115 Q. Let's focus on the question.
A. Sorry, I wasn't --
116 Q. Were you unhappy with his exclusion?
A. No. No, I wasn't unhappy.
117 Q. What thoughts or emotions did you have in respect of it? 14:10
A. I think I've said earlier, I may have missed it, but I didn't realise he was excluded until the meeting in January, albeit I know other colleagues have said they told me, like Dr. Wright in December. I don't remember that but I might have -- 14:10
118 Q. The timings are irrelevant for the purposes of this question. Mrs. Toal is recalling a conversation when you plainly did know about his exclusion. In terms of your view of it, did you form a view so that you were unhappy about it, or did you not form a view? 14:11
A. I didn't form a view. I don't remember this. Sorry for going back into it again. I didn't have a view and I don't recall giving my view to Mrs. Toal.
119 Q. So you didn't form a view. Do you remember meeting with Mrs. Toal? 14:11
A. No, I don't remember.
120 Q. Or having, it does seem to be very much an informal bumped into each other or whatever it might have been?
A. She talks about she was in my office. To be fair to Mrs. Toal, she was excellent again in her role and would have been possibly in and out to inform me of different aspects of work and her office was directly opposite me. But I don't remember that particular one 14:11

that she is referring to, why she was in the office or even talking about Mr. O'Brien.

121 Q. Yes. The evidence that she has given is clear; I've read it out. I think she's clearly trying to be fair to you, she's not attributing to you specific words but the sense of it was you were unhappy, this was an excellent doctor, and perhaps a sense of concern around his exclusion. You're not, as I understand it, challenging -- 14:12

A. No, I don't remember it. 14:12

122 Q. -- her version of events, you simply don't remember?

A. I just don't remember that. I mean, I am respectful to Mrs. Toal but I don't remember it. I don't remember her in the office and discussing that at all.

123 Q. She was the Director of Human Resources? 14:13

A. Yes, and Organisational Development.

124 Q. Do you think it would be inappropriate of you as Chair to engage with her in the way that she has reported?

A. Absolutely, absolutely, and I don't believe I did that but I don't remember her in my office. So it would be inappropriate, yes. 14:13

125 Q. I just want to be clear, you don't remember it?

A. No.

126 Q. It would be inappropriate but you don't believe you did it? 14:13

A. No, I don't remember in the office. I don't remember -- I thought you asking me what did I think if I would have done it and I'm saying I wouldn't have done it because it would be inappropriate.

Urology Services Inquiry

2. On 19th January 2017 I was appointed as the Designated Non-Executive Director ('NED') by the Chair of SHSCT, Mrs. R. Brownlee ('RB'). The primary purpose of my role was to liaise with Mr Aidan O'Brien ('AOB') and ensure the momentum of the Maintaining High Professional Standards ('MHPS') process in respect of AOB was maintained by ensuring timely responses to requests made by AOB. I met with Vivienne Toal ('VT'), Director of Human Resources and Organisational Development, to review the role of Designated NED.

3. On 24th January 2017 a meeting (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170206 - E - S Hynds to J Wilkinson.) was held with AOB, Mr Weir ('CW') and Mrs Siobhan Hynds ('SH'). CW was the Case Investigator and SH is the Head of Employee Relations who was assisting Mr Weir with the investigation.

4. On 25th January 2017 I sent a letter to AOB introducing myself as the Designated NED (see appendix) and I made him aware that I was informed about his immediate exclusion which became effective on 30th December 2016. At this time the Case Manager was Dr A Khan ('AK') and the Case Investigator was CW. The relevant documents can be located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170125 - Doc - J Wilkinson to AOB re MHPS

5. On 25th January 2017 I received an email from VT outlining the next steps in the process I received another email from VT providing me with an update prior to the Trust Board meeting (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170125 E V Toal to J Wilkinson re Confidential Mr AOB and located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170126 - E - V Toal to J Wilkinson re MHPS Case).

6. On 26th January 2017 I met with RB and we discussed the case. RB expressed her opinion about the case. She explained that she had known AOB for a number of years and that he had been her consultant; that he was an excellent surgeon and that he had helped many people; that he had built up the urology department

in SHSCT and had worked hard to meet patients' needs as they awaited surgery or a diagnosis. She asked me to make contact with AOB. I received an email (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20170126 - E - V Toal to J Wilkinson re MHPS Case) from VT who advised that AOB's exclusion would be lifted subject to the implementation of controls and restrictions on his practice. I was also advised that a formal investigation would be undertaken. This would be reported to Trust Board at its monthly meeting.

7. On 2nd February 2017 I telephoned AOB and arranged a date to meet.

8. On 6th February 2017 SH shared notes (see appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170206 - E - S Hynds to J Wilkinson.) with me for my information which were from a meeting with AOB regarding his exclusion. Having considered these notes it was apparent that AOB and the Trust that a significant interaction between the Trust and AOB had been ongoing. A letter sent by email to AOB was also copied to me indicating that the panel had agreed that there was a formal case to answer and that a decision was taken to lift the immediate exclusion. A meeting between Dr Khan and AOB to discuss an action plan to enable him to return to work was planned for 9th February 2017. An Occupational Health appointment was also arranged for that day.

9. On 7th February 2017 I attended a meeting with AOB in his office at Craigavon Area Hospital, Craigavon. His son [Mr O'Briens son] was also in attendance. AOB provided us with his view of the situation. He was annoyed at the way in which he had been 'treated'. He cited various concerns, including, appraisal, revalidation, workload, workload imbalance, why immediate exclusion had been exercised without him being given the opportunity to address the issues, SHSCT not following their own guidelines, and the lack of response to concerns he had expressed regarding process and timescales not being adhered to. AOB speculated that if he was to be found wanting in his practice then he would bring a degree of embarrassment to the SHSCT. I remember him citing a few names but I do not have a record of these. In my opinion this was a difficult meeting. There was reference made to a number of matters which I was unfamiliar with including positions and internal procedures within the Trust. I felt that I did not have a full understanding of the situation. I assured AOB that Trust was

engage with, how would you set up meetings, none of that was made explicit. I'm not sure how this proceeded in previous cases. I have no awareness of how it was done in previous cases, nor were there illustrations given as to how it was performed on previous occasions.

186 Q. You also received a telephone call or had a meeting on 26th January with Mrs. Brownlee about the case. What was the substance of that communication?

A. Sorry, what date was that again? 14:46

187 Q. 26th January 2017 you have met with Mrs. Brownlee. I can bring it up on the screen?

A. No, no, you are fine. That was a meeting?

188 Q. Yes.

A. Yes. 14:46

189 Q. At the outset; it would be the first meeting.

A. Really, the substance of that was, John, this is a really good surgeon, he has the interests of the patients at heart, I'm not sure why this process is where it is at the moment, just look after him. 14:46

190 Q. Had you been aware at that stage of any connection or friendship or relationship between Mrs. Brownlee and Mr. O'Brien? Were you aware of that, anything like that?

A. No, I wasn't aware but, sorry, at that meeting she did mention that she was a patient of his and that, in essence, her life was saved by him through surgery. 14:46

191 Q. Did you feel that that discussion or the way she approached that discussion was appropriate in the

circumstances?

A. At that time, I just took it at face value, I have to say. But as things progressed, then I began to question. I use the term "independence of the Chair".

192 Q. We will maybe come on in more detail to that. Just to go back briefly to your meeting with Mrs. Toal. What background or knowledge about the case were you given in terms of the details of the history of the case by Mrs. Toal? 14:47

A. Absolutely minimal. I have to say there was no documentation associated with that meeting, which, on reflection, would have been very useful. Because I was just working from the SAI stage but I didn't know anything about -- and maybe it wasn't pertinent, maybe it was better to be clean like that, I'm not sure. But dating back 2014, 29 and the lead-up to all of this, I was unfamiliar with that. Maybe that's the way it should have been, I'm not sure. 14:47 14:48

193 Q. Obviously throughout the process, Mr. O'Brien has asked you and come to you with different queries that it appears you didn't feel - you can correct me if I am wrong - equipped to deal with that. Would that be fair? 14:48

A. Absolutely. The concerns and then the questions were so diverse and were so scattered to be addressed by different clinicians and management within the Trust, it would have taken me an age to address. So I focused on -- I focused on Mrs. Toal and I put the monkey on her shoulders, as it were. I don't mean that in 14:48

148 Q. Do you remember that visit?
A. Yes. It was Mr. O'Brien lives about a mile, a mile and a half from our home. My husband had been informed by two different people that he was very unwell, and I went -- it was a Sunday afternoon. I remember going to see him. He was in a broken state, he was extremely unwell. So I would have left after lunch and I was back again before -- I must have been there in the afternoon but I was back again for duties on the farm. But Mr. O'Brien that I visited on that day was a very sick, upset, very stressed gentleman actually. I won't ever forget it. His wife was there, there was no one else there. I remember him saying something to me like in his head there was so much, he felt as if he was having an autopsy, he couldn't sleep and he was distraught. 14:35 14:36 14:36

And I do remember yes, saying to him -- now, Mr. Wilkinson wouldn't have met him at that stage. I did say to him that the Non-Executive Director who is supporting you will be a John Wilkinson who I held in the highest regard within the Trust, he had worked excessively with myself. That's what I remember saying to him. There wasn't a lot of detailed discussion during that visit. I went from the wellbeing point of view because he was just so unwell, and he was very unwell. 14:36 14:36

149 Q. Let's go back to Mr. Wilkinson's statement, WIT-26095, and paragraph 19 at the bottom of the page. On

users. She further expressed concern about the handling of the case by Human Resources. RB pointed out that the case was having an adverse effect on AOB and his wife. She asked me to contact AOB.

20. On 2nd March 2017 I telephoned and texted AOB seeking a meeting to discuss progress and any other concerns that he might have had. I received no response.

21. On 6th March 2017 AOB made contact with myself and raised the following concerns:-

    a. He stated he was disappointed with AK's letter and that he felt that the reply should have come from myself or the Case Manager.
    b. He further explained that he believed that the needs of the process was taking over rather than the needs of the case itself and in particular cited important points of clarity. AOB was concerned about the needs of his patients and he believed that he was taking every possible measure to expedite their needs even though it was causing him significant additional work.
    c. He believed that the process had already come to an opinion.
    d. He stated that the Trust Guidelines re the handling of MHPS were being overlooked and that the Serious Adverse Incident sequence had not been clarified.
    e. He expressed concern that other measures had not been explored prior to him being excluded.
    f. He also believed that the process that he was undergoing was being driven by Human Resources and not clinicians.

    I explained to AOB that I was meeting VT from HR and that I would bring his concerns forward. AOB asked me to also:

    i. Enquire about case progress;
    ii. Request that the Terms of Reference for the Inquiry be shared if they were agreed and available;
    iii. Clarify whether the scoping exercise was complete and if the Inquiry had begun (and, if so, on which date it began). Appendix located in Relevant to CX Chair's Office, Evidence Added or Renamed 19 01 2022, 20170302 - E - AOB to J Wilkinson

215 Q. Do you recognise that if she is speaking to Mr. Wilkinson in the terms that are mentioned on 2nd March, if that was the case, that that is advocating on your behalf?

A. What happened, which 2nd March. 14:47

216 Q. On 2nd March, sorry. If we go back to what he says at paragraph 19, if we scroll back, 26095. At paragraph 19 he's saying that she is describing your attributes as a surgeon, well-respected, setting up the Urological Service, expressing concern about the 14:47 handling of the case and asking Wilkinson to make contact with you.

A. So the question, sorry, is?

217 Q. Would you accept that's advocating on your behalf?

A. I don't know. I mean, I can't be inside 14:48 Roberta Brownlee's mind and her intentions, or whatever, at that point in time. What I can certainly state categorically is that I didn't request any such advocacy. I thought that would have been highly improper and I never sought it. She would have had, by 14:48 this stage, an awareness of the adverse effect that it was having on us as a family. And if she asked him to contact me, that was fine, but whether that amounts to advocacy of some kind, I do not know.

14:48

Part of his role was liaise with me or for me to be able to liaise with him and to make representations. So, I had a person appointed to do that, why would I seek another person to press upon them? It

into the office. Emma phoned in and said can you take a call from the Chair. I excused -- to be honest with you, I don't normally like conversations in meetings and I always tell Emma, but I suppose she checked. Because it was the Chair, Emma checked with me, look, would you like to speak to her, given her importance and all that from her position, I suppose. So I took the call. She said to me, "What's all this going on with Mr. O'Brien"? And I didn't speak, just listened. She said "You know, Esther, that man saved my life once". It wasn't a friend, it was her; she said Mr. O'Brien saved her life. This is how I know it was later on because I just was so angry. I said, well, he may have saved your life but he has potentially harmed a few others so you may let the GMC deal with it. Period. That was it. I just ended the call. Very angry indeed. 11:02 11:03 11:03

155 Q. So it was a short call; is that fair?

A. Yes. And I never spoke to her or her to me again about it, ever. 11:03

156 Q. You've explained that in terms of what Mrs. Brownlee said to you, it was "What is all of this going on" --

A. With Mr. O'Brien.

157 Q. -- with Mr. O'Brien?

A. Mhm-mhm. 11:04

158 Q. Whereas in terms of how you explained it to Tracey Boyce, it has become "Leave Mr. O'Brien alone."

A. Leave him alone. Well, that's how I interpreted it, and I probably didn't completely just say word for word

163 Q. So it's not a question of you don't remember, it's an adamant "I do not", "I did not call Mrs. Gishkori to discuss Mr. O'Brien"?

A. A particular call about Mr. O'Brien. What I'm saying is I would have made many calls and could have been talking to her. I could have been talking to Mrs. Gishkori in any given week once, twice, three times if I was up in the hospital. Indeed, she had a very complex directorate to look after and we would have talked often because some of her own struggles. But I definitely didn't make one call to talk specifically about Mr. O'Brien. What I'm saying Mr. Wolfe, is I would have made many calls and could this call that she is referring, whatever date that she's talking about, been about other things as well. What I'm saying is I didn't make one call just to talk about Mr. O'Brien and then off the phone. 14:59

164 Q. Okay. That begs another question, Mrs. Brownlee, as part of another call, maybe talking about other things, did you introduce the name of Mr. O'Brien and discuss your concerns about how he was being treated? 15:00

A. I may have discussed the timing, you know, what's happening with Mr. O'Brien and how long it's ongoing, the process, but I didn't get into anything in the investigation. Also, I wouldn't have been talking to Mrs. Gishkori about her role in the investigation because there was other people, many other people, involved in this investigation. So I mean, I may have yes, when I would have been on with her talking about 15:00

other matters, I may have said to her what on earth is going on, how long it's taking, but I didn't get into the detail of the investigation that I can recall. Actually I don't remember it, I don't know if it was '16 or '17 year. 15:00

165 Q. I wish to be fair to you, Mrs. Brownlee, about this, it is an important matter. You have had the opportunity to review the transcript that we have produced for you in respect of Mrs. Gishkori's evidence. You have had an opportunity to reflect upon it. Can I perhaps have 15:01 just a straight answer to the question, did you speak to Mrs. Gishkori about the MHPS process concerning Mr. O'Brien?

A. I may have spoken to her, yes, about the process and the timeframe but I didn't make one deliberate call to 15:01 talk about that.

166 Q. I'll take that to be a firm memory that you did speak to her about the process?

A. I mean, I'm just trying to remember that I may have spoken to her about that. 15:01

167 Q. I'm sorry to put it to you in these terms, but is it a may or is it a definite?

A. It's not a definite because I don't remember the particular call she's talking about, but what I'm saying is when I was on calls, I may have. But I have 15:02 no definite recollection of making a call to Mrs. Gishkori to discuss Mr. O'Brien or the process. I don't remember that.

168 Q. In light of the answer you've given, can you explain or

Urology Services Inquiry

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

44.1 I would like to add information about a telephone call that I inadvertently witnessed as it I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully investigate Mr O'Brien's practice.

44.2 I cannot remember the date of the meeting and I did not make a note of the incident at the time. However, I know that it must have been after the concern in relation to Mr O'Brien's triage practice was identified, as I understood the context of the call without it having to be explained.

44.3 I was in a 1:1 meeting with Mrs Esther Gishkori, Director of Acute Services, in her office on the CAH Administration floor, updating her on my pharmacy responsibilities. The telephone rang and Mrs Gishkori answered it whilst I was in the room. I realised she was speaking to the Chair of the Trust (Mrs Roberta Brownlee) and, while I indicated to Mrs Gishkori that I would leave the room to give her privacy, she told me to stay.

44.4 I could not hear what Mrs Brownlee was saying however I recall that Mrs Gishkori did not say very much in response to Mrs Brownlee during the call and that she became very flustered.

44.5 When the call ended Mrs Gishkori told me that the Chair had asked her to *"leave Mr O'Brien alone"* as he was an excellent doctor and a good friend of hers who had saved the life of one of her friends.

44.6 I remember saying to Mrs Gishkori that I thought that the Chair's behaviour was unacceptable and that she should document the call and speak to the Chief Executive about it, as her line manager.

it was reported to her that a flustered -- it was reported to her by a flustered Mrs. Gishkori that you had sought, through the telephone call, to apply pressure to Mrs. Gishkori with words to the effect of "leave Mr. O'Brien alone". That's a specific memory that Mrs. Boyce has of what was said to her. Can I have your observations on that? 15:13

A. Well, I certainly never said who had saved the life of one of my friends because I don't know who that would be. Secondly, I don't remember ever saying to Mrs. Gishkori, or anyone else, to leave Mr. O'Brien alone. I absolutely deny that. I never said that and would not have said it. I didn't say it, I couldn't have said it because Mrs. Gishkori was one of many involved in the process. Nor would I have said it because I was a highly professional person all of my life and why would I bring my profession into disrepute and get caught in a conversation to say to leave a consultant, who was under an investigation, alone. I never said it. 15:13 15:14 15:14

183 Q. Could I bring you to one final conversation just before we take a break. Mrs. O'Kane, it would appear that you met with her shortly after she took up the reins as Medical Director on 11th January 2019. You have kindly provided the Inquiry with your diary entry for that date. If I could briefly look at that, we can find it at INQ-55501. Just reflecting on where this date stands on the timeline, it is January 2019. 15:15

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

29.1 I refer to my answer for question 28.

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

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

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

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

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

thing I heard about him was that he was a close friend of the Chair of the Trust. I think that put people off, actually, challenging him. You know, what they would have said to me was he made threats back to them about who he was connected with and how he would get them into trouble if they challenged him in any shape or form.

119 Q. Did he ever say that to you?

A. No, he didn't.

120 Q. This is information you heard? 11:26

A. Second-hand, yes. The only experience I had of that was after I started in the Trust in January 2019, in the one -- the first one-to-one I had with Mrs Brownlee she made comment about the fact she felt he had been essentially persecuted by my predecessors, he was an excellent Surgeon and a good man, and she hoped I wouldn't treat him in the same way. 11:27

121 Q. We'll come on to look around the information around Mrs Brownlee. Just before, I think it might be appropriate to take a break, but just before we do that, finally, on that particular section. Would it be fair to say that those concerns that you heard about Mr. O'Brien, or the perception he may have had some sway, either personally or professionally, operated a chill factor in dealing with him? 11:27

A. Yes, it did. Definitely.

MS. McMAHON BL: Chair, I don't know if that's a convenient moment?

CHAIR: Yes. A quarter to 12.

Mr. O'Brien within the process, save that you considered him an excellent surgeon?

A. I may have said he was an excellent surgeon. I mean, I can't remember that, but I can definitely tell you I would not have been critical of former colleagues to a new person coming into post. I mean, telling someone I didn't know not to pursue another, I definitely never did that. I just can't understand how Dr. O'Kane, from a conversation - we weren't very long together, if we met at 4:00, we were certainly out by 4:40 because she has a very busy schedule - how she interpreted that from what I told her, that I just can't understand. 15:25 15:25

193 Q. Yes. We know from Mr. Devlin's evidence that she went from her meeting with you and related the conversation, as she describes there, to him, and he has recalled that in his evidence. Could I just go to her transcript because she elaborates a little on what she says. Her transcript is TRA-01461 and at question 20 -- 120, is it? 15:26

She again is talking about the first one-to-one that she had with you in January in 2019. She made comment about the fact that she felt he had been essentially persecuted by Dr. O'Kane's predecessors; repeats that you expressed the view he was on excellent surgeon and a good man and, "She hoped I wouldn't treat him in the same way". I see you shaking your head; that is something that you appear to reject? 15:26 15:27

A. Mr. Wolfe, I don't think I ever used the word

Comac, Jennifer

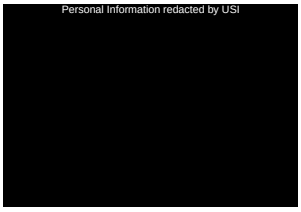
From: O'Brien, Aidan [redacted]
Sent: 10 June 2020 23:26
To: Brownlee, Roberta
Subject: URGENT COMMUNICATION
Attachments: Letter to Mrs. Brownlee 10 June 2020.docx; Letter to Mr Devlin 10 June 20.docx; Letter to Mrs Toal 09 June 2020.docx

Importance: High

Dear Mrs. Brownlee,

I attach a letter addressed to you as Chair of the Southern Health & Social Care Trust Board.
I also attach letters sent to Mr. Devlin on 10 June 2020, and to Mrs. Toal on 09 June 2020.
I would be most grateful if you would bring the contents of these letters to the attention of the non-Executive members of the Board.
I would be grateful if you would acknowledge receipt of this communication.

Aidan O'Brien



Mrs Roberta Brownlee,
Chair
Southern Health & Social Care Board
Trust Headquarters
Craigavon Area Hospital
Portadown
BT63 5QQ

10 June 2020

Dear Mrs. Brownlee,

I attach a letter which I sent to Mrs. Vivienne Toal, Director of Human Resources & Organisational Development, last evening, and a letter which I sent to Mr. Shane Devlin, Chief Executive, earlier today.

The point of both letters was to advise that I had submitted, on 06 March 2020, an application for pension benefits to become payable with effect from 30 June 2020, to coincide with an intent to withdraw from full time employment from that date, and with the intent to return to part time employment from 03 August 2020, having received the assurance of support from colleagues and line managers to do so, and without being informed by the Trust of any impediment to my doing so. I was then advised by telephone on Monday 08 June 2020 that I would not be permitted to return to part time employment in August 2020 due to the 'Trust's practice of not re-engaging people with ongoing HR processes'. If I had been informed of this practice by the Trust, I most certainly would not have submitted any notification of intent to withdraw from full time employment.

You will be aware that the ongoing HR processes to which reference has been made are the Formal Investigation (initiated on 30 December 2016 and completed on 01 October 2018) and a Formal Grievance (submitted on 27 November 2018 and not yet addressed). The Formal Grievance included an appeal of the Outcome of the Formal Investigation. That appeal has not been addressed, 20 months later.

I now feel all the more aggrieved by the Trust's claim to have a practice of not re-employing personnel if there are ongoing HR processes, when the Trust has been primarily responsible for the ongoing status of those HR processes, and not having been informed by the Trust, my employer, of that practice. It is important to note that it is the same Directorate which has failed to have my grievance and appeal addressed after 20 months in contravention of its own policy, the same Directorate which has accepted and processed my intent to withdraw from full time employment, and which would have been cognisant of my intent to return to part time employment as that intent is an integral part of the application proforma, and which would have been cognisant of a

get involved in the finer operational aspects of this situation. The NEDS (without me present) can seek clarity on the process and procedure which I understand John Wilkinson has been doing? Roberta

Please explain:

(i) When were Ms Cormac, Ms Judt, and the CX and NEDs, first made aware of "a possible conflict of interest" given you state they were made aware of it *again* on the 11th of June 2020? Please provide all relevant details and documentation in your answer, to show when they were first made aware of your possible conflict of interest.

Board meetings and from the Register of Interests as detailed previously.

(ii) why you describe your conflict as "*possible"*? What were the circumstances as you understood them to be that did not render your friendship with Mr. O'Brien an *actual* conflict of interest?

It could have been perceived that I had a conflict of interest because of my health history in Urology as a patient and, and my involvement with Mr O'Brien in CURE. I did not want to be involved in any of the finer detail details of the investigation. "possible conflict" I meant I was not involved in this subject matter.

(iii) what you mean by *the "finer operational aspects of this situation"*? How and in what way does that differ from any involvement by you generally in the situation regarding Mr. O'Brien? *I meant I didn't want to know all the details of what was being investigated I honestly never knew the details*

I did not know the specifics of misconduct/clinical capability under investigation, and I did not want to know. My only involvement was at a high level to ask whether the investigation process was being managed properly and dealt with quickly enough. This is all a matter of record.

Comac, Jennifer

From: Brownlee, Roberta
Sent: 11 June 2020 17:52
To: Comac, Jennifer
Cc: Judt, Sandra
Subject: FW: URGENT COMMUNICATION
Attachments: Letter to Mrs. Brownlee 10 June 2020.docx; Letter to Mr Devlin 10 June 20.docx; Letter to Mrs Toal 09 June 2020.docx

Importance: High

FYI see my reply. The CX is aware of this email and John Wilkinson spoken to as he was the NED involved. You are aware of my possible conflict of interest and the CX and NEDs have been made aware of this again today. Therefore I do not wish to get involved in the finer operational aspects of this situation. The NEDs (without me present) can seek clarity on the process and procedure which I understand John Wilkinson has been doing? Roberta

From: O'Brien, Aidan
Sent: 10 June 2020 23:26
To: Brownlee, Roberta
Subject: URGENT COMMUNICATION
Importance: High

Dear Mrs. Brownlee,

I attach a letter addressed to you as Chair of the Southern Health & Social Care Trust Board.
I also attach letters sent to Mr. Devlin on 10 June 2020, and to Mrs. Toal on 09 June 2020.
I would be most grateful if you would bring the contents of these letters to the attention of the non-Executive members of the Board.
I would be grateful if you would acknowledge receipt of this communication.

Aidan O'Brien

Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20200611 - Diary Entry JW and 20200615 - Diary Entry JW and 20200619 - Notes JW

53. On 18th June 2020 I received a telephone call from RB requesting that I telephone AOB, see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20200618 - Diary Entry JWT. This was a strange call as, after a number of minutes, she came back on this request. She explained that this process was exerting undue pressure on AOB and his family. I suggested that I would ring VT and get information on the following:
    a. Grievance – What are the developments and the impediments?
    b. Is there a policy re retirement and returning for 1 day per week pending an HR issue?
    c. Do NEDs / Trust Board / Chief Executive need an update on progress?

    I also intended to seek further advice re the role of the NED.

54. On 16th July 2020 I received a telephone call from VT at 3.30 pm explaining that AOB would be 'retiring' and no longer employed by the SHSCT on the 17th July 2020 (see appendix located in Relevant to CX Chair's Office, Evidence after 4 Nov 21 CX Chair, ref no 77 for John Wilkinson NED, 20200716 - Diary Entry JW. She also explained that there would likely be another case against AOB as further concerns had been identified but this wouldn't require a named/designated NED. She explained that AOB had accepted the conditions (3 of them) in line with MHPS Guidelines Section 1 para 18 on Exclusions and Restrictions and the Trust was seeking AOBs agreement to the following conditions: That AOB would no longer undertake clinical work; that he does not access or process patient information either in person or electronically; and that he would voluntarily undertake to refrain from seeing private patients. However, VT suggested that there could be High Court proceedings regarding the original grievance. VT further explained that JT was still involved in the case but was still on holiday leave. I continued to be exercised as to the role I should play and continued to seek legal advice as to the nature of my involvement in the AOB MHPS case.

55. On 24th September 2020, 14th October 2020, 15th October 2020, 23rd October 2020 and 10th December 2020 the Trust Board was informed of the progress of

in that meeting. What were your views on that?

A. I found that strange, bearing in mind that she had some sort of connection with Mr. O'Brien. She would have been careful at all other times to make sure, if there was a conflict of interest, that it was declared. But that was a reflection that I had after the meeting. I think on subsequent meetings, she did declare an interest and, therefore, did leave. Then whenever it came the telephone calls which I received, that made it even more strange for me. 16:14

327 Q. We have spoken about the meeting that you had with her on the 26th January 2017, and that was sort of at the outset of your appointment. We have also spoken about the telephone call you had with her on the 2nd March 2017. You also set out in your statement that you have received inquiries from her on the 15th February 2018, the 11th September 2018, and then 11th June 2020 and the 18th June 2020. You described the one on the 18th June 2020 as being a strange call. What made you feel that it was strange? 16:14 16:15

A. Initially, Mrs. Brownlee came on and was making requests of me, the detail of which I just can't -- I knew it was to have conversations with Mr. O'Brien to see if this matter, this whole situation, could be expedited more quickly; would I have a chat with Mr. O'Brien. I found it strange because, as Chair of the Trust, I felt that she shouldn't be making those requests of me, and that in terms of the independence of the role, then those were out of order. I think at 16:15

the end of that telephone call, she came back off that position, having listened to me. I can't remember if I noted I wouldn't be doing it. That was the just how I felt about that.

328 Q. Again, in fairness to Mrs. Brownlee, she indicates in her own statement that she didn't try to influence you in any way, but did you feel influenced in any way generally but also in respect of your feelings about what you could or couldn't tell the board? 16:16

A. So, my question on that would be what was the purpose of the telephone call? Really what I am saying, why did she ring up in the first place then, other than to make comments? That's why the word "advocate" doesn't sit easy with me. Influence, does influence mean advocate? I just know initially she wanted me to do something. 16:16 16:17

329 Q. And did it work?

A. No.

330 Q. You don't feel that you would have acted any differently? 16:17

A. Oh, definitely not. I am a fairly independent sort of person and I would judge the situation as I saw it within the rules that are there. No. No.

331 Q. I think, Mr. Wilkinson, you have given us what your reflections are or what way you think, unless you have anything that you wish to add about that? 16:17

A. Just about my role within this investigation, is that what you mean?

332 Q. Yes, things that the Panel might be interested to hear

happening, it could have happened but I don't recall it. Do you understand the distinction?

A. Well, I don't remember having a call on 18th June with John Wilkinson where these areas were discussed. I don't believe that happened. I definitely have no recollection of those areas being discussed. 16:10

221 Q. If his account is accurate, it would seem to suggest where you are able to say to him that this process, this exerting undue pressure on Mr. O'Brien and his family, that would seem to suggest, on one reading, that you are in contact with Mr. O'Brien and his family in order to obtain that kind of information? 16:11

A. Well, I have nothing in my diary, and I have checked it for the Inquiry, in relation to meeting Mr. or Mrs. O'Brien during that year of 2020. I don't remember this call. I believe from my memory it didn't happen, I appreciate how you have explained the distinction between the two. But I would not have known at 18th June about undue pressure on AOB and his family. I don't remember that. 16:11

222 Q. Of course, given your acknowledged conflict of interest which you had communicated just a few days earlier to Mrs. Judt, you would accept that it would be inappropriate for you to be engaging on Mr. O'Brien's behalf in conversations of this nature? 16:12

A. I would agree with you. I didn't do it and I wouldn't do it and I have explained why I wouldn't do it before, so I accept that.

223 Q. Just going back to Mr. Wilkinson's oral evidence at

20 Q. Okay. But you spoke to him?
A. I spoke to him on the telephone, yes.
21 Q. And you spoke to him about him being under pressure in relation to --
A. No, I have no recollection of having a conversation with Mr. O'Brien to even say he was under pressure. I don't remember that call with Mr. Wilkinson and I definitely can say I never discussed anything in relation to his employment issues with Mr. Wilkinson or anyone in the Trust. 10:18
22 Q. If we move on. I want to ask you about the circumstances in which you discovered that the Trust had become concerned about Mr. O'Brien's practice in 2020. If I can turn up your witness statement, first of all, WIT-90873. You recall that, you say: 10:19

"In July/August 2020, I recall the Chief Executive, Shane Devlin, walking into my office and he briefly mentioned that an investigation was ongoing into Mr. O'Brien regarding triage of patients' notes and delays in seeing patients not being followed up. The Chief Executive knew on that occasion that I had been a patient of Mr. O'Brien; it was common knowledge, at the Board, of my past illness. I recall informing the Chief Executive then that I assumed due process and proper investigation was being followed." 10:19

So, that's a conversation with Mr. Devlin that you relate. Could I ask you, and set beside that, the

Nothing came to Trust Board about the practice of Mr O'Brien after the MHPS reference in 2016/2017. I was aware that an investigation had been at that time. I was assured by the Interim CX and Medical Director that the investigation was being processed through proper process. I was not aware of any further details as Mr O'Brien returned to work from my recollection after a short period of absence. This was confirmed by the HR Director as the process concluded. I cannot recall when this was, but my recollection was it was informed to the Board.

In July / August 2020 I recall the CX (SD) walking into my office (again my personal assistant was in the inner office), and he briefly mentioned that an investigation was ongoing into Mr O'Brien regarding triage of patients notes and delays in seeing patients not being followed up. The CX knew on that occasion that I had been a patient of Mr O'Brien, it was common knowledge at the Board of my past illness. I recall informing the CX then that I assumed due process and proper investigation was being followed.

Because of what could have been perceived a conflict of interest I spoke around July / August 2020 in a conversation with Pauline Leeson (NED) to explain that I did not wish to attend Board meetings where Mr O'Brien was going to be discussed – I asked Pauline Lesson as a NED would she Chair the Board meeting when this topic arose about Mr O'Brien. I reminded Pauline of the importance of following due process in a timely manner and asked her to check when Mr O'Brien had his appraisal completed and about his revalidation.

