2 years experience in Corporate Human Resources Management in a Senior Role[2] **OR** have at least 5 years experience in Corporate Human Resources Management in a Senior Role.

2. Have a minimum of 1 years experience in a lead role delivering objectives which have led to a significant[3] Improvement in Service.

3. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant change in initiative.

4. Have a minimum of 2 years experience in staff management

[1] *'relevant' will be defined as a qualification such as CIPD or a University Degree with a significant component being in the area of Human Resources Management*
[2] *'Senior Role' is defined as Band 7 or equivalent or above*
[3] *'Significant' is defined as contributing directly to key Directorate objectives*

KNOWLEDGE & SKILLS

5. Hold a full current driving license valid for use in the UK and have access to a car on appointment[4].

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

KNOWLEDGE & SKILLS

6. Have an ability to effectively manage a delegated budget to maximize utilization of available resources.

7. Have an ability to provide effective leadership.

8. Demonstrate evidence of highly effective planning and organisational skills

9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

DESIRABLE CRITERIA *– these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. 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*

QUALIFICATIONS / EXPERIENCE

1. Be a full member of the Chartered Institute of Personnel & Development

As part of the Recruitment & Selection process it may 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 Trusts Smoke Free Policy

[4] *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 organize suitable alternative arrangements in order to meet the requirements of the post in full.*

SOUTHERN HEALTH AND SOCIAL SERVICES TRUST

JOB DESCRIPTION

Title of Post: Head of Education, Learning and Development (ELD)

Reports to: Director of Human Resources & Organisational Development

Role Purpose: To facilitate the development of individuals, teams and the organisation to deliver a modern, patient and client focused service**.** The Head of ELD will lead on the development of a Workforce Learning Strategy and Plan for the Trust, and the identification and implementation of education, learning and development opportunities to deliver on the objectives of the strategy. He/she will lead on a range of organisational and management development initiatives to support the Trust's values and culture and provide specialist advice on workforce learning and organisational development to senior managers.

KEY AREAS OF RESPONSIBILITY

1.0 Strategy Development

1.1 To lead on the development of a Workforce Learning Strategy for the Trust, and oversee implementation of plans to equip staff with the skills needed to support improved services for patients and clients.

1.2 To lead on the development of an Organisation Development Strategy that supports staff in working differently to improve services for patients and clients.

1.3 To lead on the development and implementation of a Management and Leadership Development Strategy.

1.4 To lead on the development of an E-Learning Strategy for the Trust.

2.0 Organisational, and Workforce Development

2.1 To work with the Director of Human Resources and other senior executives to identify a leadership development framework for the Trust, and lead on the implementation of a range of initiatives and opportunities to develop leaders at all levels in the organisation.

2.2 To lead on the development, implementation and monitoring of a trust wide performance appraisal system, that supports the overall performance of the organisation and assists staff in identification and development of required knowledge, skills and experience, in line with the Knowledge and Skills Framework (KSF).

2.3 To lead on delivery of a training plan for staff covering all aspects of mandatory training to ensure the Trust meets its legal and statutory obligations as an employer.

2.4 To promote the use of a variety of methods which can be used to meet learning and development needs.

2.5 To lead the Widening Participation Agenda for the Trust, developing a range of essential skill and vocational programmes and learning opportunities to develop support staff.

2.6 To provide high quality specialist HR advice on all aspects of workforce learning and organisation development.

2.7 To lead on the development and agreement of appropriate HR systems, policies, and procedures to support training and development within the Trust, including study leave, secondment opportunities, job rotation etc.

2.8 To identify and lead on organisation development opportunities to support organisation change and service improvement.

2.9 To lead on the development and implementation of an accreditation framework for the Trust, ensuring provision of relevant accredited programmes for staff, in line with the national qualifications framework and developments in further and higher education.

2.10 To act as an advocate for change and service improvement, providing internal consultancy support to senior staff across service groupings.

2.11 Advise members of the senior management team on their management structures and practices, to support a culture of effective team working, continuous improvement and innovation.

3.0 Commissioning Organisational Development, Management Development, Training and Education

3.1 To lead on the management of the Service Level Agreement for management and organisation development services with the Beeches Management Centre, including the specification and monitoring of service levels and quality required.

4.0 Team Development.

4.1 To develop and lead on the implementation of an organisation wide programme to support the development of effective multidisciplinary team working.

5.0 Collaborative Working

5.1 To work closely with all relevant internal and external stakeholders to secure their commitment and involvement in the implementation of the workforce learning strategy and organisation development initiatives.

5.2 To establish a mechanism/forum to ensure the co-ordination of education, learning and development throughout the Trust.

5.3 To consult, negotiate and communicate with staff side as appropriate across the range of work responsibilities.

5.4 To establish and maintain productive working relationships with professional heads within the Trust, ensuring the collation of accurate information on training and education needs to support effective decision making and targeting of funds.

6.0 Communication and Information Management

6.1 To review current information management systems and develop an information management system for the recording of staff training and development, taking account of the Knowledge and Skills Framework and other occupational standards.

6.2 To provide reports for Trust Board, and the Director of Human Resources as required, identifying progress against plans and key performance objectives.

6.3 To agree with the Director of Human Resources a number of key Performance Indicators/benchmarks and provide regular information on the Trusts progress against each of the indicators.

6.4 To undertake comparative work within the HPSS, the NHS and externally to assess the positioning, efficiency and value for money of training and development opportunities either provided directly or commissioned by the Trust.

7.0 Quality

7.1 To lead on quality initiatives for the organisation, including implementation of processes and programmes to achieve Investors in People (IIP) and other awards agreed with the Director of Human Resources.

7.2 To support the achievement of relevant controls assurance standards for human resources.

7.3 To provide appropriate Reports to Trust Board and the HR Users Group on compliance with standards.

8.0 Financial and Resource Management

8.1 To work within human resources budgetary constraints, providing advice on the costs and benefits of planned developments.

9.0 People Management and Development

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

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

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

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

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

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

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

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

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

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

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

This job description 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 Head of Education and Learning and Development. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive.

GENERAL RESPONSIBILITIES

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

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

June 2007

SOUTHERN HEALTH AND SOCIAL SERVICES TRUST

PERSONNEL SPECIFICATION

Head of Education, Learning and Development

Knowledge, skills and experience required:

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

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

  OR

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

  AND

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

SHORTLISTING

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

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

- Self Belief
- Self Management
- Seizing the future
- Drive for results

- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

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

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

June 2007

JOB DESCRIPTION

JOB TITLE	Director of Human Resources & Organisational Development
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Trust Board

JOB SUMMARY

The Director of Human Resources & Organisational Development is a Senior Executive Member of the Trust Board and will support the Chief Executive to lead the development and delivery of a high quality professional Human Resource service.

The Director of Human Resources & Organisational Development will provide specialist human resource advice to the Trust Board, share corporate responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's Corporate Plan, which will be responsive to the needs of the population in line with performance targets established by the HSCB.

The Director of Human Resources & Organisational Development is responsible to the Chief Executive for promoting the corporate values and culture of the Trust through the development and implementation of Human Resource management policies, procedures and good practice, thereby ensuring that the Human Resource Strategy is wholly integrated with the Trust strategic direction and service objectives.

He/she will support the Chief Executive in the development and maintenance of organisational structures and systems for the management of staff which support high quality and responsive services to the local population.

In addition to the Human Resource function the Director of Human Resources & Organisational Development will also be accountable for the Trust's Corporate Bank arrangements, Occupational Health Service, Equality Unit, Health and Safety and Estates. As part of this role he/she is the Executive Director responsible for Fire policy within the Trust.

PRINCIPAL ACCOUNTABILITIES

DELIVERY

- Participate in the development of a Corporate Plan for the Trust in line with regional strategies, ministerial and HSCB priorities and the needs of the local population.

- Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust deliveries services and that human resources are effectively deployed to meet those needs and achieve the best outcomes possible.

- Provide leadership and guidance on human resources issues to the Trust Board, Chief Executive and Senior Management Team.

- Participate as an Executive Director on the Trust Board.

- Provide strategic direction in the management, development and implementation of all human resource policies, procedures and good practice within the Trust, and ensure the creation of sound HR management principles at all levels of the Trust's services.

- Ensure that workforce modernisation and reform initiatives are implemented and that maximum benefits realisation is achieved.

- Develop a workforce plan for the Trust to ensure the delivery of services is effective and efficient, and contribute as required to regional initiatives in this regard.

- Contribute as a member of the Senior Management Team to the development of the annual Trust Delivery Plan for the provision of services in partnership with key stakeholders, taking into account Regional Commissioning Direction and Ministerial/Departmental priorities.

- Support the Trust in making an effective contribution to education, teaching and research and create and sustain continuous professional development and life long learning.

- Achieve high levels of performance and excellence against Human Resources Controls Assurance standards.

- Promote human resource shared services and actively participate to ensure their effective management, delivery and monitoring of outcomes.

- Ensure that effective systems are in place to take learning from complaints and other actions against the Trust and translate these into action for improvement.

- Lead the development, monitoring, measurement and reporting of key Trust human resource performance management indicators. Deliver organisational targets with an emphasis on continuous improvement in the following key areas.

    - Workforce modernisation
    - Equality and fairness
    - Retention, return, recruitment and reward
    - Employee relations
    - Staff satisfaction

- Support the health and well-being of staff through the provision of Occupational Health and professional counselling services.

STRATEGIC LEADERSHIP

- Support the Chief Executive in the provision of clear and positive leadership, motivation and development to all staff throughout the Trust to ensure their engagement with and commitment to achieving the Trust's Corporate Plan and Trust Delivery Plan.

- Work with the Trust Board, Chief Executive, staff, partners and stakeholders in the local health economy to achieve organisation goals.

- Lead change through the modernisation agenda inspiring others to be positive in their support of service improvement.

- Provide strategic leadership for the promotion of equality and diversity initiatives.

- Provide leadership at organisational, directorate and individual level within the Trust on human resource matters.

CORPORATE MANAGEMENT

- Support the Chief Executive to establish and maintain an organisational structure for the Trust, its probity and effectiveness,

- Ensure that systems and processes are in place to enable the Chief Executive to evaluate the effectiveness of the Trust's Human Resources.

- Ensure the Trust complies with all employment law and other relevant legislation, providing expert interpretation on the framework of employment law within the jurisdiction.

- Work with the Senior Executive and Senior Management Teams to ensure the achievement of Corporate Objectives.

- Participate in the development of Trust policies, the setting and monitoring of standards and the achievement of objectives so that the Trust provides high quality and safe services to patients and clients.

GOVERNANCE

- Ensure effective human resources policies and processes are in place to ensure the safety and well-being of patients, clients and their carers.

- Work with the Senior Management Team to ensure that reports on statutory functions are completed as necessary ensuring that any action needed internally in the Trust is taken promptly.

- Work with the Chief Executive to deliver effective governance in accordance with public sector values and the codes of conduct, operation and accountability.

- Monitor and report on staff performance against departmental and other delivery targets and contribute to corrective action as appropriate,

- Ensure that robust arrangements are in place to meet all statutory and other human resources information requirements in accordance with requisite deadlines.

- Ensure that Corporate and Directorate risk registers are regularly reviewed, taking into account corporate priorities and responsibilities.

INTERNAL/EXTERNAL RELATIONSHIPS

- Develop working relationships with external organisations to effectively discharge the Trust's employment responsibilities and equality duties.

- Lead partnership working with Trade Unions and Professional Associations to achieve effective transparent decision making.

- 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.

- Develop linkages with other Trusts, the HSCB and as necessary the DoH to promote best practice and innovation in the provision of human resource services.

- Establish collaborative relationships with external partners in the public, private and voluntary sectors to development initiatives which will improve services and inter-agency communication.

FINANCIAL RESPONSIBILITIES

- Develop with the Director of Finance and Procurement, staff management information on financial spend and inter-linkages such as overtime, absence and agency costs, which inform management and control of budgets.

- Responsible for the management of the human resources budget ensuring budget constraints and requirements are met.

PEOPLE MANAGEMENT RESPONSIBILITIES

- Ensure that people management practice support continuous improvement in staff capability and quality of services provided including encouragement of and widening participation in learning opportunities.

- Lead the development of systems to promote the health and well-being of staff.

- Develop and maintain systems to support development and performance appraisal for all staff to meet the Trust's corporate objectives.

- Ensure appropriate performance management policies and procedures are in place within the Trust to support line management deal with poor performance in an effective and timely way.

- Responsible for the development and provision of management information on staff utilisation, development and return on investment, which informs management and supports a rigorous continuous improvement culture.

- Responsible to the Chief Executive for ensuring that the Trust has a diverse and representative workforce and that the right skills are in the right place to deliver its objectives.

- Responsible for day to day management and development of human resource staff.

  - 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.
  - Maintain staff relationships and morale amongst staff.
  - Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall 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.

DEVELOPMENT OF SELF

- Lead by example to ensure that the Trust demonstrates commitment through its culture and actions, for all aspects of diversity in the population it serves and the staff who provide the services.

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

- Continuously strive to develop self and improve capability in the leadership of the Trust and its staff.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

- 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:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

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

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the 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.

7. 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.

8. 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.

9. 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.

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

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

PERSONNEL SPECIFICATION

JOB TITLE Director of Human Resources & Organisational Development

LOCATION Trust Headquarters, Craigavon Area Hospital

SALARY RANGE £62,323 - £83,098 per annum

Notes to applicants:

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

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

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

QUALIFICATIONS AND EXPERIENCE

Applicants must provide evidence by the closing date for application that they have:

- Hold a University degree and professional qualification (CIPD) and worked for at least 5 years in a senior management[1] role in a major complex organisation[2].
- Demonstrated the ability to be able to lead and drive significant[3] change within a major complex organisation for a minimum of 3 years.
- Worked with a diverse range of stakeholders, internally and externally to the organisation, to achieve successful outcomes for a minimum of 3 years.
- Successfully demonstrated high level people management governance and organisational skills for a minimum of 2 years.

- Hold a full current driving licence[4] valid for use in the UK and have access to a car on appointment. 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.

Further clarification on the terms used in this specification is provided as follows:

1. *"Senior management"* is defined as experience gained at Director, Assistant Director, Head of Service or equivalent in a major complex organisation.
2. *"Major complex organisation"* is defined as one with at least 200 staff or 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.
3. *"Significant"* is defined as contributing directly to key corporate objectives of the organisation concerned.
4. This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full

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

COMPETENCIES

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

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

- Sharing the vision.
- Influencing for results.
- Inspiring shared purpose.
- Engaging the team.
- Developing capability.
- Holding to account.

PERSONAL ATTRIBUTES

1. Have an ability to provide effective leadership at a Strategic level to enable the ongoing development and improvement of services.

2. Demonstrate evidence of high level skills in;
   a. effective planning and organisation
   b. Governance and Risk Management
   c. People Management

3. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

4. Demonstrate effective communication skills to meet the needs of the post in full.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment and may be required to undergo an Access NI disclosure check.

All staff are required to comply with the Trust's Smoke Free Policy.

Staff in Post in Employee Relations (aligned to Vivienne Toal, Head of Service) as at 31 December 2015

Pers.No.	Last name	First name	Contract Type	Position	Job Description	Band of Person	Organizational Unit	Date Appointed To Trust	Date Commenced Post	WTE
Personal Information redacted by the USI			Permanent	HOS-Employee Engag & Relations	Admin & Clerical (8B)	8B	Employee Engagement & Relations	08/06/1998	01/06/2011	1.00
			Permanent	Staffside Officer	Admin & Clerical (5)	5	Agenda for Change - Staff Side	24/05/1977	01/07/2010	1.00
			Bank	Admin & Clerical (7) -Bank	Admin & Clerical (7)	7	Employee Engagement & Relations	07/05/2014	07/05/2014	0.00
			Bank	Admin & Clerical (7) -Bank	Admin & Clerical (7)	7	Employee Engagement & Relations	08/06/2009	08/06/2009	0.00
			Bank	Agenda For Change Job Evaluator -Bank	Admin & Clerical (5)	5	Employee Engagement & Relations	15/12/2014	15/12/2014	0.00
			Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 1	03/06/2009	06/11/2012	1.00
			Permanent	Trade Union Chair	Admin & Clerical (6)	6	Staff Side 1	01/09/2006	01/04/2012	1.00
			Permanent	Trade Union - KSF Lead	Elderly Social Worker Supp (5)	5	Staff Side 1	21/07/2009	27/06/2012	0.50
			Permanent	Trade Union Officer	Acute Nurse Support (3)	3	Staff Side 1	03/06/2013	03/06/2013	0.40
			Permanent	Trade Union Officer	Acute Nurse (5)	3	Staff Side 1	03/07/2015	03/07/2015	0.20
			Permanent	Trade Union Officer	Biomedical Science-Supp (3)	3	Staff Side 1	24/03/2003	01/01/2009	1.00
			Permanent	Trade Union Officer	Learning Disability Nrs Sup (3)	3	Staff Side 1	08/10/2007	12/08/2013	1.00
			Permanent	Trade Union Secretary	Admin & Clerical (5)	5	Staff Side 2	01/08/1987	12/04/2010	1.00
			Permanent	Acute Nurse (5)	Acute Nurse (5)	5	Staff Side 2	01/04/2014	01/04/2014	0.67
			Temporary	Trade Union Officer	Acute Nurse (5)	5	Staff Side 2	01/10/2015	01/10/2015	0.33
			Permanent	Senior Biomedical Scientist	Biomedical Scientist (7)	7	Staff Side 3	01/09/2013	01/09/2013	0.40
			Permanent	Trade Union Officer	Elderly Social Worker (8A)	8A	Staff Side 4	21/06/1993	21/11/2005	1.00
			Permanent	Human Resources Manager	Admin & Clerical (6)	6	Attendance Management Team	27/03/1995	01/03/2008	1.00
			Permanent	Attendance Officer	Admin & Clerical (4)	4	Attendance Management Team	21/01/2003	01/03/2008	0.53
			Permanent	Attendance Officer	Admin & Clerical (4)	4	Attendance Management Team	17/07/1995	28/10/2010	1.00
			Permanent	Human Resources Manager	Admin & Clerical (8A)	8A	Employee Engagement & Relations Team	20/06/1997	30/11/2015	1.00
			Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	7	Employee Engagement & Relations Team	23/07/2001	14/07/2014	1.00
			Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	14/08/2008	14/07/2015	1.00
			Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	05/02/2001	01/03/2008	1.00
			Permanent	Senior Human Resource Advisor	Admin & Clerical (6)	6	Employee Engagement & Relations Team	09/10/1989	26/05/2008	1.00
			Permanent	Attendance Officer	Admin & Clerical (4)	4	Employee Engagement & Relations Team	03/05/2011	22/04/2013	1.00
			Permanent	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	24/03/2004	02/11/2015	1.00
			Permanent	Human Resources Manager	Admin & Clerical (7)	7	Pay & Employment Manager	02/07/2012	01/08/2015	1.00
			Permanent	Contract Payroll & Travel Specialist	Admin & Clerical (5)	5	Pay & Employment Manager	03/05/2011	01/07/2015	1.00
			Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 1	16/02/2004	01/07/2015	1.00
			Permanent	Human Resources Advisor	Admin & Clerical (5)	5	Pay & Employment Team 1	04/01/1983	01/10/2015	1.00
			Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 1	15/09/2003	01/03/2008	0.60
			Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 1	21/08/1995	01/02/2015	1.00
			Permanent	Human Resources Assistant	Admin & Clerical (2)	2	Pay & Employment Team 1	24/07/2014	01/05/2015	1.00
			Permanent	Human Resource Advisor	Admin & Clerical (5)	5	Pay & Employment Team 2	03/10/1988	01/10/2015	1.00
			Permanent	Human Resources Officer	Admin & Clerical (4)	4	Pay & Employment Team 2	28/04/2014	01/07/2015	1.00
			Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	13/09/1982	16/11/2009	1.00
			Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	15/01/2007	01/01/2012	0.56
			Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	19/03/1991	16/02/2015	1.00

Personal Information redacted by the USI	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	07/06/1994	01/03/2008	0.60
	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	04/06/1984	01/03/2008	0.81
	Permanent	Human Resources Assistant	Admin & Clerical (3)	3	Pay & Employment Team 2	22/07/2013	05/08/2015	1.00
	Block Booking	HR Assistant	Admin & Clerical (2)	2	Pay & Employment Team 2	04/11/2015	04/11/2015	1.00
	Permanent	Litigation Manager	Admin & Clerical (7)	7	Litigation	07/03/1991	01/04/2009	0.67
	Permanent	Litigation Manager	Admin & Clerical (7)	7	Litigation	03/12/2012	01/07/2014	1.00
	Permanent	Assistant Litigation Manager	Admin & Clerical (6)	6	Litigation Team	27/05/2014	27/05/2014	1.00
	Permanent	Admin & Clerical (5)	Admin & Clerical (5)	5	Litigation Team	04/11/1998	10/09/2013	1.00
	Permanent	Admin & Clerical (4)	Admin & Clerical (4)	4	Litigation Team	13/01/2003	01/01/2014	1.00
	Permanent	Admin & Clerical (4)	Admin & Clerical (4)	4	Litigation Team	23/04/2003	03/11/2008	1.00
	Temporary	Admin & Clerical (4)	Admin & Clerical (4)	4	Litigation Team	19/05/2014	19/05/2014	1.00
	Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	Litigation Team	15/05/2000	01/07/2014	1.00
	Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	Litigation Team	04/09/2006	08/04/2013	1.00
	Block Booking	Litigation Assistant	Admin & Clerical (3)	3	DHH - Medical Legal Admin Team	28/09/2015	28/09/2015	1.00
	Permanent	Litgation Assistant	Admin & Clerical (3)	3	DHH - Medical Legal Admin Team	09/07/2012	26/03/2013	1.00
	Block Booking	Litigation Assistant	Admin & Clerical (2)	2	DHH - Medical Legal Admin Team	28/09/2015	08/12/2015	1.00