I also asked Pauline to check whether his PA had any comments on lack of administration and if there were any other concerns raised by medical colleagues who worked alongside Mr O'Brien. I questioned what the GPs had prescribed for the same conditions because I knew there was an issue about what medicines Mr O'Brien had been prescribing.
This conversation with Pauline was not for the purposes of advocating on behalf of Mr O'Brien but to protect the Trust and to ensure that due process was being followed in

Comac, Jennifer

From: Wallace, Stephen Personal Information redacted by the USI
Sent: 03 August 2020 10:29
Subject: CONFIDENTIAL - Early Alert - Urology July 2020
Attachments: 31072020 EA JULY 2020 20.pdf

Dear Roberta,

Please find attached an early alert regarding Urology for your information. As per regional Early Alert processes the Board and Department have been provided with the attached information, Dr O'Kane has spoken to the CMO office to advise of the content, the CX has also been made aware.

Please note given the sensitivities and ongoing processes surrounding this issue the internal circulation list has been limited and we ask that this is not shared wider at this stage.

Regards
Stephen

Stephen Wallace
Interim Assistant Director of Clinical and Social Care Governance
Mob: Personal Information redacted by the USI

Early Alert Reference	Sent to Roberta Brownlee	Forwarded to Non-Executive Directors
20200804 EA Aug 2020 02	04th August 2020	04th August 2020
21072020 EA July 2020 16 Update	21st July 2020	27th July 2020
23072020 EA July 2020 17	23rd July 2020	23rd July 2020
2020.07.07 Early Alert UPDATE EA JULY 2020.05	07th July 2020	07th July 2020

Please see:

85. 20200804 E re Early Alert

86. 20200804 E re Early Alert A1

87. 20200727 E re Early Alert

88. 20200727 E re Early Alert A1

89. 20200723 E re Early Alert

90. 20200723 E re Early Alert A1

91. 20200707 E re Early Alert

92. 20200707 E re Early Alert A1

15.4 Prior to the 18th September 2020, the sharing of Early Alerts with Non-Executives other than the Chair was *ad hoc* and appeared to depend on the personal judgement of the Chair. This meant that members of the Board were sometimes unaware of issues that were notified to the Department about the workings of the Trust under the following categories:

a) Urgent regional action;
b) Contacting patients/clients about possible harm;
c) Press release about harm;
d) Regional media interest;
e) Police involvement in investigation;
f) Events involving children;

judgment not to send it on?

A. Well, I am sorry, Mr. Wolfe, I hope I'm allowed to say, I'm equally allowed, I believe, to say that I don't remember seeing that covering email. I'm not allowed to question anything here, I understand that, but I'd like to actually have had better clarity to know when that covering came in and an understanding of it, but I respect it's there, but I definitely don't remember that Early Alert, I mean, and the detail. But the covering email, I don't remember, but I did not withhold it for any deliberate reason to protect Mr. O'Brien and, therefore, I would never have done that in all of my career history and, therefore, I am baffled myself, whilst you ask me that, why, when that came to only me, if it only came to me, I have to see, I have no way of checking did Sandra or Jennifer see it, how none of us then picked up to do anything or to ask Shane Devlin about it, because, to be fair, Shane would have been very quick on that point, too. 10:37 10:37 10:38 10:38

44 Q. So, just so that we are clear - I don't know whether the Trust can help us further to understand your puzzlement - you're anxious to better understand what exactly in terms of the receipt of the email?

A. I don't remember, and it could be just my memory, but it would look then as if it's because it's Mr. O'Brien. I can assure you, I can't remember seeing the covering note that's referred to in the documents from Stephen Wallace. 10:38

45 Q. Just, I am anxious to precisely understand what you are

saying. If we go back to the covering email, it is WIT-101964, and it bears the name "Jennifer Comac" at the top. Does that suggest it was sent to her as your PA?

A. Well, it is sometime back, but that's the way I believe the emails were, at the top like that. But again, having been away, not talking to any of those staff, I have no way of checking that. Did that come in? Yes, we have to assume it came in and all and that. But did it come in to Jennifer and myself? I am just saying, Mr. Wolfe, I am really sorry, I can't remember seeing it, but there was absolutely nothing deliberate on my part to retain this Early Alert to protect Mr. O'Brien and not to share it with my colleagues. And what I am saying is, if I had read that, I would have been asking Shane, what does this mean, the sensitivities, and not sharing with anyone else? I mean, and if I had missed it, certainly Jennifer or Sandra wouldn't have missed it, so -- but, I am sorry, that's how I feel and I must say that to you. 10:39 10:39 10:40 10:40

46 Q. Okay. So, to summarise, what you are telling the Inquiry is, you can't remember receiving this, but if you did receive it, you wholeheartedly agree with the proposition that it should have been sent on to your Non-Executive Directors? 10:40

A. Yes, Early Alerts should have been sent on, yes, and had been always; I don't recall any that never was. And I would also want to tell the Inquiry that there is absolutely no way that I would have held anything to

2.7 The Corporate CSCG office will insert the appropriate reference number, anonymise the content and issue to the DoH/SPPG early alerts mailbox within 24 hours of the initial telephone notification at 3.3. At no time should the completed proforma be forwarded to the DoH/SPPG by anyone other than Corporate CSCG Department staff.

2.8 The report will be issued simultaneously by the Corporate CSCG office to the Chief Executive, the Chair, Directors, Non-Executive Directors, the relevant Assistant Director, the Communications Manager, CSCG staff including the Assistant Director for CSCG and any other relevant officers as deemed appropriate by the Corporate CSCG department.

2.9 The SPPG will provide an update and decision on whether the file can be closed or further follow up is required to the Corporate CSCG department Irrelevant information redacted by the USI within 4 weeks of receipt of Early Alert. Details of this update will be shared with CSCG staff within the relevant Directorate. ** Early Alerts in relation to reduced cover within GP Out of Hours will not be followed and an automatic update of "the issue in relation to reduced cover within GP Out of Hours continues, Early Alerts will continue to be submitted when the Director feels appropriate.*

2.10 There may be occasions when Directors feel it is appropriate to provide updates to the DoH/SPPG on an Early Alert which has already been reported, and where there has been a considerable passage of time since the initial report, with possible Ministerial changes. It may be appropriate, therefore, for the Director (or nominee) to communicate with a senior member of staff in the Department of Health (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional officer or Assistant Secretary) regarding the update. This is not mandatory, however it is considered to be good practice. Any telephone update should be advised to the Corporate CSCG Department to allow for a written update to be provided also.

2.11 It is the responsibility of the Trust to comply with any other possible requirements to report or investigate the event being reported in line with any other relevant applicable guidance or protocols [e.g. Police Service for Northern Ireland (PSNI), Health & Safety Executive (HSE(NI)], Professional Regulatory Bodies, the Coroner etc. This should include compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the proforma should relate only to the key issue and it should not contain any personal data.

The Chair left the meeting at this point.

Dr O'Kane brought to the Board's attention SAI investigations into clinical concerns involving a recently retired Consultant Urologist. Members asked that this matter be discussed at the confidential Trust Board meeting following the Workshop.

The Chair returned to the meeting at this point.

Dr O'Kane drew member's attention to staffing issues within the Infection Prevention Control (IPC) team along with a significant increase in workload due to Covid-19. She also alerted members to particular medical workforce challenges in the GP Out of Hours Service and Acute Physicians.

The Chair thanked Executive Directors for providing updates on important issues within their areas of responsibility.

7. ANY OTHER BUSINESS

None.

The workshop concluded at 12 noon

a conversation with Eileen Mullen as a Non-Executive about the meeting. She expressed her apologies to me, actually, for the way the meeting had progressed.

189 Q. It's fair to say that Mrs. Brownlee had attended the meeting on 27th August?

A. That's correct.

190 Q. When the issue that had been discovered in June, and the lookback and all of that, was, as I've described earlier, alluded to for the first time by reference to the SAIs. She attended that meeting and there was no protests from you, or anybody else, about her attendance at that segment of the meeting?

A. No, I don't believe so.

191 Q. Yes. She has said that she didn't attend that section of the meeting in August, and we'll ask her about that.

A. Mm-hmm.

192 Q. It's not recorded in the minutes that I can see that she stepped out?

A. Okay.

193 Q. Do you have a memory of that?

A. I can't. I mean I do know that Roberta would have stepped out of certain meetings.

194 Q. Yes.

A. I think the term wasn't conflict of interest, the term was because of her emotional connection or something. I can't say whether that was the 22nd, I'd have to refer to the minutes.

195 Q. We know, as I pointed out, that she exited the September meeting?

Comac, Jennifer

From: Brownlee, Roberta [redacted]
Sent: 23 September 2020 07:17
Subject: Fwd: Additional Paper for Confidential Trust Board - Item 7
Attachments: Summary for Trust Board Clinical Concerns 24th August 2020 vt.pdf; ATT00001.htm

NEDs

You are aware I am removing myself from this agenda item. However I still have very serious responsibility for this. The CX and I discussed this yesterday and I asked many Qs. I have read this paper and have noted many areas that need further explained.
This paper references many HR areas. I am would have liked to see in this paper in chronological order of clinical events listed with Medical input as well for ease of reference
Why has an alert/ paper on this area never come to Trust Board before or to Governance - Eileen did this ever or any aspect of it come /get discussed at Governance? You will note an early alert only went to DoH in recent weeks (during CX most leave) sorry don't have actual date at hand.
This is also a Performance issue again did it ever come to be discussed? I am not aware of this coming to performance even in relation to one consultant with such long waiting lists? Or did we miss this ? Have we missed anything on reporting?
At performance was there a comparison of all consultant urologist Individual waiting lists ?
Have we had any concerns raised by GPs Primary Care in relation to long waits and outcomes of referrals?
Have we had any complaints concerns raised by patients Re waiting and pre and post op treatments?
In this paper, I did ask CX, there is NO mention of other consultant urologist colleagues observations, intervening or escalating. Did they ever notice anything and if so what did they do about this.
Also there is no mention of Consultant A performance management by line management clinically? Where is Continuous Professional Development/ Appraisal process and Revalidation mentioned. Again this is all part of clinical supervision in its widest content.
I would be looking to the Medical Director (their deputy at the meeting) to answer these Qs.
When you read this extremely serious situation we are now in as Chair I feel this is coming to Trust Board late. I note time delays and the involvement of many senior Medics. Noting CW initially and then was removed why? Then Dr AK then Dr AC. Would need to know in the time line why so long for intervening from when first noted and the action taken and supervision. Who was supervising medically at AMD/ Medical Director level? There involvement.

I also would like to see what is the immediate learning and what action taken to prevent reoccurrences? How was learning shared.

Have the longest waits of high risk patients been spoken to and now planned to be seen by Urologist as matter of urgency. Again not listed in this paper. I read the first paper yesterday and asked for changes due to Consultant A named in pages and then his name named fully in many others. I have not fully check your attached version now.

Whilst I'm stepping out of this item, not due to any aspect of content included, I still wish to know many of these answers. I will be looking to NEDs To challenge this and have well recorded the answers.

Please be mindful of the BHSCT and their challenges around similar.
We would need to discuss with CX 1:1 meeting at 8.30 due to its seriousness.

Roberta

Sent from my iPad

Begin forwarded message:

would then engage with your Non-Executive Directors in directing their mind on issues of concern to you?

A. Well, first of all, Mr. Wolfe, I rarely, in all of my years, had to ever leave any Board meeting for conflicts of interest. So that's the first thing. This would probably have been one of the first. I mean, secondly, I do not -- well, I respect you saying "leading". I was saying, I've read this paper and here's some of the concerns I would have about it. I believe they were very balanced. They weren't in any way advocating for Mr. O'Brien or asking anybody to do anything in that way. I was saying, 'I have read this paper as the Chair and here are issues that I would want to know, I am sure you'll be asking these, and many other questions'. These Non-Executive Directors were really good people, very knowledgeable, very able. They would have had many other questions. I was not leading them in any way. I was saying here's, for me reading it, what my thoughts are, and I didn't see any harm in that. 11:33

110 Q. Yes. We've gone over, on the last occasion, the Northern Ireland Audit Office 'Guide on Conflicts of Interest', and no doubt you have had an opportunity to reflect on your behaviours around these issues. Thinking and reflecting on these issues, do you still maintain that it was appropriate to engage with your Non-Executive Directors in the way set out in this email? 11:34

A. I understand clearly the Northern Ireland Audit Office.

down to the -- just over the page, he is saying that:

"It has appeared to me that the conduct of Trust management personnel since January 2016 has been a case of purpose replaced by process, conducted improperly. For the avoidance of all doubt, let it be clearly understood that I am disclosing these facts not merely in my own interests as part of my grievance but in the interests of the public in general and these urological patients in particular." 12:23 12:24

So he's suggesting, on one view, that there is a public-interest dimension to his grievance in terms of the safety of patients and patient care in general. You've said that you would not have expected the grievance to come to the Trust Board, but you would expect it would be well-handled by the relevant Director. Is a complaint of this type, pointing concerns at how Trust management are treating patients and the safety of patients, is that something you would expect to be drawn to the Board's attention, even if it comes in the form of a grievance? 12:24 12:24

A. Yes, well, a grievance never would have come to the Board. However, the detail - and I am reading this for the first time - the detail of that, because it refers to many serious matters in relation to delays for patients and what wasn't done, as he told others, that's what -- I have read that quickly, that should have been informed to his Head of Service, his 12:25

Assistant Director and, indeed, his Clinical Lead, should have identified that, whilst all of this is going on, there's patients here that aren't having the service they should and having the care and treatment plan they should have, and, yes, where the Director didn't know how to manage that, whatever way that was, that detail of patient safety should have come to the Board. I am just talking about grievance generally don't come to the Board. But that grievance, if it raised such issues as I've seen, for the first time, then that definitely, when patients were at risk and patients not being seen, for all of the reasons as described, whoever was involved, definitely should have come to the Board so that we would have been aware of that, but I was never told that. But I'm assuming, maybe wrongly, that the Medical Director knew that and others were looking into it. But as I read that, it's referring that it wasn't dealt with, but it should have been. Those were very serious matters about patients. 12:25 12:26 12:26

131 Q. In terms of Mr. O'Brien's grievance, it certainly had the impact of delaying and ultimately preventing a conduct hearing, which was the intention of Dr. Khan following the MHPS. So the grievance process ran and ran and didn't ultimately reach a hearing until shortly after he retired. Do matters like that ever receive the attention of the Trust Board, or is that operational and it is not the kind of thing that's drawn to your attention? 12:26 12:26

A. Well, firstly, I have no recollection of anything of

Southern Health and Social Care Trust

Mr A O'Brien
Personal Information redacted by the USI

26 October 2020

Dear Mr O'Brien

RE: Stage 1 Grievance

Please find attached panel response to your Grievance heard on 30 July and 7 August 2020. In view of the level of complexity in this case, we decided that a report format was appropriate.

These documents are communicated with you electronically and to ensure an appropriate file size for transmission, your submissions of November 2018 and July 2020 have not been included with this report.

The attached report covers all the elements of our decision making. However, you raised some general issues in your correspondence to the grievance panel (8 October 2020) on which I would like to respond on behalf of the panel here.

1. It is correct that all new documents not previously seen by you have been provided.

2. There are no outstanding matters of factual dispute beyond those discussed. There are, as described in my letter of 17 September 2020, opinions and/or comments expressed by others and the grievance panel has considered these in its deliberations.

While we regret the delays on our part, we have taken care to balance the timing of our formal response with the need to understand the complex information which covered a significant timeframe. Any further distress caused by the additional weeks it took for us to prepare our final response was not intended and we are appreciative of your patience.

I would advise that you have the right to appeal against this decision. In order to do so you must write to the Director of Human Resources and Organisational Development, Mrs Vivienne Toal, Southern Health & Social Care Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ, within seven working days of receipt of this letter, clearly outlining the grounds for your appeal.

Yours sincerely

Personal Information redacted by the USI

Shirley Young
HSC Leadership Associate (Chair of grievance panel)

Aimee Crilly

From: [redacted]
Sent:
To:
Cc:
Subject:
Attachments: [redacted]etter to AO'B 26.10.20.pdf

[redacted]

Begin forwarded message:

From: "Parks, Zoe" [redacted]
Subject: Grievance Outcome
Date: 26 October 2020 at 14:39:57 GMT
To: "michael.obrien [redacted]

As promised, please see attached Grievance outcome which I am sending on behalf of the Panel.

Zoë Parks
Head of Medical HR
Southern Health & Social Care Trust
Tel: [redacted]
Mob

for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department [redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

CONFIDENTIAL

RESPONSE TO STAGE 1 GRIEVANCE

MR A O'BRIEN
CONSULTANT UROLOGIST (Retired)

November 2018 (additional submission July 2020)

26 October 2020

STAGE 1 GRIEVANCE PANEL
Dr Aisling Diamond, Deputy Medical Director, SHSCT
Shirley Young, HR Associate, HSC Leadership Centre (Chair)

CONTENTS

1 BACKGROUND

1.1 Mr O'Brien raised a Grievance on 27 November 2018 supplemented by written papers/evidence. In advance of the Stage 1 grievance hearing, he made an additional written submission on 23 July 2020 relating to post-November 2018 events and additional information available to him regarding the matters in his November 2018 submission.

1.2 Dr Aisling Diamond and Shirley Young were asked to form a Stage 1 grievance panel under the Trust's Grievance Procedure. Mr O'Brien had retired by the time the grievance was heard on two occasions, 30 July and 7 August 2020.

1.3 Given the volume of papers, information presented and the need to speak to a range of employees referenced, the panel sought, and Mr O'Brien agreed to, an initial extension of the usual response time limits. It was agreed that the time limit for the panel's formal response be extended by three weeks until Friday 28 August 2020.

1.4 As a consequence of diary availability and the challenges noted at 1.3 above, Mrs Young wrote to Mr O'Brien on 25 August 2020, changing the time limit for the panel response to Friday 18 September 2020. This deadline was subsequently altered on two further occasions before the deadline for this report of Monday, 26 October 2020.

1.5 The matters raised in this grievance have been extensive and complex and they cover a significant timeframe and therefore the panel's formal response is in report format rather than the usual letter style.

1.6 Summary of Stage 1 Grievance

1.6.1 Mr O'Brien set his concerns in the following summary provided at the outset of his written submissions:

- *"the acts and omissions of senior managers within the SHSCT re handling of concerns about my administrative practices. I believe that the actions and failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment* **(Section 2 of this response)**

- *Additionally, I am formally lodging a grievance against the decision dated 1 October 2018 of the Case Manager to classify the case as a case of misconduct"* **(Section 3 of this response)**

- In July 2020, he added other matters, namely, *"delayed handling of my grievance", "additional concerns (i) events before so December 2016, (ii) An Unfocused Trawl, (iii) Private Patients ", Duty of clinical care update"* **(Section 4 of this response)**

1.7 This response will deal with each in turn.

2 ***"The acts and omissions of senior managers within the SHSCT re handling of concerns about my administrative practices. I believe that the actions and failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment."***

2.1 To achieve an of understanding of the detail and chronology of Mr O'Brien's concerns we have organised our response in this section as follows[1]:

- March 2016 to December 2017 **(Section 2.2)**
- January 2017 to June 2018 **(Section 2.3)**
- July 2018 to November 2018 **(section 2.4)**

2.2 **MARCH 2016 TO DECEMBER 2016**

2.2.1 This time frame reflects the period between a formal letter to Mr O'Brien on 23 March 2016 and the decision to launch of the formal Maintaining High Professional Standards[2] (MHPS) investigation in December 2016.

2.2.2 **The facts established are set out at 2.2.3 to 2.2.23 below**

2.2.3 Mr Mackle, then Associate Medical Director, held a meeting with Mr O'Brien on 23 March 2016. Mr Mackle was accompanied by Martina Corrigan, Head of ENT & Urology services. A letter summarising the issues from the meeting was given to Mr O'Brien signed by Mr Mackle and Ms Trouton, Assistant Director of Acute Services (Appendix 1).

2.2.4 Mr Mackle and Mrs Corrigan are of the view that Mr O'Brien ought not to have been in any doubt that the reason for meeting him and, supplementing it with a letter, was to seek a response from Mr O'Brien to the concerns raised and, for his part, he would provide comment on the issues raised from his own perspective.

2.2.5 The letter communicated that action from Mr O'Brien was required in all aspects of the letter and not just about patient notes. The following is an extract from the letter of 23 March 2016 (Appendix 1):

> You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

2.2.6 There is no evidence of any response with a commitment of plan or any comment from Mr O'Brien between March 2016 and the Oversight

[1]These differ from how Mr O'Brien organised and presented his information but in the panel's opinion it reflects how it organized its decision making.

[2] *Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS* (Department of Health, Social Services & Public Safety - November 2005

Committee meeting on 13 September 2016. Neither is there any evidence of active follow-up from managers who had the authority to do so.

2.2.7 Mr Mackle stepped down from his role as Associate Medical Director on 30 April 2016. It was not until 13 September 2016 that the concerns about Mr O'Brien were a subject of a meeting of the Oversight Committee (see notes at Appendix 2) and were now escalated from direct line management. A decision was made at this meeting that an informal MHPS investigation should be launched.

2.2.8 Mr O'Brien expressed concern at his grievance that proper MHPS provisions had not been followed when Mr Mackle and Mrs Corrigan met him in March 2016. He says in his November 2018 submission:

> The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*".
>
> The Trust Guidelines describe how concerns about a Practitioner should be handled. Paragraph 1.5 provides that:
>
> > 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 to 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 the underlying problem
>
> If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. Yet **the Trust Guidelines were completely ignored**.

2.2.9 Mr O'Brien also logged his concern about the Trust's response to National Clinical Assessment Service (NCAS)[3] advice and input in September 2016 (Appendix 3). He considered that the Trust's information to Dr Fitzpatrick to be inaccurate and these inaccuracies informed Dr Fitzpatrick's response.

[3] The NHS National Clinical assessment Service is at the time of writing became known as NHS Resolution – Practitioner Performance Advice. For the purposes of this response, we have retained the name NCAS throughout.

2.2.10 Ms Gishkori (then Director of Acute Services) was part of the Oversight Committee. Following the meeting on 13 September 2016, Ms Gishkori asked Dr Wright to amend the plan so that her clinical management team could have the opportunity to put in an alternative plan of their choice in place (Appendix 2 Notes of Oversight Committee 13 September 2016 and Appendix 4 email trail Miss Gishkori to Dr Wright):

On 15 Sep 2016, at 14:40, Gishkori, Esther <Personal Information redacted by the USI> wrote:

Dear Richard and Vivienne,
Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.

Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
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 try their strategy first.

I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

2.2.11 Mr Colin Weir (who took up the role of Clinical Director in June 2016) developed a plan with Dr McAllister and set the details out in an email of 16 September 2016 (full email trail at Appendix 5). The following is an extract sent by Mr Weir to Dr McAllister:

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

2.2.12 The next meeting of the Oversight Committee was on 12 October 2016 (notes are contained at Appendix 6). The following extract is relevant:

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for [redacted] in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

2.2.13 By September 2016, Mr O'Brien is correct that no one had spoken to him about the intentions of any new plan from Mr Weir and Dr McAllister, supported by Ms Gishkori.

2.2.14 It is a fact therefore that, since March 2016, there had been no practical inputs to respond to the concerns from any manager or Mr O'Brien. This means that Dr Wright, Medical Director, and the Oversight Committee, by 12 October 2016, had no assurance that matters were progressing in any planned way or that there was no ongoing risk. The committee had intended that these circumstances would be reviewed at its October 2016 meeting.

2.2.15 It is correct that Mr O'Brien made arrangements with Ms Corrigan about the return of files from his home.

2.2.16 It is also a fact that, at the time of the meeting on 12 October 2016, Mr O'Brien was scheduled to have surgery in November 2016 and would be on sick leave for a period thereafter.

2.2.17 The Oversight Committee decided to keep the matters relating to Mr O'Brien under review. Its next meeting was held on 22 December 2016 (notes attached at Appendix 7).

2.2.18 At this meeting, the following extract is relevant:

Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

2.2.19 The new fact at this meeting on 22 December 2016 in relation to Mr O'Brien was that there was a Serious Adverse Incident (SAI). The committee was also provided with further update on more detail of

alleged administrative deficiencies – patient notes allegedly being held at Mr O'Brien's home and a number of undictated clinics (see notes at Appendix 7).

2.2.20 On consideration of these updates, the Oversight Committee made the following decision on 22 December 2016 (Appendix 7):

Consideration of the Oversight Committee
In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

2.2.21 Mr O'Brien drew the grievance panel's attention to discrepancies in the notes of this meeting. These were that (i) the notes referred to a "formal" MHPS process being in place in September 2016 and (ii) that the decision on 22 December 2016 planned a meeting with Mr O'Brien on 30 December 2016.

2.2.22 The reference in the notes of 22 December 2016 is incorrect when it states "*formal*" - the notes of 13 September 2016 clearly state that an "*informal*" process was in place (see Appendix 2). Mrs Toal, Director of HR, who attended the Oversight Committee meetings confirmed that an informal process was in place and the note in December is an error. The author of the notes, Mr Gibson, also acknowledges this as an error.

2.2.23 Mr O'Brien's told us that the meeting planned with Dr Wright on 3 January 2017 was brought forward at this request to 30 December 2016.

2.2.24 **The panel findings on issue at 2.2 are set out in 2.2.23 to 2.2.46 below**.

2.2.25 There was no evidence before the panel that Mr O'Brien responded to or engaged in the concerns raised by Mr Mackle in March 2016 and summarized in his and Ms Trouton's letter of 23 March 2016 (Appendix 1)

2.2.26 Mr O'Brien expressed a view at the outset of his grievance hearing that it was disproportionate to move from the March 2016 meeting with Mr Mackle to formal MHPS processes in December 2016. This is not correct and there were attempts to move the concerns forward. These were delayed within the Directorate (2.2.10 to 2.2.20 above). We accept that Mr O'Brien was not aware of them at the time.

2.2.27 In relation to Mr Weir's input, Mr O'Brien suggests that any delay in speaking to him was because Mr Weir had been told (possibly by Mr O'Carroll) that he should not speak with Mr O'Brien. The possibility of this "instruction" only exists in the context of a decision to move to a formal investigation in December 2016 when it would have been inappropriate for Mr Weir to discuss the process with Mr O'Brien outside of his assigned role of Case Investigator. It does not explain any absence of contact by Mr Weir as Mr O'Brien's Clinical Director before then.

2.2.28 Mr Mackle clearly stated in March 2016 that there were matters of concern about Mr O'Brien's practice. It was, in our opinion, in Mr O'Brien's interests, to participate in examining this matter or refuting it for the record.

2.2.29 Mr O'Brien also stated there was an agreed plan with Mrs Corrigan relating to his return of files. This is correct but, in our opinion, this was an agreement about the process of returning charts that ought not to have been at Mr O'Brien's home. This is separate from any investigation into how and why the files were at this home and his explanation of that. The fact that some files were returned did not replace the need to seek Mr O'Brien's response to them being at his home in the first place.

2.2.30 Based on the emails at 2.2.10 and 2.2.11 above (and at Appendices 4 and 5), it is the panel's view that Dr Wright and the Oversight Committee had a reasonable basis for assurance in September 2016 that Ms Gishkori and her team would have actions in place on which progress could be reported at the next meeting of the Oversight Committee in October 2016.

2.2.31 However, this did not prove to be the case. Miss Gishkori updated the Oversight Committee on 12 October 2016 that no communication had taken place with Mr O'Brien:

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for [redacted] in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

2.2.32 By December 2016, nine months had passed since Mr Mackle's intervention in March 2016. There were now significant matters of context:

- the absence of assurances about progress made to manage and attend to the concerns
- the Serious Adverse Incident
- the information provided on the quantum of the alleged performance matters.

It is our opinion that Dr Wright, Medical Director, and the Oversight Committee were entitled to seek and escalate the required assurances. In the absence of active compliance by any party with earlier Oversight Committee plans in September and October 2016 in response to concerns going back to March 2016, we find that it is reasonable and by this stage, proportionate, that this matter was escalated to a formal MHPS investigation.

2.2.33 With regard to Mr O'Brien's comments on the advice from NCAS and its context in Trust decision-making, we established the following:

- NCAS wrote to the Trust on 13 September 2016 following a telephone discussion with Mr Gibson about Mr O'Brien on 7 September 2016 (Appendix 3). The Oversight Committee met on 13 September 2016 and there is no factual evidence from the notes whether the NCAS letter was presented or discussed at the meeting or Mr Gibson's summary of it.

- An extract from Dr Fitzpatrick's letter states:

> The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.
>
> We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.
>
> With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.
>
> The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

2.2.34 Mr O'Brien suggested that this advice from NCAS is not appropriate because it is factually incorrect, i.e. he says that no such action plan existed with which he had to comply. It is correct that Mr O'Brien was not "*warned*" on 23 March 2018, but he was made aware of the concerns about the charts and was asked to demonstrate his commitment and participate in a plan. If we accept that Dr Fitzpatrick believed Mr O'Brien

to have been "warned" then his advice in that context being that the Trust could "take immediately disciplinary action" in relation to the charts at home that advice may have been correct. The Trust did not take any immediate disciplinary action. Therefore, there is no detriment in practice to Mr O'Brien and we have no evidence that Dr Fitzpatrick was misled.

2.2.35 The implication is that Dr Fitzpatrick was wrongly informed on purpose. This relates to the matters initially discussed at 2.2.3 to 2.2.5 above and to the letter of 23 March 2016 at Appendix 1.

2.2.36 To set this in context we refer again to Mr Mackle and Ms Trouton's letter of 23 March 2016 in which they also stated:

> We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

> You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

2.2.37 It is not correct that Mr O'Brien did not know that he had to respond. He did not do so. It is our opinion that the NCAS advice was delivered in the context of the issues facing the Trust. The use of the word "warned" in Dr Fitzpatrick's letter is misleading as there was no official warning in place but as stated above, Mr O'Brien was aware of the criticisms of him that needed a response.

2.2.38 With regard to Mr O'Brien's comments on policies and procedures, it is our opinion that the MHPS process is the appropriate mechanism to address matters like this about a doctor's alleged performance especially where no actions planned earlier had been implemented.

2.2.39 Mr O'Brien expressed a view in his grievance that there were viable alternatives to MHPS processes during 2016[4]. This was the case in March, but by October 2016 nothing had been implemented. It was not Mr O'Brien's fault, that matters were not progressed at this point by the clinical team. They were not progressed. This lead credibly to Dr Wright's decision on 22 December 2016 to move matters into a formal MHPS process.

[4] Section 2.3.2 (page 8) of Mr O'Brien's November 2018 submission

2.2.40 Mr O'Brien is correct about errors in the notes of the Oversight Committee meeting of 22 December 2016 (see 2.2.21 to 2.2.23 above). It is our view that the suggestion that the meeting notes were not formally written up until later has credibility. On balance, we consider it to have been the case that the notes, were not written up immediately, given the Christmas and New Year breaks. They were, in our opinion likely to have been written up in the current typed format much later.

2.2.41 It is our opinion that neither the errors nor the date the notes were written did anything but reflect the outcome of the meeting and the decision to progress to a formal MHPS investigation. Dr Wright, by the time of 22 December 2016, was then minded to formalise the Trust response regarding the alleged concerns about Mr O'Brien. He could only reasonably have escalated this from an informal stage already in place so the reference to "formal" is indeed an error.

2.2.42 Mr O'Brien told us that the meeting with Dr Wright to discuss the decision to move to the formal MHPS process was initially arranged for 3 January 2017 and it was brought forward to 30 December 2016 at Mr O'Brien's request. It is factually correct that on 28 December 2016, Mrs Toal wrote to Ms Hainey in HR asking her to accompany Dr Wright at a meeting with Mr O'Brien "this Friday" (30 December 2016). We cannot say with certainty whether a January 2017 date had already been discussed direct with Mr O'Brien and he had subsequently sought to change it by 28 December 2016 when Mrs Toal wrote her email. Either way, we see no significant issue to our findings here of impact on Mr O'Brien other than it may have been he who instigated the meeting being brought forward. We agree that it was better to do so rather than meet on his first day back at work.

2.2.43 The Trust Guidelines state that a role of the Oversight Committee is to "monitor progress"[5]. It is reasonable that, having not being assured of informal progress at its September and October 2016 meetings and then the December 2016 meeting, and with the potential of additional concerns arising from a Serious Adverse Incident, the Committee endorsed a formal approach with immediate effect.

2.2.44 It is concerning that the December 2016 notes did not reflect earlier "informal" action correctly in retrospect. In the context of our comment above at 2.2.43 about the legitimacy and reasonableness of progressing the concerns formally, it is clear from Dr Wright's actions following the meeting that invoking a formal process was the clear plan.

[5] Section 2.5 *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance* (September 2010)

2.2.45 Dr Wright's roles as Medical Director and General Medical Council Responsible Officer include significant responsibilities to the public about a practitioner's fitness to practise which should not be underestimated. This is interlinked with his role in the MHPS Framework to deal with performance concerns.

2.2.46 We note the level of non-compliance with the Oversight Committee's plans by managers/clinicians and also Mr O'Brien's non-engagement or his motivation to enquire about the concerns raised with him, even to dispute them. We have no evidence of his input in this regard. **It is our decision that by the time matters were discussed on 22 December 2016 at the Oversight Committee, the opportunity for a viable informal approach no longer existed and the Committee endorsed the decision to address them formally under the MHPS Framework. This was a reasonable response in accordance with processes and the grievance is not upheld.**

2.3 JANUARY 2017 TO JUNE 2018

2.3.1 This timeframe reflects the period covering the formal MHPS investigation until it reported on 21 June 2018. It also relates to Mr O'Brien's submission that there were variations to Trust policies and procedure to the extent that his contract of employment was breached.[6]

2.3.2 **The facts established are set out at 2.3.3 to 2.3.14 below**:

2.3.3 It is Mr O'Brien's contention that policies and procedures were not applied correctly in his case and this was a breach of his contract on the part of the Trust.

2.3.4 As well as his contract of employment, he also referred to:

- *Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS* (Department of Health, Social Services & Public Safety - November 2005 *(referred to as MHPS Framework or MHPS in this response)*

- *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance* – September 2010 *(referred to Trust guidelines in this response)*

2.3.5 We are in no doubt that the MHPS Framework is the overarching document and contractual process that applies to handling concerns about doctors employed in Health & Social Care (HSC) in Northern

[6] Section 2 heading on page 3 of Mr O'Brien's November 2016 submission

Ireland. It is our opinion that it cannot be set aside nor an alternative put in place because to do so would be outside of national terms and conditions of service.

2.3.6 Having read and considered the Trust Guidelines, our opinion is that it describes the operational processes within which the MHPS Framework is applied. It is not an alternative to the MHPS Framework nor is it a substitute for the primary process to attend to concerns about doctors.

2.3.7 Mr O'Brien is correct that there are gaps in the Trust's compliance with the requirements of these processes.

2.3.8 In relation to the stated timescales, MHPS sets out very precise requirements:

- *"the Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days*[7]*"*

2.3.9 From the date of the Case Conference on 26 January 2017 which confirmed that there was a case to answer, to the date of submission of Dr Chada's (Case Investigator) report on 12 June 2018 and then issued to him on 21 June 2018, 73 weeks had passed.

2.3.10 We therefore examined this timeline and any explanations for the passage of time. A timeline summary for the formal investigation provided by the investigators is included at Appendix 8. We also shared this document with Mr O'Brien and considered his comments on it.

2.3.11 To assist us in understanding the grievance aspects relating to procedural delay of the MHPS investigation itself, we also set out a calendar for 2017 and up to June 2018 (Appendices 9 and 10).

2.3.12 Mr O'Brien referred to other matters. At page 4 of his November 2018 grievance submission he said that "... *the Trust was always aware that the volume of work was overwhelming. It is clear from the witness statements provided in the investigation my administrative backlog was known to Trust managers for a very considerable periods of time*". This is the case and the backlog in Urology was known.

2.3.13 In his grievance, Mr O'Brien also expressed his concern that excessive time was spent in "*scoping*" the investigation and its terms of reference. He also said that there is a lack of clarity on what "*scoping*" is

[7] Paragraph 37 on page 10 of MHPS

2.3.14 Mr O'Brien further expressed his concern to us that on the one hand, the investigation was delayed significantly but when it came to his required response, the Trust was disinclined to extend any flexibility on the timeline for his responses.

2.3.15 **The panel findings on issues at 2.3 are set out in 2.3.17 to 2.3.44 below**

2.3.16 Having stated that MHPS Framework is the underlying contractual process, we are of the view that whatever practical challenges there are in its operation, its overarching intention is to resolve matters in a timely way, even before the Framework in invoked. It is our view that Mr O'Brien's lack of engagement and absence of evidence of him working with his employer before the formal MHPS investigation commenced contributed significantly to the decisions that later escalated the process to a formal MHPS context. With professional and meaningful engagement input from Mr O'Brien it is plausible that events may never had needed to be escalated and all the later delays in the investigation subsequently avoided.

2.3.17 The initial plans in March 2016 were not implemented by any clinical manager. It is credible that, when Mr Mackle ceased to be Clinical Director, that progression of the concerns raised with Mr O'Brien were not prioritised after Mr Mackle ceased his role as Clinical Director. Mr Haynes became the new Associate Medical Director, and Mr Colin Weir became the new Clinical Director in June 2016. Mr Weir intended to design a new local approach by September 2016 (2.2.11 above). There is no evidence that, as the Directorate representative at the Oversight Committee, Ms Gishkori had taken steps to check the status of Mr Mackle's intervention before she attended the 13 September 2016 meeting of the Oversight Committee or ensure that responsive action was taken to the later plan she proposed to Dr Wright as an alternative in September 2016 (2.2.10 above). This allowed Mr O'Brien's non-engagement to go unchecked and give rise further delay

2.3.18 Mr O'Brien's suggested that the letter to him of 23 March 2016 did not require his attention. We do not consider this to be the case as the letter's closing remark (Appendix 1), clearly describes the action required of Mr O'Brien. He presented no evidence of his response to the request made of him and therefore progress was stalled:

> You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

2.3.19 Mr O'Brien also states that this letter of 23 March 2016 fell outside the required Trust Guidelines.

> If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored.**

2.3.20 We do not accept this. From the notes of the meeting of the Oversight Committee an "*informal*" MHPS approach was only commenced in September 2016, not before. It is our opinion that in March 2016, Mr Mackle's intention was to draw Mr O'Brien's attention to alleged performance issues and this was in advance of entering an MHPS process. This does not make the letter itself informal and we can understand, from our consideration of the later delays, that Mr Mackle may have considered the letter to be best followed up in writing at this time.

2.3.21 We did not understand the term "scoping" that Mr O'Brien told us the Trust said that it was carrying out before the terms of reference were issued. A "*Screening Process*" is referenced in the Trust Guidelines at its Appendix 1 on page 8 of the document. This may have been what was meant by "scoping" but we cannot be clear. In any event the time taken was lengthy, irrespective of definition.

2.3.22 Mr O'Brien commented in his grievance on the letter of 23 March 2016 (see 2.2.8 - the first extract) saying that "*it does not refer in any way to a suggestion of misconduct or even to a performance issue*".

> The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*".

2.3.23 This comment is unfounded as the letter indicates in the second sentence in the extract, from the 23 March 2016 letter, below that there is an issue:

> We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you

The letter goes on to describe these and give examples (Appendix 1).

2.3.24 Mr O'Brien stated that concerns should be raised with a practitioner's clinical manager and he is correct[8]. Mr Mackle fell into this category as Associate Medical Director.

2.3.25 Mr O'Brien is also correct that there are no notes of earlier interventions with any other clinical manager before the meeting with Mr Mackle on 23 March 2016. However, is not unusual in practice that managers of all professions choose to express early concerns before they escalate them and decide that no note is necessary and that this is proportionate at this point. This is a judgment call. On balance, and in the context of everything we have examined in this grievance process, it is our view that it is credible that Mr Mackle may have been aware of previous discussions about these matters and there was no evidence of attention to them by any party, so he have decided to hold the meeting.

2.3.26 On balance, we do not consider it likely that Mr Mackle chose to have this meeting and issue a letter as a first response within the department and it was credibly an escalation of earlier unrecorded concerns. We consider that such an approach would have been fair to Mr O'Brien in the first instance. However, after 23 March 2016, Mr Mackle had ensured that Mr O'Brien could not indicate his unawareness of the alleged concerns and that there remained an opportunity to resolve these.

2.3.27 When MHPS is invoked it is a clear process and it states that when even deciding if an informal process should be applied it says:

- *"... 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 NCAS or Occupational Health Service (OHS) where necessary)* (MHPS paragraph 15 page 10)

2.3.28 In March 2016, it is our finding that Mr Mackle discussed this matter outside of the MHPS Framework and matters had not yet got to the stage of being discussed within the context of the MHPS extract above. There is no detriment to Mr O'Brien in doing this. He could reasonably be said to have neglected to take advantage of this opportunity to engage in early resolution or provide actual assurances that there was no basis to the concerns by becoming involved in active dialogue with a genuine view to this resolution.

2.3.29 Mr O'Brien stated at page 8[9] of his November 2018 submission that *"MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather*

[8] Trust Guidelines section 2.2.
[9] Second paragraph at top of page 8 of Mr O'Brien's November 2018 submission

than solely through formal action". The implication is that in not doing so, The Trust has breached his contract.

2.3.30 We do not find this to be the case. First, this assumes that the matters were clinical in nature, and there is no common ground on this matter. Dr Khan, Case Manger under MHPS, considers this to be a matter of conduct unrelated to clinical skill (this is covered in Section 3 of this report). Secondly, any resolution, clinical, or otherwise under MHPS assumes a principle of co-operation. It is our view that Mr O'Brien was persistent in his non-engagement in any process that suggested any potential for shortcoming in his role. He only engaged when he had concerns about the Trust and in this regard, he expects timely responses from them that were not reciprocated by him. Mutuality is key. In there being no common ground and, in the absence of Mr O'Brien's acknowledgement that there was the potential for an issue to be addressed from the Trust's perspective, it is not solely a failure or breach on the Trust's part that any "*remedial action*" could succeed in the one-way process that existed.

2.3.31 We noted from Mr O'Brien's submission in his November 2018 submission[10] that his workload pressures were known (to the Trust) and we inferred that he meant this backlog to be mitigation of the position in which he found himself. Our findings on this are:

- Mitigation of allegations and findings in an investigation which leads to a disciplinary process, is for that formal process and only for a disciplinary panel to consider

- In our opinion, mitigation will be only relevant where allegations are factually correct and serves to provide an explanation and context.

- None of these above is relevant to the grievance process and we cannot comment on whether it may have featured or not in a disciplinary hearing that never happened. If it had taken place and Mr O'Brien was subsequently dissatisfied with the outcome and mitigation was not considered in his view, that would be appropriately raised in a formal appeal within the disciplinary process. It is not something that this grievance panel can decide upon.

2.3.32 The MHPS Framework sets out specific timescales for the Formal investigation process i.e. *"The Case Managers should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days."* In our calendars at Appendices 9 and 10, we have set out information collated from the investigators and from Mr O'Brien in his written submissions, at the grievance hearing and in his response to seeing the panel comments sent to us. The key dates on which issues are of most significant dispute to Mr O'Brien,

[10] Page 4 section 2.3 of his November 2018 submission Mr O'Brien states in reference to his workload, *"This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming."*

(after he had seen the investigators' timeline) are set out in the table below **(NB the next section relates to the timeframe for the formal MHPS investigation only that is relevant to this Section, 2.3):**

	DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
A.	**January to March 2017**	*"It took approximately 10 weeks before the Terms of Reference were even provided to Mr O'Brien. This delay is unconscionable"*	There was a significant delay in providing the Terms of Reference to Mr O'Brien.
B.	**April, May & June 2017**	*"there is no explanation provided as to why the Case Investigator took 3 months to interview all of these witnesses. It does not feel reasonable ..."*	*Dr Chada said in response "... three months were required to interview people given I had a busy full-time clinical job and had duties and responsibilities in my tole as Associate Medical Director." She does point out that that they attempted to meet with Mr O'Brien having heard from witnesses but their statements had not been returned, "but having better understood the issues which we wished to raise with Mr O'Brien"*
		"Mr O'Brien did not receive any of the statements made by these witnesses by the time of his first interview on 3 August 2017.... The complete list was only provided to Mr O'Brien on 28 September 2017"	
		"Mr O'Brien did not meet once with Dr Chada to discuss the investigation even though it is stated in MHPS to be best practice for the Case Investigator to meet with the practitioner first."	This is not a requirement.

	DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
C.	**14 June 2017, 19 June 2017 & 5 July 2017**	*"We are concerned that these entries give the impression that Mr O'Brien was in some respects causing delay to the investigation … It proved impossible to schedule the meeting in late June to 1 July as scheduling commitments had already been made and it was agreed to schedule the meeting for 31 July and then subsequently 3 August 2017."*	Investigators pointed out that Mr O'Brien said in his own email of 19 June 2017 (00.33 hrs) that "I do not know how important that it is that I meet with Dr Chada around that time, rather than later" (29 and 30 June 2017) Investigators were able to be flexible and agreed to meet on Mr O'Brien's suggested date of Saturday, 1 July 2017. However, in his email of 19 June 2017 (15.05 hrs), Mr O'Brien said *"I believe it would be better to defer meeting until end of July 2017, and so would prefer not to have to cancel appointments, clinics etc … Therefore, I propose that we could meet Dr Chada on any day during the week beginning Monday 31 July 2017."*
D.	**3 August 2017**	*"Mr O'Brien had none of the evidence that the investigator was referring to and really only had the terms of reference and a summary of the initial concerns to respond to. The fact that this important evidence had not been provided 8 months after the beginning after the beginning of this investigate* (sic) *was astonishing …"* *"in order to mitigate the effects of this, it was necessary to arrange a second meeting."*	This is correct and is referenced in **A.** and **B.** above. The panel agreed to the second meeting.

	DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
E.	**6 November 2017**	*"The draft of the first statement [11] had been provided to Mr O'Brien on 28 October 2017 and Mr O'Brien had expressed concerns about the accuracy of these notes and wished to make amendments."*	
		"During the meeting, Mr O'Brien did advise that November and December were going to be very busy periods at work and he was going through the completion of his appraisal. It was agreed that the additional matters from the meeting of 6 November 2017 would be addressed in the new year."	Evidence from the timeline shared by the investigators and (Appendix 8) demonstrates that this is correct. They agreed that he would not have to participate in November and December 2017.
F.	**15 February to 2 April 2018**	*"There was no further communication with Mr O'Brien until 15 February 2018. The entries[12] again to give the impression that Mr O'Brien was causing delay to the investigation, it is not recorded that Ms Hynds only provided the draft of the second statement of 6 November 2017 on 4 March 2018."*	From the timelines discussed in relation to **E.** above and below. There were more than just Mr O'Brien's comments on a statement to be provided.
		"Mr O'Brien stated on 22 February 2018 that he would not be able to provide his commentary until 31 March 2018. Ms Hynds responded by insisting on receiving the remarks by 9 March 2018. ...This was impossible given Mr O'Brien's heavy commitments at work... He endeavoured throughout March 2018 to complete his commentary and ultimately the commentary was provided on 2 April 2018 following the Easter weekend."	This timescale is correct and not disputed. During this period, Mr O'Brien missed further extensions of the deadline on five further occasions (see comment at **F.** below and calendar at Appendix 10)

[11] Refers to the meeting held on 3 August 2017
[12] "*entries*" means the comments made by investigators on their investigation timeline

	DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
G.	**Other remarks from Mr O'Brien**	*"There is significant imbalance in the way that time is provided to the investigators on the one hand and Mr O'Brien on the other. Statements from witnesses in March to June 2017 were not provided to Mr O'Brien until October and November 2017. This delay is not considered noteworthy by the investigators. However, where Mr O'Brien required extra time, this became a subject of criticism."*	See **F.** above and our comment in **F.** below.
		"It is also worth noting that the Investigator's report was not in fact completed for almost another three months when finally provided on 21 June 2018. Mr O'Brien then provided his full response by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."	This is factually correct and not disputed. See section 2.4 which covers this period.

2.3.33 The investigators provided us with emails having been sent Mr O'Brien's comments of 25 September 2018. These ae in Mr O'Brien's possession as they were emails to him and he responded to them. It is our intention to eradicate the sense of imbalance between the parties' perspectives and we have set out our findings on each of the above points as follows:

A. The Terms of Reference can only be formally finalised when the preliminary enquiries have been completed and the case conference held (in this case it was held on 26 January 2017). It was therefore almost seven weeks, not ten, before Mr O'Brien was provided with these on 16 March 2017. However, this is too long and we would expect that some early consideration of these could have taken place in preparation and thereby finalised much more quickly. There has been much confusion about preliminary drafts of terms of reference (a draft had been prepared for Dr Wright's information for the December 2016 meeting), screening and scoping. None of which explains the delay on an input that is clearly the responsibility of the Trust. We do not find evidence whereby we could safely conclude that this was motivated by some sense of purposeful dishonesty and was unscrupulous as is suggested by Mr O'Brien's contention that it was "*unconscionable*". This is his view but it is not our finding.

B. We accept Dr Chada's explanation that this investigation had to be managed within her job plan and her roles. It is credible that in trying to seek diary availability with Mrs Hynds and then each of the 13 witnesses was challenging. It is not that unlike what Mr O'Brien said about his commitments preventing him from moving onwards. The difference from Dr Chada's perspective is that we have evidence of active progression on her part despite diary availability. Although, regrettably, over a period of 13 weeks, there is evidence that Dr Chada did set aside time and did meet all 13 witnesses by 5 June 2017.

While we find the overall period to do this took much longer than it ought to have, it cannot be categorised as impacting negatively on the investigation. The witnesses were essential to the investigation and there were actions happening over the period, albeit at a frequency that was not ideal where all the parties could have protected time from their jobs. This is not possible while maintaining services.

C. Investigators made attempts to meet Mr O'Brien in late June. While not attributing "blame" to Mr O'Brien, it was he who was unable to comply with the dates suggested. We understand that, like Dr Chada, these are related to work priorities. At one point, Mr O'Brien offered to meet on Saturday, 1 July 2017. Then in view of his work activity and the unavailability to his son (who accompanies him), he finally offered 31 July 2017. It is likely that Mr O'Brien's job plan was not made up entirely of Direct Clinical Care activities throughout July 2018 and we noted that he offered no alternative date in July, only 31 July 2017.

We observed that, immediately Mr O'Brien suggested 1 July 2017, a Saturday, and the investigators facilitated it, Mr O'Brien cancelled it saying, *"it would be better to defer the meeting to later in July."* We are concerned that Mr O'Brien was not demonstrating the sense of urgency that he now complains was lacking by the investigators.

D. See responses in **A.** and **B.** above.

E. Mr O'Brien asked for the process to be delayed for 2 months in November and December 2017 and we acknowledge that the investigators agreed with this proposal. However, the next actions sat also with Mr O'Brien (he wished to make comments on statements and his own inputs). Regrettably in his comment above these actions would *"be addressed in the new year".* Mr O'Brien suggests that all the remaining actions were on the part of the Trust, but he did have actions i.e. comments on witness statements. He was reminded of this on 22 February 2018 and as well as expressing some confusion on his actions, he stated *"I have not had time to attend to the process since November 2017".*

It suggests that Mr O'Brien considers that he has considerable authority to manage the timeframe of the MHPS investigation himself which is not the case. It is our opinion that both parties share responsibilities for progression.

Having said that, we fully accept that the pace required in such a complex investigation needs to be set by the investigators. However, date provision and availability need to be reciprocated and it was not until 2 April 2018 that Mr O'Brien submitted the outstanding inputs.

It is our finding that Mr O'Brien was not inclined to progress and he controlled this by his inaction. We observe with the benefit of hindsight now in 2020, that there ought to have been a more assertive management of Mr O'Brien even thought he would have been unlikely to have welcomed that. If he considered he "*had no time*" and valued faster progression of the matter with the certainty he expressed at his grievance, he ought to have asked if space could be created to allow him to progress his inputs.

Regrettably in this section we saw a similar pattern to the wasted time frame from 23 March 2016 onwards, i.e. Mr O'Brien appears to withdraw and then takes the view that he had no role in that delay.

F. Mr O'Brien appears to suggest that there were no actions from him in the period up until February 2018. This is not the case (see **E.** above and in the table). Having requested, and the panel agreeing, to exclude November and December 2017 for any actions from him, there was no curiosity from Mr O'Brien about how he could progress without a draft of his statement which he then said was essential to his comments. It appears to us that he lost interest in the investigation during this time and it was only when Mrs Hynds reminded him about outstanding matters on his part that he expressed that he had "*misunderstood the arrangements and commitments ... and wondering why there had been such a long delay.*"

In considering this grievance in its entirety, we do not find the lack of understanding on Mr O'Brien's part to be credible.

By February 2018, the required inputs were Mr O'Brien's i.e. to expedite his comments back to the Trust and to do this by 9 March 2018. Mr O'Brien was not able to meet this deadline because of work commitments. Mrs Hynds extended the deadline to 16 March 2018 and, on no receipt of comments on 16 March 2018, extended it to 26 March 2018. When this deadline was also missed by Mr O'Brien, it was extended to 29 March 2018 and finally to 30 March 2018. Mr O'Brien submitted his comment on 2 April 2018. These were available to the investigators on 4 April following the Easter Bank Holiday break.

Mr O'Brien stated at **F.** in the table above that this delay was because of him not being provided with his draft statement until 4 March 2018. We do not accept that Mr O'Brien was unable to reflect on matters raised at the meeting on 6 November and earlier, on 3 August 2017. While we do not need access to the investigation report and notes of meetings with Mr O'Brien (we cannot re-investigate the formal MHPS investigation itself), we do not find it credible that there were no matters put to him at

the meeting on which he needed to reflect and comment on. This is because he had sought time to do so. We do not accept that his response was solely dependent on him seeing how his statement was reflected to him in writing at the later date.

G. It is correct that from submitting his factual response to the draft report on 10 July 2018 to Dr Khan, the Case Manager, Dr Khan's decision on the report was not completed until 28 September 2018.

Our comments in relation to this timescale are made in Section 2.4 below (where we deal with this period until Mr O'Brien lodged this Grievance on 27 November 2018.

2.3.34 In our analysis of the facts relating to the timescale of the investigation itself, it took 350 working[13] days to complete. We then considered what accounted for the passage of time beyond what may have been considered reasonable at the outset of the investigation. In the way that it is not automatically appropriate to categorise all contribution to the extended timescale on Mr O'Brien's part as a "delay", it is also not appropriate to define all time on the part of investigators as a "delay" either. Both parties will have had to spend necessary time in their own analysis and that has to be understood as a necessity.

2.3.35 In this regard, our attempt to quantify and understand the passage of time in this case is not intended to pejorative, it is purely factual. Our view on the parties' contributions is set out separately from 2.3.36 below. It is essential in any investigation that there will be a certain amount of time that inevitably passes between scheduled interventions, for example, to read and comment on documents, set up meetings with witnesses, write up notes and draft documents. The blocks of time in the 350 working days that could not have been reasonably predicted or expected in this case are as follows:

- An investigation meeting scheduled for 28 June 2017 was changed at Mr O'Brien's request. A new date of 1 July 2017 was agreed but was immediately changed to 31 July 2017. This date was again, at Mr O'Brien's request, moved to 3 August 2017. This period accounted for 25 working days (7% of the 350 working days).

- The first formal MHPS meeting with Mr O'Brien was held on 3 August 2017 and it was 65 days later, on 3 November 2017, that the second meeting was held (18%)

- Mr O'Brien requested that he be allowed on concentrate on his workload and prepare for his appraisal in November and December 2017. From the date of his meeting with investigators on 6 November

[13] All weekends and bank/statutory holidays have been removed.

2017 (when he requested this) until end of December 2018, 76 working days were unused (21%).

- To make his response to matters on 6 November 2018 as he indicated he wished to do, from January 2018 until his response on 2 April 2018, a further 63 days had passed (18%)

- From receipt of the information from Mr O'Brien on 2 April 2018 until the Case Manager issued her report on 21 June 2018, there are 55 working days (15%)

2.3.36 These figures are concerning and we do not suggest that some of these could have definitely been shortened to one or two weeks. However, 79% of the time of the investigation was waiting for the next event to take place. It is our opinion, with the benefit of hindsight, that the setting up of the second meeting with Mr O'Brien ought to have been accelerated. It is also our opinion that Mr O'Brien's changes to dates and non-submission of responses was tolerated beyond what now looks reasonable. We understand that request for more time like these are commonly facilitated to avoid any unintended unfairness to Mr O'Brien in this case. But such facilitation did not have the intended effect of minimising any sense of unfairness and now in this grievance it has contributed to the extension of the timeframe and subsequent criticism of the Trust. This will always be a dilemma and matter of judgment for the Trust on a case by case basis because there is potential criticism either way. From our perspective, having seen significant lack of active engagement from Mr O'Brien from March 2016, more pressure on him to respond may have been appropriate.

2.3.37 We note that having conceded to three extensions to a deadline from 9 March 2018 otherwise the Case Investigator would proceed. She did not ignore his submission on 2 April 2018. Although late and she could have ignored it from a technical perspective, she did not.

2.3.38 It is our finding therefore that while there were periods of time that the Trust should have minimized, they did afford considerable leeway to Mr O'Brien.

2.3.39 On his receipt of the MHPS report on 21 June 2018, Mr O'Brien had to comment on the document and the facts. He sought more time to do so and the Trust did not willingly afford more additional time. It was an already protracted matter and a few days would not have had significant impact. However, they may have been mindful of his missing deadlines in the past and were disinclined to give more than a short extension.

2.3.40 Returning to the original catalyst for these processes, by December 2016, matters had lain in abeyance since March 2016, with no one, including Mr O'Brien, responding actively to the concerns raised about him. Mr O'Brien, as well as the Trust, had an interest in these matters

being closed one way or the other. At the point where this grievance was heard this year, Mr O'Brien continued to express a view that there is no basis for the allegations and he remains confident of that. However, from the Trust's perspective these matters could not be set aside just because of the passage of time. Mr O'Brien ought also to have attended to them and presented his evidence in the structured context of the conduct panel arising from the MHPS investigation which, by the time of the grievance, was the procedural way forward.

2.3.41 Mr O'Brien chose to present evidence to us at his grievance hearing that not only had the allegations no basis, in his view, the MHPS investigation report was flawed. This is outside of the remit of a grievance panel. The correct place for such evidence and challenge of the MHPS report is at the conduct panel hearing that was planned. Mr O'Brien presented much information to us and a high level of dispute of the content of the investigation in a forum that cannot appropriately deal with them. We explained that this was likely to be the case when we spoke to him at the grievance hearing. On balance, we consider that in not participating in a disciplinary process, Mr O'Brien has delayed proper attention to the matters and resolve them in line with the processes set out in the national terms and conditions and contractual arrangements. We are also critical of the Trust where they did not inform Mr O'Brien regularly about delays and revised timescales on their part.

2.3.42 Mr O'Brien has an entitlement to raise a grievance where he has a dispute with his employer. We note, however, the need for reciprocity in an employment contract and thereby Mr O'Brien has a responsibility to engage with and participate in his employer's use of formal processes too. This is the basis on which MHPS is intended to operate. Therefore, while we find delays existed in the investigation on the part of the Trust, when considered in their totality, they did not dispense with the expectation that Mr O'Brien ought to have complied with Trust processes at the outset In March 2016 and then during and when the lengthy investigation was completed in June 2018.

2.3.43 **Mr O'Brien's grievance about the duration of the investigation is not upheld. It does breach the 4 weeks for the investigation and the further 5 days for submitting the report. However, we consider that the "*exceptional circumstances*" do exist. While not excusing all delays in the process, on balance, there is a level of credible explanation for some of them. It does not in our view reach the threshold of a breach of his contract.**

2.4 JULY 2018 TO NOVEMBER 2018

2.4.1 The facts established are set out at 2.4.2 to 2.4.4 below

2.4.2 This timeframe reflects the period from Mr O'Brien's comments on the Case Investigator's formal MHPS report made on 10 July 2018, to the Case Manager's decision of 28 September 2018 and until Mr O'Brien lodged his grievance dated 27 November 2018 (20 weeks)

2.4.3 In section 2.3.33 above in the table at section G, we note Mr O'Brien's comments:

Mr O'Brien then provided his full response[14] by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."

2.4.4 In his grievance Mr O'Brien set out his concerns about the delay in setting up his grievance and receiving documents he sought from the Trust.

2.4.5 The panel findings on issue at 2.4 are set out in 2.4.5 to 2.4.7 below

2.4.6 In speaking to Dr Khan, Case Manager, we do consider that he clearly reflected on the report and the MHPS options. However, we find that the 21 weeks he took to do so unnecessarily protracted the process. After such a lengthy investigation, Dr Khan's response where no exchanges with Mr O'Brien were required, should have been expedited. It required Dr Khan's analysis and reflection on the facts in the report and how it fitted with MHPS decision-making. **The timescale is not explained sufficiently but Mr O'Brien's grievance is not upheld to the extent that it breached his contract of employment.**

2.4.7 From Mr O'Brien's receipt of the Case Investigators decision on 28 September 2018 until he lodged his Grievance on 28 November 2018, the period is not overly long and he appears to have used the time to prepare his lengthy submission. This is not relevant to the grievance

[14] to the Case Investigator's MHPS report received on 21 June 2018

3 ***"I am formally lodging a grievance against the decision dated 1 October 2018 of the Case Manager to classify the case as a case of misconduct."***

3.1 **The facts established are set out in 3.2 below**

3.2 The MHPS Framework states that there is a range of decisions open to the Case Manager, in this case, Dr Khan, when he has examined the report. These are set out at paragraph 38 page 12 of the Framework:

> 38. The report should give the Case Manager sufficient information to make a decision on whether:
>
> - no further action is needed;
> - restrictions on practice or exclusion from work should be considered;
> - there is a case of misconduct that should be put to a conduct panel;
> - there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
> - there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
> - there are serious concerns that fall into the criteria for referral to the GMC or GDC;
> - there are intractable problems and the matter should be put before a clinical performance panel.

3.3 **The panel findings on issue 3 are set out at 3.4 to 3.6 below.**

3.4 We spoke to Dr Khan as part of the grievance process and we also read his Case Manager's Report. We find that Dr Khan's response at that time was in line with the MHPS Framework requirements in 3.1 above and we are satisfied that he gave due consideration to the information available to him.

3.5 We are also satisfied that Dr Khan gave due consideration to whether a conduct or clinical approach was appropriate. At the time that he made this decision, it was reasonable for him to conclude that the matters before him were not concerns about Mr O'Brien's clinical skill or aptitude and a conduct approach was appropriate.

3.6 **This aspect of Mr O'Brien's grievance is not upheld.**

4 In July 2020, Mr O'Brien added other matters, namely, "*Delayed Handling of my Grievance*", "*Additional Concerns (i) events before 30 December 2016, (ii) an unfocused trawl, (iii) private patients*", and Duty of clinical care update"

4.1 *Delayed Handling of my Grievance*

4.1.1 **The facts established are set out in 4.1.2 to 4.1.4 below.**

4.1.2 Mr O'Brien's grievance is dated 27 November 2018 and the grievance hearing (day one) was held on 30 July 2020. This process took 103 weeks. We considered the period from November 2019 to April 2020 (say 25 weeks) when, because of industrial action and then the early days of the Covid-19 pandemic, much of the usual HR activity was set aside. However, even setting these events aside which significantly distracted from normal business, it still took approximately 78 weeks to arrange this grievance and we needed to examine this timeframe.

4.1.3 The Grievance Procedure states that the Trust will "*arrange for a grievance panel to hear the grievance normally within 20 working days or as soon as reasonably practicable. If it is not possible to hold the hearing within 20 working days the employee must be provided with an explanation for the delay by the Human Resources Department.*"

4.1.4 In looking at the facts of this we considered the correspondence between Mr O'Brien and the Trust in his quest for additional information.

4.1.5 **The panel findings on issue 4.1. are set out at 4.1.6 to 4.1.17 below.**

4.1.6 There is no requirement in the grievance process, once invoked by the employee, to supply him/her with ongoing information. It is enough that they set out their concerns and it is then for the panel to seek out all evidence. While it is useful for the employee to provide some of the information in his own possession, he/she is not expected to do the research and trawl for other information. This is provided for in the Grievance Procedure, *"the Grievance Panel may also additional information/clarification in the pursuit of resolution of the grievance."*[15]

4.1.7 Unusually, for a grievance, Mr O'Brien told us that he had *"set out proposed actions that would allow the grievance process to commence with a first meeting ..."*[16]. It is our understanding that it is the Trust who sets out the timetable and manages the process.

[15] Paragraph 6b of the Grievance Procedure
[16] Contained in Mr O'Brien's supplementary comments to the panel on 25 September 2020

4.1.8 Mrs Toal, Director of Human Resources, acknowledged receipt of Mr O'Brien's grievance on 14 December 2018 and in it she referred to *"arrangements being finalised to consider your grievance".* She also referred to information sought earlier by Mr O'Brien and that the Trust would endeavour to release it to him by 21 December 2018 and, if that were not possible, she would update him.

4.1.9 Further communication continued for some time:

- The Trust provided some documents by 22 December 2018 and sought an extension to provide the remaining papers by 11 January 2019

- Mr O'Brien and Mrs Toal exchanged further correspondence between 12 March 2019 and October 2019 when information was delivered to Mr O'Brien's secretary.

4.1.10 Our finding is, having examined correspondence, that the requests for more information by Mr O'Brien were considered by the Trust to be a condition of his attendance at his own grievance. In his letter to Mrs Toal of 12 March 2019 he says (when he requests further information for the Medical Protection Society - MPS:

> *"Following its receipt, you will be advised whether any further information is to be requested, and/or whether the grievance is to be amended."*

4.1.11 On 3 June 2019 Mr O'Brien wrote to Mrs Toal on 3 June 2019. In the first paragraph he refers to information connected to his grievance *"has still not been provided".* In Mrs Toal's response of 3 June 2019 (Appendix 12), she states *"once this information has been provided to you, I will be commencing your grievance process immediately to avoid further undue delay. Any additional requests for information or amendment to your grievance can be done so as it is progressed.".*

4.1.12 We have no evidence to indicate that Mr O'Brien did not agree that it was the case that his attendance at a grievance was conditional upon his receipt of information as set out, nor have we evidence that he corrected this if he did not agree.

4.1.13 We have no evidence to indicate that Mr O'Brien sought assurances about his grievance for the avoidance of any doubt that he may have had after the correspondence from Mrs Toal on 3 June 2019. We have experienced in this grievance Mr O'Brien's attention to dates and correspondence and we do not consider it likely that he believed that the Trust was the party that had not progressed the matter.

4.1.14 It is our opinion that the process stalled. Mr O'Brien sought extensive information and the Trust understood that until he no longer had outstanding information requests, he was not prepared to attend his grievance.

4.1.15 As before it is our opinion that after Mr O'Brien was provided information on 30 October 2019, the industrial action faced by all HSC employers and subsequently the Covid-19 pandemic while not related directly to Mr O'Brien's case, had the effect of all HSC HR departments having to redirect attention urgently to matters beyond normal business.

4.1.16 Finally, in this section, Mr O'Brien contended that a decision by the Medical Director to refer him to the General Medical Council (GMC) was related to him advising the Trust that he had instructed legal representation. Mr O'Brien provided no evidence on this beyond timing alone. It is therefore not possible for us to conclude safely on that basis that he is correct.