Staff in Post in Education, Learning & Development (aligned to Vivienne Toal, Head of Service) as at 31 August 2016

Pers.No.	Last name	First name	Contract Type	Position	Job Description	Band of Person	Organizational Unit	Date Appointed To Trust	Date Commenced Post	WTE
[redacted]			Permanent	HOS-Workforce & Org Development	Admin & Clerical (8B)	8B	HR_AD Organisational Development & ELD	08/06/1998	01/02/2016	1.00
			Permanent	Staffside Officer	Admin & Clerical (5)	5	Agenda for Change - Staff Side	24/05/1977	01/07/2010	1.00
			Permanent	Trade Union Chair	Admin & Clerical (6)	6	Staff Side 1	01/09/2006	01/04/2012	1.00
			Permanent	Trade Union - KSF Lead	Elderly Social Worker Supp (5)	5	Staff Side 1	21/07/2009	27/06/2012	0.50
			Permanent	Trade Union Officer	Acute Nurse Support (3)	4	Staff Side 1	03/06/2013	03/06/2013	0.40
			Permanent	Trade Union Officer	Acute Nurse (5)	3	Staff Side 1	03/07/2015	03/07/2015	0.20
			Permanent	Trade Union Officer	Biomedical Science-Supp (3)	3	Staff Side 1	24/03/2003	01/01/2009	1.00
			Permanent	Trade Union Officer	Learning Disability Nrs Sup (3)	3	Staff Side 1	08/10/2007	12/08/2013	1.00
			Permanent	Trade Union Secretary	Admin & Clerical (5)	5	Staff Side 2	01/08/1987	12/04/2010	1.00
			Permanent	Acute Nurse (5)	Acute Nurse (5)	5	Staff Side 2	01/04/2014	01/04/2014	0.67
			Permanent	Senior Biomedical Scientist	Biomedical Scientist (7)	7	Staff Side 3	01/09/2013	01/09/2013	0.40
			Permanent	Trade Union Officer	Elderly Social Worker (8A)	8A	Staff Side 4	21/06/1993	21/11/2005	1.00
			Permanent	Learning & Development Advisor	Admin & Clerical (6)	6	Corporate Social Responsibility	23/11/1995	24/06/2013	0.80
			Block Booking	Admin & Clerical (3)	Admin & Clerical (3)	3	Corporate Social Responsibility	20/07/2016	20/07/2016	1.00
			Bank	IPC Trainer -Bank	Acute Nurse (7)	7	Education Learning & Development Admin	08/02/2016	08/02/2016	0.00
			Permanent	Learning & Development Advisor	Admin & Clerical (5)	6	Education Learning & Development Admin	12/08/1991	01/04/2016	1.00
			Permanent	Admin & Clerical (3)	Admin & Clerical (3)	3	Education Learning & Development Admin	04/01/2016	04/01/2016	1.00
			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	Education Learning & Development Admin	02/02/2015	02/02/2015	1.00
			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	Education Learning & Development Admin	29/11/2011	01/05/2015	1.00
			Temporary	Admin & Clerical (2)	Admin & Clerical (2)	2	Education Learning & Development Admin	11/07/2016	11/07/2016	1.00
			Temporary	Admin & Clerical (2)	Admin & Clerical (2)	2	Education Learning & Development Admin	16/11/2015	16/11/2015	1.00
			Permanent	Admin & Clerical (2)	Admin & Clerical (2)	2	Education Learning & Development Admin	02/02/2015	01/05/2015	1.00
			Permanent	Learning & Development Manager	Admin & Clerical (6)	6	Education Learning & Development Team	02/02/2004	01/10/2015	0.91
			Permanent	Learning & Development Manager	Admin & Clerical (7)	7	ELD Organisational Development	08/10/1990	01/02/2016	1.00
			Permanent	Assessor / Internal Verifier	Physiotherapist (7)	7	Vocational Workforce Assessment Team	03/09/2001	03/09/2001	1.00
			Temporary	Peripatetic Nvq Assessor	Midwife (6)	6	Vocational Workforce Assessment Team	12/11/2012	12/11/2012	1.00
			Permanent	Assessor / Internal Verifier	Social Care Manager (6)	6	VWAC 1	30/12/1983	01/03/2004	1.00
			Permanent	KSF Administrator	Admin & Clerical (4)	4	VWAC 1	01/06/2004	01/07/2010	0.91
			Permanent	Assessor / Internal Verifier	Social Care Manager (6)	6	VWAC 2	26/08/1994	07/04/2008	1.00
			Permanent	Peripatetic NVQ Assessor	Teaching/Training Support (5)	5	VWAC 2	09/06/2008	09/06/2008	1.00
			Permanent	Assessor / Internal Verifier	Teacher/Trainer (6)	6	VWAC 3	01/08/1990	01/04/2004	1.00
			Permanent	Peripatetic Nvq Assessor	Teacher/Trainer (5)	5	VWAC 3	11/12/2000	01/09/2004	0.68
			Permanent	Assessor / Internal Verifier	Teacher/Trainer (6)	6	VWAC 4	03/08/1998	01/03/2004	0.93
			Permanent	Trainee Support Officer	Admin & Clerical (3)	3	VWAC 4	02/08/2010	21/10/2013	1.00
			Permanent	Admin & Clerical (7)	Admin & Clerical (7)	7	Vocational Workforce Assessment Team	03/08/1987	01/10/2015	1.00

Personal Information redacted by the USI

HR Analytics and Governance Team, Workforce Information Department, HROD Directorate

Received from Vivienne Toal on 26/07/2022. Annotated by the Urology Services Inquiry.

HROD Structure

Director of Human Resources & Organisational Development

Assistant Directors

- Assistant Director of Estates
  Alan Metcalfe
- Assistant Director of Human Resources
  Directorate of Older People & Primary Care
  Maura Mallon
- Assistant Director of Human Resources
  Directorate of Acute Services
  Helen Walker
- Assistant Director of Human Resources
  Directorate of Mental Health & Disability
  Jenny Johnston
- Assistant Director of Human Resources
  Directorate of Children & Young People's Services
  Lindsay McElrath

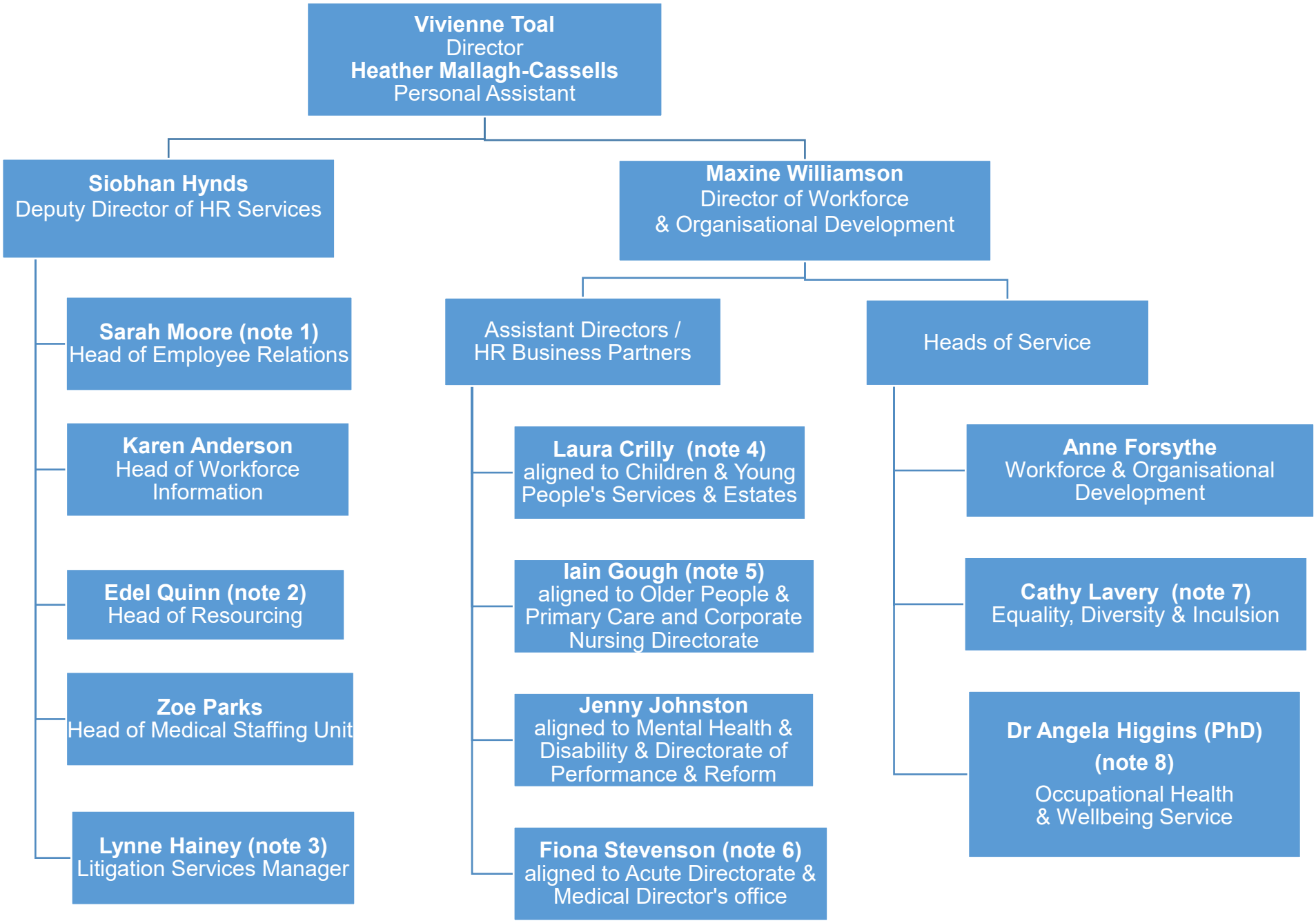
Heads of Service

- Head of Equality
  Lynda Gordon
- Head of Medical Staffing
  Zoe Parks
- Head of Occupational Health
  Catriona Campbell
- Head of Resourcing
  Iain Gough
- Head of ELD (vacant)
- Head of Employee Relations (including Litigation Services)
  Siobhan Hynds
- Head of Workforce Information
  Karen Anderson

Southern Health and Social Care Trust

2016 HROD Structure

ORGANISATIONAL CHART – DIRECTORATE OF HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT July 2022



ORGANISATIONAL CHART – DIRECTORATE OF HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT July 2022

Changes in postholders since Vivienne Toal took up post as Director of HR&OD on 21st September 2016.

Note 1 – Head of Employee Relations

Sarah Moore 1 April 2019 - to date

Post formerly held by Siobhan Hynds 1 February 2016 – 31 December 2018 (new post as Deputy Director)

Note 2 – Head of Resourcing

Edel Quinn 19 April 2021 - to date

Post formerly held by Iain Gough 1 February 2016 – 14 March 2021 (new post as Assistant Director)

Note 3 – Litigation Services Manager

Lynne Hainey 4 April 2018 – 6 October 2020, 4 January 2021 – to date
(Secondment to Corporate Governance, 7 October 2020 – 3 January 2021)

Nicola Bawn (acting cover) 2 November 2020 – 31 March 2021

Karen Wasson 1 July 2014 – 30 November 2017 (resignation)

Note 4 – Assistant Director of HR / Business Partner

Laura Crilly 1 June 2020 – to date

Lindsay McElrath 1 October 2007 - 30 June 2020 (retired)

Note 5 – Assistant Director of HR / Business Partner

Iain Gough 15 March 2021 - to date

Maura Mallon 16 April 2007 – 31 March 2021 (retired)

Note 6 – Assistant Director of HR / Business Partner

Fiona Stevenson 1 March 2022 to date

Helen Walker 16 April 2007 – 31 March 2022 (retired)

Note 7 – Head of Equality, Diversity & Inclusion

Cathy Lavery 21 September 2020 – to date

Lynda Gordon 1 February 2000 – 15 May 2020 (retired)

Note 8 – Head of Occupational Health

Dr Angela Higgins (PhD) 12 April 2018 – to date

Catriona Campbell 3 July 2008 – 31 March 2018 (retired)

Toal, Vivienne

From: Vivienne Toal <[redacted]>
Sent: 09 August 2010 16:23
To: Siobhan Hynds
Subject: FW: Managing Poor Clinical Performance - ammended paper
Attachments: RE_ Process and Guidelines for Managing Underperformance (Medical Sta....eml (316 KB); Managing Poor Performance - ncas draft.doc

From: McCullough, Elizabeth [mailto:[redacted]]
Sent: 06 August 2010 17:44
To: Vivienne Toal
Subject: FW: Managing Poor Clinical Performance - ammended paper
Importance: High

Vivienne
I'm not sure what I've attached is what Kieran is referring to in his email below. Can you take a look and see – if not, let me know.

Thanks
Elizabeth

_____

From: Donaghy, Kieran
Sent: 04 August 2010 18:03
To: Toal, Vivienne
Cc: Hynds, Siobhan; McCullough, Elizabeth
Subject: FW: Managing Poor Clinical Performance - ammended paper
Importance: High

Vivienne,

Both Debbie Burns and are both doing developing seperate papers to reflect dealing with under performing doctors (who needs HR). Debbie's is an overview that goes into flow charts and provides a useful reference point Ann Brennans paper goes into a great deal of detail and is raises a few interesting details that certainly I wasn't aware of. At a meeting with Mairead & Paddy this morning we agreed Debbies paper with a number of amendments. These are now enclosed. I'll ask Elizabeth to forward details of Anns paper.

Could you have a look and let me have your comments asap.

Kieram

_____

From: Burns, Deborah
Sent: 04 August 2010 17:28
To: McAlinden, Mairead; Donaghy, Kieran; Loughran, Patrick
Cc: Wright, Elaine
Subject: Managing Poor Clinical Performance - ammended paper
Importance: High

Hi all

Following our meeting this am please find attached draft 2 of the paper with ammendments inserted - comments welcome. Jennifer is pulling us together again as requested by the CE Thanks D Debbie Burns Assistant Director Performance Improvement Southern Trust

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

Procedure for Handling Concerns about Doctors' and Dentists' Performance

Southern Health and Social Care Trust

[redacted]

Procedure for Handling Concerns about Doctors' & Dentists' Performance

Southern Health and Social Care Trust

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1.0 Background

This procedure is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been developed to reflect the framework set out in HSC2003/012. "Maintaining High Professional Standards in the Modern NHS".

This policy applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust.

This policy and procedure applies to the management of performance and capability issues.

This policy is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been devised to reflect the framework set out in HSC2003/012, "Maintaining High Professional Standards in the Modern NHS".

Its provisions cover action to be taken when a concern about a doctor or dentist first arises and action to consider whether there need to be restrictions placed on a doctor's or dentist's practice or exclusion from work is considered necessary.

The new approach set out in the 'Maintaining High Professional Standards' framework, and which is reflected in this Procedure, builds on four key elements:

- Appraisal and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;

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- The advisory and assessment services of the National Clinical Assessment Service (NCAS) - aimed at enabling Trusts to handle cases quickly and fairly, and reducing the need to use disciplinary procedures to resolve problems;

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- Tackling the blame culture - recognising that most failures in standards of care are caused by systems' weaknesses, and not individuals per se;

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- Abandoning the 'suspension culture' - by introducing the new arrangements for handling 'exclusion from work'.

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2.0 Purpose

The purpose of this procedure is to:

- Introduce a new approach which recognises the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action
- Establish a clear and co-ordinated process for handling concerns relating to the safety of patients posed by the conduct and/or performance of doctors and dentists, which come to the attention of the Trust. Whatever the source of this information, the response will be the same, i.e. to:
  - Ascertain quickly what has happened and why.
  - Determine whether there is a continuing risk.
  - Decide whether immediate action is needed to remove the source of the risk.
  - Establish actions to address any underlying problem.

The procedure also sets out clear processes, again in accordance with the national framework, for handling disciplinary procedures relating to doctors and dentists. These include dealing with issues of Misconduct and Capability, and handling concerns relating to a practitioner's health.

3.0 Guiding Principles

In the handling of concerns relating to the conduct and performance of doctors and dentists, the following guiding principles will always apply:

- The Trust recognises that unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, will be carefully considered and, if required, properly investigated to verify the facts, such that the allegations may be shown to be true or false.
- The Trust will always endeavour to resolve issues as informally as possible, where such issues are not deemed to be of a serious nature.

- Exclusion from work will be used only in the most exceptional of circumstances, and the exclusion of a practitioner will not be viewed as a solution in itself. Furthermore, periods away from work will be kept to the minimum, through effective performance management arrangements, which will ensure that progress with an investigation is maintained and the need for continued exclusion is frequently reviewed (an exclusion will lapse and the practitioner will be entitled to return to work if the exclusion is not actively reviewed).

- The Trust will consult with the NCAS at an early stage, when action in relation to clinical concerns is being considered, and thereafter on a regular basis whilst a case is progressing. The underlying intention is that the early intervention of the NCAS will help the Trust to maintain momentum in resolving concerns about clinical competence, and thereby reduce the number of doctors and dentists who are excluded from their workplace for long periods of time.

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- The Trust will work with the NCAS to ensure that, wherever possible, alternatives to exclusion are considered.

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- Concerns relating to the Capability of doctors and dentists in training should be considered as training issues, and the Trust's Associate Medical Director of Medical Education & Training will be involved from the outset.

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- The Trust supports an open approach to reporting and tackling concerns about doctors' and dentists' practice, and recognizes the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action.

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- The Trust will maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust will only confirm that an investigation or disciplinary hearing is underway.

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4.0 Procedures when a Concern Arises

4.1 Identification of potential performance issues

Concerns regarding a doctor or dentist's performance can be flagged by a number of formal or informal sources, such as:

- Colleagues or students
- During job planning, appraisal or revalidation processes

- Monitoring of quality or performance data
- Quality improvement activities, such as clinical audit
- Complaints from patients & relatives
- Information from the General Medical Council (GMC), General Dental Council (GDC) or other regulatory bodies
- Litigation following allegations of negligence
- Information from police or coroner
- Court judgements

4.2 Stage 1 - Action when a Concern Arises

When a concern arises, relating to a particular doctor or dentist, the following procedures will be followed: These procedures will allow for informal resolution of less serious problems

The matter will be brought to the attention of the appropriate Clinical Director (CD), or their elected deputy, at the earliest possible opportunity. Should the matter relate to the conduct or performance of a CD, then the Associate Medical Director (AMD) must be informed. The CD/AMD will then inform the Operational Director and Medical Director of the nature of the concern.

All serious concerns must also be registered with the Director of Human Resources and Organisational Development and Chief Executive.

The duty to protect patients is paramount. When a serious concern is raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Section XX of this document sets out the procedures for this action.

:

~~4.4~~4.3 Stage ~~3~~ 2 - Assess the type and potential seriousness of the issue & whether full formal investigation is required.

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On behalf of the Chief Executive, the Medical Director, or nominated representative, in consultation with the HR Director, or nominated representative, will appoint a senior clinician to act as '**Case Manager**' to assess the type and

potential seriousness of the issue and provide information on whether a full formal investigation is required.

This senior clinician will be appropriately experienced or trained to enable them to carry out this role when required. The Medical Director, or Associate Medical Director, or appointed representative, will act as Case Manager in cases involving Clinical Directors.

~~On the information available, the **Case Manager needs** to decide, potentially, how serious the issue is and act accordingly. Examples of serious issues include potential gross misconduct or a serious untoward incident.~~

~~Defining the seriousness of an issue is by no means always an easy decision, and the advice of the Medical Director and the Director of Human Resources (or a nominated member of the senior HR team) should be sought. Advice from the NCAS may be sought in cases of professional misconduct or capability.~~

Where there are concerns about a doctor or dentist in training, the Postgraduate Dean and the Director of Medical Education and Training will be informed as soon as possible.

A decision to investigate commits the organization to significant work and expense, so the organization needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

The Trust supports a 'Screening' process using the NCAS 'How to Conduct a Local Performance Investigation' framework to identify whether a formal a investigation is needed.

Anonymous complaints or concerns based on 'soft' information should be put through the same screening process as other concerns.

4.3.1 What should be considered in making a decision to investigate?

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

The appointed Case Manager should contact have a preliminary meeting with the doctor/dentist, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses.

The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A

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note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police

advise that early meetings or early disclosure could compromise subsequent investigations.