4.1.17 While there are significant delays in setting up Mr O'Brien's grievance, we have been able to explain them, at least to some extent, by examining the correspondence. We inferred from Mr O'Brien's submissions that this was deliberate on the part of the Trust and we do not find this to be the case. Unlike most other grievances, Mr O'Brien's had the attention of the Director of HR and she personally attended to much of the responses to him. **This aspect of the grievance is not upheld.**

4.2 Additional Concerns

(i) Events before 30 December 2016

4.2.1 All matters on which we wish to comment are included in section 2.2.

(ii) An unfocused trawl

4.2.2 Mr O'Brien pointed out that included in Dr Lynn's (NCAS) letter to Dr Wright of 29 December 2016, *"the investigation should not be an unfocused trawl".* **(Appendix 11)**

4.2.3 It is not possible nor is it appropriate for a grievance panel to reinvestigate the matters contained in the formal MHPS investigation. This includes seeking whether the matters considered by the investigators were relevant or not. This would have required some investigation on our part and judgment of the matter to decide whether the inclusion of any item was appropriate. While we would have preferred to attend to and address all matters raised by Mr O'Brien, it is beyond our remit in this matter. This is only appropriate in the context of the disciplinary hearing that was anticipated and Mr O'Brien

presenting his evidence there and his view that he has no case to answer.

(iii) Private Patients

4.2.4 Again, it is not possible nor is it appropriate for a grievance panel to reinvestigate the matters subject to the formal MHPS investigation. By doing otherwise in relation to private patients would have required re-investigation on our part and we cannot substitute the MHPS and disciplinary processes with our analysis or judgment on this. This is only appropriate in the context of the disciplinary hearing that was anticipated and Mr O'Brien presenting his evidence and his view that he has no case to answer in this regard

4.2.5 **In relation to the items in 4.2 (i) and (ii), these are beyond the panel's remit.**

4.3 Duty of Clinical Care

4.3.1 On examination of these matters, these are outside of the remit of a grievance panel because they raise concerns of a clinical nature.

4.3.2 For this reason, these will be passed on by Dr Diamond to the Trust's Medical Director, Dr O'Kane, to alert her formally to them and to decide on what, if any, next steps may be required.

5 Data Protection

5.1.1 Although not set out as a separate matter in his grievance, Mr O'Brien described some confidential matters that had been included in information sent to him that was in breach of Data Protection and confidentiality requirements. On examination, this appeared to be the case.

5.1.2 There are separate formal processes to deal with such alleged breaches and the panel forwarded details of these to the Trust so that they could be addressed within those policy requirements and dealt with, if required.

6 SUMMARY CONCLUSIONS

6.1 **Overall, we do not find Mr O'Brien's grievance upheld.**

6.2 Mr O'Brien referenced the MHPS Framework on many occasions in his submissions and at the grievance hearing. We consider that there were issues on the part of the Trust and Mr O'Brien himself that compromised the effective operation of the Framework the way it was intended. However, even though the Trust moved beyond timescales to the extent that they were, in effect, set aside, Mr O'Brien did not actively participate in an early resolution at the outset. This may have obviated the need to the subsequent investigation.

6.3 In the period after 23 March 2016 when Mr O'Brien did not respond, we are aware that it was not his fault that he did not know about the plans suggested by Ms Gishkori in September 2016. However, none of this takes away from the responsibilities of the Medical Director to have concerns examined and the time for informal resolution had passed by 22 December 2016.

6.4 As stated above, the delays in adhering to the timeframes in MHPS, while challenging and, from experience, seldom adhered to, the duration on this occasion was a concern. We also consider that the timeframe from submitting his grievance to it being heard was the subject of delay. We have explained in the sections above how we have taken account of some on the factors contributing to the timescales.

6.5 It is also our view that there were examples where Mr O'Brien's apparent focus solely on his own perspective contributed to the challenges facing his employer in attending to their concerns at an earlier stage which in turn created the escalating context that he faced. These delays, and the context in which they existed, did not mean that his contract was breached.

6.6 This also links to the fact that Mr O'Brien summarised the overall detriment to him by the time he got to his planned retirement i.e. not being able to stay beyond retirement because HR issues were remained without conclusion. This again is factually correct but our finding is also set in the context of his choices as set out in 6.2 above.

6.7 The correct way of addressing his views or veracity of the matters set out in the MHPS investigation report after Dr Khan decided it should go to a conduct panel, was for Mr O'Brien to participate. In line with the procedures he then could present his own evidence to a panel to support his view and have it fully considered. Mr O'Brien did not do this, he sought a grievance instead, some of which we were unable to consider because it was relevant to the purpose of the conduct panel and we could not re-investigate the MHPS investigation.

6.8 We find that, had Mr O'Brien met his obligations to engage meaningfully from March 2016, there was a chance of resolution and support to him, if it was required, outside of the formal MHPS process that ensued.

6.9 In relation to the concerns about Mr O'Brien which were the catalyst for this whole process, there are three key facts:

- the absence of a response from Mr O'Brien as requested
- the lack of active follow up within the Directorate to Ms Gishkori's alternative plan in September and October 2016
- the potential for an SAI

6.10 In examining these, it was, in our opinion, reasonable that Dr Wright was not assured of a viable alternative to the formal MHPS process in December 2016. All earlier intended interventions outside of the formal MHPS process had failed to deliver progress, let alone closure.

6.11 Overall, we inferred a suggestion that the actions and, in other cases, lack thereof, were deliberate and designed to cause distress to Mr O'Brien. We did not find evidence to support that level of allegation. However, we do appreciate that any formal employment process brings an inevitable anxiety to the parties.

***** END *****

APPENDICES

APPENDIX 1

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. **Untriaged outpatient referral letters**

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. **Current Review Backlog up to 29 February 2016**

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. **Patient Centre letters and recorded outcomes from Clinics**

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Personal Information redacted by the USI

Eamon Mackle
Associate Medical Director

Personal Information redacted by the USI

Heather Trouton
Assistant Director

APPENDIX 2

Extract from notes of Oversight Committee 13 September 2016

Oversight Group H.
13 Sept 2016

AOB:

from EM & HT.

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. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

No mention of SG conversation with NCAS on 07.09.16 & NCAS advice.

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

Personal Information redacted by the USI

Handwritten notes are panel member's (Shirley Young) during deliberations

APPENDIX 3

NHS
National Clinical Assessment Service

NI office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN
Tel: Personal Information redacted by the USI
www.ncas.hscni.net
Jill.Devanney@hscni.net

PRIVATE AND CONFIDENTIAL
Sent by email only

13 September 2016

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

Relevant regulations/guidance:

- Local procedures;
- General Medical Council Guide to Good Medical Practice;
- Maintaining High Professional Standards in the Modern HPSS (MHPS).

Review date:

7 October 2016.

As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely

Personal information redacted by the USI

Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

APPENDIX 4

Mallagh-Cassells, Heather

From: Wright, Richard
Sent: 16 September 2016 13:44
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Hi Vivienne. I had a meeting scheduled with Francis and Esther this am and this topic came up. Esther agreed in principle to provide the info requested and to ensure that there was a documented meeting with Me OR outlining the implications of not getting this sorted within 3 months. Francis was keen to pursue this a under those circumstances but not to let it run further than the three months if still non compliant. Happy to discuss further. Richard

From: Toal, Vivienne
Sent: 16 September 2016 08:57
To: Wright, Richard; Gishkori, Esther
Subject: RE: meeting re Mr O'Brien.

Esther – I am conscious you go off on leave today; how do you wish to handle Richard's request below?

Vivienne

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther < [redacted] wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> 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 try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

1

Handwritten notes are panel member's (Shirley Young) during deliberations

I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.

Happy to discuss any time and I will of course brief the oversight committee of any progress we make.

Many thanks
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted Personal Information redacted by the USI Personal Information redacted by the USI

APPENDIX 5

From: Carroll, Ronan [mailto [redacted]
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.
Importance: High

Personal Information redacted by the USI

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely

7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AIMD Education and Training | Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer Personal Information redacted by the USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
.....and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by the USI Mobile Personal Information redacted by the USI
Personal Information redacted by the USI

APPENDIX 6

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Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:

N/A.

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was [redacted] likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

APPENDIX 7

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

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.

Dr O'Brien was scheduled to return to work on 2nd January following a period of [redacted] leave, but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Highlight is panel's (Shirley Young)

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

APPENDIX 8

4. Timeline of the Investigation

The dates below outline the key dates in respect of the background to the concerns and the management of the concerns under the Maintaining High Professional Standards (MHPS) Framework:

March 2016

On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns. **(Appendix 1)**

Four broad concerns were identified:

- Untriaged outpatient referral letters

It was identified at that time that there were 253 untriaged referrals dating back to December 2014.

- Current Review Backlog up to 29 February 2016

It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- Patient Centre letters and recorded outcomes from clinics

The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.

- Patient's hospital charts at Mr O'Brien's home

The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Mr O'Brien advised the review team he did not reply

to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016

Mr O'Brien was off work [redacted] from 16 November 2016 [redacted] and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr Richard Wright in late December 2016. As a result of the concerns raised with Mr O'Brien on 23 March 2016 and the serious concern arising from the SAI investigation by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

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

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016

Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken. Mr O'Brien was accompanied by his wife, Mrs Personal Information redacted by O'Brien. **(Appendix 2)**

A letter was issued to Mr O'Brien in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Mr O'Brien that Dr Ahmed Khan had been appointed as Case Manager for the case and Mr Colin Weir was identified as the Case Investigator. **(Appendix 3)**

A note of the 30 December 2016 meeting was shared with Mr O'Brien. **(Appendix 4)**

03 January 2017

Mr O'Brien met with Mrs Martina Corrigan, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr Wright on 30 December 2017.

20 January 2017

During the period of the 4 week immediate exclusion period notified to Mr O'Brien on 30 December 2016, Mr Colin Weir wrote to Mr O'Brien to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Mr O'Brien to state his case and propose alternatives to formal exclusion. **(Appendix 5)**

23 January 2017

On 23 January 2017, Mr Weir wrote to Mr O'Brien seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to Mr O'Brien but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017

The meeting between Mr Weir and Mr O'Brien took place on 24 January 2017 with Mrs Siobhan Hynds, Head of Employee Relations present. Mr O'Brien was accompanied to the meeting by his son, [redacted] O'Brien.

A note of the meeting was shared with Mr O'Brien. **(Appendix 6)**

26 January 2017

In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Mr O'Brien's immediate exclusion and to determine if, from the initial preliminary enquiries, Mr O'Brien had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting. **(Appendix 7)**

At the case conference meeting, it was determined by the Case Manager, Dr A Khan that Mr O'Brien had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as exclusion was not deemed to be required. Instead, Mr O'Brien's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Mr O'Brien verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017

A letter was sent to Mr O'Brien on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work. **(Appendix 8)**

9 February 2017

Mr O'Brien attended a meeting with the Case Manager, Dr Ahmed Khan on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs Siobhan Hynds and Mr Michael O'Brien were in attendance at the meeting. The action plan was accepted and agreed with Mr O'Brien at the meeting. **(Appendix 9)**

20 February 2017

Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Mr O'Brien was unable to return to work [redacted] He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

January and February 2017

During January and February 2017, Mr O'Brien made a number of representations to Dr Richard Wright, Medical Director and Mr John Wilkinson, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr Colin Weir should step down as Case Investigator prior to the commencement of the formal investigation. Dr Neta Chada, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017

The terms of reference for the formal investigation were shared with Mr O'Brien along with an initial witness list. **(Appendix 10)**

April, May and June 2017

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

Name	Job Title	Date
Mrs Martina Corrigan	Head of Service	15 March 2017
Mr Michael Young	Consultant Urologist	23 March 2017
Mrs Claire Graham	Head of Information Governance	03 April 2017
Mr Ronan Carroll	Assistant Director	06 April 2017
Mr Eamon Mackle	Consultant Surgeon	24 April 2017
Mr Anthony Glackin	Consultant Urologist	3 May 2017
Ms Anita Carroll	Assistant Director	19 May 2017
Mr Colin Weir	Clinical Director	24 May 2017
Mr Mark Haynes	Consultant Urologist	24 May 2017
Ms Noeleen Elliott	Personal Secretary	24 May 2017
Mrs Helen Forde	Head of Health Records	05 June 2017
Mrs Heather Trouton	Assistant Director	05 June 2017
Mrs Katherine Robinson	Referral & Booking Centre Manager	05 June 2017

14 June 2017

Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified. **(Appendix 24)**

19 June 2017

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

05 July 2017

Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern. **(Appendix 25)**

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Mr O'Brien had been furnished to him. It was agreed that a further meeting date would be arranged for this purpose once all information had been provided. Mr O'Brien's responses to the remaining terms of reference were gathered.

16 October 2017

A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017

A second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. **(Appendix 26)**

At the meeting of 6 November 2017, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018

By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore this was queried with Mr O'Brien and an update sought.

22 February 2018

No response was received and a further email reminder was sent to Mr O'Brien on 22 February 2018. On the same day, Mr O'Brien responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

In view of the timeframe to date, Mr O'Brien was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018

Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Mr O'Brien requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018

No comments were received from Mr O'Brien.

29 March 2018

A final opportunity was provided to Mr O'Brien to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018

No comments were received from Mr O'Brien.

2 April 2018

Comments on the statements from the meetings of 3 August and 6 November were received from Mr O'Brien. Mr O'Brien also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

In the interests of concluding the investigation report without further delay, all comments from Mr O'Brien have been considered and are appended with the relevant documents.

APPENDIX 9

2017

January

M	T	W	T	F	S	S
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16	17	18	19	20	21	22
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February

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27	28					

March

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April

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May

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June

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31						

August

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28	29	30	31			

September

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October

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30	31					

November

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December

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		27	28	29	30	31

KEY		Trust actions		Mr O'Brien

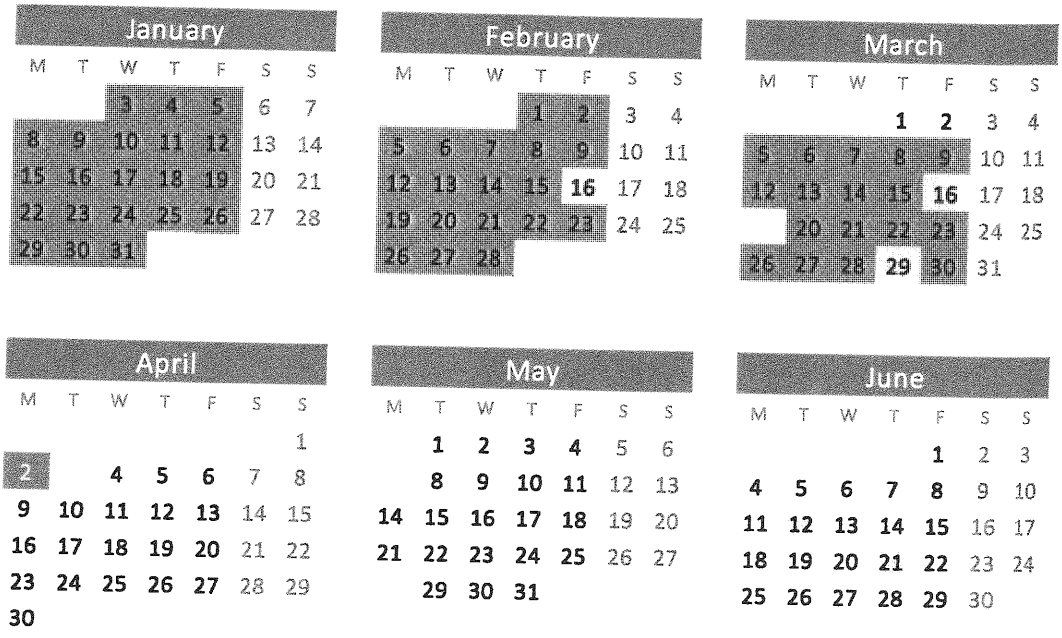
/contd overleaf

Calendar 2017/ contd

24 January 2017	Meeting - Mr Weir & Mr O'Brien to discuss concerns and opportunity to comment on them
26 January 2017	Management Case Conference - formal MHPS investigation agreed and Mr O'Brien informed (by telephone)
27 January 2017	Mr O'Brien's exclusion from work ceased
30 January - 17 February 2017	Mr O'Brien on Personal information redacted by leave
06 February 2017	Letter to Mr O'Brien notifying him of meeting on 9 February 2017
09 February 2017	Meeting - Dr Khan & Mr O'Brien (return to work action plan agreed)
20 February 2017	Mr O'Brien returned from Personal information leave
16 March 2017	Terms of Reference of MHPS formal investigation given to Mr O'Brien
3, 6 & 24 April 2017	Investigation meetings with witnesses x 13
3, 19 & 24 May 2017	
5 & 14 June 2017	
14 June 2017	Case investigator wrote to Mr O'Brien asking to meet on 28 June 2017
19 June 2017	Mr O'Brien requested to reschedule 28 June 2017 meeting to ensure he could be accompanied (agreed)
28 June 2017	Investigation meeting scheduled with Mr O'Brien (postponed at Mr O'Brien's request)
29, 30 June & 1 July 2017	Alternative dates suggested to Mr O'Brien - 31 July 2017 was agreed
05 July 2017	Mr O'Brien advised that date was not suitable and 3 August 2017 agreed as an alternative
03 August 2017	First meeting held with Mr O'Brien by Case Manager under formal MHPS framework (Private Patients issues and Terms of Reference item 4) postponed until next meeting.
16 October 2017	Date for second meeting with Case Manager agreed for 6 November 2017
06 November 2017	Second meeting with Case Manger
7 November - 29 December 2017	Mr O'Brien asked that his other priorities (work pressures and appraisal take priority over this time - agreed by investigators)

APPENDIX 10

2018



KEY | | **Trust Actions** | | **Mr O'Brien**

CASE INVESTIGATION 2018 - Key Dates

3 January to 30 March 2017	Mr O'Brien's comments from Novermber are outstanding
15 February 2018	Mr O'Brien had not yet provided comments he had wanted to make after 6 November 2017 meeting - update sought from him (Ms Hynds email 15 February 2018)
22 February 2018	Further update sought from Mr O'Brien (Ms Hynds email of 22 February 2018). Mr O'Brein responded to email expressing misunderstanding and that he was waiting for response from Trust. Requests note of the meeting of 6 November 2018 and any other documentation. He suggested that a timeframe for his response is 31 March 2018.
23 February 2018	Email response to Mr O'Brien from Ms Hynds - will send thorugh notes of 6 November 2017. Comments that on 6 November 2018, it was Mr O'Brien who had wished to make comment on previous notes and recipt of November notes (which were a reflection of his written submission) should not have held up the comments that he wished to make. Ms Hynds ought an ealrlier deadline of 9 March 2018.
09 March 2018	Deadline set for comments by investigators (not met)
16 March 2018	Comments not provided by Mr O'Brien and another deadline sought of 26 March 2018
26 March 2018	New deadline for comments from Mr O'Brien - none received
29 March 2018	Final opportunity given to Mr O'Brien to provide the outstanding comments that he wished to make of 12.00 noon on 30 March 2018
30 March 2018	Deadline not met by Mr O'Brien
02 April 2018	Comments received from Mr O'Brien and queries
12 June 2018	Dr Chada, Case Investigator, completed her report.
21 June 2018	Final report issued to Mr O'Brien

APPENDIX 11

National Clinical Assessment Service

NCAS
NHS Litigation Authority
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ

Website: www.ncas.nhs.uk
General Enquiries and Advice Line: Personal Information redacted by the USI
Direct Fax:
Email: Personal Information redacted by the USI

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

Dr Richard Wright
Medical Director
Southern Health And Social Care Trust
68 Lurgan Road
Portadown
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Dr Wright

Further to our telephone conversation on 28 December 2016, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

In summary, this case which my colleague Dr Fitzpatrick had previously discussed with Mr Gibson involves Dr 18665, a senior consultant urologist about whom there have been increasing performance concerns. The allegations are of poor record keeping, and slowness of triaging referrals and arranging reviews. Dr 18665 is also reported to have removed a very substantial numbers of charts from the Trust's premises without bringing them back; despite requests that these be returned many charts remain outstanding. Dr 18665's colleagues have, on occasions, seen patients for whom there have been no notes. Dr 18665 is currently on [redacted] leave, but has indicated that he is returning to work in January 2017

A recent Serious Adverse Incident (SAI) has caused concern that there is potential for patients to be harmed by the ongoing situation. You are awaiting the report of the SAI but on the information available to date, you feel the Trust will need to undertake a formal investigation of Dr 18665. The Trust is also considering exclusion.

As you are aware, the concerns about Dr 18665 should be managed in line with local policy and the guidance in Maintaining High Professional Standards in the Modern HPSS (MHPS). We discussed that as the information to date - no noted improvement despite the matter having been raised with Dr 18665 - suggests that an informal approach (as per paragraphs 15-17 of Section I of MHPS) is unlikely to resolve the situation, a more formal process is now warranted.

Any formal investigation should be undertaken to robust and specific Terms of Reference (ToR) and in line with the guidance in paragraphs 28-40 of MHPS Section II. The Case Manager should write to Dr 18665 as per paragraph 35 informing him of the name of the Case Investigator and Designated Board Member; any objections by Dr 18665 to the appointment of nominated individuals should be given serious consideration. The investigation should not be an unfocused trawl of Dr 18665's work but we discussed that if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/ look back to ensure that patients have received the appropriate standard of care. We noted that further preliminary information (such as from the SAI and taking account of Dr 18665's comments) may be helpful in deciding the scope of the investigation and therefore the ToR.

As well as being outwith the Trust's Information Governance policies, the allegations, if upheld, may mean that the legislation (DPA) has been breached, and once more information is available you may wish to take further advice on this. Paragraphs 20 and 21 of the GMC's Good Medical Practice also set out standards for record keeping including a requirement that records are kept in line with data protection duties.

Dr 18665 is due to attend Occupational Health to ascertain whether he is fit for work; if he is not, we noted that there would be no need at this time to consider exclusion but you may then wish to ask the Occupational Physician whether/when Dr 18665 would be fit to participate in an investigative process.

If Dr 18665 is deemed fit for work, we discussed the criteria for formal exclusion, and the option of an interim immediate exclusion for a maximum of 4 weeks (as per paragraphs 18-27 of Section I MHPS). The latter would allow for further information to be collated and to take account of Dr 18665's comments about the allegations, before deciding whether there are reasonable and proper grounds for formal exclusion such as a concern that the presence of the practitioner in the workplace would be likely to hinder the investigation. I note that there had been a concern expressed previously about a record missing for 2 years inexplicably appearing on a secretary's desk. In line with paragraph 22 of Section II MHPS, there is an obligation to inform other organisations, including the private sector, of any restriction or exclusion of a practitioner and a summary of the reasons for it.

Dr 18665 should be encouraged to contact his defence organisation/ BMA for help and advice. He may also benefit from staff support such as counselling, at what is likely to be a stressful time for him. Dr 18665 should be told of the involvement of NCAS and you are welcome to share this letter with him if you think this would be helpful.

As discussed, and as Dr 18665 may be excluded, NCAS will keep this case open and I will review it with you in approximately 1 month. Please call in the interim if you have any queries.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern HPSS (MHPS)

Review date:

27 January 2017

If you have any further issues to discuss, or any difficulty with these arrangements, please contact Case Support on the direct line above.

I hope the process has been helpful to you.

Yours sincerely

Personal Information redacted by the USI

Grainne Lynn
NCAS Adviser

cc Case Support Team

APPENDIX 12

D

Southern Health
and Social Care Trust

Quality Care - for you, with you

STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien
Personal Information redacted by the USI

& also via e-mail Personal Information redacted by the USI

3 June 2019 **Our Ref:** VT/hm-c

Dear Mr O'Brien

INFORMATION REQUEST 3

I write further to your correspondence of 12 March 2019 enclosing a request for information.

The enclosed information request is extensive in nature and will require significant time and resources within the Trust to compile together.

Your information request has been sent to the relevant named individuals within the Trust and a process is on-going to gather the requested information. I have asked a member of my Employee Relations team to co-ordinate the information from the various Trust staff named in your correspondence and it will be shared with you as it is gathered.

All reasonable efforts are being made to gather the requested information however within your request there are elements which are much too wide and not properly defined. I therefore ask for you to refine and clarify the specifics of your request as highlighted by me on the attached document and return to me as soon as possible.

Once this information has been provided to you, I will be commencing your grievance process immediately to avoid any further undue delay. Any additional requests for information or amendment to your grievance can be done so as it is progressed.

I look forward to hearing from you.

Yours sincerely,

Personal Information redacted by the USI

VIVIENNE TOAL (MRS)
Director of Human Resources
& Organisational Development

Att.

Trust HQ, Craigavon Area Hospital, 68 Lurgan Road, PORTADOWN, Craigavon BT63 5QQ,
Personal Information redacted by the USI Personal Information redacted by the USI

28. Please provide full details of all contact between you and any other person or third party (including the HSCB and the Department of Health) regarding or touching upon the issues of concern about Mr. O'Brien and his practice.

I had spoken to the Permanent Secretary, Mr Richard Pengally on two occasions: my first call was sometime in Summer 2020, and it was regarding my replacement as Chair. I remember I was interviewing in the Seagoe Hotel Portadown and stood out of the meeting to take this call. I asked Richard Pengelly when my replacement was being announced. I was advised that interviews were completed, and he would push to get an announcement. I explained then the investigation into Mr O'Brien, the situation that I was in, and that I did not wish to be involved in any meetings.

The second telephone call with Richard Pengelly was late September, again cannot recall the exact date and I did not take notes. Mr Pengelly phoned me to ask about the CURE Charity. I explained the history behind the foundation and management of this charity. I told Mr Pengelly that I had not been attending Board meetings with an agenda item on Mr O'Brien.
Mr Pengelly told me that - whilst I had a conflict of interest - it still was extremely important that I fulfilled my role and responsibilities as Chair. He reminded me that I should be careful that, in my absence from Board meetings, I was kept well informed and maintained control as Chair.

Richard stated to me that he knew me well enough to know I would act professionally. I had a particularly good meaningful conversation with Richard.

Board actions regarding urology and Mr. O'Brien

29. Please provide full details of when, how and by whom (i) you and (ii) the Board (if different or at different times) were first made aware of issues and concerns regarding the practice of Mr. O'Brien, to include all information about what was said and/or documentation provided?

Shane Devlin also helped me to think. My concern at this stage, Mr. Wolfe, was, these are -- we knew it was a very serious matter, I was now hearing that the Minister had reported through to the Northern Ireland Assembly about serious matters and was ready to go public. My Chief was in telling me this. He said he was concerned because, from memory, things like we haven't the scoping exercise complete, the review of all of the records isn't complete and we haven't enough detail and I'll be looking to the Board in October, the meeting coming up, to see should we ask for that to be delayed. So I was extremely concerned for the implications for the Trust and the outcomings of it. What on earth -- here we have, on one hand, the Minister is about to make a parliamentary announcement about a huge matter that would have big public interest and media interest, and yet, on the other hand, I was hearing we need to delay it because we haven't completed our scoping exercise and all of the reviews isn't complete. So when I'm at home completing this to give information to my solicitor, I had no records of any of this. I'm trying to recall this and, from the best of my memory, that's what I was putting in that section. It wasn't anything deliberate to say Mr. Pengelly -- Mr. Pengelly did not tell me to attend the October meeting, and I don't think I said that. What I am saying was that, in my mind, when I was working on this at home, I was trying to think what made me attend the October meeting and, definitely, it

12:52
12:52
12:52
12:53
12:53

was knowing that this was going public. I was told by Shane - I'd never worked through anything like this before - he told me it was going to be dealt with in the same way by the Minister as with Mr. Watt and how this works and it was very new to me and was very concerning, especially if we didn't completed and had accurate details to have announced. That's what, as well, influenced me. But I am sorry if I got the date mixed up. But Mr. Pengelly and I, I did discuss with him, on 26th October, my conflicts. 12:53 12:54

155 Q. Let me stop you there. It's just so that you understand the point I'm making to you perfectly well, let me reduce it to this: You've said in your original witness statement that your attendance on the 22nd was influenced by Mr. Pengelly, let me bring you to that again, it's WIT-90874. Just towards the bottom of the page, just over two thirds of the way down. So you have sat down to draft your answer to the Inquiry's Section 21 and you are thinking back a couple of years to these events. You have recorded that: 12:54 12:55

"The decision to attend was influenced by the second conversation I had with Richard Pengelly in late September 2020."

12:55

So, two things: First of all, you're recalling a telephone conversation which didn't take place; secondly, you're attributing to Mr. Pengelly an encouragement or an influence to attend a meeting when

no such sentiment was expressed by him, am I correct in both of those propositions?

A. Sorry, Mr. Wolfe, I'd like to clarify this. I'm at home, yes, preparing this statement with very little records, okay. In my mind I remembered having a call with Mr. Pengelly. Yes, we now know it was 26th October. I'm trying to think why I went to that meeting and I am probably not putting it across very clearly. But I do remember the call, I know it was after. But Mr. Pengelly did say to me the seriousness of making sure I fulfilled my roles and responsibilities and, you know, making sure that there was nothing that would have been left not attended to. So I did have that. So that's in my mind, that conversation, albeit I said it was September. It was a few weeks later. But I wasn't in any way trying to mislead or do anything. I was trying to think at home as I was writing what really made me attend this October meeting. 12:56 12:56 12:56

156 Q. So you have misremembered what Mr. Pengelly told you and when he told you it as opposed to trying to mislead the Inquiry? 12:57

A. Yes.

157 Q. You simply misremembered?

A. Yes, because when you're out of a job like I was doing, you're away a long period of time, a lot had happened, and you haven't the support of anything with you to provide you anything like, say, the Trust would have. I had no one that I could ask or talk apart from 12:57

preparing for the solicitor and then asking for discovery. So I'm trying to --

158 Q. Sorry to cut across you. What we're talking about is a telephone conversation with Mr. Pengelly?

A. Yes. 12:57

159 Q. It's only the two of you?

A. Yes.

160 Q. You had carried into your statement a memory, you say, of him influencing you to attend a meeting when that is inaccurate, do you accept it's inaccurate? 12:58

A. Well, that was probably my fault in actually getting mixed up in the dates, yes. I appreciate I gave the wrong information. But it wasn't deliberate, it was just my mind at the time, I was trying to think of why did I attend that meeting and that's what I -- 12:58

161 Q. You spoke to him on 26th October?

A. Yes.

162 Q. And we've seen the telephone record for that?

A. Yes.

163 Q. What were your actions following that in terms of attendance at meetings or discussions in relation to urology and Mr. O'Brien? 12:58

A. Well, we still probably had the virtual meetings, I think. Then there would only have been after the October meeting, there would only have been the November meeting, which was near the week I was leaving or something. There was only one more Board meeting after that. 12:58

164 Q. Isn't it the case that in several meetings

during November you declared an interest and stepped out of the meetings were they touched upon urology?

A. Yes, it probably did, yes, but I did that in previous meetings as well.

165 Q. Yes. That approach on your part, after your attendance at 22nd October and after your conversation with Mr. Pengelly on 26th October, your behaviour after those dates was to completely step away from urology issues; isn't that right? 12:59

A. Yes, I didn't attend any more meetings, no. 12:59

166 Q. Yes. Is it fair to conclude that your conversation with Mr. Pengelly on 26th October influenced you to come away from those issues and to step away from those issues completely?

A. Well, Mr. Pengelly didn't -- sorry, Mr. Pengelly didn't tell me not to attend Board meetings. What he told me was I needed to ensure as long as I was there I fulfilled my roles and responsibilities and had a process of knowing what was going on. So he didn't tell me to attend, he didn't tell me not to attend, he knew I was declaring a conflict of interest. And it was a very favourable conversation. I mean, we spent quite a bit of time talking about it. But I mean, it didn't -- and I also think after that time Eileen was coming in to take over. We had had a brief handover. So, you know, I stepped out of other meetings. But I mean -- and I do understand, but maybe you're coming to that, about there was, you know Dr. O'Kane made it clear the night before the meeting that I shouldn't 13:00 13:00 13:00

have been attending. But maybe you're coming on to that so I don't want to...

167 Q. What I want to finish with at lunchtime, just now, is this: After 22nd October meeting, you spoke to Mr. Devlin; isn't that right, and he conveyed to you Mr. Pengelly's view that you shouldn't attend to further discussions in relation to urology? 13:01

A. No. Mr. Shane Devlin spoke to me before the telephone call to Richard Pengelly, he didn't speak to me after Mr. Pengelly. 13:01

168 Q. Sorry, if I said "after", what I intended to say, after 22nd October meeting and before your phone call with Mr. Pengelly on 26th October, Mr. Devlin spoke to you, didn't he?

A. He didn't tell me not to attend any meetings that I can recall, unless I have forgotten that. But you are saying that was -- I just can't remember. But I remember Shane ringing me to tell me that Mr. Pengelly was looking to chat to me about CURE. He was off in a few minutes. But I don't remember him telling me then or after that I wasn't to attend. But I just cannot remember anymore. 13:02 13:02

169 Q. Then you spoke to Mr. Pengelly about CURE; is that right?

A. Yes, I made the phone call. Actually I said in my statement I thought he phoned me. 13:02

170 Q. Yes, you made the phone call. And he pointed out, did he, the difficulty, given your prior relationship with Mr. O'Brien through CURE, that involvement in

discussion of these urology issues was problematic, did he?

A. Sorry, just repeat that again.

171 Q. He discussed CURE with you, did he?

A. Yes, he asked me, tell me about CURE and we talked about that probably for two or three minutes. Then he said about declaring my conflicts of interest but still making sure in your final weeks that you fulfil your roles and responsibilities and that you understand and are kept very well informed what's going on. 13:03

172 Q. Yes.

A. He didn't tell me not to attend any meetings. We talked about a conflict, yes, you're declaring a conflict of interest. But I mean I don't remember him telling me or Shane not to attend any meetings. 13:03

173 Q. Okay. What happened after those conversations was that you reached a decision not to attend any further discussions concerning urology?