~~But generally, the~~

~~practitioner's response will be helpful in deciding whether to carry out an investigation.~~

Formal Investigation will usually be appropriate where case information gathered to date suggests that the doctor may:

- Pose a threat or potential threat to patient safety
- Expose services to financial or other substantial risk;
- Undermine the reputation of efficiency of services in some significant way;
- Work outside acceptable practice guidelines and standards

4.3.2 What Alternatives to Full Investigation are Available?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the
following circumstances:
• The practitioner may agree that the concerns are well-founded and agree to cooperate with required
further action. However, if the issues raised are serious enough to suggest that if upheld they might
warrant consideration of termination of employment or removal from a performers list, then the

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organisation may still need to conduct an investigation. The action to be taken subsequently would then
be decided in the normal manner.

Defining the seriousness of an issue is by no means always an easy decision, and the advice of the Medical Director and the Director of Human Resources (or a nominated member of the senior HR team) should be sought. Advice from the NCAS may be sought in cases of professional misconduct or capability.

The Case Manager will explore the potential problem with the NCAS to consider different ways of addressing it themselves. In so doing, the Case Manager may possibly recognise the problem as being more to do with work systems than the practitioner's performance, or see a wider problem needing the involvement of an outside body, other than the NCAS.

The role of the NCAS, and the responsibility of the Trust and individual practitioners towards the NCAS, are detailed in the Management Instructions and Guidelines, at **Appendix 1**.

The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analysis of adverse events should be conducted as these frequently show that causes are more broadly based and can be attributed to systems or organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions. The National Patient Safety Agency (NPSA) facilitates the development of an open and fair culture, which encourages doctors and dentists and other NHS staff to report adverse incidents and other near misses and the Case Manager will consider contacting the NPSA for advice about systems or organisational failures.

~~Having discussed the case with the NCAS and/or NPSA, the Case Manager must decide whether:~~

- ~~there is no case to answer; or~~
- ~~the issue is one that should be resolved through an informal approach; or~~
- ~~the issue is such that a formal investigation is needed.~~

The decision will be taken following consultation with the Medical Director and HR Director, or their nominated representatives, and N~~the N~~CAS.

Where an informal route is chosen the NCAS will remain involved until the problem is resolved.

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decide whether:

- there is no case to answer; or
- the issue is one that should be resolved through an informal approach; or
- the issue is such that a formal investigation is needed.

Where the issue is clearly one of alleged Misconduct or gross Misconduct, due to factors other than those directly involving the exercise of medical and dental duties (e.g. bullying; assault; theft; fraud; failure to fulfill contractual obligations; refusal to comply with the reasonable requirements of the Trust; non-attendance at work; the commission of criminal offences outside the place of work which may, in particular circumstances, amount to Misconduct or gross Misconduct), such issues will be handled under the **Trust Disciplinary Policy**, within the Staff Policy Framework, which applies to all staff.

The procedures associated with the Trust Disciplinary Policy require that a full and thorough investigation is conducted. The Case Manager and HR Manager, or their nominated representatives, are responsible for ensuring these procedures are correctly followed, and the practitioner is kept properly informed about the details of the allegations and the process. The practitioner will also be advised whether the alleged offence amounts to gross Misconduct, which if proven may lead to summary dismissal;

Where the issue involves the exercise of medical and dental duties, or where the nature of the issue is such that the **Case Manager** determines it may lead to either Misconduct or Capability proceedings, the Medical Director will, after discussion between the Chief Executive and Director of Human resources or their nominated representative, appoint an appropriately experienced or trained person as '**Case Investigator'**. The seniority of the Case Investigator will differ, depending on the grade of practitioner involved in the allegation. Several clinical managers will be appropriately trained, to enable them to carry out this role as required.

The Case Investigator is responsible for leading the investigation into the concerns about the practitioner, establishing the facts, and reporting the findings. The role of the Case Investigator is detailed in the Management Instructions and Guidelines, at Appendix 1.

~~4.5~~4.4 Stage 4 Investigation:

When it is decided that a formal approach needs to be following the CX, etc appoint a Case Manager, Case Invesigations

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As soon as the decision has been taken to commission an investigation, the Case Manager will inform the practitioner, in writing, of the name of the Case Investigator, and of the specific concerns/allegations that have been raised against them (this information will be as comprehensive as possible, in terms of incidents, dates, persons involved, etc.). The practitioner will also be given the opportunity, as early as is reasonably practicable, to see any correspondence relating to the case, together with a list of the individuals the Case Investigator intends to interview. The practitioner will be able to add to this list if important witnesses are not scheduled to be interviewed.

The practitioner will be afforded the opportunity to put their view of events to the Case Investigator and informed of their right, at any stage of this process (or subsequent disciplinary action) to be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. The companion may be legally qualified, but they will not be acting in a legal capacity.

If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the Case Manager should consider whether an independent practitioner from another NHS body should be invited to assist.

The Case Investigator should complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 days.

The Case Manager will review the report and, through further consultation with an internal Review Committee, determine whether, or not, there is a case to answer and what action should be taken.

The Review Committee will consist of the Case Manager; Medical Director; HR Director, and the LNC Chair, or their nominated representatives. The NCAS will also be invited to attend. Where it is determined that there is a case to answer, the Case Manager, in consultation with the Review Committee and NCAS, will consider whether restrictions on practice or exclusion from work should be considered, notwithstanding that this action may already have been taken (see procedures at Section 2).

The Case Investigator has no involvement in actual decisions made for action to be taken in the case and must not be a member of any disciplinary panel.

4.64.5 Stage 5 Outcome of investigation

The Case Manager will review the investigation report and make a decision with regards to the way forward. At this stage, it should be decided if the issue is one of **conduct** or one of **capability**:

- **Conduct** – the behaviour of the doctor or dentist is the source of concern. This can include failure or refusal to comply with trust standards. Where an investigation identifies issues of professional misconduct[1] as opposed to personal, the Case Investigator should additionally seek professional advice from a doctor or dentist employed in the same speciality (who has not been involved with the case)

All forms of misconduct should be dealt with under thetrust's Disciplinary Procedure

- **Capability** – the ability of the doctor or dentist to perform particular aspects of their role is in question. This is demonstrated by a clear failure by an individual to deliver an adequate standard of care, orstandard of management or clinical practice, through lack of knowledge, ability or consistently poor performance.

Inevitably, some cases will involve both Misconduct and Capability issues. These cases are likely to be complex and difficult to manage. Therefore, where a case covers more than one category of problem, they will usually be combined and considered under a Capability hearing. However, there may be occasions where it is necessary to pursue a Misconduct issue and a Capability issue separately. In these difficult cases, the Case Manager, in consultation with the NCAS and the Trust's own employment law advisers, will recommend the most appropriate course of action.

5.0 Action when an Investigation identifies possible Criminal Acts

Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust investigation (under either its Misconduct or Capability Procedure) will only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The Trust will consult the

[1] Professional misconduct is defined as actions or behaviour that do not comply with standards of professional behaviour laid down by professional regulatory bodies or failure to comply with the trust's clinical policies.

police to establish whether an investigation into any other matters would impede their investigation.

5.1 Cases where Criminal Charges are brought, not connected with an Investigation

There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for continued employment. In all cases, the Trust, having considered the facts, will need to determine whether the practitioner poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and/or exclusion. The Trust will need to give serious consideration to whether the practitioner is able to continue in their job, once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust will consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending a criminal trial, the practitioner can continue in their present job, should be allocated to other duties, or should be excluded from work. This will depend on the nature of the offence and advice will be sought from the Trust's legal adviser. The Trust will fully explain to the practitioner the reasons for taking any such action.

5.2 Dropping of Charges or no Court Conviction

When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but it is considered there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to eliminate this risk. Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It will be made clear to the police that any evidence they provide and is used in the Trust's case, must be made available to the practitioner concerned. Where charges are dropped, the presumption is that the practitioner will be reinstated.

6.0 Restriction of Practice and Exclusion from Work

6.1 Managing the Risk to Patients

When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean will be involved as soon as possible.

Under this Policy, the following guiding principles will always apply:

- Exclusion of clinical staff from the workplace is a temporary expedient whilst action to resolve a problem is being considered.
- Exclusion is viewed as a precautionary measure and not a disciplinary sanction.
- Exclusion from work will be reserved for only in the most exceptional of circumstances.

The Trust will take every measure to ensure that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues. No practitioner will be excluded from work other than through this procedure. Informal exclusions of whatever type will not be used.

The purpose of exclusion is to:

- protect the interests of patients, the practitioner, or other staff; and/or
- assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

6.2 Restriction of Practice

The Trust will always consider whether risks may be managed by restricting the practice of the individual concerned, rather than resorting to exclusion. Where

this is appropriate, the degree to which practice is restricted will be determined by the particular circumstances of each case. Ways in which risks may be managed by restricting practice might include:

- Medical or Clinical Director supervision of normal contractual clinical duties;
- restricting the practitioner to certain forms of clinical duties;
- restricting activities to administrative, research/audit, teaching and other educational duties (by mutual agreement, this might include some formal retraining or re-skilling);
- Sick leave for the investigation of specific health problems.

6.3 Immediate Restriction:

In the rare event that **immediate restriction** is necessary, this will be determined and actioned by the AMD concerned or a nominated representative, and sanctioned by a member of the executive team. Where, following formal investigation, a restriction of practice is recommended, within two weeks the nature of this restriction will be determined by the Case Manager.

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The Case Investigator will explore and report on the circumstances that led to the need to exclude the practitioner.

The Medical Director will act as the Case Manager in the case of consultant staff, or delegate to a senior manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member.

The Case Investigator will also provide factual information to assist the Case Manager in reviewing the need for exclusion and in making progress reports to the Chief Executive and Designated Board Member. The practitioner will always be notified, in writing, of the degree to which their practice is to be restricted, the means by which the restriction will be managed, and the reasons for this action being taken. All restrictions of practice will be registered with the Medical Director, and will be subject to the same review procedure that is associated with the exclusion process (see below).

6.4 The Exclusion Process

Key features of Exclusion from Work are as follows:

- An initial "immediate" exclusion of no more than two weeks if warranted;
- Notification of the NCAS before formal exclusion;

- Formal exclusion (if necessary) for periods up to four weeks;
- Advice on the case management plan from the NCAS;
- Appointment of a Board member to monitor the exclusion and subsequent action;
- Referral to NCAS for formal assessment, if part of case management plan;
- Active review to decide renewal or cessation of exclusion;
- A right to return to work if review not carried out;
- Performance reporting on the management of the case;
- Programme for return to work if not referred to disciplinary procedures or performance assessment.

Where exclusion, rather than restricting practice, is deemed an essential course of action, the Trust cannot require the exclusion of a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under exclusion procedures, key officers and the Board have responsibilities for ensuring the process is carried out quickly and fairly, kept under review, and that the total period of exclusion is not unnecessarily prolonged.

6.5 Persons involved

The **Chief Executive** has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. Therefore, before a decision is taken to exclude a practitioner, the reasons for exclusion will be discussed fully with the **Chief Executive**, **Medical Director**, **HR Director** or their nominated representatives, the NCAS and other interested parties (such as the police where there are serious criminal allegations, or the Counter Fraud and Security Management Service). In the rare cases where immediate exclusion is required (see below), the Medical Director and HR Director, or their nominated representatives, must discuss the case at the earliest opportunity following exclusion, by means of a case conference.

For immediate exclusions, the authority to exclude a practitioner at consultant level is vested in the Chief Executive, Medical Director, HR Director, or other member of the Executive Team, only. For staff below consultant level, **DCDs** and **CDs** have the authority to exclude. For staff in training grades, the Director of Postgraduate Medical and Dental Education has the authority to exclude.

~~6.3.1~~Where the decision to exclude a practitioner arises from an investigatory process, the **Investigating Officer** will provide factual information to assist the **Case Manager** in reviewing the need for exclusion and in making reports on progress to the Chief Executive or **Designated Board Member**.

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The Designated Board Member (see Management Instructions and Guidance, at **Appendix 2**) will ensure that time frames for investigation and/or exclusion are adhered to.

6.6 Immediate Exclusion

In exceptional circumstances, an immediate time-limited exclusion of no more than two weeks may be necessary, for the following reasons:

- to protect the interests of patients, the practitioner or other staff;
- following a critical incident when serious allegations have been made;
- where there has been a serious breakdown in relationships between a colleague and the rest of the team;
- where the presence of the practitioner is likely to hinder an investigation.

Such an exclusion will allow a more measured and dispassionate consideration to be undertaken, following an incident. This 'breathing space' will be used to carry out a preliminary situation analysis, to contact the NCAS for advice and to convene a case conference. The person making the immediate exclusion (i.e. **Chief Executive, Medical Director, HR Director, Executive Director, DCD, CD or Director of Postgraduate Medical and Dental Education**), must explain to the practitioner:

- in broad terms, why there is a need to make an immediate exclusion (there may be no formal allegation at this stage);

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- that they will be informed, at the earliest opportunity, when they will be called back to attend a further meeting: This will be at the earliest opportunity, but in any case, no longer than one working week following immediate exclusion, at which time the practitioner will be notified of the precise nature of the allegation, including specific incidents, dates, persons involved, etc.).

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- that immediate exclusion in no way amounts to disciplinary action.

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6.7 Formal Exclusion

No practitioner will be excluded from work, other than through a formal procedure. No 'informal' exclusions, of whatever type, will be invoked by the Trust. A formal exclusion may only take place after the Case Manager has first considered, at a case conference, involving the Medical Director, HR Director and Designated Board Member, whether there is a reasonable and proper case to exclude.

The NCAS must always be consulted, by the Case Manager, where the intention is to invoke formal exclusion, following which the appropriate CD or DCD, Medical Director and/or HR Director will be responsible for informing the practitioner of the exclusion. This action will be taken via a formal meeting, at which:

- the practitioner may be accompanied by a companion (see 5.2.13, above);
- the CD/DCD or Medical Director will have an HR colleague present who may be the HR Director, as an independent witness;
- the precise nature of the allegations or areas of concern will be conveyed to the practitioner;
- the practitioner will be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case;
- the practitioner will be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction).

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The formal exclusion will be confirmed in writing, as soon as is reasonably practicable. This confirmation will state the effective date and time; duration (up to 4 weeks); the content of the allegations; the terms of the exclusion (e.g. total exclusion from the premises - see **Management Instructions and Guidance, at Appendix 2** - or exclusion from a particular place of work); the need to remain available for work, and that a full investigation (or what other action) will follow. The practitioner will be advised that they may make representations about the exclusion to the Designated Board Member at any time after receipt of the letter confirming the exclusion.

In cases where disciplinary procedures are being followed, and where a return to work is considered inappropriate, exclusion may be extended for four-week renewable periods. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.

If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of their control (for example because of a police investigation), the case must be referred to the NCAS, who will advise whether the case is being handled in the most effective way and suggest possible ways forward. However, even during this prolonged period, the principle of four-week 'renewability' will be adhered to.

If, at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally, or with restrictions, the Case Manager must lift the exclusion, inform the Strategic Health Authority, and make arrangements for the practitioner to return to work with any appropriate support, as soon as practicable.

~~6.4~~Keeping Exclusions under Review

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Informing the Trust Board

The Trust Board will be informed of an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed, and will therefore:

- require a summary report of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed, and that all reasonable efforts are being made to bring the situation to an end as quickly as possible. The Case Manager is responsible for providing such reports to the Board, via the HR Director;

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- receive a monthly statistical summary showing all exclusions, with their duration and number of times the exclusion has been reviewed and extended (a copy will also be sent to the Strategic Health Authority). The HR Director is responsible for this activity.

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Regular review

The Case Manager will review the exclusion before the end of each exclusion period (which may be up to four weeks each), and report the outcome to the Chief Executive and Trust Board. This report is advisory and it is for the Case Manager to decide on the next steps, as appropriate. The exclusion should be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The Trust must take review action before the end of each four-week period: Otherwise, on expiry of the four-week period, the exclusion will lapse and the practitioner will be entitled to return to work. Following three successive four-week exclusion periods, the NCAS must be called in.

The review activities that will be undertaken at different stages of exclusion are as follows (see below):

Stage	Activity
First and Second Reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the situation: ▪ The Case Manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time. ▪ Case Manager submits advisory report of outcome to the HR Director and Medical Director. ▪ Each renewal is a formal matter and must be documented as such: The practitioner must be sent written notification on each occasion. The HR Director or Divisional HR Manager is responsible for ensuring these actions are completed.
Third Review	If the practitioner has been excluded for three periods: ▪ The Case Manager submits a situation report to the Chief Executive, outlining: - the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and, if the investigation has not been completed, - a timetable for completion of the investigation. ▪ The Chief Executive must then report to the Strategic Health Authority (SHA) and the Designated Board Member (see Management Instructions and Guidelines, at **Appendix 2**). ▪ The case must formally be referred to the NCAS, explaining: - why continued exclusion is appropriate; - what steps are being taken to conclude the exclusion at the earliest opportunity. The NCAS will review the case with the SHA and advise the Trust on the handling of the case until it is concluded.

6 Months Review N.B: Normally there will be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned, and where the investigation is lengthy. The Trust and the NCAS will actively review such cases at least every 6 months.	If the exclusion has been extended over six months: ▪ The Chief Executive submits a further situation report to the SHA indicating: - the reason for continuing the exclusion; - the anticipated time scale for completing the process; - the actual and anticipated final costs of the exclusion. ▪ The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any practical advice to be offered to the Trust Board.

6.8 Review

Where a practitioner considers that a decision to exclude or restrict practice has been applied unfairly, or that there are other reasonable alternatives to exclusion, then the practitioner may apply to have their reasons considered and determined at a meeting of the Review Committee (see paragraph 5.2.14). Such a referral may only proceed with the agreement of the Medical Director and LNC Chair.

7.0 Procedures for Dealing with Issues of Capability

Wherever possible, the Trust will aim to resolve issues of Capability (including clinical competence and health) through ongoing assessment and support, which might include counselling and/or re-training. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and will always be consulted by the Case Manager. Any concerns about Capability relating to a doctor or dentist in a recognised training grade will be considered initially as a training issue and dealt with via the Director of Postgraduate Medical Training and college or clinical tutor, with close involvement of the Postgraduate Dean from the outset.

Capability may be affected by ill-health. Procedures for handling concerns about a practitioner's health are detailed in **Section 5** of this policy.

The Trust will ensure that investigations and Capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability, age or indeed on other grounds. Case Managers and Investigators will receive appropriate and effective training in the operation of Capability procedures. Those undertaking investigations or sitting on Capability or appeals panels will have received formal equal opportunities training before undertaking such duties.

Capability Procedure

Further to the decision taken at Stage 5 of 'Procedure When a Concern Arises':

The Pre-hearing Process

When a report of the investigation has been submitted by the Case Investigator, the Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in particularly complex cases or due to annual leave, the deadline for comments from the practitioner will be extended.

The Case Manager will decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. Notwithstanding that such actions may already have been taken, the Case Manager will consider urgently:

- whether action under **Section 2** of this policy is necessary to exclude the practitioner; or
- temporary restrictions should be placed on the practitioner's clinical duties.

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The Case Manager will again consider, with the Medical Director and HR Director, whether the issues of Capability can be resolved through local action (such as re-training, counselling, performance review). If this action is not practicable for any reason, the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The Case Manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments. The NCAS will assist the Trust to draw up an action plan designed to enable the practitioner to remedy any lack of Capability that has been identified during the assessment. The Trust will facilitate the action plan (which has to be jointly agreed by the Trust and the practitioner before it is actioned).

There may be occasion when a case has been considered by the NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the issue should be considered by a Capability Panel (CaP), in which case a hearing will be necessary. If the practitioner does not agree to the case being referred to the NCAS, in the first instance, again a panel hearing will normally be necessary.

The following procedure will be followed prior to a Capability hearing:

- The Case Manager will notify the practitioner in writing of the decision to arrange a Capability hearing. This notification should be made at least 20 working days before the hearing and include details of the allegations and the arrangements for proceeding, including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the Capability Panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing, if they so choose.

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- Wherever practicable, all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the Trust will consider whether a new date should be set for the hearing.

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- Should either party request a postponement to the hearing, the Case Manager will be responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner's absence: The Trust will always act reasonably in deciding to do so.

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- Should the practitioner's ill-health prevent the hearing taking place, the Trust's usual sickness absence procedures will be invoked (in accordance with the Staff Policy Framework). The sickness absence procedures take precedence over the Capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend a hearing. Where the practitioner's illness exceeds 4 weeks, they will be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness and any consequences it may have for the Capability process.

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- If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the

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practitioner should have the opportunity to submit written submissions and/or have a representative attend in their absence.

- Witnesses who have made written statements at the investigation stage may, but will not necessarily, be required to attend the Capability hearing**.** Following representations from either side contesting a witness statement that is to be relied upon in the hearing, the Chairman may invite the witness to attend. The Chairman cannot require anyone other than an employee to attend**.** However, if evidence is contested and the witness is unable or unwilling to attend, the Panel will reduce the weight given to the evidence, as there will not be the opportunity to challenge it properly.

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- A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing. If witnesses required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

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1.1 The Hearing Framework

1.1.1 The CaP will normally be chaired by an Executive Director of the Trust. In addition to the Chair, the Panel will comprise a total of three people; normally two members of the Trust Board, or a senior members of staff appointed by the Board for the purpose of the hearing. The third member will be a medical or dental practitioner not employed by the Trust. The Panel will also be advised by a senior HR representative, nominated by the HR Director (whose main role will be to ensure that due process is followed, throughout) and by a senior clinician agreed with the LNC from the same speciality as the practitioner concerned, but from another NHS employer. As far as is reasonably possible or practicable, no member of the Panel or adviser to the Panel should have been previously involved in the investigation. Membership of the Panel will be agreed with the LNC.

NB: It is important that the Panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

1.1.2 Whilst it is for the Trust to decide on the membership of the Panel, the practitioner may raise an objection to the choice of any Panel member, within 5 working days of notification. The Trust will then

review the situation and take reasonable measures to ensure that the membership of the Panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The Trust will provide the practitioner with the reasons for reaching its decision, in writing, before the hearing takes place.

Representation at Capability Hearings

1.1.3 The hearing is not a court of law. Whilst the practitioner will be given every reasonable opportunity to present their case, the hearing will not be conducted in a legalistic or excessively formal manner. The protocol to be followed during the hearing is detailed at paragraph 8.7 of this Section.

1.1.4 The practitioner will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the Panel and question the management case and any witness evidence.

Decisions

The Panel will have the power to make a range of decisions including the following:

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale, with a written statement of what is required and how it might be achieved (stays on record for 6 months).
- Written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Final written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Termination of contract.

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It is also reasonable for the Panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the Trust that the Panel wishes to comment upon.

A record of oral agreements and written warnings will be retained in the practitioner's personnel file, but will be removed following the specified period.

The decision of the Panel will be communicated to the parties as soon as possible, and normally within 5 working days of the hearing. Because of the potential complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

The decision will be confirmed in writing to the practitioner. This notification will include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC, or any other external/professional body. The practitioner has the right to appeal against the decision, in accordance with the Appeals Procedure at **Section 4** of this policy.

Protocol to be followed for Capability Hearings

As soon as it has been determined that a Capability Panel (CaP) needs to be formed, the practitioner will be provided with written confirmation of this decision, confirmation of the allegations made against them and details of their rights to be accompanied. As soon as possible, thereafter, and at least 20 working days before the hearing, the practitioner will also be informed of the constitution of the Panel, provided with copies of the Case Manager's report and any associated investigation documentation and any documentation and/or evidence that will be made available to the Panel, including witness statements. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing (normally not in excess of 30 days) while this matter is resolved. The trust will provide the practitioner with the reasons for reaching for reaching its decision in writing before the hearing takes place.

The Panel's appointed HR representative will act as the Panel Co-ordinator, who is responsible for the administrative aspects relating to the hearing. The Panel Co-ordinator will write to the practitioner to confirm the date and venue set for the hearing, and to request that any written evidence the practitioner wishes to present at the hearing, including witness statements, are submitted at least three working days before that date. The practitioner may invite witnesses to attend the hearing, if they so wish. The Panel Co-ordinator will confirm that everyone involved with the hearing is available to attend, and inform all parties of any necessary changes to the administrative arrangements.

Once the Panel, the practitioner and their representative are assembled, the Chair of the Panel is responsible for managing the hearing, and ensuring the following protocol is followed:

- Chair introduces those present, summarises why the hearing has been convened, and explains how the hearing will be conducted.

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- Chair explains that the Panel Co-ordinator will make a written record of the proceedings.
- Chair calls the Case Manager or the Trust's representative to present the case against the practitioner. Case Manager will provide documentary evidence and call witnesses, as appropriate.
- Practitioner and their representative are given the opportunity to ask any questions of the Case Manager and witnesses.
- Panel members are invited to ask questions of the Case Manager and witnesses.
- Practitioner and/or their representative are invited to present their case, and to provide any documentary evidence and call witnesses, as appropriate.
- Case Manager, or the Trust's representative, is given the opportunity to ask questions of the practitioner, their representative, and witnesses.
- Panel members are invited to ask questions of the practitioner, their representative and witnesses.
- Chair may ask questions of either party, and ask for points of clarification.
- Case Manager, or the Trust's representative, is asked to sum up.
- Practitioner, or their representative, is asked to sum up.
- Both parties are asked to leave the hearing, whilst the Panel members confer in private, but to be available to return should the Panel need clarify any points of uncertainty.
- Panel makes its decision and both parties are recalled to be informed, by the Chair, of that decision.
- Where the Panel has determined that there is a proven Capability issue, the practitioner is informed of the disciplinary/administrative action to be taken against them. The practitioner is informed of their right to appeal against the Panel's decision.

Witnesses will be admitted only to give their evidence and answer any questions, and will then retire. The procedure for dealing with any witnesses attending the hearing will be the same and reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;

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- the side calling the witness may question the witness;
- the other side may then question the witness;
- the Panel may question the witness;
- the side that called the witness may seek to clarify any points that have arisen during questioning but may not at this point raise new evidence.

Following the hearing, and within three working days, the Panel Coordinator will ensure the practitioner receives written confirmation of the outcome, and of any disciplinary/ administrative action to be taken against them. The practitioner will also be reminded of the Appeals Procedure at **Section 4**, below.

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8.0 Appeals Procedure

8.1 Purpose

The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a Panel decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that, in arriving at their decision, the Panel acted fairly and reasonably, based upon:

- a fair and thorough investigation of the issue;
- sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether, in the circumstances, the decision was fair and reasonable, and commensurate with the evidence heard.

The Panel may also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The Panel, however, will not re-hear the entire case.

A dismissed practitioner will, in all cases, be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the

hearing panel. The appeal panel has the power to confirm or vary the decision made at the Capability hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the Panel will have the power to instruct a new Capability hearing.

Where the appeal is against dismissal, the practitioner will not be paid during the period of appeal, from the date of termination of employment. Should the appeal be upheld, the practitioner will normally be reinstated and will receive backdated pay, to the date of termination of employment. Where the decision is to re-hear the case, the practitioner will also normally be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and will receive backdated pay, to the date of termination of employment.

8.2 The Appeal Panel

The appeal panel will consist of three members, who will not have had any previous direct involvement in the matters that are the subject of the appeal. For example, they must not have acted as the Designated Board Member. Membership will be as follows:

- an independent member (trained in legal aspects of appeals) from an approved pool (as agreed and established by the BMA, BDA and NHS Employers - see Appendix 3), designated Chairman;
- the Trust Chairman (or other Trust Non-Executive Director), who will have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate), who is not employed by the Trust, but agreed by the LNC.

All members will be suitably experienced or trained to be able to participate in an appeal hearing.

The Panel will call on others to provide specialist advice. This should normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another NHS employer;
- a Senior HR specialist.

It is important the Panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable

to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original hearing. Wherever practicable, the following timetable will apply:

- appeal by written statement to be submitted to the designated appeal point (the HR Director, or their nominated representative) within 25 working days of the date of the written confirmation of the original decision;
- hearing to take place within 25 working days of date of lodging appeal;
- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

In all cases, the timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager is responsible for ensuring that extensions are absolutely necessary, and kept to a minimum.

8.3 Powers of the Appeal Panel

The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party , then it will have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it will consider whether an adjournment is appropriate: Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a Conduct/Capability hearing panel.

8.4 Conduct of Appeal Hearing

All parties will be in possession of all documents, including witness statements, from the previous hearing, together with any new evidence.

The appellant will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. Such a representative may be legally qualified but they will not, however, be representing the appellant formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the Panel and question the management case and any witness evidence.

Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the Panel. When all the evidence has been presented, both parties will briefly sum up. At this stage, no new information may be introduced, however the appellant (or their companion) may make a statement in mitigation.

The Panel, after receiving the views of both parties, will consider and make its decision in private.

8.5 Decision

The decision of the appeal panel will be made in writing to the appellant and copied to the Case Manager, such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There will be no correspondence on the decision of the Panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it must be sought in writing from the Chairman of the appeal panel.

8.6 Action following Hearing

Records will be kept, including a report detailing the Capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records will remain confidential and retained in accordance with the Data Protection Act 1998. These records will be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Employment Tribunal.

9.0 Procedures for Handling Concerns relating to a Practitioner s Health

9.1 Introduction

A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress. The underlying principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained, and kept in employment, rather than be lost from the NHS.

5.4 Retaining the Services of Individuals with Health Problems

Wherever possible, the Trust will attempt to continue to employ the practitioner, provided this does not place patients or colleagues at risk[2]. This may involve one or more of the following activities:

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to maintain contact and prevent them from feeling isolated);
- removing the practitioner from certain duties;
- reassignment to a different area of work;
- arranging re-training or adjustments to the practitioner's working environment, with appropriate advice from the NCAS and/or deanery, under reasonable adjustment provision in the Disability Discrimination Act 1995.

At all times, the practitioner will be supported by the Trust and the Occupational Health Service (OHS), who will ensure that the practitioner is offered every available resource to be able to return to practise, where appropriate. The Trust will consider what reasonable adjustments might be made to their workplace conditions, or other arrangements. Examples of reasonable adjustment include:

- making adjustments to the premises;
- re-allocation of some duties to colleagues;
- transfer of the practitioner to an existing vacancy;
- altering the practitioner's working hours, or pattern of work;
- assignment to a different workplace;
- allowing absence for rehabilitation, assessment or treatment;
- provision of additional training or re-training;
- acquiring/modifying equipment;

[2] *Maintaining High Professional Standards in the Modern HPSS*

- modifying procedures for testing or assessment;
- establishing mentoring arrangements.

In some cases, retirement due to ill-health may be necessary. Ill-health retirement will be approached in a reasonable and considerate manne. However, it is important that the issues relating to conduct or Capability that have arisen are resolved, using the agreed procedures, where appropriate.

9.2 Handling Health Issues

Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine the precise nature of that problem.

In such cases, the Case Manager will immediately refer the practitioner to a consultant occupational health physician within the Trust's OHS. NCAS will also be approached to offer advice on any situation and at any point where the Trust is concerned about a practitioner's health. Even apparently simple or early concerns will be referred, as these are easier to deal with before they escalate.

The Occupational Health physician will agree a course of action with the practitioner and send their recommendations to the Medical Director.

A meeting will then be convened with the HR Director, or their nominated representative, the Medical Director, or their nominated representative, or Case Manager, the practitioner and case worker from the OHS. The purpose of this meeting will be to agree a timetable of action and rehabilitation (where appropriate).

The practitioner may wish to bring a support companion to these meetings, who might be a family member, a colleague or a trade union or defence association representative. Confidentiality will be maintained by all parties, at all times.

If a practitioner's ill-health makes them a danger to patients and they do not recognise that danger, or are not prepared to co-operate with measures to protect patients, then exclusion from work will be considered and the professional regulatory body informed, irrespective of whether or not the practitioner has retired on the grounds of ill-health.

In those cases where there is impairment of performance solely due to ill-health, disciplinary procedures will only be considered in the most exceptional of circumstances, for example if the practitioner refuses to co-operate with the Trust to resolve the underlying situation by repeatedly refusing a referral to the OHS or

the NCAS. In these circumstances, the procedures for dealing with issues of Capability (see Section 3.0) will be followed.

There will be circumstances where a practitioner who is subject to disciplinary proceedings submits a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the practitioner to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

DRAFT

Managing Poor Performance – Consultant Medical Staff

Southern Health & Social Care Trust (SHSCT)

1. The SHSCT wish to set out principles which can be applied in relation to the management of poor performance for all Trust staff to minimise potential risk for patients, practitioners, clinical teams and the organisation.

2. One element of this document would specifically describe Trust guidance concerning Consultant Medical Staff (including Associate Specialist grades) and would be based on external best practice guidance including
"*How to conduct a local performance investigation"* NCAS, 2010
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

3. This guidance will also seek to take account of the new role of the Responsible Officer which Trust's in Northern Ireland must have in place by October 2010. The interfaces between this role and the management of poor medical performance must be considered and defined (NCAS, 2010)

4. Before deciding action is required in relation to poor performance all concerns and reports of potential issues should be screened. **Screening** determines whether action, in the form of an investigation, should be taken or not, and if so how this should be done – ie informally or formally

5. MHPS (2005) states:

   - that **al**l concerns must be registered with the Chief Executive (CE)
   - An initial verification and assessment of the issues raised should be undertaken by the clinical manager of the practitioner (Clinical Director or Associate Medical Director)
   - This assessment should be presented to decide on whether an informal or formal investigation is required. This is a difficult decision and should not be taken alone but in consultation by key people within the organisation and advice from NCAS and OHS as required.

6. In order to assure and promote fairness, transparency and consistency in approach to the process of performance investigation, and to ensure protection for the Medical Director / Responsible Officer, the SHSCT is proposing that an oversight group (OG) ~~decision making group (DMG)~~ **is appointed by the Chief Executive, this will normally** comprise~~ing~~ of the Medical Director / Responsible Officer, the Director of Human

Resources (DHR as recommended by MHPS, 2005) and the relevant Operational Director (OD) **who will consider the initial verification/assessment by the clinical manager of the practitioner / issue and will** take the decision to investigate or not and whether this is a formal or informal investigation, while taking advice from NCAS or OHS and the clinical line manager. ~~-~~ -The case assessment should be presented to them for a decision by the clinical manager. This decision will be ratified by the Chief Executive. SMT Governance Committee cannot be involved in decisions at this point as Executive representation may be required at a Panel Hearing. **Please note: If the initial report / concern is made directly to the medical director (in error) then the medical director cannot be involved in the oversight group nor can they sit on any formal panel hearing. All staff require to be fully briefed as to how to raise an issue of concern re performance.**

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7. NCAS also recommends that no person involved in one stage of an investigation should take part in subsequent disciplinary proceedings or appeals based on the same set of facts. Separation of roles is an important element of securing fair process. (NCAS, 2010) Just need to be clear here that as is written above oversight group are guiding principle of whether informal or formal investigation – is this ok?? **Kieran**

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8. While the Responsible Officer / Medical Director must discharge his statutory role, this is one of establishing and overseeing the process of initiating investigations into potential poor performance.

9. Where a further investigation is likely to lead to conduct or clinical performance proceedings – ie the Trust invoking their disciplinary procedures and/ or onward referral to the police and / or GMC then a formal investigation process should be followed (See Flow Chart 2)

10. The oversight~~decision making~~ group should first seek, if possible and appropriate, a local action plan agreed with the practitioner and resolution of the situation (NCAS to advise) via monitoring of the practitioner by the Clinical Manager.

11. The various processes involved in managing performance issues are described in a series of flow charts and text. They include in sequence:

- An informal process [**Flow Chart 1]** – this can lead to resolution or move to
- A formal process **[Flow Chart 2]** – this also can lead to local resolution or to
- A conduct panel OR a clinical performance panel depending on the nature of the issue **[Appendix 2]**

- An appeal panel can be invoked by the practitioner following a panel determination. **[Appendix 3]**

- Exclusion can be used at each step of the process **[Appendix 4]**

The process moves from informal to formal if NCAS and the organisation agree it is required due to the seriousness or repetive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAs referral or recommendations.

Please note if any of the above processes are entered into and findings are anything more than the practitioner being exonerated, these findings should be recorded and available to appraisers.

Flow charts and text describe who should be involved when and the timescales involved. The Southern Trust will also present all formal investigation processes to the SMT Governance committee retrospectively post any further panel or appeal, to promote learning and for peer review.

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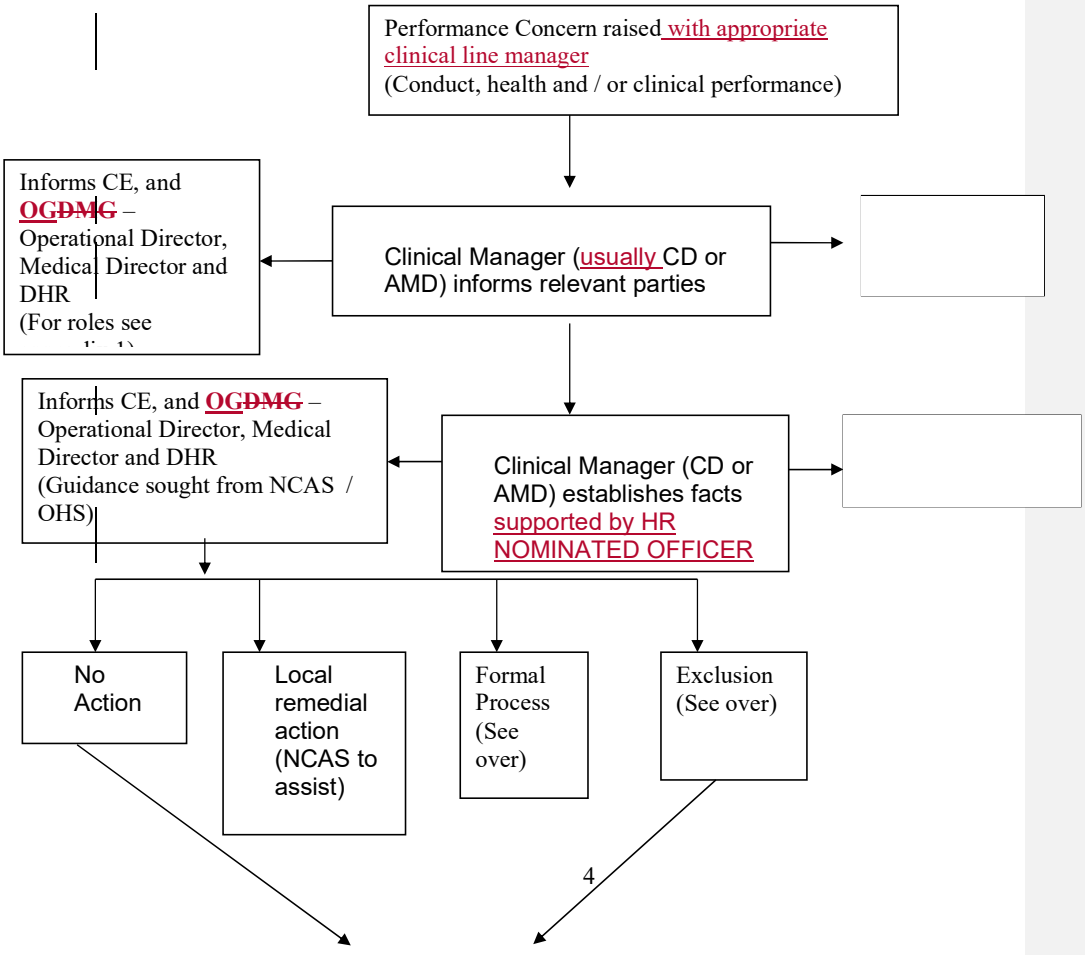
INFORMAL PROCESS - Flow Chart 1



Clinical Manager to inform Practitioner and if local remedial action required Clinical manager to agree this with practitioner, monitor and report back to OG re compliance~~DMG~~

~~Note: DMG = Decision Making Group (NCAS, 2010)~~

FORMAL PROCESS - Flow Chart 2

Clinical Manager (CD or AMD) informs relevant parties

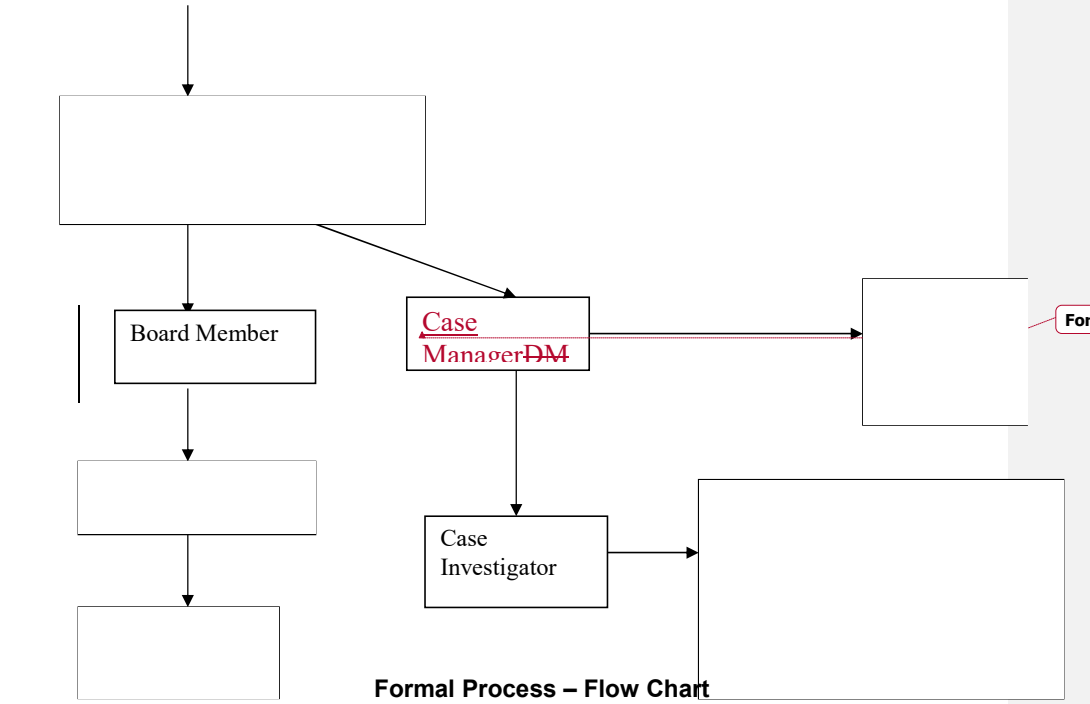
Informs CE, and **OG~~DMG~~** – Operational Director, Medical Director and DHR (Guidance sought from NCAS /