A. Yes, I didn't attend anymore, I probably had become exhausted to be honest. 13:04

174 Q. Can I suggest to you that what can be inferred from that is that you had been influenced in your conversations with Mr. Pengelly and Mr. Devlin to completely step away from discussion of urology issues?

A. Yes. Well, I certainly don't remember having any conversation with Shane about it and I wasn't talking to Richard Pengelly again after that call. He certainly didn't tell me not to attend any meetings. He told me to make sure and declare my conflict of 13:04

interest and I have expanded on what he told me. I mean, I remember him saying 'Roberta, you have been around a long time, we trust you, you just need to make sure you know what's going on'. But by this stage the travel journey for Mr. O'Brien had already -- decisions had been made. So I don't remember Shane Devlin talking to me again after -- neither before the October meeting to tell me about concerns Dr. O'Kane had. He never discussed it with me nor after it either or anything like that. He never discussed the Board meeting with me again that I can recall. And I again would have kept very good notes. Every time I met Shane I wrote down what I was wanting to talk to him about and what he was going to talk to me about in my diary. So I don't have anything. But I didn't attend any more meetings. But I am just saying, Mr. Wolfe, that Shane didn't talk to me about attending meetings. 13:04 13:05 13:05

MR. WOLFE KC: Well, I'll maybe pick up on that point and just put exactly what he said to you after lunch. Thank you. 13:05

CHAIR: Thank you. We'll come back, Ladies and Gentlemen, at ten past two.

THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS: 14:06

CHAIR: Thank you, everyone. Sorry for the delay.

175 Q. MR. WOLFE KC: Yes, Mrs. Brownlee, apologies for the delay. Just a couple of matters we required some time

Stinson, Emma M

From: Devlin, Shane
Sent: 21 October 2020 00:29
To: OKane, Maria
Cc: McClements, Melanie; McKimm, Jane; Toal, Vivienne
Subject: RE: TB Confidential item 7

Maria

Happy to discuss, although the chair has Not been a patient in recent years, she was a patient nearly 20yrs ago.

I think as chair she needs to be part of the conversation and the whole board need to be in the middle of this.

Catch up tomorrow

Shane

On 20 Oct 2020 23:54, "OKane, Maria" <Personal Information redacted by the USI> wrote:
Shane my understanding from what the Chair has disclosed openly is that she has been a patient of this doctor in recent years. Given that we will be discussing the impact on patients potentially I am concerned. Maria

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From: Devlin, Shane
Sent: 20 October 2020 10:52
To: OKane, Maria; McClements, Melanie; McKimm, Jane
Subject: FW: TB Confidential item 7

Please see below.

Can we have clear answers to the Chair's comments for the meeting

Thanks

Shane Devlin
Chief Executive
Southern HSC Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Tel: Personal Information redacted by the USI

From: Brownlee, Roberta
Sent: 20 October 2020 10:48
To: Devlin, Shane
Cc: Judt, Sandra; Comac, Jennifer; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; McDonald, Martin; Mullan, Eileen; Wilkinson, John
Subject: TB Confidential item 7

Shane

I wish to confirm that I will be staying in for this item as Chair (item 7). This is an extremely serious matter for the Board and I need to be present. I have no conflict with this particular matter. My past personal illness I will try to overcome the emotions.

As mentioned when we last spoke of this at 1:1 will Dr Damian (as Dr Maria not coming to TB) be able to confirm that one Urologist Dr Mark (only) having reviewed files is adequate and acceptable under process. Just want to be sure we don't need other specialist opinions of assessment on patients conditions/notes etc on such serious matters (stents/medications). Also are we sure legally (and by DoH CMO) that AOB must not be informed of this all taking place to date and not until the morning of the press release??

We need to be assured that process is as perfect and robust as possible. I appreciate the Dr Watt legal information but was there any learning from it when he wasn't told to the morning of – any legal difficulties. Hope you understand where I am coming from – protecting patients is paramount and the Board too.

Roberta

Mrs Roberta Brownlee
Chair
Southern Health and Social Care Trust

Tel: Personal Information redacted by the USI **(External);** Personal Information redacted by the USI **(Internal)**
Email: Personal Information redacted by the USI

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But I just wanted someone to tell us how did this happen? How was this missed? Have we done everything we are meant to do.

207 Q. Well, is it -- I've listened carefully to what you have said and I have read the minute. Is it possible to detect, in anything you have said at the meeting, any indication of concern for the patients who had been caught up in this, as opposed to -- and others have said this in evidence, others who were present at the meeting, they were detecting, in terms of what you had said at the meeting, a strong degree of defensiveness of Mr. O'Brien, something close to advocacy on behalf of Mr. O'Brien, a sense of, certainly, uncomfortableness that you were approaching matters as you did, so do you think, when you read that minute, that you got the emphasis wrong; it should have been more patient-focused? 15:13 15:13 15:14 15:14 15:14

A. No, we'd already -- it was discussed about the patients and the number that had been identified and what was happening. That was already in a process, it was following on; you know, we had discussed that or had had that in the report. I do not believe the questions I was asking was in any way an advocacy, I mean, and I have heard what others have said about me, I've read that, but I don't believe that -- maybe now, as I've said, looking back, I mean, would you have attended the meeting? We've covered that all. But at that time, my interest that I was asking was the safeguards for the Trust and, of course, patients and all were involved in

manner as a Chair."

That was one of your Non-Executive Directors, who you obviously had some trust and faith in, you had previously asked her to Chair in your -- because of the conflict at the previous meeting. She's sitting, listening and observing your input. When you reflect upon it now, do you understand how your fellow Non-Executive Directors could have taken that view of your input? 15:18 15:19

A. Well, it was a Zoom meeting, that's the first thing. And secondly, I don't believe I was defensive for Mr. O'Brien, mindful that he had already gone. Decisions had been made and that travel for Mr. O'Brien had already been determined. I note she said she supports Mr. Devlin and all in that. I have explained already why I attended that meeting, and I believe I was asking relevant questions and I was an objective Chair and I was always a challenging Chair and at the heart of everything I did was looking after my patients. I'm not going to be critical, Mr. Wolfe, of any of my Non-Executive Directors, that's not my style. I had a very good working relationship with Mrs. Leeson. If that's what she believes happened. But what I find strange in all of this, and I have said it to the Inquiry, if my Non-Executive Directors, even after that meeting, had concerns about me, or Mr. Devlin before it or Dr. O'Kane, I'm just amazed how none of them, at any time, ever spoke to me about it. 15:19 15:19 15:20

	threat to any organisation. The churn in Interim and Acting CEOs and Interim Directors during the 2016 – 2018 period had a huge impact on the Southern Trust. Succession planning for Board and Senior Management is required to ensure the organisation does not experience this type of flux again. ➢ Having substantive Executive and Operational Directors provides for stability, ownership, and individual and collective responsibility.
Committee escalation to Trust Board	➢ Creating a written Committee Chair Role Specification, with guidance on escalation from Committee to Trust Board, has been a necessary development. ➢ As has been the specific inclusion within the Committee Chairs' Reports of items for escalation to Trust Boa
Oversight of the role of Chair of the Trust Board	➢ A Senior/Lead Non-Executive Director role should provide a designated point of contact for all Board Members and Directors who have concerns about the Chair as part of broader remit to provide a level of oversight of the role of Chair. This is common practice in Boards within Great Britain.

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

MHPS Process	The absence of detailed reporting of MHPS cases, and providing the right route for this information to make its way to the Trust Board, is a concern of which I am now aware. The Trust Board or its Governance Committee should have been made aware of the progress of the MHPS process, the difficulties experienced in the MHPS process, the issues with Mr O'Brien's adherence to his action plan, the outcome of the MHPS process, the implementation of the Case Manager's recommendations, and the issues with Mr O'Brien's adherence to the action plan after the Determination.
Under-resourcing with governance support functions	Whilst it is correct that the Chief Executive (Shane Devlin) had raised concerns about under-investment in governance within the Trust and that the Champion Review along with Dr O'Kane had started the process to identify where governance needed strengthening and change, I believe that I wasn't aware of the scale of governance deficit that has become apparent through the Inquiry. This information ought to have been brought to the attention of the Trust Board.
Early Alerts	Early Alerts were not consistently issued to all Board Members prior to September 2020. I believe that the Early Alert system is as important to the Trust Board as it is to the Department of Health. The Trust Board should therefore have received all Early Alerts including, in particular, that dated 31st July 2020.
Declaration of conflict of interest and	I was unaware of the extent and depth of the relationship between Mrs Brownlee and Mr O'Brien. When I now consider the

management of it	Confidential Trust Board meetings and the meetings between Chair, CEO, and NEDs, between August 2020 and the end of November 2020, I see an inconsistent approach by the former Chair - from making no declaration of interest at one meeting to declaring an interest and leaving another meeting to denying an interest yet still leaving yet another meeting. As a result of evidence now before the Inquiry, it appears to me that there was a clear conflict of interest for the former Chair. The Trust Board should have been made aware of the extent and fullness of the relationship between her and Mr O'Brien. At the October 2020 meeting, when I realised there was more to this issue, a very simple Google search revealed to me that the former Chair and Mr. O'Brien had governance roles in a charity. At this point, the Chief Executive (Shane Devlin) raised the conflict with the former Chair. The Northern Ireland Audit Office defines a conflict of interest as: *"A conflict of interest involves a conflict between the public duty and the private interest of a public official in which the official's private-capacity interest could improperly influence the performance of his/her official duties and responsibilities."* It further explains: a) *The interest in question need not be that of the public official or Board member themselves. It can also include the interests of close relatives or friends and associates who have the potential to influence the public official or Board member's behaviour.*

that there was a distinct change in culture when Maria O'Kane, Dr. O'Kane, came into post. She emphasised, and I think it is not just for myself, it was for the whole Board, which is composed of Non-Executive Directors and Executive Directors, she emphasised 13:59
patient safety but she also emphasised psychological safety. And certainly I think Maria, along with the current Chair, Eileen Mullan, has created a forum and a space that makes that environment much more open to people to be curious and to ask questions. The 14:00
biggest difference for me is actually, I think, the Executive Directors asking questions. I think previously my own experience was that it was the Non-Executives that asked the questions and the Executive Directors replied. Now, it's a collaboration, a 14:00
partnership between the whole Board. You know, some of those discussions are quite robust, they are not soft questions. And I think that for me has been the cultural change in the Trust's Board.

153 Q. Thank you, that's helpful. I will come later in the 14:00
context of urology specifically to ask whether that cultural change or any deficit in the culture may have been responsible for not tackling these issues before the panic set in, in 2020, if I can put it in those terms. But let me come back to MHPS and just pull up 14:01
something you've said in your statement. If we go to WIT-9976. Just allow me a moment.

So we can see in the document in front of us that, with

FEBRUARY 2024

Southern Health and Social Care Trust

Putting **TRUST** back in to The Southern **TRUST**

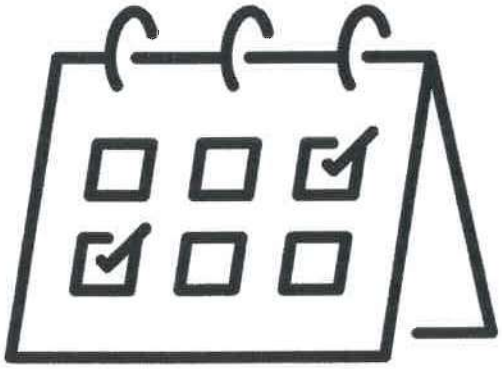
Eileen Mullan

Trust Board Chair

JUNE 2023

Southern Health and Social Care Trust

Working together Excellence Openness & Honesty Compassion



A time of change

The next 18 months

TRUST BOARD

SQIE

the Bed to Board Accountability. Work on this is has begun as the new directors come into post.

12) To support this, staff require training in governance and patient safety and we are in the process of developing this throughout the Trust, not just for Urology.

13) The Southern Trust also needs to embrace a culture that empowers staff, patients and carers to “Speak Up” when they have concerns. At times there has been a sense that because of busyness and work demands, staff have found it difficult to recognise when things are going wrong or to have the confidence to trust their own eyes in relation to this . Particularly where there has been fear of litigation and fear of reputational damage, there is a sense that staff have not always felt empowered to speak up or discuss their concerns and to proactively triangulate or share. I welcome the Department of Health’s consultation on Whistle blowing and the Trust will be formulating its response in the context of best practice nationally and in relation to its experiences in relation to Urology. To date we have been undertaking developmental work through HROD with Mersey Care NHS Foundation Trust in our approach to this and Mrs Vivienne Toal will be able to provide further details of this, and as part of the response to the Hyponatraemia Inquiry I had established a “Being Open Group” in the Trust to facilitate the awareness of responding to poor and good practice. To encourage staff to Speak Up and to reinforce good behaviours we have used the learning from one of the Scottish Patient Safety Fellows in the Trust to lead on Greatix which uses the principles of Nudge theory to promote good behaviours.

14) Typically, in most NHS organisations the tenure of senior doctors and nurses tends to be for much longer than managers and each team then often develops its own implicit identity and subculture which can be difficult to understand and where necessary, address, when difficulties arise. Mr O’Brien was employed in the Trust for 27 years. Most of the senior managers who worked with him were in post for a few years only.

Southern Health and Social Care Trust

Surgery and Clinical Services

Update on the Action Plan

In response to the Dermot Hughes SAI Recommendations Action PLAN

Private and Confidential

Evidence of Improvement against Root Cause Analysis Report on the review of a Serious Adverse Incident including Service User / Family Carer Engagement Checklist D Hughes 26 February 2021 (produced 28 February 2024)			
<u>Recommendation 1.</u> Southern Health and Social Care Trust must provide high quality Urological Cancer Care for all patients. ***This will be achieved by Urology Cancer Care delivered through a co-operative mutli-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through diagnosis, treatment, planning and completion and survivorship. Assurance from comprehensive pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review/ External Service Review by Royal College.***			
To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document references (Appendix 1)

I. Baseline assessment of all Trust Cancer Multidisciplinary Team meetings (7 local Cancer MDM meetings including Urology)	**Update as at 28 February 2024:**
	• All local MDTs completed a baseline assessment using NICAN guidance and the National Cancer Audit Tool (NCAT) June –August 2021.
	• Individual action plans agreed for all MDTs including Urology highlighting improvements which would be made
	• Cancer Service improvement lead supported implementation of this work with each cancer MDT lead
	• Principles document developed based on best practice outlining how each MDT, including Urology would function. This was implemented from January 2023.
	• System assurance audits established from April 2022 (starting with Urology) to evidence that each MDT was working in line with the MDT Principles document
	• System assurance audits include monthly reports:
	  ○ Quoracy
	  ○ Confirmation that new cancer cases are brought to MDT for discussion
	  ○ Allocation of key worker to each newly diagnosed patient
	  ○ Confirmation that plan agreed at MDT has been implemented
	
	If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:
	
	System assurance audits are completed monthly and reviewed within the governance structures within the Cancer Services Division. To date no significant system / process concerns have flagged, however there continues to be regional pressures around Oncology Services which impact on quoracy. These pressures are logged as a risk on the Trust
			NCAT baseline improvement plan (November 2021)
			
			MDT principles document (January 2023)
			
			Sample MDT system assurance audits (include selection from 2023)

		Directorate risk register and are escalated to Belfast Trust Cancer Service throughout the year, at regional cancer meetings and on the MDT annual reports. If concerns are noted there is an agreed escalation framework through which these issues will be escalated within the Directorate and corporately if required. Cancer Service Improvement lead continues to work closely with MDT leads to implement further improvement work as required. **IF not GREEN, what is the mitigation:** Not applicable		

II.	Feedback from Urology patients from a variety of sources	**Update as at 28 February 2024:**
		
		• Review of patient feedback from a range of sources including:
		  o Complaints
		  o Datix
		  o Care opinion
		  o 10,000 Voices
		  o Patient Surveys
		  o Engagement with patients / relatives involved in the Urology SAIs
		• Care Opinion kiosk established in Urology Outpatients to actively seek feedback from patients accessing urology Services commenced in February 2022
		• Training in Care Opinion provided for Urology Cancer Nurse Specialists and Urology medical staff- February 2022 and feedback via care opinion is ongoing
		• Macmillan Peer Support facilitators undertook engagement work in September 2022 with Urology Service users to secure feedback on their experience which was presented to the Urology Service. An example of a change made through this exercise was that patients should be aware that the title for roles may be used interchangeably such as Cancer Nurse Specialist / Key worker / Macmillan nurse, and if in doubt, to ask the staff member if you have any queries about any terminology
		• Patients feedback shared with the Urology team in February 2023 and service user feedback is a standing item on the Urology monthly Departmental meeting
		
		If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:
				Urology Patient Experience report (September 2022)
				
				Patient Engagement Report for Urology SAIs (September 2022)

		Patient feedback continues to be reviewed monthly by the Urology specialty and is a standing item on the Department meeting **IF not GREEN, what is the mitigation:** Not applicable		
III.	Data mapping the patient pathway for the Urology Service	**Update as at 8 March 2024:** • A process mapping exercise was completed for the Urology patient pathway on January 2022 supported by the Trusts Quality Improvement Team. The exercise highlighted opportunities to streamline the patient pathway. • The Trust are now adopting this focus across other cancer patient pathways including GI and Renal and the Cancer Service Improvement Lead is supporting this work with cancer specialties and Cancer MDT leads. • Work to identify and deliver on opportunities for improving cancer pathways is also being progressed through the Cancer Optimisation Plans which are being implemented across all HSC Trusts in NI focussing on Urology, lower GI, Skin and Gynaecology • In addition to the work outlined above, regional work is ongoing through the NICAN Cancer Clinical Groups **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The immediate work which needed to be delivered in relation to Urology has been completed. The Trust is adopting an ongoing improvement focus across all cancer Pathways supported by the Cancer Service Improvement Lead working in partnership with the relevant specialties and MDT leads. The RAG status for this sub action is therefore YELLOW, however the overall status for the recommendation is GREEN **IF not GREEN, what is the mitigation:** Not applicable.		**Urology Pathway Process Map (January 2022)** **Renal Pathway (May 2023)** **Urology Cancer Optimisation Plan** **Urology Cancer Optimisation Plan (February 2024)**
RAG rating for Recommendation 1		GREEN		

<u>Recommendation 2.</u> All patients receiving care from the Southern Health and Social Care Trust Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectations of Cancer Peer Review.

This will be achieved by ensuring all patient receive Multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent. Assurance from comprehensive Cancer Pathway Audit and Patient Experience.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference (Appendix 2)
i. Information Pathway Review	**Update as at 28 February 2024:** • In line with NICAN Guidelines, it was agreed that core information should be provided to patients at the point of diagnosis and throughout their cancer journey consistently across all cancer specialties in the Trust • Each Cancer Nurse Specialist provides patient with core information as well as specific information which applies to the patient's condition • Requirement for informing patients throughout their cancer journey has been included in the Cancer MDT Principles document (January 2023) • Within the Trust it has been agreed that the Cancer Nurse Specialist is the key worker for the patient • As the key worker, the Cancer Nurse Specialist takes a lead role in sharing information with the patient throughout their cancer journey. The responsibility is also a Key Performance Indicator for Cancer Nurse Specialists • Snapshots audits have been undertaken in Urology (June 2022 and September / October 2022) to evidence that information is being shared. This continue to be monitored through the monthly pathology reports in order to provide assurance. • Further work is being planned regionally to enhance the Cancer Patient Pathway System (CAPPS) which will enable this to be checked automatically in the future. This enhanced functionality has been delayed due to the rollout of ENCOMPASSS **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Sharing information with Cancer patients is a key requirement for all Cancer Nurse Specialists. This is also a Key Performance Indicator for a Cancer Nurse Specialist.		**Cancer Nurse Specialist KPI document**

	IF not GREEN, what is the mitigation: As the new CAPPS functionality is not yet available which will allow monitoring of this and other KPIs, and given that sample audits have been undertaken for Urology, we have a level of assurance on this however we cannot yet fully sign this recommendation off as being GREEN.		
ii. Advanced Communication Skills	**Update as at 28 February 2024:** • A number of advanced communication skills course have been delivered from January - March 2024 aimed at core members of Cancer MDTs including Urology • This is a two day course which staff need to attend once • Certificate of attendances are logged in Cancer Services and summarised in the Annual Report for each cancer MDT • Core MDT members that require training are prioritised **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The Trust secured non recurrent funding for the courses that ran January-March 2024, however currently there is no recurrent resources available for these courses year on year. This has been escalated through the regional Cancer Programme Board however due to the ongoing financial position, there is not yet regional funding for these courses. **IF not GREEN, what is the mitigation:** Whist we await recurrent funding, the Trust will continue to seek non recurrent funding opportunities and may consider the use of Trust Charitable Funds for these courses.		
iii. Allocation of Key Worker at Diagnosis	**Update as at 28 February 2024:** • It has been agreed that the key worker is the Cancer Nurse Specialist and this is outlined in the Cancer MDT Principles document (January 2023) and each of the cancer tumour site Operational Policies (including Urology) • The name of the Cancer Nurse Specialist / key worker is recorded on CAPPS either during or soon after the Cancer MDT meeting		**Sample Boxi Key Worker report**

	• The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASSS rollout • In the interim, a BOXI report is ran monthly from CAPPS to check that patients are being allocated a key worker as described above. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASS rollout **IF not GREEN, what is the mitigation:** Enhanced functionality will enable automated reports which require less manual work**.**		

iv. Key Performance Indicator Audit Framework for CNS	**Update as at 28 February 2024:**
	
	• Key Performance Indicators (KPIs) for Cancer Nurse Specialists are agreed regionally
	• There are 5 KPIs as follows:
	  ○ Service delivery
	  ○ Service improvement
	  ○ Holistic approach
	  ○ Patient information and support
	  ○ Supporting professional activities
	• In future monitoring of CNS KPIs will be supported through enhanced CAPPS functionality, and this will be a standing agenda item in the CNS forum and developed within the work plan
	• In the interim, it is the responsibility of each service to monitor adherence to these KPIs through the annual appraisal process
	
	If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:
	
	A Cancer Nurse Specialist workshop was held in March 2022 and as an action from this workshop it was agreed to establish a CNS Forum, and the first meeting of this forum was
			Summary from CNS Workshop / First meeting of CNS Forum (June 2022)

	held in June 2022. This forum is led by Nicola Shannon as Lead Nurse for Cancer Services. The Forum meets quarterly. **IF not GREEN, what is the mitigation:** Although progress has been made against this sub action, and whilst the new CAPPS functionality is outstanding, further work is needed through the CNS Forum to provide further assurance and the completion of an assurance report on the Cancer Nurse Specialist KPIs		
v. Staffing complement within CNS and Support Workers across all Tumour sites	**Update as at 28 February 2024:** • Regional Cancer Nurse Specialist Workforce Expansion plan completed in September 2023 • This expansion plan highlighted areas where the Trust would require additional CNS support across tumour sites. This work was led regionally by Lorna Nevin / PHA • As yet there has not been any update on recurrent funding to address the workforce requirements outlined through the September 2023 expansion plan • Tumour sites most challenged in terms of CNS capacity in the expansion plan were – Colorectal, Gynae and Skin • Whilst awaiting allocation of funding, the Trust has allocated 0.5 wte Band 7 non recurrently for Gynae and 1.0 wte Band 6 temporary for 3 years in partnership for Macmillan **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Awaiting allocation of funding to address the requirements outlined in the regional CNS Expansion Plan (September 2023). **IF not GREEN, what is the mitigation:** Awaiting allocation of funding to address the requirements outlined in the regional CNS Expansion Plan (September 2023). In the interim, other opportunities for funding are sought by specialty teams however this is challenging due to the financial climate regionally.		**CNS Workforce Expansion Plan (September 2023)**

	Targeted non recurrent investment has been made in Urology (0.5 WTE funded out of the Trust's Public Inquiry spend, and 1.5 WTE where the Trust have went at risk), and upper GI and Gynae as noted above. More recently, SPPG have indicated they will support additional funding for 2.0 wte for Skin although this is not yet finalised.		
RAG rating for Recommendation 2	AMBER		

<u>Recommendation 3.</u> The Southern Health and Social Care Trust must promote and encourage a culture that allows all staff to raise concerns openly and safely.

This will be achieved by ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collaborative and equal culture. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight monthly agenda. There must be action on issues escalated. Assurance form the number of issues raised through Cancer Services, Datix incidents identified, numbers of issues resolved and number of issues outstanding.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference (Appendix 3)
i. Review of Trust and Regional Guidelines and Policies • Whistle Blowing Policy • DOH Your Right to Raise a Concern Guide • Nursing & Midwifery Accountability & Assurance Framework • Working Well Together Policy	**Update as of May 2022** • Work commenced January 2022 to Review of all current Trust & Regional Policies including: ○ Whistle Blowing Policy ○ DOH Your Right to Raise a Concern ○ Nursing and Midwifery Accountability and Assurance Framework ○ Working Well Together Policy • Focus on Induction Pathway • Support and encourage raising of concerns / potential concerns. • Review of historical reporting of concerns completed. • Recognised that theme of concerns raised was based on working conditions associated with staffing levels. • Leadership "walkabouts" from Operational and Corporate Senior Staff across all directorates established. • Allows staff to become familiar with management and be comfortable in potentially raising concerns. • Identifying learning from other Inquiries for example Muckamore.		**Raising Concerns Policy** **DOH Your Right to Raise a Concern** **Working Well Together Policy** **Nursing and Midwifery Accountabilty Framework** **Terms of Reference – Cancer Nurse**

	• Cyclical emails on Global to all staff highlighting Whistle Blowing and individual responsibility, support and encouragement. • This work was completed May 2022 • Cancer Nurse Specialist Forum operational from June 2022 for all Cancer Specialties in the Trust. Support to raise issues/ concerns and opportunity to collectively discuss and agree standardised approach to Cancer care. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Immediate work completed and reinforced on an ongoing basis and outlined above. **IF not GREEN, what is the mitigation:** Not applicable		**Specialist Forum (June 2022)** **Code of Conduct for HSC Employees** **Medical Revalidation Sharepoint Resource** **Nursing Revalidation Sharepoint Resource**
	Update as at 28 February 2024: • All registrants of both medical and nursing professions revalidate in line with the professional body they are aligned to. • Revalidation process ENCOMPASSses the 4 fundamental aspects of a nurses responsibilities within their Code of Conduct • Prioritise People • Promote Professionalism • Practice Effectively • Preserve Safety • Staff aware of the Duty of Candour (Nursing and Medical) • Revalidation team for nursing staff. Monthly emails to staff and line managers to ensure prompt submission of documents/ fees to ensure no lapse in status on register. • Revalidation every 3 years which is signed off by another registrant whereby the nurse must demonstrate how they meet the 4 principals of the code uploaded to NMC personal record and NMC validate. • Escalation Process for staff who have lapsed on Revalidation • Medical staff follow the same process within the Trust. • Medical Revalidation Oversight Group established to address issues identified also in the 2016 SAI recommendations • HR processes and supporting Policies for guidance to address poor practice, non-compliance and performance issues.		

	• Encourage and support effective proactive management of issues early to protect patient safety. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Immediate work completed and reinforced on an ongoing basis and outlined above. **IF not GREEN, what is the mitigation:** Not applicable		
iii. Available & Accessible Information that supports the raising of concerns and management of concerns with the Organisation.	**Update as at 28 February 2024:** • Review of incidents within the Trust raised regarding concerns of Treatment. • Currently the National Incident Reporting system (DATIX) does not allow for categorising "concern". • Of the report run from Jan 2019 to Dec 2021 themes that could include a concern were: • Diagnosis-Wrong (8 reports) • Failure to Note Relevant Info In A Patients Record (61 reports) • Failure to Discontinue Treatment (10 reports) • Failure/ Delay to Order Correct Tests/ Images (125 reports) • Inadequate Investigation/Inadequate Assessment (7 reports) • Treatment/ Procedure Not Clinically Indicated (13 reports) • Treatment/ Procedure Inappropriate/ Wrong (38 reports) • Of note there has been more reporting since 2019 and steady increase year on year • Reflective of staff awareness to raise concerns and confidence to report. • Discussed with Governance Team. Datix can code concerns but staff awareness of this is limited. • Shared with Lead Nurses for sharing at Sisters • Meeting to disseminate to teams regarding use of Datix for reporting concerns. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Immediate work completed and reinforced on an ongoing basis and outlined above.		

	IF not GREEN, what is the mitigation: Not applicable		
RAG rating for Recommendation 3	GREEN		

<u>Recommendation 4</u>. The Southern Health and Social Care Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals

This will be achieved by all MDM's being quorate with professionals having appropriate time in job plans. This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (eg. Oncology, Palliative Care, Community Services)
Assurance from quorate meetings, sufficient Radiology input to facilitate pre MDM Quality Assurance of images. Cancer Patient pathway audit, Audit of recurrent MDM discussion and onward referral audit of patients to Oncology/ Palliative Care etc.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference (Appendix 4)
i. All MDMs meeting follow the guidance from National Cancer Action Team (NCAT) and meetings formatted in accordance with this framework as recognised as best practice regionally	**Update as at 28 February 2024:** • Update as noted for Recommendation 1 (i) above. • MDM quoracy has been significantly approved across all 8 local Cancer MDMs. Quoracy is monitored through monthly reports • Radiology and pathology input to the Urology MDM has improved significantly • There continues to be challenges around Oncology input to Cancer MDMs due to regional gaps in Oncology consultant and middle tier posts in Belfast Trust. These pressures are logged on the Directorate risk register • Cancer MDM chairs have additional time set aside in their job plan to enable them to fulfil this role • The Trust track patients from referral to first definitive treatment in line with what happens across all HSC Trusts in NI. The Trust is resourced to enable tracking to this scope and the CAPPS system can only support tracking from referral to first definitive treatment. • Cancer Services monitor tracking monthly to ensure this is kept up to date to support escalation of any delays patients may experience on their cancer journey • The Trust has been commended by SPPG for keeping cancer tracking up to date, especially given the high and increasing trend in Red Flag Cancer referrals		**NCAT Improvement Plan**

		If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier: This work has been completed and is subject to ongoing audit by way of assurance. **IF not GREEN, what is the mitigation:** Not applicable		
ii.	MDM Chairs and essential representation e.g. CHS will have job plan sessions for the MDM role. This should also be reflected in the Job description.	**Update as at 28 February 2024:** • Cancer MDM chairs have additional time set aside in their job plan to enable them to fulfil this role • The role of Cancer MDM chair has been reviewed and an updated Job Description produced **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The immediate work to address this recommendation is complete. It is however recognised that with the high level of Red Flag referrals and the volume of cases requiring discussion at Cancer MDMs, the time allocated for Cancer MDMs and for its members will need to be kept under review. The Clinical Director for Cancer will be working closely with Cancer MDM chairs to consider other ways to manage this demand differently including protocolisation of cases for registration at MDM rather than for discussion as the management plan for these cases may be pre-determined in line with recognised treatments. **IF not GREEN, what is the mitigation:** Not applicable		**Update Cancer MDM Chair job Description**
RAG rating for Recommendation 4		**GREEN**		

<u>Recommendation 5.</u> The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations/ actions are completed.

This will be achieved by appropriate resourcing of the MDM tracking team to ENCOMPASSs a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by a safety mechanism from laboratory services and Clinical Nurse Specialists as Key Workers. A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit/assurance. It is essential that current limited clinical resource is focused on patient care. Assurance from comprehensive cancer care pathway audit, exception reporting and escalation.			
To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG staus	Evidence document reference (Appendix 5)
i. Compliance with regional tracking requirements. Currently 31 &62 day tracking is the only requirement in accordance with CaPPS	**Update as at 28 February 2024:** • The Trust track patients from referral to first definitive treatment in line with what happens across all HSC Trusts in NI. The Trust is resourced to enable tracking to this scope and the CAPPS system can only support tracking from referral to first definitive treatment. • Cancer Services monitor tracking monthly to ensure this is kept up to date to support escalation of any delays patients may experience on their cancer journey • The Trust has been commended by SPPG for keeping cancer tracking up to date, especially given the high and increasing trend in Red Flag Cancer referrals • All patients with a new cancer diagnosis discussed are discussed at a Cancer MDM • All patients will be allocated a Cancer Nurse Specialist as their Key Worker. A monthly report is produced by Cancer Services to evidence that patients are being allocated a Key Worker in line with the Cancer MDM Principles document (January 2023) • Monthly snapshot reports are completed for all local Cancer MDMs to check that the plan agreed at MDM is implemented. These audits are completed by Cancer Services and issues flagged to Cancer Senior Management Team in line with an agreed escalation process **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Immediate work has been completed to address this recommendation. **IF not GREEN, what is the mitigation:** Not applicable		**Cancer Tracking guidelines** **Key Worker monthly report** **Escalation flowchart /Supporting Safer and effective Care**

ii.	All patients with positive pathology results are identified and referred to MDT promptly	**Update as at 28 February 2024:** • A pathology cross check mechanism has been established to check that all patients that are diagnosed with cancer via the laboratory are being brought to a Cancer MDT with monthly reports to evidence that this is happening **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Monthly assurance report produced and reviewed by Cancer Services **IF not GREEN, what is the mitigation:** Not applicable		**Pathology Cross check report**
iii.	Robust systems to enable alerts/cross checking and sign off of pathology results for patients on tracking	**Update as at 28 February 2024:** • The Cancer Tracking Team are now resourced to cover all cancer MDMs • The team are fully staffed with no gaps currently and are up to date with tracking • Cancer Services received a monthly report to monitor tracking position • If cancer trackers identify any delays with patients on cancer pathways, they follow up on these issues with consultant secretaries and consultants as required. Cancer MDM chair may also be alerted to significant delays or issues. Cancer Senior management team and specialty Heads of Service / Assistant Directors will also be alerted to any significant issues **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Monthly reporting in place to check that this is happening. Reports produced and reviewed by Cancer Services. **IF not GREEN, what is the mitigation:** Not applicable		**Escalation process for Cancer Trackers**
RAG rating for Recommendation 5		GREEN		

<u>Recommendation 6.</u> The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting Cancer Care based on patient need, patient experience and patient outcomes.