Informs CE, and **DMG** – Operational Director, Medical Director and DHR (Guidance sought from NCAS / OHS)

Clinical Manager (CD or AMD) establishes facts supported by nominated HR officer

Informs Practitioner

Informs Practitioner



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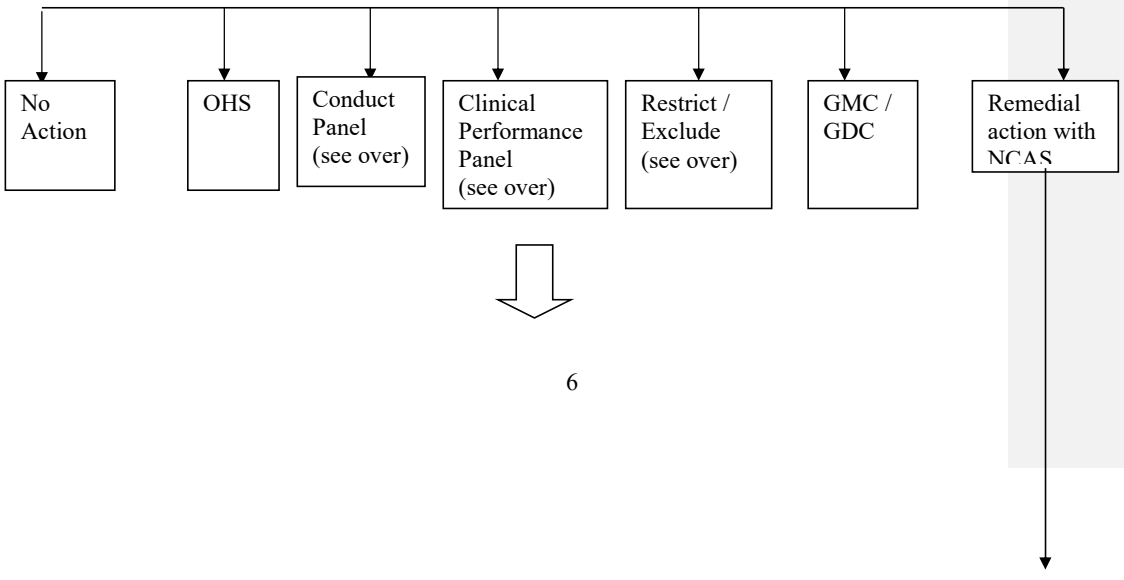
Formal Process – Flow Chart

Case ~~Report~~ Report and recommendations / decisions presented by case manager to OG and CEO. Csae manager will receive support from a nominated HR officer and NCAS. Decisions by case manager can be as follows~~given to DMG~~

OG~~DMG~~ gives practitioner opportunity to comment



Practitioner informed by Case Manger~~DMG~~

Clinical Manager to inform Practitioner if local remedial action required Clinical manager to agree this with practitioner, monitor and report back to OG re compliance ~~DMG~~

APPENDIX 1

Informal Investigation – Roles

Clinical Manager: AMD or CD (usually CD unless concerns re they themselves) to whom concerns are expressed and who informs Chief Executive and Practitioner, and conducts initial assessment to present to an Oversight group ~~Decision Making Group~~. Conveys to the practitioner the findings of the initial screening~~Decision making group~~ and monitors any remedial action required.

Chief Executive: Appoints an appropriate oversight group~~Decision Making Group~~ – usually the Medical Director / Responsible Officer, Director of HR and the relevant Service Director. Ratifies the decisions throughout the process.~~of this group~~.

Oversight Group~~Decision Making Group~~: Screens initial concerns and decides if informal or formal investigations required.

Formal Investigation – Roles

Chief Executive: Appoints a case manager - usually the AMD~~decision making group above~~. Ratifies the findings of the formal investigation. Appoints a case investigator, usually the CD~~AMD~~. Appoints a non executive board member to monitor progress and report findings to the Trust Board.

Case Manager: Usually the AMD~~decision making group – Medical Director/ Responsible Officer, Director of HR and the Service Director~~. Co ordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. They keep all parties informed of the process and they also determine the outcome once the formal investigation has been presented. Should the concerns involve a CD then the case manager becomes the MD – and they can no longer chair or sit on any formal panel hearings. The AMD would be the case investigator in this instance.

Case Investigator: Usually the CD~~AMD~~, examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager ~~/ DMG~~ in a report format.

Non Executive Board Member: Assures that the investigation is completed in a fair and transparent way, in line with Trust procedures and in a timely way. Reports back findings to Trust Board.

Appendix 2

Conduct Panel

- Applies when the outcome of a **formal investigation** shows a case of misconduct – either personal or professional. "*Misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question"* MHPS, 2005

- If a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure.

- NCAS should be used in cases of misconduct for advice, particularly in relation to cases of professional misconduct

- *"Examples of misconduct will be found in the Employers Code of Conduct. Examples can include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and / or discrimination in the exercise of duties towards patients, the public or other employees. It can also include actions such as deliberate falsification or fraud."* MHPS, 2005

- *"In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC"* MHPS, 2005

Insert trust procedure with inclusion of independent professional advice - to sit on panel – ie not employed by the Trust – Kieran can you do this bit

Clinical Performance Panel

- Applies when the outcome of a **formal investigation** shows a case of poor clinical performance.

- Failures of an individual to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance are clinical performance issues.

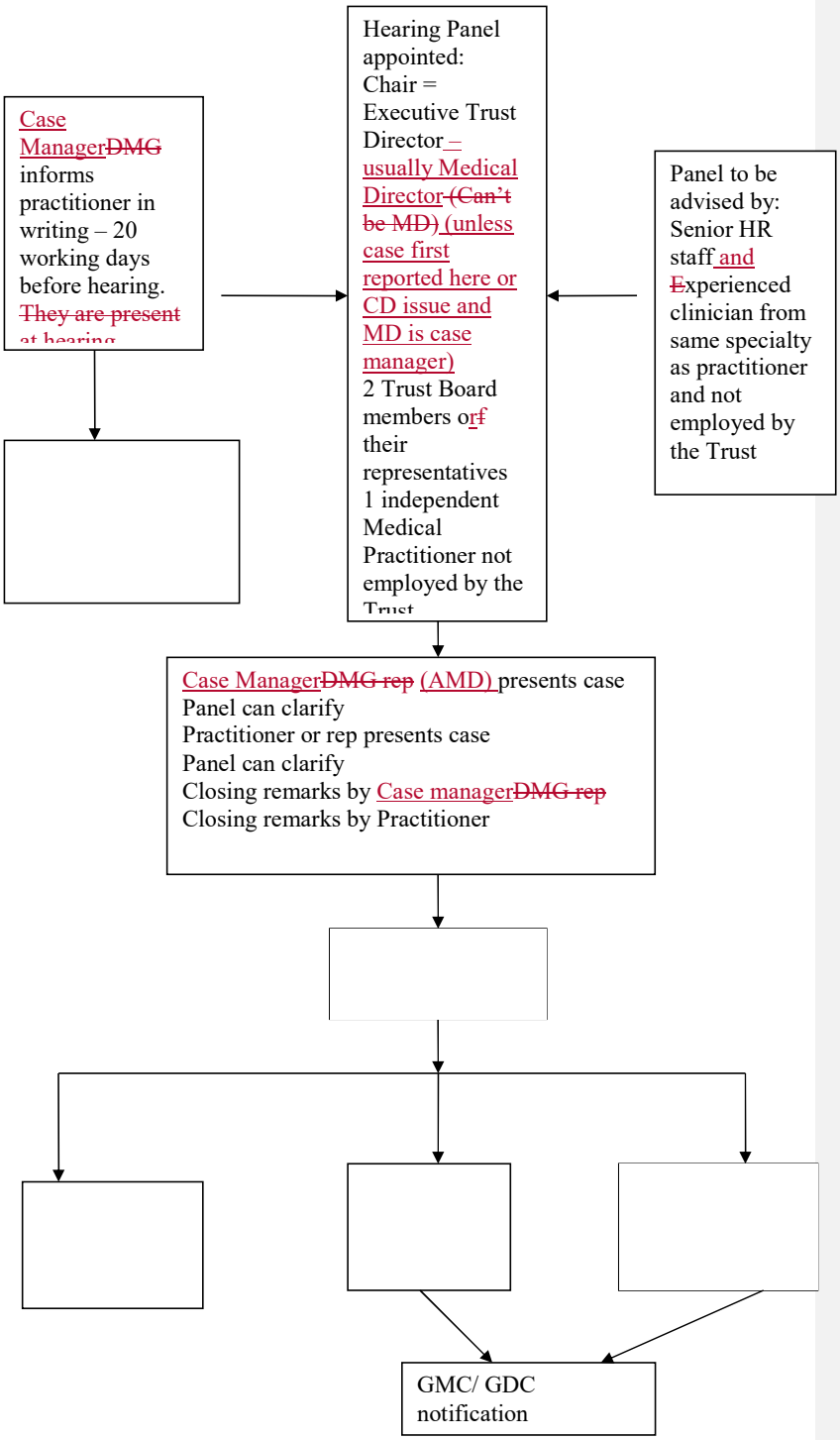
- These include

  - out moded clinical practice
  - inappropriate clinical practice arising from a lack of knowledge or skill that puts patients at risk
  - incompetent clinical practice
  - inappropriate delegation of clinical responsibility
  - inadequate supervision of delegated clinical tasks
  - ineffective clinical team working skills

- NCAS can advise the organisation whether to proceed with a locally agreed remedial action – which will be monitored and reviewed by the clinical manager OR NCAS may advise that the practitioner's performance is so fundamentally flawed that no educational / organisational plan will succeed. In the latter case the Case Manager (AMD)~~DMG~~ will take a decision as to whether or not to proceed to a clinical performance panel hearing.

- A clinical performance panel hearing will also result if the practitioner fails to agree a referral to NCAS and/or to participate in any remedial plan.

Performance Panel Hearing Process –Flow chart 3



Appendix 3

Appeals Process

- This can be invoked by the practitioner within 25 days of a formal conduct or clinical performance panel determination.

- **Appeal Panel:** An independent member (trained in legal aspects) from an approved pool, who would act as Chair of the panel, Chairperson of the Trust and an independent clinician not employed by the Trust who is trained in the appeals process.

- **Advisors to the Panel:** A clinician from the same specialty as the appellant but not employed by the Trust and a senior HR specialist

- Request for appeal should be received by the DHR within 25 working days of the Panel determination

- Appeal hearing to take place within 25 working days of date of lodging appeal

- Appeal panel to report within 5 working days of the appeal hearing.

Appendix 4

EXCLUSION

- **Immediate exclusion** may be invoked as a temporary measure to
  - Protect the interests of patients or staff
  - Where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care

- Immediate and temporary exclusion periods should be used to carry out a preliminary situation analysis by the clinical manager and for the OG~~DMG~~ to determine a clear course of action – including the need for formal exclusion.

- NCAS must be informed, where possible, prior to the implementation of an immediate exclusion.

- The authority to exclude a member of staff must be vested in a nominated manager(s) of the Trust – including where possible the CE, MD, DHR and for staff of lower grade than a consultant - the AMD. The Clinical Manager seeking an exclusion must make a representation to these officers as there may be no formal allegation at this stage.

- Immediate exclusion must be for the shortest time possible and be no longer than 4 weeks.

- **Formal exclusion** is a precautionary measure and not a disciplinary sanction. It should be reserved for only the most exceptional circumstances:

- To protect the interests of patients or other staff, and/or
- To assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence

- The Trust should ensure that where a practitioner is excluded it is for the minimum necessary period of time – this can be up to but no more than 4 weeks at a time

- All extensions of exclusion are reviewed and a brief report provided to the CE and the Board.

- A detailed report is provided to the nominated board member when requested - they are responsible for monitoring the situation until the exclusion has ended.

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Toal, Vivienne

From: Vivienne Toal <[redacted]>
Sent: 11 August 2010 19:58
To: 'v.toal[redacted]
Subject: Fw:
Attachments: handlin_Concerns_policy_4august10.doc

----- Original Message -----
From: Brennan, Anne <[redacted]>
To: Vivienne Toal; Siobhan Hynds; DBurns[redacted] <DBurns[redacted]>
Sent: Wed Aug 11 09:53:49 2010
Subject: FW:

For our meeting today

Anne Brennan

Senior Manager - Medical Directorate

[redacted]

Tel: [redacted]

-----Original Message-----
From: Loughran, Patrick
Sent: 05 August 2010 10:52
To: Brennan, Anne
Subject: FW:

Anne

Attached includes thinking from wed meeting with MMcA, DB,PL and KD,

I have also talked with Grainne from NCAS to run some scenarios past her and this conversation is reflected in the additions I have made.

Can we look at presenting MHPS electronically without any alteration and then inserts in ?shaded boxes to reflect the ST guidance/understanding and proposed practice guidance. Including reference to LPI as a subsid document.

This will leave MHPS untouched as a framework and reference and protect the ST, and the explicit guidance threaded throug it is for our staff ??

Talk Mon

Paddy

-----Original Message-----

From: pgloughran [mailto:[redacted]

Sent: 04 August 2010 23:24

To: Loughran, Patrick

Subject:

Procedure for Handling Concerns about Doctors' and Dentists' Performance

Southern Health and Social Care Trust

[redacted]

Procedure for Handling Concerns about Doctors' & Dentists' Performance

Southern Health and Social Care Trust

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1.0 Background

This procedure is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been developed to reflect the framework set out in HSC2003/012. “Maintaining High Professional Standards in the Modern NHS”.

This policy applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust.

This policy and procedure applies to the management of performance and capability issues.

This policy is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been devised to reflect the framework set out in HSC2003/012, “Maintaining High Professional Standards in the Modern NHS”.

Its provisions cover action to be taken when a concern about a doctor or dentist first arises and action to consider whether there need to be restrictions placed on a doctor’s or dentist’s practice or exclusion from work is considered necessary.

The new approach set out in the ‘Maintaining High Professional Standards’ framework, and which is reflected in this Procedure, builds on four key elements:

- Appraisal and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;
- The advisory and assessment services of the National Clinical Assessment Service (NCAS) - aimed at enabling Trusts to handle cases quickly and fairly, and reducing the need to use disciplinary procedures to resolve problems;
- Tackling the blame culture - recognising that most failures in standards of care are caused by systems' weaknesses, and not individuals per se;
- Abandoning the ‘suspension culture’ - by introducing the new arrangements for handling ‘exclusion from work’.

2.0 Purpose

The purpose of this procedure is to:

- Introduce a new approach which recognises the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action
- Establish a clear and co-ordinated process for handling concerns relating to the safety of patients posed by the conduct and/or performance of doctors and dentists, which come to the attention of the Trust. Whatever the source of this information, the response will be the same, i.e. to:
  - Ascertain quickly what has happened and why.
  - Determine whether there is a continuing risk.
  - Decide whether immediate action is needed to remove the source of the risk.
  - Establish actions to address any underlying problem.

The procedure also sets out clear processes, again in accordance with the national framework, for handling disciplinary procedures relating to doctors and dentists. These include dealing with issues of Misconduct and Capability, and handling concerns relating to a practitioner's health.

3.0 Guiding Principles

In the handling of concerns relating to the conduct and performance of doctors and dentists, the following guiding principles will always apply:
Trust recognizes that MHP document contains a framework which must be adhered to. Current document is guidance for the SHSCT staff to follow as it uases the framework.LPI is a subsidiary advisory text – is subservient to MHPS supports MHPS mainly in the informal part of mhps para 15,16 1nd 17

- The Trust recognises that unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, will be carefully considered and, if required, properly investigated to verify the facts, such that the allegations may be shown to be true or false.

- The Trust will always endeavour to resolve issues as informally as possible, where such issues are not deemed to be of a serious nature.

  - Exclusion from work will be used only in the most exceptional of circumstances, and the exclusion of a practitioner will not be viewed as a solution in itself. Furthermore, periods away from work will be kept to the minimum, through effective performance management arrangements, which will ensure that progress with an investigation is maintained and the need for continued exclusion is frequently reviewed (an exclusion will lapse and the practitioner will be entitled to return to work if the exclusion is not actively reviewed).

  - The Trust will consult with the NCAS at an early stage, when action in relation to clinical concerns is being considered, and thereafter on a regular basis whilst a case is progressing. The underlying intention is that the early intervention of the NCAS will help the Trust to maintain momentum in resolving concerns about clinical competence, and thereby reduce the number of doctors and dentists who are excluded from their workplace for long periods of time.

  - The Trust will work with the NCAS to ensure that, wherever possible, alternatives to exclusion are considered.

  - Concerns relating to the Capability of doctors and dentists in training should be considered as training issues, and the Trust's Associate Medical Director of Medical Education & Training will be involved from the outset. The training agency will also be informed at the outset

  - The Trust supports an open approach to reporting and tackling concerns about doctors' and dentists' practice, and recognizes the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action.

  - The Trust will maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust will only confirm that an investigation or disciplinary hearing is underway.

4.0 Procedures when a Concern Arises

4.1 Identification of potential performance issues

Concerns regarding a doctor or dentist's performance can be flagged by a number of formal or informal sources, such as:

- Colleagues or students
- During job planning, appraisal or revalidation processes
- Monitoring of quality or performance data
- Quality improvement activities, such as clinical audit
- Complaints from patients & relatives
- Information from the General Medical Council (GMC), General Dental Council (GDC) or other regulatory bodies
- Litigation following allegations of negligence
- Information from police or coroner
- Court judgements

4.2 Stage 1 - Action when a Concern Arises

When a concern arises, relating to a particular doctor or dentist, the following procedures will be followed: These procedures will allow for informal resolution of less serious problems

The matter will be brought to the attention of the appropriate Clinical Director (CD), or their elected deputy, at the earliest possible opportunity. Should the matter relate to the conduct or performance of a CD, then the Associate Medical Director (AMD) must be informed. The CD/AMD will then inform the Operational Director and Medical Director of the nature of the concern.

All serious concerns must also be registered with the Director of Human Resources and Organisational Development and Chief Executive. The service director and the MD along with the two above will be known as the oversight group. The duty of the over sig t group is to see that the process described in the MHP progress in a timely and fair manner and to ensure the Trust keeps the investigation process separate from the decision making process

By strict adherence to the above insulation of the MD and only allowing the MD to have limited knowledge/facts of the case – only those facts which are needed for oversight then the MD will be free and able to act later, if needed, in a conduct or clinical panel

The duty to protect patients is paramount. When a serious concern is raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. **Section XX** of this document sets out the procedures for this action.

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:

4.3 Stage 2 - Assess the type and potential seriousness of the issue & whether full formal investigation is required.

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On behalf of the Chief Executive, the Medical Director, or nominated representative, in consultation with the HR Director, or nominated representative, will appoint a senior clinician to act as '**Case Manager**' to assess the type and potential seriousness of the issue and provide information on whether a full formal investigation is required.

The med dir should refrain from learning any more the a minimum amount of detail about the issue – enough only to allow a decision to be reached about the need for the next step or otherwise

While the MHPS document para xxxxx states that the md is usually the CM the st has a layer of senior doctors who discharge a governance role – "the AMD" . If an appropriate AMD is trained and available to act as the case manager then on a case by case basis the AMD may be nominated to replace the MD as a CM

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This senior clinician will be appropriately experienced or trained to enable them to carry out this role when required. The Medical Director, or Associate Medical Director, or appointed representative, will act as Case Manager in cases involving Clinical Directors.

Where there are concerns about a doctor or dentist in training, the Postgraduate Dean and the Director of Medical Education and Training will be informed as soon as possible.

A decision to investigate commits the organization to significant work and expense, so the organization needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

The Trust supports a 'Screening' process using the NCAS 'How to Conduct a Local Performance Investigation' framework to identify whether a formal investigation is needed.

Anonymous complaints or concerns based on 'soft' information should be put through the same screening process as other concerns.

4.3.1 **What should be considered in making a decision to investigate?**

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

The appointed Case Manager or the Service Director should contact have a preliminary meeting with the doctor/dentist, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. At this point the case manager should avoid an exchange which might be construed as gathering information/evidence, since the is the duty of the Case Investigator

A short note of the contents of this meeting must be made and agreed by both parties

The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations.

Formal Investigation will usually be appropriate where case information gathered to date suggests that the doctor may:

- Pose a threat or potential threat to patient safety, or the index concern is very serious [eg a death or serious loss of a vital function to a patient]
- Expose services to financial or other substantial risk;
- Undermine the reputation of efficiency of services in some significant way;
- Work outside acceptable practice guidelines and standards
- The initial contact with the doctor gives a strong indication that informal resoloution will be impossible

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4.3.2 **What Alternatives to Full Investigation are Available?**

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;

- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the
following circumstances:
• The practitioner may agree that the concerns are well-founded and agree to cooperate with required
further action. However, if the issues raised are serious enough to suggest that if upheld they might
warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then
be decided in the normal manner.

Defining the seriousness of an issue is by no means always an easy decision, and the advice of the Medical Director and the Director of Human Resources (or a nominated member of the senior HR team) should be sought. Advice from the NCAS may be sought in cases of professional misconduct or capability.

The Case Manager will explore the potential problem with the NCAS to consider different ways of addressing it themselves. In so doing, the Case Manager may possibly recognise the problem as being more to do with work systems than the practitioner's performance, or see a wider problem needing the involvement of an outside body, other than the NCAS.

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The role of the NCAS, and the responsibility of the Trust and individual practitioners towards the NCAS, are detailed in the Management Instructions and Guidelines, at **Appendix 1**.

The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analysis of adverse events should be conducted as these frequently show that causes are more broadly based and can be attributed to systems or organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions. The National Patient Safety Agency (NPSA) facilitates the development of an open and fair culture, which encourages doctors and dentists and other NHS staff to report adverse incidents and other near misses and the Case Manager will consider contacting the NPSA for advice about systems or organisational failures.

The decision will be taken following consultation with the Medical Director and HR Director, or their nominated representatives, and NCAS.

Where an informal route is chosen the NCAS will remain involved until the problem is resolved.

Having discussed the case with the NCAS and/or NPSA, the Case Manager must decide whether:

- there is no case to answer; or
- the issue is one that should be resolved through an informal approach; or
- the issue is such that a formal investigation is needed.

Where the issue is clearly one of alleged Misconduct or gross Misconduct, due to factors other than those directly involving the exercise of medical and dental duties (e.g. bullying; assault; theft; fraud; failure to fulfill contractual obligations; refusal to comply with the reasonable requirements of the Trust; non-attendance at work; the commission of criminal offences outside the place of work which may, in particular circumstances, amount to Misconduct or gross Misconduct), such issues will be handled under the **Trust Disciplinary Policy**, within the Staff Policy Framework, which applies to all staff.

The procedures associated with the Trust Disciplinary Policy require that a full and thorough investigation is conducted. The Case Manager and HR Manager, or their nominated representatives, are responsible for ensuring these procedures are correctly followed, and the practitioner is kept properly informed about the details of the allegations and the process. The practitioner will also be advised whether the alleged offence amounts to gross Misconduct, which if proven may lead to summary dismissal;

Where the issue involves the exercise of medical and dental duties, or where the nature of the issue is such that the **Case Manager** determines it may lead to either Misconduct or Capability proceedings, the Medical Director will, after discussion between the Chief Executive and Director of Human resources or their nominated representative, appoint an appropriately experienced or trained person as '**Case Investigator'**. The seniority of the Case Investigator will differ, depending on the grade of practitioner involved in the allegation. Several clinical managers will be appropriately trained, to enable them to carry out this role as required.

The Case Investigator is responsible for leading the investigation into the concerns about the practitioner, establishing the facts, and reporting the findings. The role of the Case Investigator is detailed in the Management Instructions and Guidelines, at Appendix 1.

4.4 Stage 4 Investigation:

When it is decided that a formal approach needs to be following the CX, etc appoint a Case Manager, Case Invesigations

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As soon as the decision has been taken to commission an investigation, the Case Manager will inform the practitioner, in writing, of the name of the Case Investigator, and of the specific concerns/allegations that have been raised against them (this information will be as comprehensive as possible, in terms of incidents, dates, persons involved, etc.). The practitioner will also be given the opportunity, as early as is reasonably practicable, to see any correspondence relating to the case, together with a list of the individuals the Case Investigator intends to interview. The practitioner will be able to add to this list if important witnesses are not scheduled to be interviewed.

The practitioner will be afforded the opportunity to put their view of events to the Case Investigator and informed of their right, at any stage of this process (or subsequent disciplinary action) to be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. The companion may be legally qualified, but they will not be acting in a legal capacity.

If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the Case Manager should consider whether an independent practitioner from another NHS body should be invited to assist.

The Case Investigator should complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 days.

The Case Manager will review the report and, through further consultation with an internal Review Committee, Anne this needs to bediscussed as the yielding of too much info to others at this stage will contaminate for example the MD ----why can we not allow the CM who is senior and trained and who will be well supported by a AD in HR to make a recommendation para 38 page 12……determine whether, or not, there is a case to answer and what action should be taken.

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The Review Committee will consist of the Case Manager; Medical Director; HR Director, and the LNC Chair, or their nominated representatives. The NCAS will also be invited to attend. Where it is determined that there is a case to answer, the Case Manager, in consultation with the Review Committee and NCAS, will consider whether restrictions on practice or exclusion from work should be

considered, notwithstanding that this action may already have been taken (see procedures at Section 2).

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The Case Investigator has no involvement in actual decisions made for action to be taken in the case and must not be a member of any disciplinary panel.

4.5 Stage 5 Outcome of investigation

The Case Manager will review the investigation report and make a decision with regards to the way forward. At this stage, it should be decided if the issue is one of **conduct** or one of **capability**:

- **Conduct** – the behaviour of the doctor or dentist is the source of concern. This can include failure or refusal to comply with trust standards. Where an investigation identifies issues of professional misconduct[1] as opposed to personal, the Case Investigator should additionally seek professional advice from a doctor or dentist employed in the same speciality (who has not been involved with the case)

All forms of misconduct should be dealt with under thetrust's Disciplinary Procedure

- **Capability** – the ability of the doctor or dentist to perform particular aspects of their role is in question. This is demonstrated by a clear failure by an individual to deliver an adequate standard of care, orstandard of management or clinical practice, through lack of knowledge, ability or consistently poor performance.

Inevitably, some cases will involve both Misconduct and Capability issues. These cases are likely to be complex and difficult to manage. Therefore, where a case covers more than one category of problem, they will usually be combined and considered under a Capability hearing. However, there may be occasions where it is necessary to pursue a Misconduct issue and a Capability issue separately. In these difficult cases, the Case Manager, in consultation with the NCAS and the Trust's own employment law advisers, will recommend the most appropriate course of action.

- [1] Professional misconduct is defined as actions or behaviour that do not comply with standards of professional behaviour laid down by professional regulatory bodies or failure to comply with the trust's clinical policies.

5.0 Action when an Investigation identifies possible Criminal Acts

Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust investigation (under either its Misconduct or Capability Procedure) will only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The Trust will consult the police to establish whether an investigation into any other matters would impede their investigation.

5.1 Cases where Criminal Charges are brought, not connected with an Investigation

There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for continued employment. In all cases, the Trust, having considered the facts, will need to determine whether the practitioner poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and/or exclusion. The Trust will need to give serious consideration to whether the practitioner is able to continue in their job, once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust will consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending a criminal trial, the practitioner can continue in their present job, should be allocated to other duties, or should be excluded from work. This will depend on the nature of the offence and advice will be sought from the Trust's legal adviser. The Trust will fully explain to the practitioner the reasons for taking any such action.

5.2 Dropping of Charges or no Court Conviction

When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but it is considered there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to eliminate this risk. Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It will be made clear to the police that any evidence they provide and is used in the Trust's case, must be made available to the practitioner concerned. Where charges are dropped, the presumption is that the practitioner will be reinstated.

6.0 Restriction of Practice and Exclusion from Work

6.1 Managing the Risk to Patients

When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean will be involved as soon as possible.

Under this Policy, the following guiding principles will always apply:

- Exclusion of clinical staff from the workplace is a temporary expedient whilst action to resolve a problem is being considered.
- Exclusion is viewed as a precautionary measure and not a disciplinary sanction.
- Exclusion from work will be reserved for only in the most exceptional of circumstances.

The Trust will take every measure to ensure that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues. No practitioner will be excluded from work other than through this procedure. Informal exclusions of whatever type will not be used.

The purpose of exclusion is to:

- protect the interests of patients, the practitioner, or other staff; and/or
- assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

6.2 Restriction of Practice

The Trust will always consider whether risks may be managed by restricting the practice of the individual concerned, rather than resorting to exclusion. Where

this is appropriate, the degree to which practice is restricted will be determined by the particular circumstances of each case. Ways in which risks may be managed by restricting practice might include:

- Medical or Clinical Director supervision of normal contractual clinical duties;
- restricting the practitioner to certain forms of clinical duties;
- restricting activities to administrative, research/audit, teaching and other educational duties (by mutual agreement, this might include some formal retraining or re-skilling);
- Sick leave for the investigation of specific health problems.

6.3 Immediate Restriction:

In the rare event that **immediate restriction** is necessary, this will be determined and actioned by the AMD concerned or a nominated representative, and sanctioned by a member of the executive team. Where, following formal investigation, a restriction of practice is recommended, within two weeks the nature of this restriction will be determined by the Case Manager.

The Case Investigator will explore and report on the circumstances that led to the need to exclude the practitioner.

The Medical Director will act as the Case Manager in the case of consultant staff, or delegate to a senior manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member.

The Case Investigator will also provide factual information to assist the Case Manager in reviewing the need for exclusion and in making progress reports to the Chief Executive and Designated Board Member. The practitioner will always be notified, in writing, of the degree to which their practice is to be restricted, the means by which the restriction will be managed, and the reasons for this action being taken. All restrictions of practice will be registered with the Medical Director, and will be subject to the same review procedure that is associated with the exclusion process (see below).

6.4 The Exclusion Process

Key features of Exclusion from Work are as follows:

- An initial "immediate" exclusion of no more than two weeks if warranted;
- Notification of the NCAS before formal exclusion;

- Formal exclusion (if necessary) for periods up to four weeks;
- Advice on the case management plan from the NCAS;
- Appointment of a Board member to monitor the exclusion and subsequent action;
- Referral to NCAS for formal assessment, if part of case management plan;
- Active review to decide renewal or cessation of exclusion;
- A right to return to work if review not carried out;
- Performance reporting on the management of the case;
- Programme for return to work if not referred to disciplinary procedures or performance assessment.

Where exclusion, rather than restricting practice, is deemed an essential course of action, the Trust cannot require the exclusion of a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under exclusion procedures, key officers and the Board have responsibilities for ensuring the process is carried out quickly and fairly, kept under review, and that the total period of exclusion is not unnecessarily prolonged.

6.5 Persons involved

The **Chief Executive** has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. Therefore, before a decision is taken to exclude a practitioner, the reasons for exclusion will be discussed fully with the **Chief Executive**, **Medical Director**, **HR Director** or their nominated representatives, the NCAS and other interested parties (such as the police where there are serious criminal allegations, or the Counter Fraud and Security Management Service). In the rare cases where immediate exclusion is required (see below), the Medical Director and HR Director, or their nominated representatives, must discuss the case at the earliest opportunity following exclusion, by means of a case conference.

For immediate exclusions, the authority to exclude a practitioner at consultant level is vested in the Chief Executive, Medical Director, HR Director, or other member of the Executive Team, only. For staff below consultant level, **DCDs** and **CDs** have the authority to exclude. For staff in training grades, the Director of Postgraduate Medical and Dental Education has the authority to exclude.

Where the decision to exclude a practitioner arises from an investigatory process, the **Investigating Officer** will provide factual information to assist the **Case Manager** in reviewing the need for exclusion and in making reports on progress to the Chief Executive or **Designated Board Member**.

The Designated Board Member (see Management Instructions and Guidance, at **Appendix 2**) will ensure that time frames for investigation and/or exclusion are adhered to.

6.6 Immediate Exclusion

In exceptional circumstances, an immediate time-limited exclusion of no more than two weeks may be necessary, for the following reasons:

- to protect the interests of patients, the practitioner or other staff;
- following a critical incident when serious allegations have been made;
- where there has been a serious breakdown in relationships between a colleague and the rest of the team;
- where the presence of the practitioner is likely to hinder an investigation.

Such an exclusion will allow a more measured and dispassionate consideration to be undertaken, following an incident. This 'breathing space' will be used to carry out a preliminary situation analysis, to contact the NCAS for advice and to convene a case conference. The person making the immediate exclusion (i.e. **Chief Executive, Medical Director, HR Director, Executive Director, DCD, CD or Director of Postgraduate Medical and Dental Education**), must explain to the practitioner:

- in broad terms, why there is a need to make an immediate exclusion (there may be no formal allegation at this stage);
- that they will be informed, at the earliest opportunity, when they will be called back to attend a further meeting: This will be at the earliest opportunity, but in any case, no longer than one working week following immediate exclusion, at which time the practitioner will be notified of the precise nature of the allegation, including specific incidents, dates, persons involved, etc.).
- that immediate exclusion in no way amounts to disciplinary action.

6.7 Formal Exclusion

No practitioner will be excluded from work, other than through a formal procedure. No 'informal' exclusions, of whatever type, will be invoked by the Trust. A formal exclusion may only take place after the Case Manager has first considered, at a case conference, involving the Medical Director, HR Director and Designated Board Member, whether there is a reasonable and proper case to exclude.

The NCAS must always be consulted, by the Case Manager, where the intention is to invoke formal exclusion, following which the appropriate CD or DCD, Medical Director and/or HR Director will be responsible for informing the practitioner of the exclusion. This action will be taken via a formal meeting, at which:

- the practitioner may be accompanied by a companion (see 5.2.13, above);
- the CD/DCD or Medical Director will have an HR colleague present who may be the HR Director, as an independent witness;
- the precise nature of the allegations or areas of concern will be conveyed to the practitioner;
- the practitioner will be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case;
- the practitioner will be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction).

The formal exclusion will be confirmed in writing, as soon as is reasonably practicable. This confirmation will state the effective date and time; duration (up to 4 weeks); the content of the allegations; the terms of the exclusion (e.g. total exclusion from the premises - see **Management Instructions and Guidance, at Appendix 2** - or exclusion from a particular place of work); the need to remain available for work, and that a full investigation (or what other action) will follow. The practitioner will be advised that they may make representations about the exclusion to the Designated Board Member at any time after receipt of the letter confirming the exclusion.

In cases where disciplinary procedures are being followed, and where a return to work is considered inappropriate, exclusion may be extended for four-week renewable periods. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.

If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of their control (for example because of a police investigation), the case must be referred to the NCAS, who will advise whether the case is being handled in the most effective way and suggest possible ways forward. However, even during this prolonged period, the principle of four-week 'renewability' will be adhered to.

If, at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally, or with restrictions, the Case Manager must lift the exclusion, inform the Strategic Health Authority, and make arrangements for the practitioner to return to work with any appropriate support, as soon as practicable.

Keeping Exclusions under Review

Informing the Trust Board

The Trust Board will be informed of an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed, and will therefore:

- require a summary report of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed, and that all reasonable efforts are being made to bring the situation to an end as quickly as possible. The Case Manager is responsible for providing such reports to the Board, via the HR Director;

- receive a monthly statistical summary showing all exclusions, with their duration and number of times the exclusion has been reviewed and extended (a copy will also be sent to the Strategic Health Authority). The HR Director is responsible for this activity.

Regular review

The Case Manager will review the exclusion before the end of each exclusion period (which may be up to four weeks each), and report the outcome to the Chief Executive and Trust Board. This report is advisory and it is for the Case Manager to decide on the next steps, as appropriate. The exclusion should be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The Trust must take review action before the end of each four-week period: Otherwise, on expiry of the four-week period, the exclusion will lapse and the practitioner will be entitled to return to work. Following three successive four-week exclusion periods, the NCAS must be called in.

The review activities that will be undertaken at different stages of exclusion are as follows (see below):

Stage	Activity
First and Second Reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the situation: ▪ The Case Manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time. ▪ Case Manager submits advisory report of outcome to the HR Director and Medical Director. ▪ Each renewal is a formal matter and must be documented as such: The practitioner must be sent written notification on each occasion. The HR Director or Divisional HR Manager is responsible for ensuring these actions are completed.
Third Review	If the practitioner has been excluded for three periods: ▪ The Case Manager submits a situation report to the Chief Executive, outlining: - the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and, if the investigation has not been completed, - a timetable for completion of the investigation. ▪ The Chief Executive must then report to the Strategic Health Authority (SHA) and the Designated Board Member (see Management Instructions and Guidelines, at **Appendix 2**). ▪ The case must formally be referred to the NCAS, explaining: - why continued exclusion is appropriate; - what steps are being taken to conclude the exclusion at the earliest opportunity. The NCAS will review the case with the SHA and advise the Trust on the handling of the case until it is concluded.

6 Months Review N.B: Normally there will be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned, and where the investigation is lengthy. The Trust and the NCAS will actively review such cases at least every 6 months.	If the exclusion has been extended over six months: ▪ The Chief Executive submits a further situation report to the SHA indicating: - the reason for continuing the exclusion; - the anticipated time scale for completing the process; - the actual and anticipated final costs of the exclusion. ▪ The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any practical advice to be offered to the Trust Board.

6.8 Review

Where a practitioner considers that a decision to exclude or restrict practice has been applied unfairly, or that there are other reasonable alternatives to exclusion, then the practitioner may apply to have their reasons considered and determined at a meeting of the Review Committee (see paragraph 5.2.14). Such a referral may only proceed with the agreement of the Medical Director and LNC Chair.

7.0 Procedures for Dealing with Issues of Capability

Wherever possible, the Trust will aim to resolve issues of Capability (including clinical competence and health) through ongoing assessment and support, which might include counselling and/or re-training. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and will always be consulted by the Case Manager. Any concerns about Capability relating to a doctor or dentist in a recognised training grade will be considered initially as a training issue and dealt with via the Director of Postgraduate Medical Training and college or clinical tutor, with close involvement of the Postgraduate Dean from the outset.

Capability may be affected by ill-health. Procedures for handling concerns about a practitioner's health are detailed in **Section 5** of this policy.

The Trust will ensure that investigations and Capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability, age or indeed on other grounds. Case Managers and Investigators will receive appropriate and effective training in the operation of Capability procedures. Those undertaking investigations or sitting on Capability or appeals panels will have received formal equal opportunities training before undertaking such duties.

Capability Procedure

Further to the decision taken at Stage 5 of 'Procedure When a Concern Arises':

The Pre-hearing Process

When a report of the investigation has been submitted by the Case Investigator, the Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in particularly complex cases or due to annual leave, the deadline for comments from the practitioner will be extended.

The Case Manager will decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. Notwithstanding that such actions may already have been taken, the Case Manager will consider urgently:

- whether action under **Section 2** of this policy is necessary to exclude the practitioner; or
- temporary restrictions should be placed on the practitioner's clinical duties.

The Case Manager will again consider, with the Medical Director and HR Director, whether the issues of Capability can be resolved through local action (such as re-training, counselling, performance review). If this action is not practicable for any reason, the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The Case Manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments. The NCAS will assist the Trust to draw up an action plan designed to enable the practitioner to remedy any lack of Capability that has been identified during the assessment. The Trust will facilitate the action plan (which has to be jointly agreed by the Trust and the practitioner before it is actioned).

There may be occasion when a case has been considered by the NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the issue should be considered by a Capability Panel (CaP), in which case a hearing will be necessary. If the practitioner does not agree to the case being referred to the NCAS, in the first instance, again a panel hearing will normally be necessary.

The following procedure will be followed prior to a Capability hearing:

- The Case Manager will notify the practitioner in writing of the decision to arrange a Capability hearing. This notification should be made at least 20 working days before the hearing and include details of the allegations and the arrangements for proceeding, including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the Capability Panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing, if they so choose.

- Wherever practicable, all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the Trust will consider whether a new date should be set for the hearing.

- Should either party request a postponement to the hearing, the Case Manager will be responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner's absence: The Trust will always act reasonably in deciding to do so.

- Should the practitioner's ill-health prevent the hearing taking place, the Trust's usual sickness absence procedures will be invoked (in accordance with the Staff Policy Framework). The sickness absence procedures take precedence over the Capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend a hearing. Where the practitioner's illness exceeds 4 weeks, they will be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness and any consequences it may have for the Capability process.

- If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the

practitioner should have the opportunity to submit written submissions and/or have a representative attend in their absence.

- Witnesses who have made written statements at the investigation stage may, but will not necessarily, be required to attend the Capability hearing**.** Following representations from either side contesting a witness statement that is to be relied upon in the hearing, the Chairman may invite the witness to attend. The Chairman cannot require anyone other than an employee to attend**.** However, if evidence is contested and the witness is unable or unwilling to attend, the Panel will reduce the weight given to the evidence, as there will not be the opportunity to challenge it properly.

- A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing. If witnesses required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

1.1 The Hearing Framework

1.1.1 The CaP will normally be chaired by an Executive Director of the Trust. In addition to the Chair, the Panel will comprise a total of three people; normally two members of the Trust Board, or a senior members of staff appointed by the Board for the purpose of the hearing. The third member will be a medical or dental practitioner not employed by the Trust. The Panel will also be advised by a senior HR representative, nominated by the HR Director (whose main role will be to ensure that due process is followed, throughout) and by a senior clinician agreed with the LNC from the same speciality as the practitioner concerned, but from another NHS employer. As far as is reasonably possible or practicable, no member of the Panel or adviser to the Panel should have been previously involved in the investigation. Membership of the Panel will be agreed with the LNC.

NB: It is important that the Panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

1.1.2 Whilst it is for the Trust to decide on the membership of the Panel, the practitioner may raise an objection to the choice of any Panel member, within 5 working days of notification. The Trust will then

review the situation and take reasonable measures to ensure that the membership of the Panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The Trust will provide the practitioner with the reasons for reaching its decision, in writing, before the hearing takes place.

Representation at Capability Hearings

1.1.3 The hearing is not a court of law. Whilst the practitioner will be given every reasonable opportunity to present their case, the hearing will not be conducted in a legalistic or excessively formal manner. The protocol to be followed during the hearing is detailed at paragraph 8.7 of this Section.