This will be achieved by developing a proactive Governance structure based on comprehensive ongoing Quality Assurance audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources. This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other Directorates. Assurance form the Cancer Pathway Audit outcomes with exception discussion and escalation. Date should be declared externally to Cancer Peer Review.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG staus	Evidence document reference (Appendix 6)
i. Feedback from patients from a variety of sources	**Update as at 28 February 2024:** • Update as same as for Recommendation 2 (ii) above **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Patient feedback continues to be reviewed monthly by the Urology specialty and is a standing item on the Department meeting **IF not GREEN, what is the mitigation:** Not applicable		**See documents for Recommendation 2 above**
ii. Allocation of Key Worker at diagnosis	**Update as at 28 February 2024:** • See update above for Recommendation 2 (iii). **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASSS rollout		

	IF not GREEN, what is the mitigation: Enhanced functionality will enable automated reports which require less manual work**.**		
iii. External quality assurance	• BSO / Internal Audit team recently completed an audit of a selection of cancer pathways in the Trust including Urology. This audit focussed on evidence to demonstrate improvements delivered against the urology SAI recommendations. This audit found significant evidence of improvements delivered. • There is still no commissioned Peer review process for cancer services in Northern Ireland or in GB. It is expected that a new Peer review process will be rolled out eventually, however there is no timeframe for this to happen. Once agreed a new peer review process will need to be funded regionally.		**Internal Audit report for Cancer pathways (February 2024)**
RAG rating for Recommendation 6	YELLOW		

<u>Recommendation 7.</u> The role of the Chair of the MDM should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG staus	Evidence document reference (Appendix 7)
i. MDM Chairs will have Job planned sessions for the MDM role. This should also be reflected in the Job Description	**Update as at 28 February 2024:** • MDM chairs have time set aside for this role from April 2023 • The job description of the role of MDM chairs has been updated • A new Clinical Director for Cancer Services is now in post **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Consultant job plans will be reviewed as part of the annual job planning cycle **IF not GREEN, what is the mitigation:**		**DMD for Cancer and Clinical Services** **CD for Cancer and Clinical Services**

	Not applicable		
RAG rating for Recommendation 7	**GREEN**		

Recommendation 8. All patients should receive cancer care based on accepted best practice guidelines (NICAN Regional Guidance, NICE Guidance, and Improving Outcome Guidance).

This will be achieved by ensuring the Multidisciplinary Team meeting is the primary forum in which the patient merits of all appropriate treatment options for the management of their disease, can be discussed. As such, a clinician should either defer to the option of his/ her peers or justify any variation through the patients documented informed consent.
Assurance from the variance from accepted Care Guidelines and MDM recommendations should form part of Cancer Pathway Audit. Exception reporting and escalation would only apply to cases without appropriate peer discussion.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference

i. Feedback from Patients from a variety of sources	**Update as at 28 February 2024:**
	• Review of patient feedback from a range of sources including:
	  ○ Complaints
	  ○ Datix
	  ○ Care opinion
	  ○ 10,000 Voices
	  ○ Patient Surveys
	  ○ Engagement with patients / relatives involved in the Urology SAIs
	• Care Opinion kiosk established in Urology Outpatients to actively seek feedback from patients accessing urology Services
	• Training in Care Opinion provided for Urology Cancer Nurse Specialists and Urology medical staff
	• Macmillan Peer Support facilitators undertook engagement work in September 2022 with Urology Service users to secure feedback on their experience which was presented to the Urology Service. An example of a change made through this exercise was that patients should be aware that the title for roles may be used interchangeably such as Cancer Nurse Specialist / Key worker / Macmillan nurse. And if in doubt, to ask the staff member if you have any queries about any terminology
			Patient Engagement Report (September 2022
			
			Urology Patient Experience
			
			Service User Group- Communication (September 2023)

	• Patients feedback shared with the Urology team in February 2023 and service user feedback is a standing item on the Urology monthly Departmental meeting **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The monitoring will continue as part of normal business across all services **IF not GREEN, what is the mitigation:** Not applicable		
ii. Allocation of Key Worker at Diagnosis	**Update as at 28 February 2024:** • It has been agreed that the key worker is the Cancer Nurse Specialist and this is outlined in the Cancer MDT Principles document (January 2023) and each of the cancer tumour site Operational Policies (including Urology) • The name of the Cancer Nurse Specialist / key worker is recorded on CAPPS either during or soon after the Cancer MDT meeting • The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASS rollout • In the interim, a BOXI report is ran monthly from CAPPS to check that patients are being allocated a key worker as described above. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASS rollout **IF not GREEN, what is the mitigation:** Enhanced functionality will enable automated reports which require less manual work**.**		**As recommendation 2 (iii)**

iii) System assurance audits for Cancer MDTs	• To support adherence best practice in delivery of cancer care across all local cancer tumour sites including Urology, the Trust has focussed on ensuring that patients with a cancer diagnosis are brought to a Cancer MDT for discussion • The Trust has worked to ensure that Cancer MDTs are as quorate as possible whilst recognising some regional workforce pressures in Oncology in Belfast Trust. A monthly quoracy report is produced to check that MDTs are quorate • Establishing the pathology cross check mechanism to check that all patients that are diagnosed with cancer via the laboratory are being brought to a Cancer MDT with monthly reports to evidence that this is happening • By ensuring all patients are allocated a key worker at the point of diagnosis and that this will be a named Cancer Nurse Specialist • By auditing that the plan agreed at the cancer MDT is implemented and any deviation is brought to the attention of the MDT lead as required • Further audit work is planned for 2024/25 looking at cancer outcomes across the Trust's cancer MDTs. This is to address a recommendation in the Royal College of Surgeon's review of a selection of Urology Case notes. The context of this recommendation was to be assured that the plan agreed at MDT was the correct plan for the patient. There is a level of assurance in that the plan will have been agreed through an MDT approach, however further audit would provide an additional level of assurance. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Monthly reports will continue to be reduced by cancer services by way of assurance. **IF not GREEN, what is the mitigation:** Not applicable		**See documents for Recommendation 1**
RAG rating for Recommendation 8	GREEN		

Recommendation 9. The roles of the Clinical Lead of Cancer Services and Associate Medical Director Cancer Services should be reviewed. The Southern Health and Social Care Trust must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.			
To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG staus	Evidence document reference (Appendix 9)
i. Job Descriptions must reflect the requirements for robust Governance and Quality Assurance processes for Cancer Service Leads, AMD's and Divisional Medical Directors.	**Update as at 28 February 2024:** • The role of Clinical Director for Cancer Services and Divisional Medical Director for Cancer Services have been reviewed and updated • Updated Job Descriptions have been produced for these roles as well as the MDM Chair role • This work was taken forward in partnership with all DMDs involved in the delivery of cancer care and all MDM chairs in post at that time • The Clinical Director for cancer was vacant for a period of time. This post has now been filled by Dr Adam Uprichard (Medical Oncologist from Belfast Trust). Dr Uprichard also sits on two Trust Cancer MDM groups – namely urology and Lung as a core MDM member **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The immediate work has now been completed, however all consultant job plans and associated roles are reviewed as part of the annual Job Planning cycle. **IF not GREEN, what is the mitigation:** Not applicable		**See documents for Recommendation 7**
ii. Each of the above will have full oversight of the requirements with the SAI Implementation Action Plan.	**Update as at 28 February 2024:** • All Acute DMDs and CDs were core members of the Task and Finish group that overseen the implementation of the 11 recommendations in the D Hughes report • Given that the Task and Finish Group has now been stood down as most of the work has been implemented, The DMD for Cancer and the CD for Cancer will continue to appraise MDMs and cancer MDT Chairs of progress by sharing a quarterly high report going		

	If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier: Immediate work has been implemented with most work completed. Further work is still to be done and updates will be provided through a quarterly report and shared widely in the Directorates, to Trust SLT and through the Trust Governance Structures **IF not GREEN, what is the mitigation:** Not applicable		
RAG rating for Recommendation 9	GREEN		

<u>Recommendation 10.</u> The families working as "Experts by Experience" have agreed to support implementation of the recommendations by receiving updates on assurances at 3, 6 and 12 monthly intervals

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference
i. The contribution of patients and/or relatives to the implementation of the recommendations. Evidencing their contribution throughout, in supporting and maximising the patient centred focus	**Update as at August 2022** • Task and Finish Group with Service Users commenced August 2021, with monthly meetings until August 2022. • The purpose of this group was to review SAI Action Plans and implement improvement. • Each Tumour site lead provided updates on work within their areas eg audits, development of MDM proformas providing a checklist for how MDMs should perform. • Draft of the 3 and 6 monthly update letters discussed and approved at this meeting and finalised letters forwarded to patients/relatives of SAIs. • This group was formally stood down on 8th August 2022 **Update as at 8 March 2024:**		**Service user Group Minutes (August 2023)** **Service User Update One (September 2022)** **Service User Update Two (January 2022)** **1st Letter Issued (September 2021)** **2nd letter Issued (January 2022)**

	Urology Lookback Team Engagement with Service Users In March 2023 the Urology Lookback Review Team setup The Communication/Service User group which met in person 2-weekly. The Terms of Reference for this Group focuses on actions to improve communication with, and information provided to patients who are part of the Urology Lookback Review. It is therefore a cross-directorate/cross divisional group which focuses on all aspects of communication with patients in the Urology Lookback Review delivered in partnership with servicer users. With direct input and robust challenge from the service users the Lookback Team produced a comprehensive suite of information/resources for the Lookback Review. These include: · Patient appointment letters; · Information leaflet; · FAQs; · Clinic outcome letters; · Press releases; and · "Scripts" for phone calls to patients. The Group work through each piece of communication line-by-line interrogating the language used and the messages conveyed, to ensure appropriate tone and messaging with no jargon or information overload. They also script and role-play the telephone calls made to patients advising they were to be included in Cohort 2 of the Lookback Review. This ensured that staff/patient interaction provided fully informed responses and appropriate tone for telephone calls with patients. The service users directly influenced the process of communication i.e. they advised on the date for launch of the communication for Cohort 2 (a Wednesday) as feedback from the service users from Cohort 1 was that letters should not arrive on a Friday ie over the weekend meaning patients are left anxious with no-one to speak to until the Monday. The learning from this partnership and process has recently been applied to another complex review with members of the Urology Communication / Service User Group being involved in planning, design and delivery of that work. Cancer Services provided an update with respect to the SAI actions to the Urology Communication/Service user group in September 2023 Engagement is continuing and the group will influence communication for the closure of Cohort 2 and the Activity Outcomes Report for same. A telephone Update to all SAI/Relatives of SAI patients planned for 7th/8th March – advising that Cohort 2 is reaching completion and that a written update will be provided enclosing a		**Letter enclosing copy of Activity Outcomes Report for Cohort 1 Urology Lookback Review – August 2023**

	copy of the Activity Outcomes Report for Cohort 2 together with updates on any outstanding actions for the SAI's. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** **IF not GREEN, what is the mitigation:** Not applicable		
RAG rating for Recommendation 10	GREEN		

<u>Recommendation 11.</u> The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG staus	Evidence document reference (Appendix 11)
ii. Following implementation of the recommendations the Trust should assess if aspects of Quality Improvement can be applied to any service / team / specialty outside Cancer Care	**Update as at 28 February 2024:** • The Cancer Senior management Team have provided updated to HOS / ADs in the legacy Acute Directorate by way of sharing the learning • Cancer Senior Management Team have presented at Trusts SLT and Trust Board updating on improvement work arising from the Urology SAIs • The Cancer Senior Management Team have presented to a Service User group in September 2023 to update on learning and improvement from the Urology SAIs • The Cancer Senior Management team have provided an update to the Safety and Quality Steering Group		**Presentation for Trust Board (June 2023)** **Safety and Quality Steering group meeting update (Jan 2023)**

	If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier: Significant work has already been done to share the learning however the Corporate Governance Team should consider what further actions need to be taken to fully maximise the learning from the Urology SAIs and the improvements that have been delivered in Urology and Cancer Services **IF not GREEN, what is the mitigation:** Not applicable		
i. The Trust is to consider if there is a requirement to extend the review of patient's records beyond the current time period, based on the findings of the current review, and if additional opportunities for improvement can be availed of.	**Update as at 28 February 2024:** Cohort One Urology Lookback Review Outcomes Report provides high-level outcome data for people who were under a named Consultant Urologists care as of January 2019 until June 2020. As a result of the findings from Cohort 1, it is recognised that a further cohort of individuals (Cohort 2) will need to be further analysed and reviewed. In identifying this group of patients the Trust determined that these are the patient groups where there would be a greater opportunity to change their clinical management pathway for a more positive outcome. This includes patients with Urological Cancer and patients who were diagnosed with renal stones, who were treated with or without ureteric stents and any patient who continues to have an "open" episode of care and has yet to be discharged or their care taken over by another Trust urologist. In addition, there has been concern raised that this Consultant saw and treated patients privately in their own home. Due to the ongoing difficulties in gaining access to this Consultants private patients Cohort 2 will include any private patients, who wish to be included in this Cohort, to come forward and make contact with the Trust directly. In summary, the Urology Lookback Review should extend to a second cohort of patients to include: 1. Patients diagnosed with a Urological Cancer (prostate, penile, bladder and kidney tumour groups) diagnosed from 1 April 2010 (this is when Cancer MDM's because functional in Southern Trust) who are currently alive; 2. Patients with Renal Stone Disease, which may or may not have been treated with Ureteric Stenting and any patient who continues to have an "open" episode of care; 3. Any patient who was seen and treated privately by the named Consultant Urologist.		**Activity and Interim Outcome Report Cohort 1 (August 2023)**

	The Trust considers that when this second cohort of patients has progressed through the Trust's Lookback Review, all of this Consultants patients, for whom there may have been a requirement to change or adjust their ongoing clinical management plan, will have been reviewed. There is no expectation that review of a third cohort will be required. However, this situation will be kept under review. Cohort Two is nearing completion and the Outcomes Report of this will be drafted in due course. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** **IF not GREEN, what is the mitigation:** Not applicable		
RAG rating for Recommendation 11	**GREEN**		

RECOMMENDATION 1					
The Trust should review the comments made in this report, alongside the local information it holds, and determine if the patient records contain the information they would expect for the patient episode(s). The Trust should ensure that the current practice meet the agreed standards as set out in the RCS England Surgical Care Team Guidance Framework.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
A number of audit tools are available to review the content of surgical notes (STAR / e-CRABEL). These tools will be adapted for use in the Trust against the Recommendations in the RCS Report. STAR Surgical Tool for Auditing Records.c The STAR Score - A method for auditing e-CRABEL score.pdf **The Trust would welcome further clarification on the RCS Guidance and which aspects could assist with record standards.** RCS Surgical Care Team Guidance Frame	Service Director	A chart review audit of the patient records will be undertaken using a surgical note audit tool (STAR / e-CRABEL). Learning will be developed from the results of this audit and recommendations implemented as required. **Update 5/6/23** Audit tools relate to patients who had surgery only and not outpatient episodes, therefore, not applicable. Recommendation is for ST to determine if what RCS has in the notes is agreed by ST. Trust to agree who will audit the 100 notes; and if there is adequate information recorded in the notes. A clinician group (does not need to be urologist) to undertake this review, suggestion of the medical leaders group to undertake the review. Estimate 15 minutes review per chart x 100 charts = 1500 minutes (25 hours). Group to draw up practical standards. Action: Consider use of medical leaders group to do this audit. Southern Trust would welcome further clarification on the RCS Guidance and which aspects could assist with record standards – have requested from RCS but no response to date **Update 09/10/23** It should be noted that almost all of these cases have been reviewed using the SCRR process, but a specific audit has not yet taken place. Use of Medical Leaders Group has been considered, but due to the range of specialties (paediatrics, general medicine, anaesthesia, ED, and psychiatry), use of this group would prove challenging in respect of both familiarity with the issues to be considered and also consistency of approach. Additional options will be considered to address this.	Aug 2023		

RECOMMENDATION 2					
The Trust should consider the conclusions of this report, as well as the other information it holds, and on this basis, provide further follow-up of any patients for which it considers this to be required, in particular those patients identified in Section 3.12 of this report. This should protect patient safety and ensure that patients or their families have received communication in line with the responsibilities set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Identify Patients (96) referenced in section 3.1 - 3.12 and ensure follow up provided as required. The Trust has established that a proportion of these reviews have been completed as part of the Trust's Lookback process. Any patients who have not been reviewed under the Lookback process will be reviewed separately. Correspondence were necessary to be drafted for updating patients and families.	Service Director Lookback Team	The Trust is following up on patients were it has considered this is required to maintain patient safety. Relevant communication with these patients is being progressed in line with relevant responsibilities. The Look Back Team have provided details of 35/96 patients known as part of the Urology Lookback Review. The Urology Service to complete the remaining review for the other patients. There are 7 patients noted in section 3.12. 5 of these 7 patients are known to the Lookback Review. • 1 Patient's case is undergoing a Structured Clinical Record Review • 4 Patients are undergoing 1st Level Triage • 2 Patients are not known to the lookback review and are being followed up by the Trust Urology Team 13 Patients are noted in section 3.7 of the report as requiring follow-up care. • 3 Patients' cases have been closed following review with no concerns identified • 5 Patients' cases are awaiting 1st Level Triage • 8 Patients' cases are not known to the lookback and are being followed up by the Trust Urology Team The 96 patient's notes will be reviewed by members of the substantive southern trust team and where follow up is required will be arranged.	Estimate Jan 2024		

		The ability to complete this work will be balanced against the need to meet the current uro-oncology and clinically urgent urological demand from patient referrals to Southern Trust. The current urology team in Southern Trust consists of 3 full time substantive consultants, 1 locum consultant and 2 part time consultants. Current clinical capacity is therefore limited with difficulty managing current clinical demand and against the capacity of the clinical team. Any work to undertake clinical review of the patients identified in the RCS Review will be provided by the same limited clinical resource as listed above. **Updated 5/6/23** The 35 patients with the cohort 1 of the Lookback have all been reviewed and actioned within the Lookback Review process. They are now closed on the Lookback database For the remaining patients - these patients Review backlog has been validated, to determine how many patients are left to be reviewed. **02/10/2023** The Trust is currently working through the 100 patients - estimated to be complete by end of October 23.			

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 3					
The Trust should review the consent-taking practices within the urology service to ensure appropriate discussion of risks, complications, benefits and alternatives of treatment takes place and is legibly documented and signed by the surgeon and the patient. Clinical records should clearly detail the giving of information and the decisions made by the **The RCS England good practice guide may be of assistance in this process.**					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Trust Policy on 'Gaining Consent' has been reviewed and updated (November 2022) and includes reference to the Montgomery ruling. The new consent policy will apply Trust wide.	Service Director	The consent policy was formally approved by the Trust in January 2023. A communications plan to all staff is being developed by the Trust communications team with launch of the policy and training development currently taking place. Follow up audit of the consent processes in urology will take place 3 months after the implementation of the new consent policy. It is planned that a random sample of urology procedures will be audited. Use of Internal Audit processes are being considered to assist with this audit as part of a wider Trust consent audit. **Update 5/6/23** Describe what the consent process is at present, compare against the Montgomery Ruling; include documentation used. Urology Team to complete – to be added to agenda of Department al meeting. Dr Austin to ask another clinician to review findings when complete **02/10/2023** Added to Urology November Department meeting agenda for update Also to be added to Urology audit plan for 23/24	2023/24 Internal audit cycle		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 4					
In addition to recommendation 3, the Trust should review this sample of records and ensure that there was appropriate informed consent obtained for each procedure or operation.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Audit of the consent process / documentation for the patients identified in the RCS report will be undertaken take place as per Recommendation 3 above.	Service Director	Use of Internal Audit processes are being considered to assist with audit of consent processes as part of a wider Trust consent audit. **Update 5/6/23** Medical clinicians who are reviewing the 100 notes to undertake consent audit **Update 09/10/23** This audit has not taken place to date. See response to Recommendation 1. Alternative proposals to be developed address this	2023/24 Internal audit cycle		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 5					
The Trust should share this report with the wider urological team for the 96 cases reviewed and discuss its contents with them. They should be given the opportunity to reflect on					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Report to be shared and discussed at Urology Service patient safety / governance meeting. The urology multidisciplinary team will be encouraged and supported to reflect on the contents of the RCS Report and to identify learning for the service.	Service Director	The RCS Report has been shared with individual consultant urologists. The RCS Report will be formally been shared with the Urology Service Team at the Urology department meeting on 2nd / 9th February 2023. Reflection will be undertaken to develop any additional learning.	09/02/2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 6					
The Trust should review the MDT arrangements within the urology service to ensure that there is appropriate MDT input into the decision-making for every patient. All MDT decisions and communication should be adequately documented in each patient's record.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust will undertake a review of patient pathways in Urology with respect to MDT arrangements and decision making using i. Process mapping of the relevant urology oncology MDT pathways ii. Audit of MDT decision making processes, documentation and communication with patients for respective patient records. Existing audit work in this area will be reviewed for additional learning taking account of the recommendations of the RCS report.	Service Director	Process mapping of the MDT patient pathway has been completed. Audits of the MDT Pathways has commenced focussing on MDT attendance / quoracy, cross referencing pathology confirmed cancers to patients discussed at MDT, allocation of Cancer Nurse Specialist as the key worker and spot checks of MDT actions to confirm actions have been progressed. Additional work is ongoing within Cancer Services to further develop the MDT pathway and to develop enhanced methods of assurance relating to decision making for patients. Regional work will be required to further develop regional / specialist MDT arrangements. The Trust will input to this work, but this will be outside the control of the Trust. **<u>Update 5/6/23</u>** Monthly audits up and running for Urology, reviewing 5 cases for MDT per month. This is part of a rolling audit	Jan 2023 Ongoing July / August 2023 Regional timescale		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 7					
It was unclear to the review team whether the MDT meetings that Surgeon 1 attended and chaired, were local urology MDT or specialist urology MDT. The Trust should ensure that complex cancer cases, especially those where major surgery are being considered, should always be discussed at a specialist MDT. In the review team's opinion, these decisions should not be made on a purely local basis.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
In line with IOG and NICE defined complex cancer guidance, cases must be discussed at Specialist Urology Cancer MDT. There is a specialist urology cancer MDT and there is clear guidance as to what cases should be discussed. The designation of urology MDT meetings (general or specialist urology MDT) should be recorded against each MDT meeting.	Service Director	Complex urology cancer cases will be discussed at specialist MDT meetings developed on a regional basis with neighbouring HSC Trusts. The designation of urology MDT meetings (general or specialist urology MDT) will be recorded against each MDT meeting. At the time of the RCS Report the specialist renal services had not been commissioned, however, this surgery currently being commissioned now (from 2018). Regional work will be required to further develop regional / specialist MDT arrangements. The Trust will input to this work, but this will be outside the control of the Trust. **<u>Updated 5/6/23</u>** There an audit being undertaken currently. The designation of the MDT meeting is being recorded i.e MDT in Southern Trust (local) or Belfast Trust (regional). **<u>02/10/2023</u>** Cancer - the audit refers to one being conducted by Belfast MDM. MDH to double check re penile and testicular cancers being discussed regionally is addressed as part of this audit. Last update received was that data collection was underway and anticipating the audit to be completed relatively quickly.	Ongoing April 2023 Completed 2018 Regional timescale		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 8					
In addition to recommendations 6 and 7, the Trust should consider whether there are sufficient safeguards in place to monitor clinical decisions made at MDT meetings and to ensure that recommendations are appropriately carried out.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust will review current and develop additional safeguard processes as required to ensure that clinical decisions made at MDT meetings are enacted and that processes are in place to monitor and audit the implementation of clinical decisions arising from the MDT.	Service Director	Process mapping of the MDT patient pathway has been completed. Additional resource is now in place to carry out audits of actions taken at MDT. Recognising the number of patients presented at MDTs each week and the number being actively tracked at any time, these audits will initially be spot checks across all local MDTs. Further resource will be put in place to increase the number of checks completed weekly. **Update 5/6/23** Sample of MDT prostate and bladder outcomes to check if management plan is as per NICE guidance Audit to be undertaken twice yearly **Update 03/10/23** Monthly MDT outcomes audit report i.e sample of 5 patients outcomes are audited on a monthly basis and reports of this are shared with Urology MDT Lead, Urology Service Management and Cancer services management teams. To date there have been no issues identified.	Jan 2023 August 2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 9					
The Trust should consider whether there are sufficient safeguards in place within the electronic system to identify priority clinical decisions which needs escalation.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Current NIECR development has been frozen due to implementation of Encompass, with implementation in the Trust scheduled for 2025. Any adjustments to current computerized systems will be either not possible or very challenging to implement.	Service Director	The Trust will review existing electronic systems (eg NIECR) to identify if sufficient safeguards are in place to identify priority clinical decisions and thereafter consider resolution of any deficiencies identified. As part of the review from recommendation 8, other systems will be put in place as required. **Update 5/6/23** RCS to clarify 'electronic system' – do they mean CaPPs? Clarify role of cancer Trackers for onward escalations/recording on CaPPs , escalation to oncology **Update 09/10/23** Cancer Trackers are in place to expedite care provided to individual patients – this only covers patients on cancer pathways. Further work to be progressed to address this more comprehensively.	Aug 2024		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 10					
The Trust should review the adequacy of clinical correspondence following clinical decisions being made, and whether they are checked and followed up to ensure actions are subsequently carried out.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
No systems are currently in place to review all clinical correspondence and to check that all actions arising from clinical correspondence have been implemented, mainly due to manual paper based systems and lack of implementation of an EMR system in Northern Ireland. To provide such a system will require significant investment. The Encompass programme (full EMR) for NI is due to be implemented in the five HSC Trusts over the next 1-2 years coming to the Trust in 2025. This should facilitate better follow of actions arising from clinical correspondence as this will be built directly into the system.	Service Director	An audit of clinical correspondence and decisions arising from that correspondence will be undertaken. A phased audit approach will be developed to include three strands of audit in relation to multidisciplinary review actions as below: 1. Audit MDT recommendation implementation 2. Audit of Clinical correspondence 3. Audit of Discharge letters Standards to use as parameters to be agreed. **<u>Update 5/6/23</u>** It is standard practice that the Urology team dictate correspondence to GP / other Healthcare professional (HCP) after every MDT encounter. Their support teams ensure the actions are carried out	Dec 2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 11					
The Trust should review the sufficiency of waiting list processes, ensuring that waiting lists are monitored and ideally shared by all consultants who do the same procedures. In addition, the Trust should review what priority is given to certain procedures, who checks waiting lists, and what the criteria is for assigning priority to operations.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Prioritisation of operations in NI is undertaken by a regional system of categorization from P1 to P5 (similar to that used during Covid). Due to limited resources in NI and the Trust and across NI, patients are prioritised so that in effect only Priority 2 are being scheduled for surgery. Urological waiting lists are extensive in the Trust and regionally, only treating P2 patients on the elective theatre lists. Due to volume of patients waiting, it would be impractical to review each patient at the present time. A briefing paper to implement an Urology Scheduler is completed and is awaiting funding consideration.	Service Director	The Trust has developed a business case for an Urology Scheduler system to assist with waiting list management. This is awaiting consideration for funding. A review of scheduling and booking processes for surgery (and prioritisation) commencing with Urology will be undertaken in order to enhance administrative processes based on clinical priority. The Trust will explore development of pooled waiting lists within the wider urology surgical team. An audit of private practice patient change of status from the private sector to the HSC will be undertaken to provide assurance that appropriate priority placement of private patients on waiting lists is occurring. This will be incorporated into the Internal Audit work plan for 2024/25. Internal audit to be engaged in the annual Trust Internal Audit plan to undertake a comprehensive independent audit of processes for waiting lists and prioritisation of patients on waiting lists. **<u>Update 5/6/23</u>** The Urology Scheduler position is with finance for sign off, once approved then with BSO for recruitment **<u>Updated 2/10/23</u>** Urology Scheduler in post from 11/09/2023	Pending Funding August 2023 August 2023 April 2025 April 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 12					
The Trust should ensure immediate recognition amongst management and clinicians that no patient should wait for longer than a pre-agreed period for surgery and follow up. The management of each case should be consistent with the surgeon's own standards for how they would like to be treated.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust seeks to maintain safe care is maintained by ensuring patients do not wait longer than pre-agreed periods for surgery and follow-up however limited action can be taken due Northern Ireland's regional issues pertaining to waiting list management. In practice, this is unachievable due to capacity issues across Northern Ireland.	Service Director Medical Director	The commissioning system within N.I means that each speciality is commissioned to provide a level of service: beyond that level there is no funding or capacity to see and treat patients. This risk will be articulated clearly in the Trust Risk Register(s). **Update 5/6/23** No update due to resource issues **Update 9/10/23** No change in the current funding position in Northern Ireland. GIRFT Review of Urology services for Northern Ireland has taken place with opportunities identified for reconfiguration of care on a regional basis which should impact to some extent on waiting lists when implemented. The final GIRFT report remains awaited.	April 2023		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 13					
The Trust should improve the quality of record keeping in clinical records. This should include but is not limited to: **(iii) More detail in clinic notes and letters, which should document the reasoning and evidence for clinical decisions. This should include details of MDT discussions;** **(vii) Clinical correspondence, radiology reports and investigation results.**					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
Core standards for record keeping will be reviewed and additional guidance developed to incorporate the factors listed in this recommendation.	Medical Director	Regular audits of the quality of clinical notes will be undertaken using standardized tools (RCP tool). Implementation of Encompass will facilitate improved record keeping. **<u>Update 5/6/23</u>** Check with Fiona, Audit Manager re record keeping is on the Urology audit plan for 23/24 Action: Head of Service **<u>02/10/2023</u>** Record keeping is not on the urology audit plan for 23/24 - audit plan to be reviewed to ascertain if there is capacity to undertake audit	April 2024 Dec 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 14					
The Trust should audit the standard of clinical documentation to ensure there are contemporaneous and comprehensive notes of patient care at each stage of the surgical pathway.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust will under audit of the surgical urology patient pathway to assess the standard of clinical documentation using the *Surgery Tool for Auditing Records* (STAR) audit tool.	Service Director	Urology audits (as above) will be rolled out to other surgical specialities within the Trust. See Recommendation 13.	Aug 2024		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 15					
The Trust should consider whether there are recurring issues within the electronic patient record system, and whether there are sufficient safeguards for administrative staff to					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The Trust to continue work with BSO to link dictation to electronic systems to increase safeguards. This will include system testing to ensure recommendation is met. During the implementation work for the NI encompass programme, work will be undertaken to ensure that audit of correspondence can be undertaken.	Performance Director	The Trust will consider current processes within medical records to identify and escalate missing correspondence. Implementation of Encompass will facilitate improved record keeping and tracking of correspondence. **<u>Update 5/6/23 & 5/10/23</u>** Monthly meeting with Urology Managers / administrative team when outstanding dictation is discussed and actions undertaken. SOP for administrative staff when dictation is not undertaken Southern Trust encompass implementation is estimated April 2025 Unable to update further until encompass is implemented**.**	April 2024 Dec 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 16					
The Trust should ensure there are safeguards in place to monitor decisions made during follow-up appointments and to identify and escalate missing correspondence from outpatient clinics.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
There is no timescale for the clinical staff re completion of dictation after OPD. There is currently no safe guarding process in place to monitor decisions made during follow up appointment. Further to this, there is a requirement to undertake an appropriate audit and action plan that can adequately provide assurance and monitoring that decisions made are adequately followed up.	Performance Director	**Update 5/6/23** **– see response to recommendation 15** In terms the escalation of missing correspondence, this will require testing of recent developments between BSO and IT department which looks to link the digital dictation/ system to patient administration system. This will aim to directly link outpatient attendance to creation of electronic document which would be approved and sent via electronic document transfer directly to GP practice. The Trust will review secretarial systems regarding secretarial responsibility for flagging that there is no dictation undertaken after outpatient clinic. A process to escalate missing correspondence from outpatient clinics will be required to be identified. Implementation of Encompass will facilitate improved record keeping and tracking of correspondence.	Aug 2024 Dec 2025		

RECOMMENDATIONS OF ROYAL COLLEGE OF SURGEONS UROLOGY SERVICES REVIEW IMPLEMENTATION PLAN 2022

RECOMMENDATION 17					
The Trust should ensure there are systems in place to monitor that letters are written and sent out to patients and their GPs after each clinic visit.					
Comments	**Responsible Director**	**Action(s) Required to Deliver Recommendation(s)**	**Target Date**	**Status RAG**	**Evidence of Completion**
The NICE Shared Decision Making Guideline NG197 highlights the issue of letters written to patients and GPs, particular section 1.2.20 which suggests writing to patients and copying to the relevant health professional. This is not standard practice within Northern Ireland.	Medical Director	Work is ongoing across the Trust to implement this aspect of NG197 (write to patients with copies sent to GPs). **Update 5/6/23** Expectation of standard that patients receive a letter following consultation **Update 9/10/23** Implementation of NICE NG 197 Shared Decision Making is proceeding in Southern Trust and across Northern Ireland. This incorporates specific guidance on writing to patients. Sending letters to patients is reviewed but work is ongoing to develop more robust systems in the Trust to improve monitoring.	April 2024		

RQIA SCRR Review Recommendations

Action Plan

Summary

Total Number of Trust Actions Required = 25

Date	RAG Rating	Number
24/10/22		8
		14
		3
18/11/22		9 ↑
		13 ↑
		3 =
16/12/22		18 ↑
		5 ↓
		2 ↓
03/02/23		18 =
		6 ↑
		1 ↓
20/03/23		20↑
		4↓
		1=
24/04/23		22↑
		2↓
		1=

RQIA SCRR REVIEW RECOMMENDATIONS IMPLEMENTATION PLAN

RECOMMENDATION 1				
1 (a) SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.				
Action Required to Deliver Recommendation(s)	**Responsible Officer[1]?**	**Update**	**Status RAG**	**Evidence pf Completion**
Update PID – with detail and purpose of SCRR,	LBR Project Manager (LE)	**20/10/22** – work commenced on this **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
Draft a "stand-alone" summary of the background, purpose, objectives and process of SCRR	LBR Project Manager (LE)	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report
1(b) SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.				
Add lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust **18/11/22** - no further progress **16/12/22** – Two lay reps identified and joining Operational & Steering Groups	Complete	Emails confirming TOR
Patient / family information materials required for Phase 2 to be activity considered by Lay representatives and tested within other PPI forums either internal or external to Trust.	This is an action for the future – will be addressed and evidenced in phase 2			

[1] Responsibility for delivery this action plan sits with the SRO for the LBR who is chair of the LBR Steering Group (MOH)

RECOMMENDATION 2				
2(a) SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Reorganise structures for the LBR process and reset role and function of steering group including membership	Chair of Steering Group (MOH)	**20/10/22** – complete	Closed	- Terms of Reference for Steering Group - Diagram of new structure
2(b) SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.				
Lookback Review in line with project management principles and processes. Draft PID to summaries the LBR process	Chair of Steering Group (MOH)	**20/10/22** – complete – new structure and process	Closed	- PID - New structure and process in place to include clarity on reporting and accountability

RECOMMENDATION 3				
Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Appoint project manager to oversee the implementation of the Lookback Review in line with project management principles and processes	Chair of Steering Group (MOH)	**20/10/22** – complete LE in post from 1 September 2022 **27/02/2022** – LE completed PRINCE2 Foundation and Practitioner Training	Closed	- Staff in post - Certificate of P2 completion

RECOMMENDATION 4				
4(a) SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Same as per recommendation 1(a) above	See recommendation 1(a) above	**20/10/22** – work commenced **18/11/22** - draft complete being reviewed prior to being finalised **16/12/22 -** Complete	Complete	Report

RECOMMENDATION 5				
5(a) SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Draft options paper for extending the Urology Lookback Review and progress with option agreed by UAG.	Chair of Steering Group (MOH)	**20/10/22** – work commenced **18/11/22 –** Options paper shared with UAG on 17 November	Complete	Options paper
5(b) RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.				
RQIA to action not Trust				

RSC requested – not accepted SCRR process is currently outsourced to individual external urologists accessed via BAUS. Request to be made to RCP	Dep MD (DG)	**20/10/22** – unable to secure RCS to undertake this work, **18/11/22 –** IS (3FiveTwo) sourced – IS contract being urgently drawn up to commission this work **16/12/22 –** IS now being utilised		Emails from RSC Emails with BAUS First tranche (14 cases) passed to IS on 13 December

RECOMMENDATION 7				
SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Sampling approach to case selection for SCRR to be included in the options paper on progressing with the SCRR process for consideration by UAG	Chair of Steering Group (MOH)	**20/10/22** – work commenced – **18/11/22** – to be further clarified when IS contract in place **16/12/22** – All of the outstanding cases (29) of the original 53 cases will be passed to IS. Consideration will be given to sampling the remaining 38 plus any new SCRRs added at screening in the NY **03/02/23** – Now 125 SCRR in total (potential for up to a further 9 which are	Closed	

		planned for screening – which when compete finishes screening for cohort 1. A paper to be drafted for UAG to consider sampling of the current outstanding 72 SCRR cases. **20/03/23 –** All original 53 index SCRR cases are now completed. Comparative review has been completed. Direction from UAG as of 13.02.23 is to move to a "targeted" approach to the remaining SCRR cases. LBR Team currently assessing those remaining cases for determination of issue and if this is a new theme.		