1.1.4 The practitioner will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the Panel and question the management case and any witness evidence.

Decisions

The Panel will have the power to make a range of decisions including the following:

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale, with a written statement of what is required and how it might be achieved (stays on record for 6 months).
- Written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Final written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Termination of contract.

It is also reasonable for the Panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the Trust that the Panel wishes to comment upon.

A record of oral agreements and written warnings will be retained in the practitioner's personnel file, but will be removed following the specified period.

The decision of the Panel will be communicated to the parties as soon as possible, and normally within 5 working days of the hearing. Because of the potential complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

The decision will be confirmed in writing to the practitioner. This notification will include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC, or any other external/professional body. The practitioner has the right to appeal against the decision, in accordance with the Appeals Procedure at **Section 4** of this policy.

Protocol to be followed for Capability Hearings

As soon as it has been determined that a Capability Panel (CaP) needs to be formed, the practitioner will be provided with written confirmation of this decision, confirmation of the allegations made against them and details of their rights to be accompanied. As soon as possible, thereafter, and at least 20 working days before the hearing, the practitioner will also be informed of the constitution of the Panel, provided with copies of the Case Manager's report and any associated investigation documentation and any documentation and/or evidence that will be made available to the Panel, including witness statements. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing (normally not in excess of 30 days) while this matter is resolved. The trust will provide the practitioner with the reasons for reaching for reaching its decision in writing before the hearing takes place.

The Panel's appointed HR representative will act as the Panel Co-ordinator, who is responsible for the administrative aspects relating to the hearing. The Panel Co-ordinator will write to the practitioner to confirm the date and venue set for the hearing, and to request that any written evidence the practitioner wishes to present at the hearing, including witness statements, are submitted at least three working days before that date. The practitioner may invite witnesses to attend the hearing, if they so wish. The Panel Co-ordinator will confirm that everyone involved with the hearing is available to attend, and inform all parties of any necessary changes to the administrative arrangements.

Once the Panel, the practitioner and their representative are assembled, the Chair of the Panel is responsible for managing the hearing, and ensuring the following protocol is followed:

- Chair introduces those present, summarises why the hearing has been convened, and explains how the hearing will be conducted.

- Chair explains that the Panel Co-ordinator will make a written record of the proceedings.
- Chair calls the Case Manager or the Trust's representative to present the case against the practitioner. Case Manager will provide documentary evidence and call witnesses, as appropriate.
- Practitioner and their representative are given the opportunity to ask any questions of the Case Manager and witnesses.
- Panel members are invited to ask questions of the Case Manager and witnesses.
- Practitioner and/or their representative are invited to present their case, and to provide any documentary evidence and call witnesses, as appropriate.
- Case Manager, or the Trust's representative, is given the opportunity to ask questions of the practitioner, their representative, and witnesses.
- Panel members are invited to ask questions of the practitioner, their representative and witnesses.
- Chair may ask questions of either party, and ask for points of clarification.
- Case Manager, or the Trust's representative, is asked to sum up.
- Practitioner, or their representative, is asked to sum up.
- Both parties are asked to leave the hearing, whilst the Panel members confer in private, but to be available to return should the Panel need clarify any points of uncertainty.
- Panel makes its decision and both parties are recalled to be informed, by the Chair, of that decision.
- Where the Panel has determined that there is a proven Capability issue, the practitioner is informed of the disciplinary/administrative action to be taken against them. The practitioner is informed of their right to appeal against the Panel's decision.

Witnesses will be admitted only to give their evidence and answer any questions, and will then retire. The procedure for dealing with any witnesses attending the hearing will be the same and reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;

- the side calling the witness may question the witness;
- the other side may then question the witness;
- the Panel may question the witness;
- the side that called the witness may seek to clarify any points that have arisen during questioning but may not at this point raise new evidence.

Following the hearing, and within three working days, the Panel Coordinator will ensure the practitioner receives written confirmation of the outcome, and of any disciplinary/ administrative action to be taken against them. The practitioner will also be reminded of the Appeals Procedure at **Section 4**, below.

8.0 Appeals Procedure

8.1 Purpose

The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a Panel decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that, in arriving at their decision, the Panel acted fairly and reasonably, based upon:

- a fair and thorough investigation of the issue;
- sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether, in the circumstances, the decision was fair and reasonable, and commensurate with the evidence heard.

The Panel may also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The Panel, however, will not re-hear the entire case.

A dismissed practitioner will, in all cases, be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the

hearing panel. The appeal panel has the power to confirm or vary the decision made at the Capability hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the Panel will have the power to instruct a new Capability hearing.

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Where the appeal is against dismissal, the practitioner will not be paid during the period of appeal, from the date of termination of employment. Should the appeal be upheld, the practitioner will normally be reinstated and will receive backdated pay, to the date of termination of employment. Where the decision is to re-hear the case, the practitioner will also normally be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and will receive backdated pay, to the date of termination of employment.

8.2 The Appeal Panel

The appeal panel will consist of three members, who will not have had any previous direct involvement in the matters that are the subject of the appeal. For example, they must not have acted as the Designated Board Member. Membership will be as follows:

- an independent member (trained in legal aspects of appeals) from an approved pool (as agreed and established by the BMA, BDA and NHS Employers - see Appendix 3), designated Chairman;
- the Trust Chairman (or other Trust Non-Executive Director), who will have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate), who is not employed by the Trust, but agreed by the LNC.

All members will be suitably experienced or trained to be able to participate in an appeal hearing.

The Panel will call on others to provide specialist advice. This should normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another NHS employer;
- a Senior HR specialist.

It is important the Panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable

to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original hearing. Wherever practicable, the following timetable will apply:

- appeal by written statement to be submitted to the designated appeal point (the HR Director, or their nominated representative) within 25 working days of the date of the written confirmation of the original decision;
- hearing to take place within 25 working days of date of lodging appeal;
- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

In all cases, the timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager is responsible for ensuring that extensions are absolutely necessary, and kept to a minimum.

8.3 Powers of the Appeal Panel

The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party , then it will have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it will consider whether an adjournment is appropriate: Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a Conduct/Capability hearing panel.

8.4 Conduct of Appeal Hearing

All parties will be in possession of all documents, including witness statements, from the previous hearing, together with any new evidence.

The appellant will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. Such a representative may be legally qualified but they will not, however, be representing the appellant formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the Panel and question the management case and any witness evidence.

Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the Panel. When all the evidence has been presented, both parties will briefly sum up. At this stage, no new information may be introduced, however the appellant (or their companion) may make a statement in mitigation.

The Panel, after receiving the views of both parties, will consider and make its decision in private.

8.5 Decision

The decision of the appeal panel will be made in writing to the appellant and copied to the Case Manager, such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There will be no correspondence on the decision of the Panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it must be sought in writing from the Chairman of the appeal panel.

8.6 Action following Hearing

Records will be kept, including a report detailing the Capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records will remain confidential and retained in accordance with the Data Protection Act 1998. These records will be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Employment Tribunal.

9.0 Procedures for Handling Concerns relating to a Practitioner's Health

9.1 Introduction

A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress. The underlying principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained, and kept in employment, rather than be lost from the NHS.

5.4 Retaining the Services of Individuals with Health Problems

Wherever possible, the Trust will attempt to continue to employ the practitioner, provided this does not place patients or colleagues at risk[2]. This may involve one or more of the following activities:

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to maintain contact and prevent them from feeling isolated);
- removing the practitioner from certain duties;
- reassignment to a different area of work;
- arranging re-training or adjustments to the practitioner's working environment, with appropriate advice from the NCAS and/or deanery, under reasonable adjustment provision in the Disability Discrimination Act 1995.

At all times, the practitioner will be supported by the Trust and the Occupational Health Service (OHS), who will ensure that the practitioner is offered every available resource to be able to return to practise, where appropriate. The Trust will consider what reasonable adjustments might be made to their workplace conditions, or other arrangements. Examples of reasonable adjustment include:

- making adjustments to the premises;
- re-allocation of some duties to colleagues;
- transfer of the practitioner to an existing vacancy;
- altering the practitioner's working hours, or pattern of work;
- assignment to a different workplace;
- allowing absence for rehabilitation, assessment or treatment;
- provision of additional training or re-training;
- acquiring/modifying equipment;

[2] *Maintaining High Professional Standards in the Modern HPSS*

- modifying procedures for testing or assessment;
- establishing mentoring arrangements.

In some cases, retirement due to ill-health may be necessary. Ill-health retirement will be approached in a reasonable and considerate manne. However, it is important that the issues relating to conduct or Capability that have arisen are resolved, using the agreed procedures, where appropriate.

9.2 Handling Health Issues

Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine the precise nature of that problem.

In such cases, the Case Manager will immediately refer the practitioner to a consultant occupational health physician within the Trust's OHS. NCAS will also be approached to offer advice on any situation and at any point where the Trust is concerned about a practitioner's health. Even apparently simple or early concerns will be referred, as these are easier to deal with before they escalate.

The Occupational Health physician will agree a course of action with the practitioner and send their recommendations to the Medical Director.

A meeting will then be convened with the HR Director, or their nominated representative, the Medical Director, or their nominated representative, or Case Manager, the practitioner and case worker from the OHS. The purpose of this meeting will be to agree a timetable of action and rehabilitation (where appropriate).

The practitioner may wish to bring a support companion to these meetings, who might be a family member, a colleague or a trade union or defence association representative. Confidentiality will be maintained by all parties, at all times.

If a practitioner's ill-health makes them a danger to patients and they do not recognise that danger, or are not prepared to co-operate with measures to protect patients, then exclusion from work will be considered and the professional regulatory body informed, irrespective of whether or not the practitioner has retired on the grounds of ill-health.

In those cases where there is impairment of performance solely due to ill-health, disciplinary procedures will only be considered in the most exceptional of circumstances, for example if the practitioner refuses to co-operate with the Trust to resolve the underlying situation by repeatedly refusing a referral to the OHS or

the NCAS. In these circumstances, the procedures for dealing with issues of Capability (see Section 3.0) will be followed.

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There will be circumstances where a practitioner who is subject to disciplinary proceedings submits a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the practitioner to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

Toal, Vivienne

From: Vivienne Toal [redacted]
Sent: 14 August 2010 10:36
To: Siobhan Hynds
Subject: MHPS HR Version VT August 2010
Attachments: MHPS HR Version VT August 2010.docx

Siobhan

Please see attached MHPS procedure.

When you are talking to Kieran can you ensure he is happy with role of Oversight Group in that they are endorsing the decision of the Clinical Manager as to action to be taken. In light of NCAS formal advice I think this is safe enough and they can have a sufficient challenge function.

Also will you check with him about copying it to LNC - just in case it gets off on wrong footing because they haven't been advised of the document and the roles that individuals will play.

There is definitely room for more cross referencing of the procedures to the MHPS framework and best practice guidance - will you have a look to see if more references can be entered?

Finally - will you read through to make sure I have not stated anything that is not correct i.e. goes against MHPS framework.

Sorry to dump this on you - but hopefully this gets the bulk of the text done.

Before sharing with Kieran - will you run it past Debbie, and then send to Kieran with copy to Anne and Debbie. Let Kieran send it on to Mairead and Debbie once he is happy with it.

Thanks

Vivienne

Southern Health and Social Care Trust

Procedure for Handling Concerns and Doctors' and Dentists' Performance

DRAFT

1.0 Introduction

1.1 **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

1.2 The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This procedure, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.

c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem.

1.5 This procedure also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of poor medical performance.

1.6 This procedure applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.7 This procedure should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also indicates that that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director (in error) then the Medical Director cannot be involved in the OG nor can they sit on any formal panel hearing. Up to MD to stop someone from making complaint known to him, in the same way as someone making a complaint to one of our Assistant Directors – they don't get involved in the detail and refer the person to the relevant Manager where possible?? **Siobhan – will you speak to KD on this point – Debbie had it in her version.**

2.3 MHPS (2005) states that **all** concerns must be registered with the Chief Executive and therefore the Clinical Manager will be responsible for informing the Chief Executive that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human

Resources & Organisational Development and the relevant Operational Director.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for assessing what action should be taken in response to the concerns raised. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach.

2.8 The Clinical Manager and the HR Case Manager will present their assessment to the OG for endorsement of their decision on the action to be taken to deal with the concerns raised. The role of the Oversight Group is therefore to quality assure the decision of the Clinical Manager and HR Case Manager and promote fairness, transparency and consistency of approach to the process of handling concerns. Reference Paragraph 15 - MHPS 2005

2.8 The Chief Executive will be informed of the action to be taken by the OG.

2.9 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the OG will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

3.0 MANAGING PERFORMANCE ISSUES

3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 6 of this document.

Appendix 1
An informal process. This can lead to resolution or move to:

Appendix 2
A formal process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 The Southern Trust (who? - MD) will also present all formal investigation processes to the SMT Governance Committee retrospectively after any panel hearing, to promote learning and for peer review.

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

The person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a Senior HR Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

Usually the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group endorses the decision of the Clinical Manager and Senior HR represent as to action to be taken in response to concerns raised following initial assessment.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group, appoints a Case Manager and Case Investigator. Chief Executive will inform the Chairman of formal investigation and requests that a Non-Executive Director is appointed as “designated Board Member”.

Case Manager
Usually the Associated Medical Director. S/he coordinates the investigation, ensure adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator
Usually the Clinical Director. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and present the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in the instance.

Non Executive Board Member
Assures that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to trust Board.

Toal, Vivienne

From: Donaghy, Kieran <[redacted]>
Sent: 16 September 2010 13:05
To: McAlinden, Mairead; Rice, Francis; Dornan, Brian; Rankin, Gillian; Loughran, Patrick; McVeigh, Angela; McNally, Stephen; Clarke, Paula; Walker, Helen
Cc: Burns, Deborah; Hynds, Siobhan; Toal, Vivienne; Clegg, Malcolm; Brennan, Anne
Subject: Trust Guidelines for Handling Concerns about Doctors and Dentists Performance
Attachments: Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 15 September 2010.doc

As discussed at SMT yesterday, please find enclosed copy of the final and agreed version of the above guidelines. This will now form the basis of our training on 24th September 2010.

Please circulate as appropriate.

Regards,

Kieran

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

16 September 2010

1.0 Introduction

1.1 **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem.

1.5 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.6 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.7 This guidance should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.

2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
An informal process. This can lead to resolution or move to:

Appendix 2
A formal process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.

3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→

Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

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Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

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Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

→ No Action Necessary

→ Informal remedial action with assistance and input from NCAS

→ Formal Investigation

→ Exclusion / Restriction

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Appendix 1

Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

The Clinical Manager should seek advice from NCAS. This may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding compliance.

Appendix 2

Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 3a

Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

→ Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

↓

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

→ Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

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Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

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Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

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Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

→ Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

During the hearing:
- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:
- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:
- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:
1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 8 September 2010 @ 2.00pm in the Boardroom, Trust Headquarters

Present: Mairead McAlinden
Dr Rankin
Dr Loughran
Angela McVeigh
Paula Clarke
Kieran Donaghy
Brian Dornan
Helen O'Neill (for Stephen McNally)
Francis Rice
Edel Bennett (for Ruth Rogers)
Elaine Wright (Notes)

Apologies: Stephen McNally, R Rogers

ITEM	NOTE	*ACTION*
1	APOLOGIES Apologies were received from Mr McNally and Mrs Rogers.	
2	NOTES OF MEETING HELD ON 1 SEPTEMBER 2010 The notes of the meeting held on 1 September 2010 were approved.	
3	MATTERS ARISING 3.1 Junior Doctors Allocation: Analysis of Service/Finance Risks Dr Rankin distributed a paper regarding Obs & Gynae and discussed the detail with members. Members considered the suggested options and approved some elements.	

	Following discussion, Dr Rankin agreed to update the paper for the remaining proposals. Surgical – Dr Rankin distributed and spoke to the Surgical paper. It was agreed that Dr Rankin and Dr Loughran would address separately, and Dr Rankin would bring this paper back to the table for next SMT. 3.2 Procedures for Handling Concerns about Doctors & Dentists Performance – draft paper A draft report on the procedures for Handling Concerns about Doctors and Dentists Performance was distributed. Members were asked for comments before the next meeting, when formal sign off will take place. Mr K Donaghy agreed to issue an up to date version prior to the next meeting, incorporating Dr Loughran's comments. NCAS Training – diary date of 24 September was noted for Directors attendance. 3.3 Professional Development & Training – Medical Staff An updated paper was distributed. Following consideration, members agreed to a combination of option 1 and 2 and with the changes noted, Dr Loughran agreed to amend and reissue via his office. 3.4 SUMDE Funding This item was deferred to the next meeting.	*Dr Rankin* *Dr Rankin/ Dr Loughran* *K Donaghy SMT: 15 Sept 2010* *All* *Dr Loughran* *SMT: 15 Sept 2010*
4	PERFORMANCE UPDATE 4.1 Performance Report Mrs Clarke referred to the Trust Performance and members noted areas of emerging risks and measures to address same. Mrs Clarke advised that the quarterly report had previously been circulated. Mrs Clarke gave an update on the Directors Performance meeting also.	

5	FINANCIAL PLAN 2010/11 5.1 Scrutiny Process – Approvals for Recruitment Members addressed the Scrutiny Process. Approvals were agreed. It was agreed that turnover information would be provided to inform further discussions. 5.2 Hospital at Night Dr Rankin referred to Hospital at Night and provided a position update. Further updates will be given at the next meeting. 5.3 NIAO – 2009/10 Report to those Charged with Governance Members noted the above NIAO Report. Ms O'Neill advised that action required was underway to address highlighted areas. Directors were asked to note recommendations and action required. 5.4 Financial Stability Programme – Assessment Review Report The Acting Chief Executive provided an update following the Regional Board Financial Stability Programme Meeting. The Chief Executive provided an overview of the action plan and referred to a copy of the presentation given at the meeting. 5.5 Charges for A&E Attendances Members referred to the paper regarding Charges for A&E Attendances. Dr Rankin provided an update on the Trust position and actions taken to date. Members agreed to implement from 1 October 2010 and to adopt the higher rate outlined.	*Mr Donaghy* *SMT: 15 Sept 2010* *All* *Dr Rankin*
6	GOVERNANCE ISSUES 6.1 Preceptorship Briefing Paper Dr Glynis Henry attended the meeting to discuss the briefing paper regarding Preceptorship. Dr Henry advised that this should be applied as best practice to new registrants and those returning to practice.	

	Discussion took place regarding the practicalities of the programme and the need to include guidance on how to support appointments outside the recruitment cycle. Members agreed, that with the caveats mentioned, the programme should proceed, and approved same. 6.2 Registered Nurses employed on Bank only contract – Acute & OPPC Directorates Dr Henry referred to the above paper which affects Acute and OPPC Directorates primarily. Dr Henry outlined the content of the paper, which provides a basic induction for staff to facilitate them to work in a ward setting. Issues pertaining to specific areas such as MEWS were raised. Mr K Donaghy said that this work was welcomed and suggested its application across other disciplines. Dr Henry advised that work was ongoing in relation to bank staff and associated training. Members approved the principle of the paper. 6.3 SAI Personal Information Dr Rankin provided a verbal update to members regarding SAI Personal Information. She assured members that measures are in place to address issues raised by this SAI. 6.4 Call for Evidence & Post Implementation Review on the Current Data Protection Legislative Framework Members referred to the above paper and Mrs Clarke outlined the main content of same. She advised that a composite response from all NI Departments will be issued and this provides the Southern Trust inclusion to that. Members were asked to submit any final comments to Mrs Clarke by Friday 10 September and Mrs Clarke will then submit the Trust response.	*Mr Rice* *All/P Clarke*

	6.5 RQIA Review of GP Out of Hours Services Mrs McVeigh referred to the RQIA Review of GP Out of Hours Services and the recommendations highlighted within. Members referred to the Trust's action plan to address the recommendations and Mrs McVeigh assured members that work was progressing to address these. It was agreed to table at the next SMT Governance Meeting and then to Trust Board in November. 6.6 Card Before you Leave Scheme Members referred to the recent media coverage surrounding the 'Card before you Leave Scheme' and the Trust's paper addressing issues raised. Members were assured that the Trust was handling the Scheme and has a process in place to address any issues that may arise. Mr Rice agreed to consider evaluation of impact/effectiveness. 6.7 Dress Code Policy Members noted the proposed communication in respect of the Dress Code Policy and the need to issue to all staff as soon as possible to reinforce the need to adhere to Trust Policy in this regard. Members approved for circulation. 6.8 1st Quarter Patient Support Services Report, 1.04.2010-30.06.2010 Dr Rankin referred members to the Patient Support Services Report for the period 1 April 2010 – 30 June 2010. Members agreed this was a useful report which will now be tabled at the forthcoming Patient/Client Experience Committee. 6.9 Report on Out of Hours Data Breach Mrs McVeigh provided an updated SAI/RCA report. The Chief Executive advised that a Trust Wide circulation had been issued reminding staff of their responsibilities with regard to the handling of such data. The GP Out of Hours Data Breach SAI/RCA will be tabled at the next Governance Committee.	*SMT Governance – 29 Sept 2010* *Trust Board – 30 Nov 2010* *Mr Rice* *Paula McKeown* *Dr Rankin – next Patient/ Client Exp Committee* *Governance Committee – 7 December 2010*

7	INFECTION CONTROL UPDATE 7.1 Weekly Hand Hygiene and Commode Audit Overview The Audit exemption reports with regard to hand hygiene and commodes were noted. 7.2 Environmental Cleanliness Weekly Exception Reports Members noted the environmental cleanliness exception reports. Directors to action as necessary.	
8	CSR/CHANGING FOR THE BETTER – 5 YEAR STRATEGIC PLAN 8.1 Changing for Children – draft consultation report Members noted the Changing for Children consultation document which will be tabled at Trust Board on 30 September 2010. Members were asked for views/comments before next weeks SMT meeting, where the report will be signed off. Members discussed the key issues of the report and the need to ensure a safer service whilst striving to meet targets. A presentation of the outcomes of the consultation will be made at the Trust Board Meeting. 8.2 Corporate Plan Members considered the format for the Corporate Plan which will be presented to Trust Board on 30 September 2010. Discussion took place with regard to how the Trust move and progress its objectives and making the connection between objectives and the 5 year plan.	*SMT – 15 September 2010* *Trust Board 30 September 2010* *Trust Board 30 September 2010*
9	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 9.1 Summary of Internal Capital Business Cases This paper was deferred to the next SMT meeting.	*SMT – 15 Sept 2010*

	9.2 Minor Works Members referred to the paper regarding Minor Works, and were asked to prioritise their lists for SMT on 22 September 2010.	*SMT – 22 Sept 2010*
10	WORKFORCE ISSUES 10.1 Trust Excellence Awards Members noted that the material regarding the Trust Excellence Awards had been circulated throughout the Trust. 10.2 Hope Exchange Programme – NHS Institute Following consideration of the Hope Exchange Programme, it was agreed that the Trust would not avail of the opportunity to participate this year. 10.3 Travelwise Mr Rice referred members to the Travelwise Scheme which involves joint working arrangements between the Trust and DRD Transport Policy Division, who will work with the Trust to develop a travel plan. Members noted that the Trust would not incur any financial charges with this scheme. Members approved to proceed.	*Mr Rice*
11	CARBON REDUCTION COMMITMENT (CRC) ENERGY EFFICIENCY SCHEME SUMMARY REPORT Mrs Clarke referred to the CRC Energy Efficiency Scheme Summary Report. She advised that the report provides information and raises awareness of action that can be taken within Directors to reduce Carbon Energy. Mrs Clarke advised that systems are being put in place to monitor energy usage within facilities. Members noted the report and its content.	
13	WEEKLY COMMUNICATIONS TELECONFERENCE Members considered the content of the weekly communications teleconference.	