RECOMMENDATION 8				
SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.				
Action Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence of Completion**
Papers on SCRR and extending the Lookback Review to be shared with Trust ethic committee when complete	TBA	**20/10/22** - Not yet commenced – to discuss with new Medical Director when he takes up post **18/11/22 –** no update **16/12/22** – no update **03/02/23** – a seating of the ethic committee to be arranged to consider ethical considerations of Cohort 2 **24/04/23** – not considered necessary as both agreed by UAG.	Closed	Minutes of UAG from 7 March 2023

Share SCRR related papers with DLS	Chair of Steering Group (MOH)	**20/10/22** - Current SCRR process arrangement shared with DLS. The options paper on the way forward re SCRR will be shared with DLS when complete and prior to discussion with UAG. **18/11/22** – to be further considered if SCRR to change when IS contract in place. **16/12/22** – unchanged **03/02/23** – paper referred to above under recommendation 7 to be shared with DLS when complete **23/3/23** – shared with DLS and USI		Email to DLS dated 23/3/23 & in document in USI discovery folder

RECOMMENDATION 10				
SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
As per recommendation 1(b) add Lay representation to the Urology Lookback Review steering and operational group.	Head of the Lookback Review (SW)	**20/10/22** – Lay representation sought via PPI team in Trust	Complete	Meeting with Head of LBR and 2 lay reps

Provide information and bespoke induction of new Lay representatives to assist in contributing to the Lookback Review		**18/11/22 –** no update while Head of LBR is unavailable **16/12/22** – Two lay reps identified and joining Operational & Steering Groups		Information pack

RECOMMENDATION 11				
SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Share current process for communicating with patients / families re SCRR outcomes with DLS for feedback and advice.	Chair of Steering Group (MOH)	**20/10/22** – As per DLS advice for an individual patient –patients to be offered either report in full or summary from section 2.11. Letter also includes opportunity to discuss the finding with clinical team face to face and separately an offer of a clinical appointment with consultant urologist. Also includes an unreserved apology from the CX on behalf of the Trust	Completed & Closed	Email from DLS (21/7/22)

RECOMMENDATION 12				
SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider the above recommendation	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered and decision taken not to change SCRR inter-process as calls into question the validity the work done previously.	Closed see below re next phase of LBR	
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 13				
DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
DOH to action not Trust				

RECOMMENDATION 14				
14(a) SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Establish if RCP can facilitate the SCRR process	DMD (DG)	**20/10/22** – await feedback from RCP **18/11/22 –** no further feedback – response chased **16/12/22 –** Complete – IS contract in place	Complete	Contract Returned reports from IS
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applies at that time.	This is an action for the future – will be addressed and evidenced in phase 2			
14(b) A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Review the document that currently exists for the SCRR reviewers and update it in terms of good practice identified in RQIA review document as the basis for further review should SCRR continue to be utilised in the extended Lookback Review.	Project Manager (LE)	**20/10/22** – This work has commenced **18/11/22 –** Being prepared to support IS contract **16/12/22** – draft guideline shared with IS as part of contracting process	Closed	IS Contract Contract monitoring notes

14 (c) A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Consider this action	Chair of Steering Group (MOH)	**20/10/22** – recommendation considered – due to lack of SCRR reviewers it is not possible to undertake a second review of a sample of the returned SCRR reports. For this cohort of patients a comparative analysis of reasons for SCRR verse findings from SCRR has been undertaken and both align	Closed see below re next phase of LBR	SCRR theming analysis
SCRR process to be reviewed - if being utilised for the extended cohort of patients. This recommendation to be applied at that time.	This is an action for the future – will be addressed and evidenced in phase 2			

RECOMMENDATION 15				
A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Commission a "Thematic Review" undertaken when all 53 SCRR reports and complete.	Medical Director	**20/10/22** – an external urologist identified to complete this work when the report are returned. Currently on 24 of the 53 reports have been returned. **18/11/22 –** no further SCRR returned **16/11/22** – Meeting with Dr Sally Williams on 13/12 – Dr William agreed to coordinate a thematic Review when SCRR complete **03/02/23** – five outstand SCRR returns. Dr Williams to be contacted to start process for undertaking a thematic review **20/03/23-** Contract pending with Dr Sally Williams with support of the IS SME's who undertook the completion of the SCRR reports. **24/04/23** – DAC being drafted – delayed due to checking if an external urologist would complete negating need for a DAC	Ongoing	
Provide an analysis of the themes identified by Trust senior doctors through the internal "SCRR Screening" process and complete to themes identified external SCRR urologists	Head of the Lookback Review (SW)	**20/10/22** – Complete and will be kept up to date as reports are returned	Closed	Up to date report available

RECOMMENDATION 16				
SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Agree and document the process(s) for disseminating regional learning following the Lookback Review for consideration by UAG	Head of the Lookback Review (SW)	**20/10/22** – work commenced **18/11/22 –** no update to report **16/12/22** – no further progress **03/02/23** – no further progress as cohort 1 still to complete. **20/03/23 –** date agreed for Learning and Development Group this month. HOS will attend to disseminate from LBR Process. (Update from meeting will be reflected in next action plan update) **24/04/23** – learning to be shared following completion of Cohort 1 outcomes report.	Ongoing	
Update Communication plan to include this aspect of communication	Project Manager (LE)	**20/10/22** – cannot commence until above action completed **16/12/22** – no change **03/02/23** – no change **20/03/23** – no change **24/04/23** – no change – Outcomes report due end May for discussion and agreement at UAG on 7 June 23	Not started	

RECOMMENDATION 17				
SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft a "Statement of Purpose"	Project Manager (LE)	**20/10/22** – Copy in draft awaiting review and sign-off **18/11/22** – no update to report **16/12/22** – not signed off until cross-reference against template requested from BOH (via RQIA) – not yet received **03/02/22** – database developer completing – request made for draft to be shared **20/03/23** – Document Finalised	Complete	Statement of Purpose document

RECOMMENDATION 18				
18(a) SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process				
Action(s) Required to Deliver Recommendation(s)	**Responsible Officer?**	**Update**	**Status RAG**	**Evidence pf Completion**
Draft communications strategy including communication plan	Communications Manager (PT)	**20/10/22** – draft plan complete – awaiting review and sign-off **18/11/22 –** no update to report **16/11/22** – Phase 1 plan complete – will be revised for Phase 2	Complete and closed	PID including phase 1 comms plan
18(b) A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.				

Action(s) Required to Deliver Recommendation(s)	Responsible Officer?	Update	Status RAG	Evidence pf Completion
Consider above recommendation		**20/10/22** – channel of communication currently exists with GMC and USI. Communication with PSNI and / or coroner not warranted at this time – this will be established if required in the future.	Complete and Closed	Emails and documents shared with GMC and USI.

Southern Health and Social Care Trust

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Policy and Procedures for the Reporting and Management of Adverse Incidents

Version 2.0 2023

Lead Policy Author & Job Title:	Caroline Doyle, Interim Assistant Director of Clinical & Social Care Governance
Directorate responsible for document:	Medical Directorate
Issue Date:	19 December 2023
Review Date:	19 December 2025

Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Policy and Procedures for the Reporting and Management of Adverse Incidents, Version 2.0
Lead Policy Author & Job Title:	**Caroline Doyle, Interim Assistant Director of Clinical and Social Care Governance**
Director responsible for Policy:	Dr Stephen Austin, Medical Director
Directorate responsible for Policy:	Medical
Equality Screened by:	**Caroline Doyle, Interim Assistant Director of Clinical and Social Care Governance**
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	19 December 2023
Date approved by SLT:	Revised policy - SLT approval not applicable
Policy circulated to:	All Directors and Assistant Directors for sharing amongst teams within Directorates All Governance Coordinators
Policy uploaded to:	Sharepoint

Version Control

Version:	**Version 2.0**		
Supersedes:	Southern Health and Social Care Trust Incident Management Procedure (2014 working draft)		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
Version 2.0 2023 Draft	**Circulated to Policy Scrutiny Committee and SLT for comment**	19/12/2023	**Caroline Doyle, Interim ADCSCG**
Version 1.0 2014 Working Draft		01/10/2014	**Margaret Marshall, ADSCG**

1.0 Introduction

Arising out of the recommendations of the Regional Learning System Project Report (August 2015), it was agreed to develop a regional policy on the reporting and management of adverse incidents to be used by all Health & Social Care Trusts, the Northern Ireland Ambulance Service (NIAS) and the Strategic Planning & Performance Group (SPPG) hereinafter called ("the organisation").

The following document has been developed in accordance with the Southern Health and Social Care Trust's (SHSCT) Key Principles for Policy development.

1.1 Purpose and Aims

The manner by which an organisation manages and learns from adverse incidents is one of the key markers of success in relation to risk management, corporate and clinical and social care governance standards. Consistent identification, monitoring and review of incidents is central to the organisation's strategic and operational processes to ensure it can achieve its vision for safe and effective care.

It recognises that no health and social care environment will ever be absolutely safe and, on occasions, errors or incidents will occur. Equally, it recognises that when incidents do occur it is important to identify causes to ensure that lessons are learned to prevent recurrence.

The organisation is committed to an open, honest and just culture and reporting of adverse incidents is encouraged so that the organisation can learn from incidents and take actions including changes in practice to reduce the risk of recurrence. It also will ensure that staff learn and are supported in making changes to their practice, post incidents, as required.

1.2 Objectives of this Policy

This policy provides guidance on the reporting and management of adverse incidents which affect service users, staff and visitors on its premises or have an impact on the organisation, its reputation or its legal duty of care. It will also enable a robust and systematic approach to the management of adverse incidents that will be consistently applied across the organisation ensuring that it meets all relevant statutory[1] or mandatory responsibilities and reporting requirements, thereby safeguarding the wellbeing of service users, staff and visitors.

It has been developed to ensure organisational wide learning takes place within a structured framework and that any lessons learned are disseminated widely throughout the organisation and to external agencies, as appropriate.

Adverse incident management systems assist organisations to ensure that systems are in place to secure service user, staff and visitor safety, ensure internal accountability and safeguard the organisation's assets and reputation. Learning from adverse incidents enables the organisation to proactively reduce risk and improve

[1] Health & Safety at Work Order 1978, Management of Health and Safety at Work Regulations (Northern Ireland) 2000 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

services. It recognises that most incidents occur because of problems with systems rather than individuals but may also on occasions be multifactorial in nature.

The objectives of this policy are: -

- To promote and provide a unified regional organisational wide system for the reporting, recording, review and analysis of all adverse incidents;
- To improve the safety and quality of care through reporting, analysing and learning from incidents involving service users, staff and visitors (including contractors);
- To comply with relevant legislation and standards relating to the reporting of incidents;
- To ensure all adverse incidents are dealt with appropriately and in a timely and consistent manner;
- To provide a means of analysing trends in incidents within teams and the Trust Clinical and Social Care Governance (CSCG) structures;
- Identification of factors contributing to incidents to assist in implementation of learning, service improvement and risk reduction strategies, thereby minimising risk to service users, staff and visitors and the organisation; and
- To support staff when things do not go as planned and encourage staff to review and reflect on their practice post review of incidents.

1.3 Policy Statement

The Trust is committed to providing the best possible services for its service users, staff and visitors. It recognises that adverse incidents will occur and that it is important to identify causes to ensure that lessons are learnt to prevent recurrence. It is, therefore, essential that a responsive and effective incident recording, reporting and management system is in place to achieve this aim. Where learning from such adverse incidents is identified, the necessary changes should be put in place to improve practice.

2.0 Policy Principles

2.1 Definitions

Adverse Incident: Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation/Special Agency or commissioned service[2]. A suggested list of broad categories of adverse incidents to be reported is listed in Appendix 1 for guidance purposes.

Harm is defined as: “injury (physical or psychological), disease, suffering, disability or death”.[3] In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient’s/client’s illness or underlying condition.

Serious Adverse Incident (SAI): is an adverse incident that must be reported to the Health and Social Care Board (HSCB) because it meets at least one of the criteria as

[2] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[3] Doing Less Harm, NHS, National Patient Safety Agency 2001

defined by the HSCB within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs), Oct 2016[4].

Service User[5]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

2.2 The organisation's approach to Adverse Incident Reporting and Management: A just and learning culture[6]

As part of its proactive approach to risk management, the organisation promotes a just and learning culture in which errors or service failures can be admitted, reported and discussed without fear of reprisal. This will enable lessons to be identified and allow active learning to take place and the necessary changes made or reflected in policies, procedures and practices.

All staff must report and manage adverse incidents according to this policy (and any related operational procedures) for adverse incident reporting. Crucial to the effectiveness of adverse incident reporting and management is the organisation's commitment to the promotion of a just and learning culture where all staff can participate in reporting adverse incidents. Staff are encouraged to report incidents and to look critically at their own actions and those of their teams, to ensure the organisation can provide quality services for our service users, staff and visitors.

Ultimately, the organisation wants to encourage staff to report areas of concern and to foster a positive ethos around reporting. Trust staff work within complex systems in which many factors influence events and outcomes. The principles of a just and learning culture will be applied to determine the most appropriate response when things do not go as planned. It is important that learning takes place to prevent a reoccurrence of an adverse incident rather than adopting a punitive approach. Staff who make a prompt and honest report in relation to an adverse incident should not expect to be subject to disciplinary action except under the following circumstances: -

- A breach of law;
- Wilful or gross carelessness or professional misconduct;
- Repeated breaches of Trust policy and procedure;
- Where, in the view of the Trust, and/or any professional registration body, the action causing the incident is far removed from acceptable practice; or
- Where there is failure to report a serious incident in which a member of staff was involved or about which they were aware.

Completion of an adverse incident report does not discharge staff of their duty of care and their risk management responsibility. There should be timely and appropriate follow-up of adverse incidents. Where preventative measures and/or procedural changes are identified these should be put in place to minimise the risk of the adverse incident recurring.

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[4] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[5] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

[6] *a just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. ''…generally in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts'. (NHS England, A Just Culture Guide; Professor Sir Norman Williams's Review into Gross Negligence Manslaughter in Healthcare report, June 2018).*

All employees must be honest, open and truthful in all their dealings with patients/clients and the public, and organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.

2.3 External reporting arrangements in respect of other incidents not covered by this policy

Depending on the nature of the adverse incident the organisation may be required to report relevant details to other statutory agencies and external bodies e.g. HSCB, RQIA, HSENI, UKAS (United Kingdom Accreditation Service). Staff should ensure that they are aware of their local reporting requirements to other statutory agencies and external bodies as per their local policy/procedures. These incidents must also be recorded on the organisation's incident reporting system.

2.4 External reporting arrangements in respect of Independent Service Providers (ISPs) and Contractors

With regard to Independent Service Providers (ISPs) and contractors, they will be required under their contractual arrangements to maintain a system of reporting and recording of adverse incidents related to service users referred to them by the Trust for assessment, treatment or care. ISPs are also required to submit monitoring information to the organisation as required. Both adverse incidents and SAIs are discussed at contract meetings between Trusts and ISPs. As per the HSCB (now SPPG) procedure for reporting SAIs (November 2016), the Trust will decide whether an ISP adverse incident meets the criteria for reporting as a SAI and is, therefore, responsible for reporting the SAI to the SPPG.

This policy does not cover the arrangements for the reporting of Early Alerts to the Department of Health as this is the subject of separate guidance/policy.

3.0 Scope of Policy

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care.

This policy excludes detailed arrangements in respect of the following areas which are covered by separate regionally agreed policies:

- Policy on the reporting of Early Alerts;
- Policy of Being Open;
- Policy on Raising Concerns;
- Policy on Reporting of Adverse Incidents under RIDDOR Regulations;
- Policy on Supporting Staff involved in Incidents, Complaints, Claims and Coroners Inquests;

- Policy on Liaison and Effective Communications with PSNI and HSENI when investigating Patient Safety Incidents involving Unexpected Death and Serious Untoward Harm; and
- Policy on Mortality & Morbidity Guidance.

4.0 Responsibilities

Trust Board is responsible for ensuring that a robust system is in place for reporting and management of adverse incidents and will receive regular management reports on this subject matter.

Chief Executive is the responsible Officer for the Trust's statutory duty of quality and is required to drive the delivery of the Trust's corporate priorities, particularly the priority to provide safe, high quality care. Through the overview of this Trust Policy and Procedure, the Chief Executive will seek to embed the Trust's value of all staff being open and honest and acting with integrity and candour.

The Executive Medical Director is the lead Director responsible for the reporting and management of adverse incidents within the Trust. He/she will ensure that systems, policies and procedures are developed and implemented on an organisational basis including the onward reporting of relevant incidents to external agencies for e.g., Strategic Planning & Performance Group (SPPG), Health & Safety Executive for Northern Ireland (HSENI) and the Regulation, Quality Improvement Authority (RQIA). On a daily basis this function is delegated to the Assistant Director of Clinical and Social Care Governance.

Directors and Divisional Medical Directors are responsible for ensuring that the Trust's policy on adverse incident reporting and management is widely disseminated, promoted and implemented within their areas of responsibility.

Assistant Directors/ and Clinical Directors are responsible and accountable to their respective Directors for ensuring that this policy and any associated procedures are effectively implemented within their areas of responsibility. They should also promote a just and learning reporting culture and ensure that appropriate reviews are carried out.

Senior Managers, Heads of Departments/Services are responsible for:

- ensuring that this policy and associated procedures are effectively implemented across their area of responsibility;
- promoting an open, honest and just reporting culture;
- ensuring that staff are appropriately trained in the reporting and management of adverse incidents;
- ensuring that appropriate review of adverse incidents is carried out; and
- reviewing, approving and/or escalation of incidents via DatixWeb.

Person/s who report an incident (Reporter) is responsible for reporting the incident using DatixWeb in line with Trust reporting criteria and timescales.

Person/s who review incidents (Reviewer) is responsible for ensuring that incidents are reported in line with Trust reporting policies and procedures and the content of the report is appropriate. They will also be responsible for initiating any relevant reviews within agreed Trust timeframes. On completion of this process they are responsible for moving the incident to 'awaiting final approval' stage.

Person/s who approve incidents (Approver) is responsible for ensuring the incident reporting and review process have been followed and that all information and/or actions contained within the report and review have been acted upon appropriately prior to agreeing 'final approval' and closure of the incident within agreed Trust timeframes.

Medicines Governance Pharmacist (MGP) is responsible for the expert review, quality assurance and identification of learning from reported medication incidents. In the event an adverse incident is categorised as a Serious Adverse Incident, the MGP should be involved in the review. He /she is also responsible for submission of HSC Trust medication incident data for regional analysis by the Medicines Governance Teams.

All staff have a responsibility to:

- ensure the safety of individuals involved (service users, visitors and staff), the environment and equipment;
- avoid putting themselves and others in situations of danger;
- ensure their line manager/s and/or person in charge of the area is informed of the incident;
- record and report all adverse incidents using the organisation's reporting systems as soon as possible and ideally within 24 hours of the occurrence or becoming aware of the adverse incident; and
- co-operate with any review process including the provision of witness statements, if appropriate.

Senior Information Risk Owner (SIRO) is the lead Director for ensuring Information Governance (IG) incidents are reported and appropriately managed
including reporting to Information Commissioner's Office, if necessary. He/she (or nominee) will provide advice and support to managers in respect of IG incidents, as appropriate.

5.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

The key legislative reporting requirements for organisations in respect of adverse incidents are as follows:

- Health & Safety at Work (NI) Order 1978;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1997;
- Social Security Claims and Payments Regulations 1979; and
- The Public Interest Disclosure Act 1998.

6.0 Implementation of Policy

6.1 Learning and Feedback

Learning from adverse incidents can only take place when they are reported and investigated in a positive, open and structured way. Where learning from such adverse incidents is identified the organisation will ensure that the necessary changes will be put in place to improve practice. Where learning from incidents is relevant to other areas across the organisation, and/or externally, the learning should be shared as per current organisational arrangements, e.g. established sub committees and groups.

Feedback to staff is vital in respect of incidents they report. Managers should ensure it occurs in their respective areas. This can be on a one to one basis or feedback can be given to all staff at regular Incident, Staff or Assurance / Governance Meetings.

6.1 Dissemination

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care. All staff employed by the Trust should be provided with access to this policy. The latest version of this policy (and related documents) is available on the Trust's Sharepoint.

6.2 Resources

6.2.1 Training

Adverse Incident Training is **mandatory** for all staff and appropriate training and guidance will be provided to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to report adverse incidents. The organisation's training administration system, LearnHSCNI, should be used appropriately to record staff training. Senior Managers/Heads of Departments are responsible for ensuring that training on Incident Reporting is covered in local Directorate induction programmes.

7.0 Monitoring

An audit of the policy will be undertaken post implementation to ensure adherence to the principles and procedures outlined in this policy document. Changes will be made to the policy, as required. This policy will be reviewed on a regular basis by the Assistant Director of Clinical and Social Care Governance in the light of best practice, changing legislation or new/updated policy guidance.

8 .0 Sources of Advice & Further Information

- Health & Safety at Work (Northern Ireland) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997;
- HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016;
- Six steps to Root Cause Analysis, 2002, Consequence UK Limited;
- National Patient Safety Agency;
- Seven Steps to Patient Safety (2004); and
- Being Open, Patient Safety Alert, November 2009.

9.0 APPENDICES

Appendix 1	*Process for Reporting and managing an Adverse Incident*
Appendix 2	*Examples of Adverse Incidents that should be reported*
Appendix 3	*Regional Risk Matrix*
Appendix 4	*Guidance for Incident Review and Grading*

10.0 Equality & Human Rights Considerations

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

Southern Health and Social Care Trust

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Operational Procedure for the Reporting and Management of Adverse Incidents

1.0 Purpose of procedure

This procedure sets out the organisation's processes for reporting, recording, reviewing and communication with service users and staff following an adverse incident.

2.0 What to do when an adverse incident occurs – immediate action

- The extent of injuries/damages to person(s) or property should be ascertained, and a determination made regarding the need for emergency or urgent treatment / action. For patient / client care related incidents, contact the relevant medical team to assess where required;
- Appropriate obvious treatment / actions should be taken to minimise the likelihood of the incident recurring;
- Any equipment involved in the incident should be removed from use and clearly labeled, "Do not use", until appropriate checks can be carried out. Do not dispose of equipment involved in an incident;
- **The service user/patient/client and/or their family/or carers** should be informed, as soon as possible of the incident and of any treatment that may be necessary taking into consideration any consent issues and referring to the Trust's "Being Open" policy;
- Any incident involving a patient or client, and the action taken, should be recorded in their healthcare record;
- If the incident is major or catastrophic and requires an immediate action plan to prevent further harm the line manager (if out of hours, the Senior Out of Hours Manager) should be informed;
- For incidents requiring further in-depth investigation e.g. SAIs/Internal Root Cause Analysis (RCA's) / Reviews, patient/client records should be returned as soon as is practical to the Directorate Governance Coordinator to ensure all recorded information is available for review. Retrospective notes are permitted as long as these are clearly marked as being made in retrospect;
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property;
- CCTV footage should be sourced, and a copy made for all cases which would be subject to PSNI investigation;
- Security staff and/or the PSNI should be informed where appropriate;
- Consideration should also be given to the need to activate site-based emergency / contingency plans if necessary (in line with current emergency procedures).

3.0 Reporting an Incident:

Appendix 1 – sets out the process for reporting and managing an adverse incident.

Appendix 2 - sets out some examples of incidents that should be reported via the Trust's DATIX incident management system

Where: All incidents must be recorded electronically via the Datix Web based form (IR1 form) which can be accessed as follows from the Trust intranet site. **(Trust intranet/ useful links/ other useful links and scroll down to click on 'Datix Web')**

By Whom: This form must be completed by all staff who are involved in or have witnessed an incident, or by the person the incident has been reported to.

When: All incidents should be reported via the electronic reporting form (IR1 form), no later than the end of the working shift or day during which it occurred, **or** its occurrence became known.

How: Information concerning the incident must be accurate, complete and factual. The description of the incident should not contain opinions, conclusions, subjective or speculative statements. The following instructions should be followed when filling in the electronic incident form. *See Hyperlink below:*

http://vsrintranet/SHSCT/documents/DatixWebIR1FormUserGuidance_000.pdf

Incidents given an initial severity rating of major or catastrophic (as a minimum) will automatically be triggered to the appropriate Head of Service/Team Manager and relevant Assistant Director in an email via Datix Web.

In circumstances where the incident is considered as a potential Serious Adverse Incident (SAI), immediate telephone contact should be made to the relevant Head of Service/ Line Manager or Out of Hours Manager if appropriate. They will notify the appropriate Director, Assistant Director/Divisional Medical Director and Clinical and Social Care Governance Coordinator at the earliest opportunity. The incident will then be reviewed by the latter group against the HSCB SAI criteria and the DHSSPS Early Alert criteria. The appropriate Director should brief the Chief Executive on incidents that occur that meet the SAI criteria.

4.0 Procedure for Reviewing, Grading and Monitoring Adverse Incidents:

All incidents are to be reviewed on a weekly basis by the service area's Incident Review Teams. The purpose of the Incident Review Team is to undertake a local assessment / review of the incident in a timely manner. This review should include:

- Quality assure the information submitted via the Datix system and the initial severity rating given to the incident. Where the review team believes the

severity rating should be changed – the incident reporter should be contacted, and this should be discussed and agreed

- Calculate the actual and potential risk rating for the incident using the Risk Grading Matrix and impact Table (Appendix 3)
- Consider the need for additional internal and /or external reporting e.g. RIDDOR, NIAIC, HSCB, RQIA, UKAS, Vulnerable Adults (PVA), Fire.
- If the incident is also an adult safeguarding review (this will be recorded on Datix) then the Incident Review team should link with the adult safeguarding Designated Officer (DO) for that incident.
- Develop and agree learning and action plans as appropriate. All **moderate, major** and **catastrophic** incidents reported will require a time bound action plan which **must** include relevant learning points. This learning should be communicated and actioned within teams
- Feedback the outcome of the review of **moderate, major and catastrophic** incidents to the incident reporter.
- Inform the appropriate Assistant Director of any immediate learning which could minimise the risk of further reoccurrence of the incident
- Escalate any barriers to implementation of action plans relating to incidents to the appropriate Head of Service and the Assistant Director
- Close all incidents following completion of the review process

N.B: The Medicines Governance Pharmacist will lead on the multidisciplinary review, monitoring and analysis of medication related incidents and will link with the Regional Medicines Governance Team to inform the content of regional medication related governance reports.

4.0 Deciding what to review

Appendix 4 – Sets out guidance for Adverse Incident Review

Many organisations typically report thousands of incidents each year. It is therefore unrealistic to suggest that all incidents should be reviewed to the same degree, or at the same level, within the organisation. Furthermore, the outcome of an incident, including a 'near miss', at the time of occurrence is sometimes a poor indicator of the level of review required. The application of a simple risk assessment process to incidents at the time of occurrence can enable the organisation to implement a structured approach to its incident management.

5.0 Communication with Service Users and/or relatives (for incidents resulting in moderate to catastrophic harm incidents)

The lead member of staff responsible for the treatment and/or care will retain the responsibility for communicating with the service user and their relatives about the incident. However, there may also be a liaison person at a senior level identified to make contact with the family.

Harming a service user can have devastating emotional and physical consequences for the individuals, their families and carers, and can be distressing for the

professionals involved. ***'Being Open'***[7] is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident. **"Saying sorry is not an admission of liability".**

'*Being Open'* involves:

- acknowledging, apologising and explaining when things go wrong.
- keeping service users and carers fully informed when an incident has occurred.
- conducting a thorough review into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident reoccurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened; and
- recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff. Permission will be given to seek emotional support.

The organisation is committed to improving the safety and quality of the care we deliver to the public. Our '*Being Open'* policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven Steps to Patient Safety'*.

Further guidance on communicating with service users and their relatives is available in the Being Open and/or Serious Adverse Incident Policy.

6.0 Debriefing of Staff after Adverse Incidents

Assistant Directors/ Senior Managers and Heads of Department should ensure that local procedures and training is in place for the debriefing of staff after incidents. Agreed timescales for debriefing should be specified. The Line Manager should ensure that the staff member has access to appropriate help immediately post incident as necessary e.g., referral for medical opinion in case of assault, counselling etc. Line managers should, where appropriate, seek medical advice as to whether it is advisable for the staff member to return to (or stay in) the workplace.

In the case of assaults, line managers should discuss with the staff member whether or not they wish the police to be involved. Line managers should make staff aware of the availability of the services of Occupational Health Services and other staff care services.

It should be standard practice at all debriefing sessions with staff to consider the contributing factors, which may have led to an incident. This should assist staff in reviewing practice and updating care plans, risk assessments etc. in order to minimise the risk of recurrence. Details of debriefing offered/arranged should be documented and retained in the staff member's local personnel file.

7.0 Communication with the Media

All communications with the media regarding Adverse Incidents should be co-ordinated by the Trust's Communication Team.

Appendix 1 – Process for Reporting and Managing an Adverse Incident (Including level of Incident review based on potential risk grading)

INCIDENT

IMMEDIATE ACTION

1. Make person(s) / area safe.
2. Obtain medical aid if required.
3. Inform manager on duty ASAP.
4. Complete an incident form.
5. Consider level of communication with the patient.
6. Consider level of review required and action accordingly. If incident meets SAI criteria, follow relevant procedures.

GREEN INCIDENT (LOW RISK)	YELLOW INCIDENT (MEDIUM RISK)	AMBER INCIDENT (HIGH RISK)	RED INCIDENT (EXTREME RISK)
Green incidents – Should normally be reviewed locally in the ward or department in which the event occurred. The investigative lead will normally be the Ward/Team/Departmental manager. It is the local team's responsibility to identify learning points, or safety improvement measures that are within the departments control and ensure that those safety measures identified that are not within the control of the department are appropriately communicated to the relevant Management Team for consideration. Incident types frequently falling into this category should also be subject to aggregate analysis by the Ward/Team/Departmental Manager to identify any need for more targeted data collection. It is acceptable for the ward/departmental manager to close such incidents following review and recording of findings and lessons learned on Datix. Review of this grade of incident should normally be completed and **closed within 5 working days**.	**Yellow Incidents** – These should also be reviewed locally, as for Green Incidents, but reviewed by the **incident review teams identified** for that area. Again, it is the local team's responsibility to identify learning points, or safety improvement measures within the departments control and ensure that those which are not, are appropriately communicated to the relevant Management Team for consideration. Frequently occurring events attracting this risk category should also undergo Trust-wide aggregate review to identify any need for more targeted data collection. It is acceptable for the Ward/Team/Departmental Manager to close such incidents following review and proper recording of findings and lessons learned on Datix. Review of this grade of incident should normally be completed and **closed within 4 weeks**.	**Amber Incidents** – These incidents should be subject to the appropriate level of review. The **Governance Coordinator /Clinical Manager/Senior Nurse/Senior Manager** should discuss with the relevant **Assistant Director/Co-Director**, who is going to take the lead. It is the responsibility of the relevant management team to ensure that all learning points and safety improvements are appropriately identified and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate. **Note** – Improvement strategies arising out of this group of events should be monitored as part of the organisation's Governance arrangements. . Where necessary advice can be sought from the **Directorate Governance Coordinators** Review of this grade of incident should normally be completed and **closed within 12 weeks**.	**Red Incidents** – Where major (i.e., long-term permanent harm/disability [physical/emotional injuries/trauma]) or tragic harm (i.e., permanent harm/disability [physical/emotional trauma] or incident leading to death) has occurred the Chief Executive of the organisation (**or nominated Director and/or Assistant Director/Co-Director**), with the support and advice of the relevant Director/s and Governance lead(s), should appoint a team led by a trained facilitator in SEA/root cause analysis. All of the resulting reports and improvement strategies arising from these events should be monitored by the organisation's [insert name of Committee/sub-committee]. Review of this grade of incident should normally be completed and **closed within 12 weeks.**

Appendix 2 – Examples of Adverse Incidents that should be reported

Broad categories of possible adverse incidents are shown below and may assist reporters. This list is not comprehensive but gives a broad indication of what should be reported

- Abusive, violent, disruptive, challenging or self-harming behaviour
- Delays or difficulties during appointments, admissions, transfers or discharges
- Accidents e.g. falls, medical sharps injuries, manual handling, exposure to hazardous substance, burn or scalds
- Cardiac arrests involving CPR and/or Defib
- Issues with clinical investigations, scans, x-rays, lab tests etc.
- Communication breakdowns between staff and/or with service users, issues with consent and confidentiality
- Diagnosis, missed or delayed
- Financial loss to the Trust
- Infrastructure or Resources (staffing, facilities, environment) – for example, unsafe environment, waste issues, misuse, failure or theft of IT equipment or systems, lack of facilities, equipment or supplies, inadequate staffing levels
- Infection control issues, pressure sores, fluid maintenance, pain management, any other issues relating to implementation of care or ongoing monitoring / review
- Labour or delivery adverse incidents
- Medical device/equipment related Incidents – any preventable equipment related event that could have or did lead to patient harm, loss or damage. Includes incidents related to training, servicing, disposal, storage, and suitability as well as failure of the equipment itself
- Medication incident (i.e., any preventable medication related event that could have or did lead to patient harm, loss or damage).
- Patient Information issues e.g. records, documents, test results, scans. This may also include any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
- Treatment, procedure – any adverse incident immediately before, during or immediately after
- Security – for example, fires and fire risks, theft or damage to personal property, premises or vehicles, intruders or break-ins

DOMAIN	Appendix 3(Table 1) Regional Risk Matrix - IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid. • Non-permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration). • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity,* *enquiries from public representatives/media* *Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7-day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest > 3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.

Appendix 3 table 2 - Risk Likelihood Scoring Table

Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Risk Matrix/Consequence (Severity Levels)				
Likelihood Scoring Descriptors	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Appendix 4 – Guidance for Incident Review & Grading

This section is a general guide to the review of incidents. **It is recognised that each organisation will have different organisational arrangements and therefore it is acceptable to replace this appendix with local arrangements provided they are based on the undernoted principles.**

Deciding what to review

Organisations should grade all incidents on DatixWeb for actual impact at the time of reporting the incident. This is usually completed by the reporter of the incident using the Regional Risk Matrix (Impact Assessment Table) (see Appendix 3). The Reviewer/Approver should complete the potential risk grading also using the Regional Risk Matrix (Impact Assessment Table /Likelihood Descriptors) on Datix Web **The** following steps should be used:

- **Step 1** – grade the adverse incident according to the **actual impact/ severity** to the individual and/or organisation.
- **Step 2** – determine the **potential impact/consequence** and **likelihood** of reoccurrence; and
- **Step 3** – calculate overall risk rating (i.e. Red [Extreme Risk], Amber [High Risk], Yellow [Medium Risk] or Green [Low Risk]).

The organisation's on-line reporting system allows staff to input this information directly into the electronic system.

Step 1 – What is the actual impact/severity of the event?

Use the Impact Assessment Table at Appendix 3 to determine the **actual impact/severity** of the event by considering the outcome of the incident in terms of harm to: People, Quality & Professional Standards/guidelines, Reputation, Finance, Information & Assets, Resources or Environmental issues.

If two or more domains (see Appendix 3) have been affected by the incident, consider which has been affected the most to assist in your judgement of the impact/severity of the incident. The impact/severity categories are as follows: Insignificant, Minor, Moderate, Major or Catastrophic. This information should be recorded within the "Actual Impact/Severity" field within Datix.

Step 2 – Assessment of potential future risk

This grading is required to alert the organisation to incidents that, should they occur again in similar circumstances, have the potential for serious harm to services users, staff or visitors, or major impact on the organisation, in order that appropriate preventative measures may be implemented. In order to obtain a realistic assessment of potential future risk you need to consider the following factors: -

- **Potential Impact/Severity/Consequence** – Think about the potential impact if the incident were to occur again without having implemented further control measures to make the impact less severe and grade accordingly (refer to Impact Table in the Risk Matrix). You should also consider the **most likely or typical impact** for that type of incident.

- **Likelihood** – consider how likely it is that the event will occur again? This can be done by considering the likelihood table (Table 1) at Appendix 3.

Grading of potential future risks following incidents helps to inform the extent of review required and the level at which review should be conducted. Grading should be based on best judgement taking into consideration all facts known about the incident at the time of occurrence.

Action required based on the Incident Grading

The Table in Appendix 1 details the actions required with regard to the level of review based on the potential risk grading.

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STRUCTURED EARLY LEARNING TOOL

This tool should be used by multidisciplinary teams to facilitate the **early screening** of any case from which it is likely **learning** can be gleaned concerning patient safety and quality of care. It has been adapted from the RCPsych Mortality Review Tool, which was itself an adaptation of the Structured Judgement Review tool from the RCP, both of which focus on reviewing the care after a patient's death. The triggers to initiate the use of this tool will, however, be determined by each clinical specialty in conjunction with the Trust's clinical governance team. The intended outputs from this process are: to indicate the need for **immediate improvements** in patient safety and/or quality of care, to highlight **examples of good quality care** and to **indicate the need for a more in-depth review** where necessary.

Reviewing Team:		Date of Review:	

Section 1: Details of Case

Patient identification number:		Gender:	M/F
Date of birth (dd/mm/yyyy)		Age:	
Social deprivation index (first 3−4 letters of postcode)		Ethnicity:	
Date of incident:		Time: (00:00)	
Incident Report/ Datix Ref Number			
Location			
Cause of death (if relevant)			
Primary diagnosis, including ICD-10 code			
Co-morbidities			
Healthcare teams involved in the patient's care at the time of death			
Dates of last admissions to hospital (where relevant)			
Dates of last presentations to team			
Patient summary (to be completed by the clinical team)			

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Trigger Categories
Specialty/ Trust Predetermined Triggers ☐ Cases likely to engender learning ☐ Cases considered 'near misses' ☐ Cases where concerns are raised by patient, family, carers or staff ☐
Information Sources
Please state the information sources used for the review, including the names of the electronic systems accessed NIECR ☐ PARIS ☐ Clinical Manager ☐ PAS ☐ Datix ☐ Other:_____

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Section 2 SELT REVIEW (SELT)

Note: In making these judgements bear in mind that the quality of care delivered is the outworking of the interactions between the care delivery system, the care delivered by the clinical team and the care delivered by individual clinical staff. Thus, by considering both system and human factors, **useful learning** concerning the quality and safety of patient care is more likely to be generated. *(The phases of care below can be adapted or added to according to the needs of the specialty.)*

2.1. Phase of care: Allocation and initial assessment or review (where relevant) Please record your ***explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant
Please rate the care received by the patient during this phase as being: ☐ **Of an acceptable standard or above, noting areas of good practice** ☐ **Of an adequate standard, noting any areas which may require improvement** ☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.** **OR** ☐ **It was not possible to reach a consensus view.**

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2.2 Phase of care: Ongoing care (where relevant)

- **Was mental health monitored adequately?**
- **Was physical health monitored adequately?**
- **Please list medication if known and relevant, and comment on medication monitoring where appropriate**

Please record ***your explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant

Please rate the care received by the patient during this phase as being:

☐ **Of an acceptable standard or above, noting areas of good practice**
☐ **Of an adequate standard, noting any areas which may require improvement**
☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.**

OR

☐ **It was not possible to reach a consensus view.**

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2.3. Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant) Please record ***your explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as being: ☐ **Of an acceptable standard or above, noting areas of good practice** ☐ **Of an adequate standard, noting any areas which may require improvement** ☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.** **OR** ☐ **It was not possible to reach a consensus view.**

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2.4. Phase of care: End of life care (where relevant) Please record ***your explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as being: ☐ **Of an acceptable standard or above, noting areas of good practice** ☐ **Of an adequate standard, noting any areas which may require improvement** ☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.** **OR** ☐ **It was not possible to reach a consensus view.**

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2.5. Phase of care: Discharge plan of care (where relevant) Please record ***your explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as being: ☐ **Of an acceptable standard or above, noting areas of good practice** ☐ **Of an adequate standard, noting any areas which may require improvement** ☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.** **OR** ☐ **It was not possible to reach a consensus view.**

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2.6. Other areas of care (please specify) Please record ***your explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as being: ☐ **Of an acceptable standard or above, noting areas of good practice** ☐ **Of an adequate standard, noting any areas which may require improvement** ☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.** **OR** ☐ **It was not possible to reach a consensus view.**

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2.7. Overall care

Please record ***your explicit judgements*** about the quality of care the patient received and whether it was in accordance with current good practice.
Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as being:

- ☐ **Of an acceptable standard or above, noting areas of good practice**
- ☐ **Of an adequate standard, noting any areas which may require improvement**
- ☐ **Below acceptable standards, noting what requires immediate improvement and what may require further review.**

OR

- ☐ **It was not possible to reach a consensus view.**

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Section 3: OUTPUTS

NOTE: This section will require **collaboration** between clinical teams, clinical governance and the relevant operational management team. When care has involved more than one clinical team it may be necessary **for more than one review** to be carried out initially. In doing so, **teams must restrict their judgements to their phases** of care but of course include their part in any handover/interface with other teams.

Please tick appropriate box (more than one box can be selected)

3.1	If all phases of care are judged to be of **an acceptable standard or above,** then staff should be **commended** and examples of good care should be shared across relevant teams.	
3.2	If aspects of the safety and quality of care are judged to be **below an acceptable standard,** or there is a **significant lack of consensus,** a more **in-depth review** will be necessary. An immediate **action plan** to improve **safety** must also be drawn up and implemented.	
3.3	Ensue early **learning points** are clearly linked to, and extracted from, the evidence accrued during the structured judgement review process. A learning output mechanism must follow and an assigned person must be tasked with **dissemination and implementation**.	
3.4	If the **patient, family, carers or staff** have raised **concerns**, or if it deemed appropriate (taking account of the **principles** of the duty of **candour**) the conclusions from the SELT must be shared with them. Their perspective will then be an important influence on any or all of the above outcomes.	

Section 4 Learning outcomes (if appropriate)

4. Learning Outcomes Please note any learning that came from the review. Where possible note any allocated persons for the dissemination, implementation and progressing of same.

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Quality Care - for you, with you

SHSCT Clinical Audit Strategy

2022 - 2024

This document describes how SHSCT will implement it's clinical audit policy and increase the impact of clinical audit on the provision of safe, high quality care to patients and service users.

Working together Excellence Openness & Honesty Compassion

Table of Contents

Executive Statement

The Southern Health & Social Care Trust remains committed to delivering effective clinical audit in all the services it provides. The Trust sees clinical audit as essential to its ability to continually evolve, develop and maintain high quality patient and service user centred services.

When carried out in accordance with best practice standards, clinical audit:

- ✓ Provides assurance of compliance with clinical standards
- ✓ Identifies and minimises risk, waste and inefficiencies
- ✓ Improves quality of care and patient outcomes

The Trust is committed to ensuring that clinical audit delivers these benefits, and has developed a policy on the governance and practice of clinical audit, which applies to all staff (see draft clinical audit policy).

Achieving the objectives set out in this 2022 – 2024 strategy will ensure that the Trust policy is implemented and effective, resulting in sustained improvements and directly contributing to the Trust Vision of 'quality care – for you, with you'.

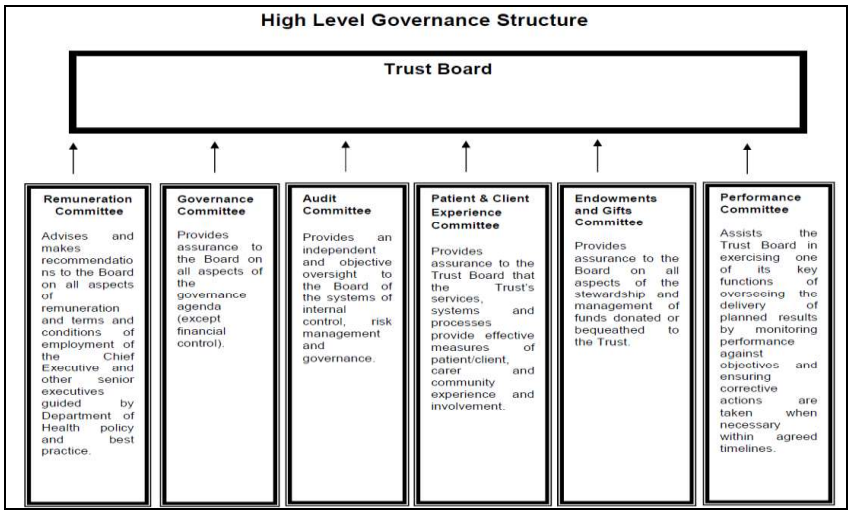
It is expected this three year clinical audit strategy, in line with the Trust's wider clinical and social care governance and corporate assurance mechanisms, will inform and enhance the process of learning and improving services.

Dr Maria O'Kane
Medical Director

1.0 Organisational Context - Governance and Assurance Structures

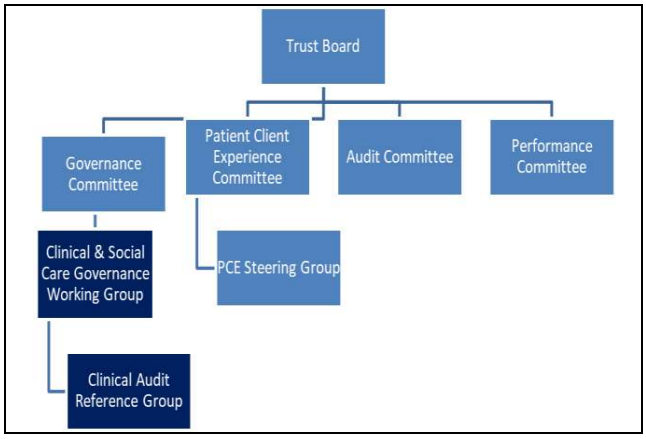
1.1 The role of clinical audit as a tool for **corporate assurance** sits within the: **Board Assurance framework**[1]**(June 2021)** where clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care. This assurance is provided through the Committee structure to Trust Board, primarily through the Governance Committee.

Figure 1 - High Level Governance Structure



The Medical Director as Executive Director with responsibility for Clinical and Social Care Governance sits on and reports to this committee along with other members of the Senior Management Team via quarterly meeting and reporting schedules. The reporting schedule provides information and assurance to support decision-making and effective operation of the Trust at all levels. In reviewing the Governance Committee sub structure a new CSCG working group[2] (see Fig 1) is being established and a proposed **Clinical Audit Reference Group** will be one of 18 groups which will report to it.

Figure 2 - Proposed Trust Governance Structure



[1] Pages 6 & 7

[2] Title to be agreed

1.2 The role of clinical audit as a tool for **corporate governance** sits within the:

Integrated Governance Framework (IGF) (2017/18 – 2020/2021). This framework incorporates arrangements for delivering clinical and social care governance, through which HSC organisations are accountable for continually improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in care will flourish[3].

The IGF designates the Medical Director as the Executive Director with responsibility for strategic leadership for risk management and clinical and social care governance. This includes the development of the strategic approach to patient client safety initiatives, patient client liaison (management of complaints and users views), litigation, **effectiveness and evaluation** (this includes standards, guidelines and **audit**) and risk management.

These corporate frameworks ensure SHSCT position's it's clinical audit function to assist meeting it's statutory, mandatory requirements for providing safe and effective care[4]. These 2006 Quality Standards and Quality 2020[5], require all HSC organisations to have in place a comprehensive programme of evidence based practice, research, evaluation and quality improvement activities that includes healthcare professionals participating in regular clinical audit. This is reported on annually in the SHSCT Annual Quality Report.

1.3 The choice of national, regional and local clinical audit topics is central to supporting these key aspects of governance and quality reporting and in developing an annual clinical audit work programme that considers:

a) Clinical effectiveness: examining clinical outcomes and making improvements

b) Evidence-based practice: ensuring practice is based on current research findings

c) Clinical risk management/patient safety: auditing in response to concerns highlighted proactively by risk assessment and reactively by adverse incidents

d) Complaints and other forms of patient feedback: auditing in response to themes arising

e) Service improvement: involving transformation teams in discussions about clinical audit topic choice

f) Regulation: ensuring requirements such as the fundamental standards of the RQIA are being met.

1.4 Clinical audit also has role in supporting professional and other corporate governance functions:

a) Consultant appraisal, revalidation, and health professional registration: enabling clinicians to comply with their professional codes of conduct

b) Information governance: ensuring that clinical audit activity meets the requirements of information governance legislation

[3] A First Class Service, DOH 1998

[4] The Quality Standards for Health & Social Care, Supporting Good Governance and Best Practice in the HPSS (2006)

[5] Quality 2020 - a ten year strategy to protect and improve quality in health and social care in Northern Ireland (Nov 2011)

c) Patient and public involvement (PPI): ensuring that service user voices are central from planning to delivery, using insightful methods of listening and working in co-production with patients, families and carers to improve outcomes

d) National recommendations and guidance: issued by national bodies such as the National Institute for Health and Care Excellence (NICE), the Clinical Outcomes Review Programme (CORP – covering National Confidential Enquiries and Inquiries), National Clinical Audit and Patient Outcomes Programme (NCAPOP), and national service reviews

e) National Service Frameworks: defining standards of care, e.g. for cancer, coronary heart disease, chronic obstructive pulmonary disease, diabetes, kidney disease, long-term conditions, mental health, old age, and stroke care

f) Litigation Services: clinical audit used to assure that care processes have improved.

g) Research and development: mutually supportive of clinical audit

h) Service evaluation: clinical audit may form a part of service evaluation projects

i) Statements of Internal Control: clinical audit's contribution to the process by which an organisation gains assurances about the quality of its services and the effective management of risk.

1.5 This second SHSCT clinical audit strategy seeks to build on the work of the 2018 strategy, specifically addressing areas where the clinical audit function requires strengthening in providing a common framework for delivery across the whole organisation. This to ensure that the clinical audit activity delivered in each Directorate, Division or Service area:

- follows best practice guidance,
- is rigorous and adequately supported and resourced and the
- outcomes are utilised robustly to inform assurance processes as the foundation of our quality improvement efforts underpinning the Trust's Patient Safety and Quality Improvement Strategies.

1.6 The value of such a strategic audit approach across the organisation is realised within the clinical assurance process, when the improvements arising as result of audit recommendations are further measured and we demonstrate that improved practice has been sustained on an on-going basis.

2.0 Scope

This strategy is intended to inform, support and apply to all staff working in the SHSCT who have an interest in and responsibility for contributing to and overseeing the development, direction and delivery of national, regional and local clinical audit activity. This will includes clinicians and practitioners, clinical audit & QI leads, corporate clinical audit team, Medical, Nursing, AHP and Social Work leaders, Governance Teams, Service Managers, Senior Management Team and Trust Board committees and reference groups. The clinical audit policy contains a full description of roles and responsibilities of those involved in clinical audit in SHSCT.

3.0 Definition of Clinical Audit

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. They are an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices and are acknowledged as the leading voice on clinical audit.

HQIP's definition of clinical audit is used, as follows:

"clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes"

4.0 Strategic Aim

The aim of this strategy is to use clinical audit[6] as a process to **assure clinical quality** at all levels of the organisation over the next three years. The strategy focuses on **creating a culture** that is **committed to learning** and **continuous organisational development** through **measurement of evidence-based practice** to deliver **demonstrable improvements** in patient and service user care.

5.0 Objectives

5.1 SHSCT is committed to developing a number of areas of clinical audit practice throughout the lifetime of this three year strategy to achieve the strategic aim. The action plan contains objectives supported by actions that are **Specific, Measurable, Achievable, Relevant, Time-based, Evaluated, Resourced** (SMARTER).

5.2 Explicit SMARTER objectives covering aims for improving clinical audit practice are:

Strategic Aim 1 – Use clinical audit to assure clinical quality at all organisational levels

- To overcome barriers to healthcare staff participating in clinical audit
- To develop a partnership approach to clinical audit within directorates and supported corporately
- To ensure that staff have the necessary competency, support and time to participate in clinical audit

Strategic Aim 2 – Create a culture committed to learning and continuous organisational development

[6] Includes a range of health and social care professionals

- To link clinical audit to appraisal and revalidation
- To demonstrate and celebrate the benefits of clinical audit
- To ensure clinical audit activities are fully integrated with other quality improvement approaches and programmes

Strategic Aim 3 - Measurement of evidence-based practice to deliver demonstrable improvements in patient care

- To establish a robust system for reporting the outcomes of clinical audit activity
- To ensure that the Trust is fully compliant with the requirements of the National Clinical Audit and Patient Outcomes Programme (NCAPOP)
- To ensure organisational compliance with regulatory standards

6.0. Operational Action Plan (SMARTER Objectives)

Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Resourced

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 1 - To use clinical audit to assure clinical quality at all organisational levels						
Objective 1. **To overcome barriers to health and social care staff participating in clinical audit**	**S** - Delivery of a stakeholder engagement exercise to identify 'as is' position across Acute / CYP / MHD / OPPC. **M –** No. Surveys Requested & No. of Responses **A –** Dependent on level of stakeholder engagement **R –** First stage in any QI process is understand the current system **T –** Outcome by 30/06/2022 **E –** Results analysed for RAG rating and what works well / requires improvement **R –** Conducted by Head of Service	Head of Clinical Audit	DMD – Improvement Group MDO – Governance SMT	Priority for response during sustained C19 pandemic period Low response rate Low confidence of resulting in change Variation in how directorates engage	Analysis of surveys responses how CA is embedded in directorates (RAG Status) Qualitative information on what is working well and areas of improvement required.	30 June 2022 Annual Monitoring

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 1 - To use clinical audit to assure clinical quality at all organisational levels						
Objective 2. **To develop a partnership approach to clinical audit**	**S –** Produce updated strategy and develop policy document, SoPs and annual programme **M –** High level documents produced, consulted, uploaded to SharePoint and disseminated. **A –** Drafting completed January 2022 for consultation and dissemination by March 2022 **R –** Updated governing documents required ensuring partnership roles and responsibilities and aims of clinical audit programme are clear and understood. **T –** Strategy completed by 30/06/2022 with supporting documents 31/12/2022 **E –** Documents will be consulted upon and agreed. **R –** Head of Clinical Audit	Head of Clinical Audit	DMD – Improvement Group MDO – Governance SMT	Integration with other Corporate documents e.g. - Patient Safety Strategy - QI Strategy - People Strategy Engagement with consultation / feedback / comments	2nd Clinical Audit Strategy New Clinical Audit Policy and Procedures Manual Annual Audit Programme	30 June 2022 To lead to establishment of the Clinical Audit Reference Group (CARG) 31st December 2022

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 1 - To use clinical audit to assure clinical quality at all organisational levels						
Objective 3. **To ensure that staff have the necessary competency, support and time to participate in clinical audit**	**S –** To develop a resource plan that incorporates the staffing to deliver, to support the delivery, monitoring and reporting, as well as the training needed across the organisation. **M –** Staff identified, staff in post, roles identified, job planning (clinical leads), job descriptions, training plan and resources, corporate support and monitoring team. **A –** Phased approach to implementation dependent on funding, recruitment and training roll-out **R –** Progress monitoring across year 1, 2, and 3 **T –** Resource Plan submitted to SMT by 31/01/2021 **E –** External organisation resources used as benchmark **R –** Head of Clinical Audit	Head of Clinical Audit Head of Patient Safety Data & Improvement	DMD – Improvement Group MDO – Governance SMT Clinical Audit Reference Group	Separation of Patient Safety from Clinical Audit Function Recruitment of new staff posts Identification and delivery of training programmes	2nd Clinical Audit Strategy New Clinical Audit Policy and Procedures Manual Annual Audit Programme Annual Analysis of participation including patients and service users and doctors in training and	Resource Plan sign-off 30/06/2022 6 monthly Progress Reporting to: Clinical Audit Reference Group Dec 22 Jun 23 Dec 23 Jun 24 Dec 24

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 2 – Create a culture committed to learning and continuous organisational development						
Objective 4. **To link clinical audit to appraisal and revalidation**	**S –** Development of a robust system for linking information on clinical audit into individual appraisal of doctors. **M –** Annual no. of medical staff appraisals containing audit activity. **A –** Dependent on 'searchable' database functionality and central team capacity to deliver. **R –** Requirement of the supporting information needed for GMC re-validation Your supporting information - quality improvement activity - GMC (gmc-uk.org) **T –** First submissions - Autumn 2022 **E –** Annual Feedback from Appraisers and Appraisees of value added to Re-validation Process **R –** Part of the responsibility of a resourced corporate clinical audit team.	Clinical Audit Manager Clinical Audit Assurance & Improvement Manager Head of Clinical Audit Senior Re-validation & Appraisal Manager	MDO – Governance SMT Clinical Audit Reference Group	Searchable central register Compliance with audit registration process Availability of Action plan / re-audit information	Clinical Audit re-validation scorecard for clinical audit / QI activity that will support the appraisee in demonstrating and reflecting on the quality of their work Annual feedback from Appraisers and appraisees	6 monthly progress update - new process to be established. Dec 2022, Jun / Dec 2023, Jun / Dec 2024

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 2 – Create a culture committed to learning and continuous organisational development						
Objective 5 **To ensure clinical audit activities are fully integrated with other quality improvement approaches and programmes**	**S** – To ensure QI / Clinical Audit strategies are mutually supportive and complementary **M** – Audit registration / QI plans note if another method of QI has been considered **A** – To be completed **R** – Clinical audit as a QI tool is used to check care meets defined quality standards and monitor improvements to address shortfalls identified. **T** – Strategies reviewed by 30/09/2022 **E** – A comparative analysis of both strategies. No. of CA and No. of QI projects **R** – Head of Clinical Audit / Head of Quality Improvement A guide to quality improvement tools – HQIP The tools described include clinical audit; Plan, Do, Study, Act; model for improvement; LEAN/Six Sigma; performance benchmarking, process mapping and statistical process control.	Head of Clinical Audit Clinical Audit Assurance & Improvement Manager Head of Quality Improvement	MDO – Governance SMT CSCGWG Executive QI Steering Group	Prioritisation of work area Stakeholder engagement	Comparative analysis of both strategies Overarching CA / QI schedule Annual Quality Report to contain Clinical Audit section	6 monthly reporting progress – Sept 22 March 23 Sept 23 March 24

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 2 – Create a culture committed to learning and continuous organisational development						
Objective 6 **To demonstrate and celebrate the benefits of clinical audit**	**S –** Each Directorate establishes a dedicated forum for the presentation of clinical audits **M –** KPI reporting of meeting dates, agendas, minutes and outcomes. **A** - To be combined / incorporated within another forum if required to prevent duplication **R –** Service / Directorate CA / QI leads required to provide leadership, set agenda **T –** Monthly, Bi-monthly quarterly depending on directorate, volume of audit activity **E –** Monitor activity against the HQIP 4 stage cycle - Agenda, Attendance, Audits shared, Outcomes, Action Plans, Learning, Risk / Escalation, Celebration **R –** Each CA Forum supported by directorate or corporate audit facilitator	Head of Clinical Audit Directorate Clinical Audit Leads Clinical Audit Assurance & Improvement Manager Clinical Audit Manager Phased recruitment process for clinical audit team	DMD – Improvement Group to establish forum network MDO – Governance SMT Clinical Audit Reference Group	CA /QI leads to be established Meeting overload Lack of engagement / non attendance	Regular scheduled annual timetable of meetings Use of Greatix to: - celebrate / acknowledge participation and - when 4 stage (HQIP) audit cycle has been completed	Project plan for establishment 6 monthly progress updates Clinical Audit Reference Group from Dec 2022 Updates on forum monitoring activity to each meeting

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 3 - Measurement of evidence-based practice to deliver demonstrable improvements in patient care						
Objective 7 **To establish a robust system for reporting the outcomes of clinical audit activity**	**S –** Monitoring Schedule for Clinical Audit KPIs developed and contained in new clinical audit policy **M –** KPIs developed will measure the function **A** - Dependent on robust data flows from a central registry. **R –** Monitoring of clinical audit performance requirement **T –** Quarterly reporting to CARG & CSCG WG and 6 monthly reporting to CSCG **E –** Templated report developed for the CARG that will highlight performance, areas of non-compliance and escalation. CARG will report to the CSCG working group which in turn reports to Governance Committee **R –** Clinical Audit Manager	AD Systems Assurance Head of Clinical Audit Clinical Audit Assurance & Improvement Manager Clinical Audit Manager	MDO – Governance SMT CARG CSCGWG GC	CA /QI leads to be established Forum	Quarterly monitoring reports on KPI compliance - Audits registered - Approved - In progress (HQIP Stages 1 – 4) - Action plan developed - Re-audits - Progress against directorate plans	31st December 22 (Schedule developed) Quarterly reporting

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 3 - Measurement of evidence-based practice to deliver demonstrable improvements in patient care						
Objective 8 **To ensure that the Trust is fully compliant with the requirements of the National Clinical Audit and Patient Outcomes Programme**	**S –** To provide an annual overview of the SHSCT's participation in the NHS England quality accounts list of national audits. **M –** Participated versus non participated audits, progress updates and nil returns **A –** Currently delivered on an annual basis. **R** - requirement to ensure that all relevant audits are participated **T –** annually to November Governance Committee **E –** Provides an updated SHSCT position on the progression of recommendations arising from participation in national audits, including those from previous years. **R –** Clinical Audit Manager National quality improvement programmes – HQIP	AD Systems Assurance / DMD Head of Clinical Audit Clinical Audit Assurance & Improvement Manager Clinical Audit Manager	Governance Committee (GC) CSCGWG CARG	Priority for response during sustained C19 pandemic period Information Governance Constraints preventing data sharing	Annual National Audit Assurance Report - 6 monthly progress update, as required.	November 2022 Annually Nov 2023, 2024 Interim updates, if due May 2023, May 2024

Objective	Action	Responsible Person / Lead	Responsible Forum	Potential Barrier / Constraint	Expected Outcome	Monitoring Date / Completion
Strategic Aim 3 - Measurement of evidence-based practice to deliver demonstrable improvements in patient care						
Objective 9 **To ensure organisational compliance with regulatory standards**	**S –** Develop the high level processes to link S&G implementation to requirement of audit for compliance **M –** S&G indicated audits included as part of directorate clinical audit plan, and enter the audit registration and KPI monitoring process **A –** Dependent on identifying S&G change leads and a CA lead **R –** Potential recommendation of S&G Internal Audit **T –** To be agreed **E –** Audit action plan, outcomes, learning & recommendations to be shared and implemented **R –** Part of the responsibility of a resourced corporate clinical audit team. Measuring the use of NICE guidance | Into practice | What we do | About | NICE	Head of Clinical Audit Clinical Audit Assurance & Improvement Manager Senior Manager Standards Risk & Learning	MDO – Governance SMT CARG CSCGWG GC	Difficulty identifying change leads and clinical audit leads during and following the sustained C19 pandemic period	KPI – no. of audits registered linked to S&G Audits completed with action plan / learning outcomes linked to S&G Re-audits linked to S&G compliance.	To be agreed Entirely new system / process to be developed

7.0 Acknowledgement

7.1 Developing a Clinical Audit Strategy, Healthcare Quality Improvement Partnership (HQIP) – Revised April 2020