14	ANY OTHER BUSINESS 14.1 Mono Hips Dr Rankin advised members regarding the 'alert' received for mono hips and the possible impact upon the Trust. Discussion took place with regard to the approach the Trust should take regarding this matter. Dr Rankin agreed to advise further at the next meeting. 14.2 CAWT This item was deferred to the next meeting. 14.3 Community Development Training Programme Mrs McVeigh advised that information was in the process of being circulated and an updated action plan being prepared. 14.4 Governance Review Members were advised that following the Governance Committee Meeting, proposals for new structures will be prepared and released as part of the consultation process. This process will commence at the end of October/beginning November.	*Dr Rankin SMT 15 Sept 2010* *SMT – 15 Sept 2010*
15	DATE OF NEXT MEETING The next SMT meeting will be held on Wednesday 8 September 2010 commencing at 2.00pm.	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 15 September 2010 @ 2.00pm in the Boardroom, Trust Headquarters

Present: Mairead McAlinden
Dr Rankin
Dr Loughran
Angela McVeigh
Paula Clarke
Kieran Donaghy
Brian Dornan
Stephen McNally
Francis Rice
Paula McKeown (for Ruth Rogers)
Elaine Wright (Notes)

Apologies: R Rogers

ITEM	NOTE	*ACTION*
1	APOLOGIES Apologies were received from Mrs Rogers.	
2	NOTES OF MEETING HELD ON 8 SEPTEMBER 2010 The notes of the meeting held on 8 September 2010 were approved.	
3	MATTERS ARISING 3.1 Junior Doctors Allocation: Analysis of Service/Finance Risks - *Surgical* Copies of a revised paper where issued to members. Following consideration, members agreed to approve, proposing Option 4 which enables a reduced level of additionality and covers educational concerns which may arise. Members approved.	*Approved*

	3.2 Procedures for Handling Concerns about Doctors & Dentists Performance – draft paper Members considered the revised procedures and following clarification of some issues and with the caveats agreed, members approved and adopted the process outlined. Dr Loughran advised of the various groups who will receive the procedures and Elaine Wright to amend and forward to Dr Loughran and K Donaghy immediately following SMT for circulation as agreed.	*E Wright to amend and issue – Dr Loughran/K Donaghy*
	3.3 Professional Development & Training – Medical Staff Members noted the changes following discussions at the last SMT meeting, which allow for the management of the speciality budget and flexibility within. Members endorsed the documents.	*Approved*
	3.4 Hospital at Night Dr Loughran advised that the Southern Trust has now received £146K for the Hospital at Night Project. Members noted that costs were now covered and acknowledged this good news.	
	3.5 CAWT Issues/Update Mrs McVeigh referred members to the paper entitled: 'CAWT Promoting Independence & Providing Social Support for Older People Project'. Members discussed the content of the paper and following consideration of the options outlined, agreed to option 2 in principle – *to ensure the needs of older people are assessed using agreed criteria to ensure need is prioritised and the services targeted at those most in need and within available resource*.	*Agreed – A McVeigh*
	3.6 Mono Hips Dr Rankin advised that further correspondence had been received and that she had raised the issue regionally. Dr Rankin informed members that lists were being validated and a plan of action will be drawn up by the end of October.	*Dr Rankin – end October 2010*

	3.7 Shared Services Mr McNally advised that he would table a local response at the next SMT Meeting. 3.8 Structure for Trust Sub Deanery This item was deferred to the next SMT Meeting. Dr Loughran agreed to respond to the most recent correspondence regarding the Trusts response to this.	*S McNally SMT 22 Sept 2010* *Dr Loughran to respond and SMT 22 Sept 2010*
4	PERFORMANCE UPDATE 4.1 Performance Report Mrs Clarke asked Directors to give thoughts to inclusions within the Performance Report and agreed to table a paper at the next SMT Meeting, for approval for submitting to Trust Board on 30 September 2010. 4.2 Variation to Corporate Performance Management Report – Proposal for Discussion Mrs Clarke outlined suggestions for new format of this report which were agreed by SMT. 4.3 Corporate Performance Dashboard, August 2010 Members referred to the Corporate Performance Dashboard for August 2010 which is used as an exception reporting tool. Mrs Clarke asked members to provide her with comments as appropriate. 4.4 SBA Performance Report April-July 2010 Mrs Clarke referred to the SBA Performance Report for the period April-July 2010. Mrs Clarke advised that this report will come to SMT every second month and will be a rolling programme of work within the Trust. Members agreed their content to the process. 4.4 Elective Care PfA Waiting Time Targets, Letter from John Compton 14 September 2010 The Chief Executive referred to correspondence from Mr John Compton regarding Elective Care PfA Waiting Time Targets and the request to have the Trusts detailed plans	*P Clarke - SMT 22 Sept 2010* *P Clarke* *All*

	by the end of the week. Members agreed that the Trust were progressing, although it would not be feasible to have finalised by week end.	
5	FINANCIAL PLAN 2010/11 5.1 Scrutiny Process – Approvals for Recruitment Members addressed the Scrutiny Process. Approvals were agreed. Mr K Donaghy requested that the report regarding 'turnover' is deferred until the next SMT Meeting. 5.2 Gifts and Hospitality 2010/11 Mr McNally tabled a paper regarding the outcome of the Internal Audits review of the Trusts Gifts & Hospitality for 2010/11. Members noted that the issue still remains regarding 'sponsorship' and Mr K Donaghy advised that a one page guidance for staff was being produced. 5.3 SUMDE – Infrastructure Upgrade Funding Dr Loughran advised that he was currently working on this alongside Mrs Clarke and this item was deferred to the SMT Meeting on 22 September 2010 when a report would be available. 5.4 SUMDE Funding – draft briefing paper Members noted the SUMDE Funding draft briefing paper and were asked to consider its contents. This will be tabled for further discussion at SMT on 29 September 2010. 5.5 Proposal to remove payment of telephone line rental to Trust Staff Members considered and agreed the paper proposing to remove payment of telephone line rental to Trust staff and Mr K Donaghy advised that he would bring this proposal through staff side. Mr Donaghy advised that there is currently no provision for this payment under AfC.	*K Donaghy – SMT 22 Sept 2010* *K Donaghy* *SMT 22 Sept 2010* *SMT 29 Sept 2010*

6	GOVERNANCE ISSUES 6.1 NIAO – 2009/10 Report to those Charged with Governance This item was discussed at SMT on 15 September 2010. 6.2 Blood Transfusion Policy Members noted the changes following discussion at SMT on 15 September 2010 and agreed same. 6.3 Thrombosis Committee – terms of reference This item was deferred to SMT on 22 September 2010. 6.4 Newborn Blood Spot Screening Programme Performance Report This item was deferred to SMT on 22 September 2010. 6.5 Unallocated Cases Mr Dornan referred members to the Unallocated Cases statistics which will be tabled at Trust Board on 30 September 2010. 6.6 Transforming Care at the Bedside Information Session – 11 November 2010 – HSC Safety Forum The Chief Executive referred to information regarding the forthcoming HSC Safety Forum and Directors confirmed that relevant staff would be attending.	*Dr Loughran SMT – 22 Sept 2010* *SMT – 22 Sept 2010* *Trust Board – 30 Sept 2010*
7	INFECTION CONTROL UPDATE 7.1 Weekly Hand Hygiene and Commode Audit Overview The Audit exemption reports with regard to hand hygiene and commodes were noted. 7.2 Environmental Cleanliness Weekly Exception Reports Members noted the environmental cleanliness exception reports. Directors to action as necessary.	

	7.3 Verbal Update on the Unannounced Hygiene Inspection at CAH on 14 September 2010 Dr Rankin provided a verbal update to members following the Unannounced Hygiene Inspection carried out at CAH on 14 September 2010. Dr Rankin advised that the inspection concentrated on the areas at A&E and Outpatients and noted the particular issues raised by the Team. Dr Rankin assured members that measures are in place to address the issues outlined. The Trust will await the formal report from RQIA. 7.4 HCAI Update Dr Loughran updated members on the current position with regard to HCAI within the Trust.	
8	CSR/CHANGING FOR THE BETTER – 5 YEAR STRATEGIC PLAN 8.1 Proposal for the Centralisation of Planned Paediatric Surgical Care & EIA – draft consultation report Members noted the further revised version of the Proposal for the Centralisation of Planned Paediatric Surgical Care. The final Trust Board version will be tabled at SMT on 22 September for endorsement prior to going to Trust Board. 8.2 Corporate Plan Mrs Clarke advised that the Corporate Plan will be tabled at the next SMT meeting on 22 September 2010.	*SMT – 22 Sept 2010* *SMT – 22 Sept 2010*
9	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 9.1 Summary of Internal Capital Business Cases The summary of Internal Capital Business Cases was tabled and approval given by members. 9.2 Lurgan Hospital Refurbishment Mrs McVeigh referred to the paper regarding the Lurgan Hospital Refurbishment which outlines the options available for refurbishment works.	*Trust Board – 30 Sept 2010*

	Following consideration of the proposed options members agreed to implement option 2 – *refurbish ward 5 and relocate the Stroke Unit to Ward 5 on the first floor. Refurbish ward 7 and 8 and move ward 6 to 7 and 8. Refurbish ward 6 and move ward 4 to ward 6.* 9.3 Lurgan Hospital Lift Proposals Mrs McVeigh outlined to members the proposals for the lift at Lurgan Hospital and members discussed the option of a fire lift and agreed as the best way to move forward.	*Both:* *A McVeigh* *Approved*
10	WORKFORCE ISSUES 10.1 Legal Judgement: Working Time Regulations – verbal update Mr K Donaghy referred to the legal judgement regarding the working time regulations and advised that the recent appeal hearing has been overturned. 10.2 CEF – Federal Executive Institute 2011 – Leadership for a Democratic Society Programme Members noted the CED Federal Executive Institute Leadership programme. 10.3 Newspaper Article – Inquest into Junior Doctor Rota Review The Chief Executive referred members to the recent Newspaper Article following the inquest into Junior Doctors Rota Review in Taunton and Somerset NHS Foundation Trust. Members provided assurance that the Trust had sufficient safeguards in place, including Hospital at Night.	
11	SECTION 75 NI ACT 1998 Mrs Lynda Gordon attended the meeting to present to members Section 75 of the NI Act 1998. Mrs Gordon outlined the background and context to the equality scheme, highlighting areas of change and the statutory duty upon the Trust.	

	Members were advised of the requirement by Public Authorities to provide an action-based plan on how they would address this work. The finalised scheme and action plan is required to be submitted formally by 1 May 2011. Members agreed the importance of having a robust model to work to and it was agreed that a populated framework would be brought back to SMT in mid-October. Members thanked Mrs Gordon for a very comprehensive presentation.	
12	IMPLEMENTATION OF THE COMMUNITY DEVELOPMENT STRATEGY & ACTION PLAN 2005-09 Mrs McVeigh referred members to the Community Development Strategy & Action Plan for 2005-2009. Members noted and accepted the plan.	
13	OPERATIONAL ACTION PLAN TO ENHANCE PERSONAL & PUBLIC INVOLVEMENT WITHIN THE SHSCT – APRIL 2010 – MARCH 2011 Mrs McVeigh referred to the operational action plan to enhance Personal & Public Involvement within the Trust and advised that the plan provides an overview/summary of the high level trends and issues coming from Directorate PPI plans. Members agreed the importance of embedding into activity at ground level and the need to keep it simple and basic but yet measurable. Mrs McVeigh to continue to progressing this work.	*A McVeigh*
14	IMPROVING EMPLOYMENT OPPORTUNITIES FOR DISABLED PEOPLE – POSITION PAPER FOR APPROVAL Mr Donaghy referred members to the paper regarding Improving Employment Opportunities for Disabled People. He proposed 10 placements across a range of settings which are rotational. Members considered the content of the paper and agreed in principle to proceed.	*K Donaghy*

	Mr Donaghy to undertake a more detailed implementation plan.	
15	REVIEW OF TEENAGE PREGNANCY & PARENTHOOD STRATEGY & ACTION PLAN – TRUST RESPONSE FOR APPROVAL Mrs McVeigh referred to the completed draft response to the Teenage Pregnancy & Parenthood Strategy and Action Plan. Members considered and approved same for submission. Elaine Wright to submit by 17 September 2010.	*E Wright to submit by 17 Sept 2010*
16	WEEKLY COMMUNICATIONS TELECONFERENCE Members considered the content of the weekly communications teleconference.	
17	STAFF E-BRIEF Members noted the staff e-brief due to be circulated to all staff.	
18	ANY OTHER BUSINESS 18.1 Launch of Volunteer Now Bursary Scheme for the 2012 Olympics Mrs McVeigh raised with members the launch of the Bursary Scheme for Volunteers for the 2012 Olympics. The Chief Executive asked Mrs McVeigh and Mr Donaghy to prepare a proposal for the next SMT meeting on 22 September 2010. 18.2 Admin Review Mr Rice referred to the ongoing Admin Review and proposals arising from the review and the need to co-ordinate across Directorates. Members agreed the importance of synchronising across Directorates and agreed to take forward with a joint approach.	*K Donaghy/ A McVeigh – SMT 22 Sept 2010* *Mr Rice/ Dr Rankin*

	18.3 Performance Workshop Mrs Clarke advised that dates would be circulated shortly regarding a proposed performance workshop. 18.4 Internal Audit Programme for 2010/11 Mr McNally advised that the current year's programme for Internal Audit is due to commence and informed members that the Review of Travel Expenses would be one of the initial audits to take place. Members were reminded of the importance of timely submission of expense forms and the need to inform staff accordingly. In principle it was agreed that travel claims submitted after 3 months would not be processed. Mr McNally agreed to provide communication to staff regarding same.	*Mr McNally*
19	DATE OF NEXT MEETING The next SMT meeting will be held on Wednesday 22 September 2010 commencing at 2.00pm.	

Toal, Vivienne

From: Brennan, Anne [redacted]
Sent: 16 September 2010 14:26
To: [redacted]
Cc: Donaghy, Kieran; McAlinden, Mairead; Loughran, Patrick; Hynds, Siobhan; Toal, Vivienne
Subject: Medical Leadership Network: 16.09.2010
Attachments: agenda_24sept2010-revised16sept2010.doc; Procedure for Handling Concerns about Doctors and Dentists Performance (MHPS) FINAL 15 September 2010.doc

Dear Colin –
Thank you very much for agreeing to lead the training afternoon on 24th September. I explained that this is part of an Associate Medical Director/Clinical Director Medical Leadership training programme and we are concentrating on performance concerns for doctors and dentists. In terms of the timetabled programme I can confirm that after the introductions and background we can give you about 1 hour to talk about the work of NCAS. I enclose the draft of our guidance in relation to this subject and following your presentation – as discussed, two senior members of our HR team will go through the principles within the guidance and how it links to maintaining high professional standards. After a short break we can then work through the 5 scenarios and expect to be finished around 4.30 I look forward to hearing to seeing you on the 24th.

Regards, Paddy

Anne Brennan

Southern Health & Social Care Trust

Tel: [redacted]
www.southerntrust.hscni.net

Southern Health and Social Care Trust

Southern Health and Social Care Trust
Medical Leadership Network

Friday 24th September 2010 at 1.30pm
Venue: Board Room, Trust Headquarters, Craigavon Area Hospital

Purpose:
This session provides an opportunity to explore how we handle performance concerns about doctors and dentists.

Programme

1.30 Welcome and Introductions – Christine McGowan

1.40 Background to Workshop Event – Dr P Loughran

1:50 NCAS – Dr Colin Fitzpatrick

2:50 Southern Trust Guidance on Handling Concerns about Doctors and Dentists – V Toal/S Hynds

3.10 Break

3:30 Case Studies via Group Work:

Scenario 1:
The Coroner expresses concern that an elective Aortic Aneurysm case was poorly managed resulting in the death of the patient. The Trust has been asked to look at the doctors competence. He is recently appointed. You are the AMD what action would you expect the Trust to take?

Scenario 2:
A member of the multidisciplinary team contacts you as AMD to express concern about the competency of a doctor who carries out procedures. They advise you that

they have already raised the concern with the Clinical Director who feels that no action is required. What steps do you take to address the team members concern?

Scenario 3

Your colleague and close friend turns up for work and smells strongly of alcohol. He explains that he was at a party the previous night. He insists that he is capable of working today. You know him well and you do not agree. What actions do you take? Does the Trust have policies to assist?

Scenario 4

In audit of antibiotic prescribing there is one paediatric nephrologist who does not follow the Trusts published antibiotic guidance. You are the Clinical Director – how would you manage this situation?

Scenario 5

The Trust's quarterly report which looks at Clinical Indicators suggests that there is an excess of morbidity in one doctors' practice [large number of admissions to ICU]. What actions should the Medical Director, Operational Director and AMD take?

4.30 Review and Close

In preparation for the workshop attendees have been sent a copy of the **Trust Guidance on Handling Concerns about Doctors and Dentists** to consider. If you have not received a copy of this, please contact Laura White at Personal Information redacted by USI a copy will be forwarded to you.

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

FINAL
15 September 2010

1.0 Introduction

1.1 **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This procedure, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem.

1.5 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.6 This procedure applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.7 This procedure should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 MHPS (2005) states that **all** concerns must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.

2.9 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
An informal process. This can lead to resolution or move to:

Appendix 2
A formal process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 All formal cases will be presented to SMT Governance by Medical Director and Operational Director to promote learning and for peer review when the case is closed.

3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→

Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

→ No Action Necessary

→ Informal remedial action with assistance and input from NCAS

→ Formal Investigation

→ Exclusion / Restriction

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Appendix 1

Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

The Clinical Manager should seek advice from NCAS. This may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding compliance.

Appendix 2

Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

→ Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

↓

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

↓

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

↓

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case reviewed by SMT Governance for action / learning points.

Appendix 3a

Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

Following assessment by NCAS, if the Case Manager considers a Practitioners practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

During the hearing:
- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:
- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:
- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:
1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case reviewed by SMT Governance for action / learning points.

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Toal, Vivienne

From: Siobhan Hynds <[redacted]>
Sent: 23 September 2010 15:04
To: Brennan, Anne
Cc: Donaghy, Kieran; Vivienne Toal
Subject: Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 23 September 2010.doc
Attachments: Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 23 September 2010.doc

Anne,

Please see attached amendments following comments from the AMD's - could you review and let me know if this reflects their comments before I issue out.

Thanks

Siobhan

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

1.0 Introduction

1.1 **Maintaining High Professional Standards in the Modern HPSS** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 This document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patient's harmed.

1.3 The MHPS framework is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.4 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.5 This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem.

1.6 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.7 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.8 This guidance should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns[1] should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

[1] Examples of Concerns may include: - when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.